University of Alberta

Concurrent Disorders: The Lived Experience of Youth in the Continuum of Alberta Treatment Services

by

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Dedication

For all of the creative and ambitious students out there who have struggled to get their thesis research running and off the ground—it will happen!

Abstract

With the recent amalgamation of Addiction and Mental Health treatment systems in Alberta, I wanted to understand what it feels like to be a youth with both addiction and mental health concerns, in the treatment system. Specifically, I was interested in what it's like to navigate both systems and to see if any headway has been made towards *integrated* treatment. Six youth, aged 15-17 with mental health and suspected addiction concerns, were recruited from a specialized mental health treatment program. They took part in interviews and using an interpretative phenomenological analysis approach, I identified themes in their verbatim interview responses. The major themes included: "Just a Diagnosis", The Power of Home, "We Know What We Need", "We Don't Know Where to Get It" and The Impact of Stigma. The results support service delivery recommendations to enhance addiction and mental health treatment in Alberta.

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Introduction

Concurrent disorder (CD), also referred to as dual diagnosis and co-occurring disorder, is a diagnostic label assigned to someone who has both a substance use and mental health problem at the same time; for example, an individual may have a co-existing anxiety disorder and alcohol problem (Skinner, O'Grady, Bartha, & Parker, 2004). Research indicates that concurrent disorders are common, especially among clients seeking addiction treatment, and that there is a high prevalence of concurrent mental health and substance use disorders (Currie, Patten, Williams, JianLi, Beck, el-Guebaly, & Maxwell, 2005; Minkoff, 2001). When compared to the general population, individuals with schizophrenia are 4.6 times as likely and individuals with bipolar disorder are 6.6 times as likely to have a substance use disorder (Grant, Stinson, Dawson, Chou, Dufour, Compton, Pickering, & Kaplan, 2004). As stated by Rush, Urbanoski, Bassani, Wild, Strike, Kimberley, and Somers (2008), rates of comorbid mental disorders among Canadian substance abusers were relatively consistent across age groups: 15.6% for 15-24 and 25-34 age groups, 15.4% for the 35-44 age group, 15.7% for the 45-54 age group and 10.0% for those 55 years or older. Increasing evidence suggests that concurrent disorder onset occurs during adolescence (CCSA, 2009), which makes improving our capacity for early detection and intervention all the more imperative (CCSA, 2009).

Patients with concurrent disorders face an array of increased lifestyle complications (Dixon, Haas, Weiden, & Frances, 1991; Mueser, Bellack, &

Blanchard 1992; Owen, Fisher, & Booth 1996; Dixon, McNary, & Lehman 1998; Bartels, Drake, & Wallach 1995), including:

- Increased risk of suicide
- Homelessness and victimization;
- Greater symptom severity;
- Poorer treatment and medication compliance;
- More frequent hospitalizations;
- More severe mental health symptoms, hospitalization, and medical non- compliance;
- Disruptive behaviors in comparison to non-concurrently disordered clients.

Like the above listed lifestyle complications for adults with concurrent disorders, the same can be said for youth experiencing a concurrent disorder. Suicide, premature mortality, physical problems, poor functioning and low quality of life are just some of the complications associated with concurrent disorders in youth (Adair, 2009). Once youth start to develop a mental health disorder, their chances of having it develop into a full disorder or having another episode increase. By mid-adolescence, while some youth may outgrow some childhood disorders, adult disorders like depression, panic disorder and substance use disorders emerge as most the most common concern (Adair, 2009). The proportion of adolescents that receive care for a substance use disorder, a mental disorder, or both is below 50% (Adair, 2009). The course of

treatment is challenging and outcome findings are discouraging, with high rates of relapse and drop-out and sustained improvement hard to achieve (CCSA, 2007; Adair, 2009). However, to date, treatment outcome studies are typically not very rigorous and their findings are difficult to interpret and generalize (Drake & Wallach, 2008; Adair, 2009). As reported by Hawkins (2009), youth who abused substances were approximately four times more likely to have co-morbid depression and were two times more likely to have an anxiety disorder. Bukstein and Horner (2010) reported that in a community survey of adolescents in addictions treatment, the majority had a co-occurring psychiatric disorder. They also reported that the most commonly reported disorders included conduct problems, attention deficit/hyperactivity disorder (ADHD), mood disorders (e.g., depression), and trauma-related symptoms. Adair (2009) states that the majority of adolescents seeking services are likely to have mental health diagnoses, substance use concerns and social, behavioral and familial problems. Kaminer and Bukstein (2008) state that in community surveys of youth with a substance use disorder and samples of teens in addiction treatment centers, the majority had a co-occurring non-substance related mental disorder (e.g., 63% in the Drug Abuse Treatment Outcome Study; Hser et al., 2001). They also state that more than half of teens in addiction treatment have three or more co-occurring psychiatric disorders, with the most common disorder being ADHD or conduct disorder. Yaminer and Bukstein (2008) further identify that community surveys predicted that youth with a childhood mental illness generally initiated

substance use at an earlier age.

The high rates of concurrent disorders among youth and the poor integration of treatment services pose challenges to successfully treating these youth. Bukstein and Horner (2010) state that adolescents with co-occurring disorders often fail to receive effective treatment, if any, because of the failure to detect the concurrent disorder. Although both mental health and addiction concerns are considered psychiatric conditions and are in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV; APA, 1994), the concerns are targeted by two, distinct treatment systems that differ in terms of assessment and treatment protocols--hence the problems screening, detecting and addressing both addiction and mental health concerns at once.

Yaminer and Bukstein (2008) mention that, for the last ten years, the National Institute of Drug Abuse has recommended integrated treatment for co-occurring disorders as one of their nine core treatment principles. They state that despite the existence of evidence-based practice guidelines, implementation of integrated treatment has been slow. Hawkins (2009) reports that a model for concurrent disorder treatment has not yet been widely accepted and, as a result, specialist certifications or the establishment of dually certified/licensed practitioners has been slow to occur. This means that while the demand to have staff trained for concurrent disorder treatment is urgent, it represents a financial burden for the individual service provider to invest in the training and, thus, there are few providers at the local level that are knowledgeable and capable of

treating concurrent disorders.

Bukstein and Horner (2010) assert that services for adolescents in the United States involve parallel systems of treatment for substance abuse issues and psychiatric concerns. They state that the education, training, and professional requirements have varied between the mental health and substance treatment systems with cross training opportunities only now starting to emerge between both systems. Bukstein and Horner state that there are philosophical differences that exist between mental health and substance treatment systems and these differences interrupt effective treatment planning, efforts at coordination and collaboration, and result in poor communication and disjointed care. For instance, as stated by Reis (1995), mental health professionals including psychiatrists, psychologists, social workers, clinical nurse specialists and other therapists and counsellors including marriage, family, and child counsellors and paraprofessionals, provide varying mental health services. This includes a range of settings, theories and approaches for the treatment of specific psychiatric disorders. Addiction treatment also has a diverse group of practitioners including physicians, psychiatrists, psychologists, certified addiction counselors, and other therapists, counselors, and recovering paraprofessionals, who deliver different types of services. These addiction services also range in treatment goals and philosophies and can include medical detoxification programs, short and long term residential program, methadone maintenance and self help groups like 12-step programs. It is evident that mental health and addiction treatment service

providers have distinct cultures, population of providers and infrastructure. Bukstein and Horner mention that these services also have different funding streams and administrative requirements. These separate funding streams and administrative details further impede system collaboration and coordination, which in turn impedes the development of integrated treatment service processes.

Within the separate mental health and addiction systems, there is consistent evidence that providers under-detect concurrent disorders in their respective patients/clients and services often fail to develop appropriate treatment protocols. Meaning that, even when in touch with services, individuals with concurrent disorders receive suboptimal treatment and have poor outcomes, which can lead to overuse of resources in criminal justice, primary health care, child protection, and women's and homeless shelter systems (Sacks, 2008; Gamble & Ayim 2006; Strathdee et al, 2002).

In Alberta, the needs of people with concurrent disorders have also historically been served by two parallel systems. In 2008, the integration of addiction and mental health services within Alberta Health Services (AHS) provided a unique opportunity to systematically address the needs of clients with concurrent disorders. In 2009, AHS identified 10 priorities for implementation, including adopting a concurrent capable approach across addiction and mental health services. One element of a "concurrent capable approach" is to have a standardized approach to screening at any service entry

point into the system. This approach means that clients will be greeted and screened in a consistent manner across all addiction and mental health services. The approach also means that training initiatives to enhance staff competencies and the identification of appropriate interventions for clients with concurrent disorders will be focused on in all addiction and mental health services across the province (Alberta Health Services, 2009a, Addiction and Mental Health Strategic Plan 2009-2012; Alberta Health Services, 2009b, Report and Recommendations of the Screening and Assessment Sub-group of the Service Delivery Working Group re: Integration of AHS Addiction and Mental Health Services). It is hoped that this approach, while not prescriptive, will improve collaboration between addiction and mental health services throughout the province; however, the specific health zones are encouraged but not required to adopt this approach.

For my thesis study, I wanted to find out how youth with concurrent disorders would describe their experiences within the Alberta treatment continuum. This includes their previous experience with mental health treatment or addiction treatment, and current experiences in a specialized treatment program. I wanted to hear their perspectives on how treatment in Alberta is delivered and, if in their opinion, integration has successfully started to happen. To get this narrative, the interpretive phenomenology method was the chosen as the best fit for this study. As Lopez and Willis (2004) state, interpretive phenomenology is the interpretation of narratives given by participants that provides understanding and context for an experience(s). I relied on the youth's

stories of their experiences to provide the context of what it is like to be an adolescent client with CD, receiving treatment in Alberta.

Interpretive Phenomenology

Phenomenology is the process of understanding how meaning is created through the lived experience and perception of the research participant (Starks & Trinidad, 2007). The phenomenological approach is often expressed in the form of stories or anecdotes, with a goal of conveying a blended story of what the participants experience and feel. The phenomenological approach promotes an enhanced understanding of what individuals live through and how they make sense of their environment (Starks & Trinidad, 2007).

As Harper and Thompson (2012) state, phenomenology is the process of studying an "experience of a being" (p.54). This includes experiencing what the individual experiences and being open to their subjective interpretation of that experience. Harper and Thompson assert that there are two different types of phenomenology: descriptive phenomenology and interpretive phenomenology. Descriptive phenomenology attempts to portray the individual's experience in their own terms, while interpretive phenomenology goes beyond the text and attempts to interpret and find a deeper meaning and place the participant's experience in broader social, cultural and theoretical contexts. Harper and Thompson (2012) state that interpretive phenomenology involves semi-structured interviews, one on one with the participant, with a goal to capture

their story, while the researcher derives meaning from these personal stories. They explain that to analyze this experience, the researcher takes the interview transcript and reacts to it first with their own emotions, statements and themes. This allows the researcher to then go back to the transcript with their biases and reactions out of the way to provide an unbiased analysis. This is called the interpretative phenomenological analysis and includes a line-by-line annotation of the interview, where the researcher looks at every line and captures emerging themes and categories followed by a summarization of the main themes.

Smith (2008) states that interpretative phenomenological analysis (IPA) is effective for a researcher trying to determine how participants see and make sense of their current situations, in both their personal and social worlds. It is the assumption, Smith says, that IPA aims for an understanding of the participants' psychological world, to capture the complexity of the meanings and beliefs associated with the participant's lived experience. Benner (1994) mentions that IPA researchers want to understand the "concerns, habits and skills" reflected in the participants' narratives and actions. These understandings can then be compared to other participants' narratives and actions to look for similarities or differences. Chan, Brykczynski, Malone and Benner (2010) state that IPA is dedicated to finding the meaning an individual experiences in a specific world or social situation, and to articulate daily actions, scenarios and circumstances that people experience. Ultimately, IPA's goal is to articulate the

shared meanings that emerge in a specific context or situation (Smith, 2008; Koch, 1996).

Methods

Treatment Context

Adolescents that participated in this study were in a voluntary residential, specialized mental health treatment program for youth aged 12-18 years old. The program is for four to five months in length, dependent on the adolescent's needs, and focuses on treating adolescents who require a higher degree of intensive treatment and interventions, who have had extreme problems with their family life, and who have had problems being able to actively participate in school. This program works on rebuilding the adolescents' relationships with their families by resolving conflict and encouraging the adolescents to continue to work on their personal growth. This program had also recently initiated efforts to integrate mental health and addiction interventions, and thus represented an ideal setting for collection of data relevant to the research objectives.

Ethics

The study received ethics approval from Panel B (Health Research) of the University of Alberta Health Research Ethics Board. After approval was received, the treatment centre then granted permission for access to the youth.

Recruitment Process

Adhering to recommendations made by Smith (2008), Harper and

Thompson (2012) and Larkin (2011), I recruited six participants. According to Smith (2008), IPA study sample sizes depend on the degree of case study and the level of analysis/reporting, the richness of the individual cases, and the constraints the researcher is operating under (such as, access to the specialized population I needed). He states that four to six participants is a reasonable size for a project as it allows exploration of engagement with participants, richness of the analysis, and examinations of similarities and differences along with convergence and divergence. Larkin (2011) states that a sample of three to six participants is a very good size for any IPA study.

IPA studies have small, homogenous sample sizes due to the detailed analysis that is required. Crist and Tanner (2003) state that IPA studies need to have inclusion criteria that ensure a homogenous sample in order to determine what a particular experience means to a particular group of people. I had previously struggled to gain access to adolescent treatment centres, with the original intention of seeking youth with addiction issues. However, I was lucky enough to have a committee member connect me with the Director of the center, who agreed to grant me access to this specialized population. To initiate the research involvement, the Director of the treatment centre and I had a face-to-face meeting to explain my research intent. After his approval, I met with the treatment staff to explain my research. The treatment staff were key in pointing me towards the youth suspected of drug use. I then had a face-to-face meeting with twenty nine parents/guardians to explain my research; those parents who

were interested in having their child participate in my studysigned a consent form. Out of those twenty nine parents, eight agreed that their child could participate if they wanted. I then followed up with the eight youth in a one-on-one meeting where six out of the eight youth screened positively for a concurrent disorder and agreed to be a participant in my study. During this consent and assent process, I also asked them for permission to access their documented mental health diagnosis assigned by the treatment team. I discussed the study with each of the six youth and described their role, and, if they were still interested, we set up an interview. This was an effective method and it also allowed for early relationship and trust building with each youth.

Inclusion Criteria

Inclusion into my study required that youth had both a mental health disorder and substance abuse issues.

Screening for CD

To ensure proper inclusion of a homogenous sample, I had the youth complete a short concurrent disorder screen. I used the Global Appraisal of Individual Needs – Short Screener (GAIN-SS), a 3-5 minute screen designed to accurately identify clients with addiction and mental health concerns. It is a 20-item tool with 4 subscales that address:

- Internalizing disorders (somatisation, depression, suicidal ideation, anxiety, trauma)

- Behavioral disorders (attention-deficit/hyperactivity disorder, conduct disorder)
- Substance use disorders (abuse, dependence)
- Behavioral crime/violence (interpersonal violence, property crime) (Chestnut, 2010).

A score of 5 or higher on the GAIN-SS is considered "moderate" and confirms that the youth has both an addiction concern and mental health concern. Scores for the six participants can be found in Appendix 3.

Participants

Six youth with a concurrent disorder took part in this study. Brian (16 years), diagnosed with Attention Hyperactivity Deficit Disorder (ADHD), Anxiety Disorder and Alcohol Abuse; Georgina (16 years), diagnosed with Major Depressive Disorder (MDD) and anxiety disorder; Penelope (15 years), diagnosed with ADHD, conduct disorder and bipolar disorder; Tasha (16 years), diagnosed with MDD and Anxiety Disorder; Rebecca (17 years), diagnosed with Conduct Disorder, Unknown Substance Abuse, deferred ADHD(combined type) and Unknown Substance Induced Psychotic Disorder, in remission; and Tatum (15 years), diagnosed with ADHD and Oppositional Defiant Disorder. Participant names and identifying treatment centre information have been changed to respect confidentiality. Research indicates that 50% of adolescents with mental health issues will have or have had substance abuse issues and vice versa. The

population of this treatment facility can be characterised by concurrent disorders and thus represents an ideal population to access. It is also provides an opportunity to look at a treatment setting within AHS, to see if integration of mental health and addiction services has started to happen. (See Appendix 3 for diagnosis and GAIN-SS scores.)

All six youth mentioned in their interviews that they were trying to achieve abstinence while in the program, but were still using substances periodically (except for two of the youth undergoing regular drug testing procedures).

Structured Interview

I conducted 60 minute, semi-structured interviews. To develop my interview guide, I drafted the questions I wanted the youth to answer, and then routed these questions through two experts in qualitative studies. I had an Assistant Professor in the Department of Educational Psychology, a known expert in interpretive phenomenology, edit and approve my questions. From there, the draft interview was routed to a psychiatrist and Director of the Pediatric Complementary and Alternative Medicine Research and Education Network (PedCAM) to approve a final set of questions. This final set of questions was then sent to my committee for approval. (See Appendix 1 for Interview Guide.)

Interview Procedure

I was able to briefly meet and talk with each youth and their

parent/guardian, prior to the semi-structured interview, to build a rapport with them and hopefully enhance their engagement and trust in the interview process. Before any recordings were done, I explained in detail my research and my plans for the interview, and asked them for their thoughts or concerns before we got started. I found that this 15 minute introduction allowed them to relax and know that I was only there to get them to tell their stories; my agenda was made clear. I then met with each youth and engaged in the 60 minute interview with them. During the interviews, I had my guide close by but I did move the order of questions around as per the flow of the conversation, in order to retain flexibility with the interview process. As a result, I was able to have a relaxed and open conversation with each youth.

Approach to Analysis

Interviews were recorded and transcribed verbatim, using the transcription program Express Scribe. The transcribed interviews were then checked for accuracy by two blind readers. To ensure credibility of my data, as recommended by the literature, I maintained a field journal to capture my experiences of each interview, along with documenting any physical expressions, gestures, observations and any obvious themes that I noted during the interviews. These field notes were incorporated into the interpretation process. After each interview was transcribed, I compared transcripts to see where the youth had similarities in perceptions and understandings, where they had differences, and where themes converged or diverged. Before I went into the

coding of each transcript, I consulted with Dr. Michael Larkin of the University of Birmingham, a Senior Researcher in the Department of Psychology and a prominent interpretive phenomenology researcher. He offered helpful suggestions and literature on how to go about the coding process and I double checked my coding process with him once I got started.

It was important that I read and re-read the transcription of each case to understand the content well and to document any insights that emerged (Crist & Tanner, 2003). Moving sequentially across interview transcripts, I documented similarities, differences, contradictions, or duplication of a specific point of what was said in each transcript, along with my own interpretations and thoughts regarding the transcribed material (Sandelowski, 1986). I followed the recommendations made by Sandelowski (1986) and Smith (2008), and listed each emergent theme on a separate piece of paper. It is recommended that the researcher refer to these emergent themes often while going through the interview transcript. While this happens, the researcher is interpreting what the participant is saying, while also comparing their interpretations to the transcript of what the participant said (Sandelowski, 1986; Smith, 2008). They identify that the next step is to organize the clustered themes and compile them in a table format. This helped me to keep my material organized and made it easy to refer back to the coded material when checking and confirming themes. Each theme is then given an identifier to trace back to the context in the original transcript (Smith, 2008). See Appendix 2 for identified and coded themes.

Once each interview has been analyzed, all of the major themes of each transcript are compiled in a table format. As suggested by Smith (2008), I retained the themes that reflected the most richness in my interview material and highlighted those segments of each interview that I felt best reflected the evidence for my thematic interpretations. I also took these final themes and the analysis process and verified the process was done correctly with Dr. Jacqueline Pei in the Educational Psychology department with the University of Alberta. Dr. Pei has experience working with the IPA method and confirmed the analytical process was executed correctly.

Analytical Procedure

In summary, and as recommended by Shinebourne and Smith (2010), the following IPA analytic procedure was followed:

1. In the first stage, each transcript was read and re-read to identify emergent themes. Themes were underlined and comments and notes were recorded in the left-hand margin of the transcript.
2. The next stage examined the major themes and how these clustered together according to conceptual similarities. Thematic clusters were given a descriptive label that conveyed the conceptual nature of each of the themes. As the clusters emerged, the transcripts were checked to ensure that the connection with what the participant had actually said was maintained (see Appendix 2).
3. Themes of all transcripts were compared and a master table of themes

was created (see Appendix 4). This process was iterative and required repeated returns to the data to check meanings.

4. In constructing the final table of themes, it was necessary to prioritize and reduce the data included in the individual tables. In selecting, I took into account the richness of the data and the capacity to highlight the themes and accounts as a whole. The master themes chosen and presented are themes that have been interpreted as central to the participants' experience of treatment, and which also demonstrated links to the current literature.

Results

The master themes that emerged were:

- ”Just a Diagnosis”
- The Power of Home
- ”We Know What We Need”
- “We Don’t Know Where to Get It”
- The Impact of Stigma

“Just a Diagnosis”

Tasha, Tatum, Georgina and Brian all spoke of how treatment services seemed “impersonal.” They mentioned that one of the main reasons seeking services was uncomfortable was because they felt like their concerns had been “medicalized.” From feeling like they weren’t being heard to feeling like they were “just a diagnosis,” the youth articulated how this approach made them feel sceptical of treatment services. As a result, they were less likely to open up and discuss their substance abuse issues and feelings with addiction and mental health staff.

Tasha elaborates on her first experience with mental health treatment and how it made her feel:

> “*…I don’t know…I don’t really remember* ***but I do remember feeling like I wasn’t being heard…****They don’t know background things or know how to take what you tell them and give you coping skills or ways to deal with it by, like, your traumatic experiences and stuff like that. Because not everyone is the same but the way I felt it was like that, everything was the same.”*

> *"I'd rather talk to someone in AHS that is not biased* ***and can actually talk to me and be reasonable and help me out****…".*

Tasha mentioned that when she first went to treatment services she didn't feel like she was being heard by her therapist and felt like she was being placed into a mould of a diagnosis or problem. She stated that if mental health and addiction staff went through the process of getting to know her first versus rushing her through, it would have been a better experience for her. She later talked about how she found a therapist she liked and stuck with that therapist because she had taken the time to get to know her and make her feel it was safe to share her feelings and be open and honest. Tasha also mentioned that her current counsellor in the specialized treatment setting was insightful and helpful to her. She was feeling confident in the progress she was making with her individualized sessions.

Tatum mentioned that the first time he accessed mental health services, he was hospitalized. He stated that he felt like no one really wanted to take the time to get to know him or care enough about him as a person, but, instead, they just wanted to fit him into a diagnosis and assign him to a treatment centre:

> "***I don't know…they don't really care about you, they just want to get it over and done with and kick you out****…they listen but they don't understand…they don't really understand the experiences and stuff we are going through, so they don't really know what to do. They just read stuff out of a book."*

Tatum was the most defiant youth I interviewed. His first experience of accessing services resulted in him being placed into a specialized hospital unit for

observation, and the impression left on him on was that the staff didn't care about who he was. As a result, his engagement and trust in the treatment process was minimal and he felt like he was "only a diagnosis." Tatum stated that once the treatment staff had felt comfortable with a diagnosis for him, they sent him home. He felt like he was a specimen under observation and that his symptoms were matched up to what was said in a book and he was then pushed out of services once they figured it out:

> "*They get straight to the point and they don't really care about what you say or what you are doing. They just want to get it over and done with and try to fix you.*"

This experience left a negative impression on Tatum and he does not seem to have gained any more trust in the system or services as a result. Throughout the interview, Tatum spoke negatively of the workers in the mental health system he has come in contact with, all of which could be related to his introduction to services during the initial hospital admission. Tatum mentions that the first time he was hospitalized, he was trying to joke around but it was not received very well by the staff:

> *"No, but they never joke around, they, like, tackle you. Well, not really like tackle you, but this guy like attacked me when I was in there because I was hiding behind a laundry basket…because I was goofing around.* ***And then he grabbed me and pulled me to the, um, quiet, time out room****."*

Tatum was joking around, and whether it was inappropriate or not, he was "tackled" by a staff member because they thought he was "crazy." Tatum said this scenario made him feel labeled and he was not responsive to his environment as a result.

Georgina mentioned that she felt like professionals she has encountered in the system assume they know what is wrong with her:

> *"..they like to assume they know what you're thinking but sometimes they don't**…I think just hearing people out** because I will tell you what I think is beneficial and if you want to discuss that or you don't think that's right then give me your opinion all you want**. But I think just hearing us out more rather than pulling out your text book and going 'Well, this kid is a kid from an addiction family, that means you do ABCD**'".*

Georgina felt like her therapists and counsellors related more to their medical books then they did to her, causing her to feel uncomfortable in the majority of interactions she has had up until now. Part of this could be related to her own insecurities as well, but her experiences "bouncing around" with counsellors and therapists, with only a few empathizing with her, are telling. She rarely felt heard and often felt under the medical microscope instead. That being said, Georgina also mentioned that her counsellor in the current program was one of the most useful counsellors she had experienced yet, and as a consequence she was gaining insight into her patterns of use and coping strategies.

Brian highlighted the importance of engagement before trying to figure out what the diagnosis or problem is:

> *"Um, well, if you're just starting off seeing this person, I would try to, like, just take it easy for the first couple of sessions and don't go for the mental health right away-**get to know the person and who you are talking to so it's more comfortable.**"*

He also talks about the importance of not feeling rushed, as appointments often are, and again alludes to the importance of feeling less like a number in the system and more like a respected client:

> *"...yeah, I've felt rushed a few times. Actually, the first time I went to see my counsellor I see now for a long time, um**, I was rushed at first and then I kind of told him my thoughts and what I was thinking of being there actually**. And he was like, 'it's totally cool, it's up to you if you want to start but I would rather get to know you first.'"*

The therapist, who took to the time to get to know him before diving into the mental health part of the sessions, ultimately gave Brian a positive experience in the treatment system. This therapist was the first one he had seen and throughout the interview, Brian reports positive experiences and outcomes with the majority of services he accessed. This shaped his impression of what services are like, illustrating the importance of engaging and welcoming clients versus rushing them through appointments and processes.

Georgina mentions how it feels to access the treatment system and that she feels she is labelled and will be treated as such:

> *"I think it's their approach and how they are getting me to deal with it. Like, kids my own age are, like, 'I know how you feel, like, you should get help.' And I'm like 'How?' You go to a hospital and they put you on lock down and they think you're crazy. **So like…is it worth it to get help? Because of the way you're going to get treated**?"*

It is clear that Georgina did not have a positive first experience accessing treatment services and, much like Tatum mentioned earlier, has negative feelings attached to the process of receiving help. Georgina later mentions the label she feels becomes attached to her: *"and feeling like you're just a label and not like a person who needs help."* Georgina's insecurity after accessing services, being judged, medicalized, and further stigmatized, has left her feeling negative about treatment services in general:

> *"…I was filling the prescription a lot and started putting the pieces together and they labelled me as an addictive personality, and so don't give her prescription drugs that are addictive. And so as soon as that happened, I was like,* ***'Ugh! Now I'm a label in the system.' So now I just feel, like, useless and going nowhere and where's my life going to go?****"*

She also spoke to her negative impression of doctors and how when you access them and tell them your problems, they immediately prescribe medication:

> *"And, like, doctors specifically are not good with that. Like, I'd tell them that I had depression and they were like****, 'oh, well, here's some pills' and I'm like, 'ok, I have a problem but, ok, I'll take them****.' Like, so you can't really go to your doctor because they don't refer to you to the right people."*

When Georgina approached her doctor with concerns, instead of being offered treatment or referrals, she was offered a prescription. This depleted the confidence that Georgina may have had in the system as well; Georgina has watched the system fail her parents, indicating that perhaps her negative opinion was also shaped at a young age.

The Power of Home

The youth specifically spoke about their home environments and identified that this environment either positively or negatively impacted their mental health and substance abuse issues. A supportive home environment can act as a protective factor to youth, especially youth with a concurrent disorder, or it can act as an additional risk factor (Francis, 2011; Mallet, Rosenthal and Key, 2005).

<u>Positive home environment</u>. Brian has a respectful relationship with his adoptive parents and mentions that he felt relieved when he was caught using

drugs, thereby forcing him to get the services he needed: "*Yeah, well once my parents found out, it was a lot easier to go because I didn't really want to disappoint them or lose respect and stuff like that."* Later, he speaks of how his parents wanted him to enter a specialized program:

> *"Um, cause some of my friends were in it and, like, we were talking about it afterwards and they were, like, 'it didn't really help so I wouldn't suggest it', going there.* ***And then my parents kept pushing me and pushing me to go and I was like 'ok, I might as well try' and everyone is different so I might as well try it****."*

Brian has a positive and respectful relationship with his parents and part of the reason he entered treatment was to avoid disappointing them. He has had generally positive experiences being in treatment and his supportive home environment has been a contributing factor to his success in the rehabilitation programs he has accessed. He values his parents and their opinions affect his outlook on treatment and the decisions he makes.

Penelope spoke about the importance of having her parents as supports. When asked what advice she would give to youth in a similar situation, she said:

> *"****Tell them to tell their parents so they can get more support*** *and their parents can feel what they are going through and get them all the support they need and all that."*

Penelope encourages youth to tell their parents so they (the parents) can understand what they are feeling and can offer the support they need. She identified the importance of telling her parents that she was struggling with mental health and substance abuse issues and the support they subsequently offered her. Penelope has developed a more positive, functioning relationship

with her parents since she accessed treatment services and started seeing results. This positive home environment has enabled Penelope to mature and work on her communication skills while also stabilizing her mental health and substance abuse issues.

Tasha was asked about the important supports in her life that have helped her in recovery:

> *"My mom, my auntie, um…my friend Mark (who is now sober)…cause I used to do drugs with him all the time.."*

When asked if she wished she had any other supports she responded: *"my dad, because I haven't seen him in a year…and so….or so…yeah. It's been a long time."* This statement can reflect the hurt Tasha feels about the absence of her father in her life. It also can speak to potential abandonment issues, a possible trigger for drug use. However, she does mention that she has some strong maternal figures in her home life that she feels comfortable talking to, so it gives her hope that she will maintain her sobriety and stabilization when she leaves the current program.

Rebecca spoke of her mother's support and how it has helped her to want to get better:

> *"Um,* ***my mom was really strongly into my well being and my health****…she loves me….and she just wants the best for me so she did what she had to do."*

Rebecca's mother had to call the police to have her entered into a court-ordered drug recovery program for youth. While there, she was transferred to an inpatient hospital setting where she was later diagnosed with drug induced

psychosis. She stated that she was originally really upset at her mother but now is grateful for her mother's intervention and the support of her family. She mentioned in the interview that she is thankful for the support of her family while in recovery and feels like she can tell any of them how she is feeling. Rebecca has since stabilized both her addiction and mental health symptoms in the current program and, with the support of the staff and her family, has recognized her pattern of use and how it has been negatively affecting her life.

Negative home environment. Georgina spoke of how her parents impeded her recovery with her mental health and substance abuse issues by their lack of support:

> *"My Aunt was a big help too, but other than that just, like, figuring out things by myself and **parents are a big, can be a big problem with kids with mental health disorders.** Because, like, I used to cry all the time for no reason, like when my depression was really bad, and my dad was like 'snap out of it,' like, 'stop crying,' like, 'what girlfriend problems are you having at school right now' and I'm, like, 'you don't get it.'"*

Georgina mentions later in the interview that both of her parents suffered from a concurrent disorder and did not offer their support to her growing up because they never acknowledged that they had mental health and substance abuse issues. Georgina alludes to the fact that she wasn't taken seriously in her household with her substance abuse issues and that mental health and substance abuse were not topics she was allowed to address:

> *"And, like, both my parents have depression and really bad anxiety and blah, blah, **but it was never spoken about in my house**. Yet, I would find my dad's prescription and would Google the name of the med and it would be an antidepressant and so I was like 'ok, well, depression obviously shouldn't be talked about' because I've never heard of it though*

I knew what it was. ***So it was just like, well, I have it too. But I can't talk about it cause that's what I wasn't told."***

This lack of communication and negative home life experiences set Georgina on a path of her own concurrent disorder. She was encouraged not to speak about her problems and was left to figure things out on her own. Georgina's home environment could be seen to be negatively impacting her treatment trajectory.

The specialized program the youth are currently in addresses a family-centered model of care that features a high level of family involvement in treatment in order to maximize outcomes for both the youth and their families (CASA, 2010). The program helps to resolve conflict that exists within the family and facilitates the adolescents' work on individual growth. This will benefit Georgina as she works her way through the program, especially considering her addiction and mental health symptoms have stabilized. It will also continue to enhance the relationships the youth have with their families while they stabilize in their mental health and addiction recovery.

"We Know What We Need"

Structured services. Throughout the interviews, all of the youth were articulate in explaining the kind of treatment they wanted and acknowledging what they needed to be successful in recovery from their substance abuse and mental health issues. I believed that they all felt empowered explaining what they wanted from treatment services.

The degree of structure offered by treatment was discussed by some of the youth and while it was acknowledged that structure (program that set up

specific hours and activities to set the youth on a routine) helped to stabilize all of them, some liked it and some did not. Brian speaks of the first program he ever accessed and how it lacked any kind of structure, resulting in him not benefiting from it:

> *"….like, you could do whatever you want and you could, like, go for a walk outside the hospital and stuff and, like, I don't know.* ***Just, it didn't really help and it wasn't really structured."***

The lack of structure in the first program he went to did not work for him. Brian mentioned that he wanted structure to help him become stabilized but didn't experience structure until he found the program he is currently in:

> *"And then when I came here, it was, like, actually structured and they actually had authority and stuff like that."*

While Brian admitted that the structure of the program he is currently in can be confining and restraining at times, he did identify the positive effects it had on him in his recovery as a result:

> *"..and I was here for two weeks and I went home on the weekend and my parents could see the changes. And I was like,' wow, this is helping.'"*

Brian feels positive about the changes he has experienced in the current treatment program, and feels optimistic about accessing services in the future as long as they are structured and can help him to gain insight into managing his problems: *"I'll take any help that I can get."* When asked if Brian felt positive about his future moving forward, he answered: *"Yeah, my future and my career and what I want to go for in college and stuff like that."* Brian is experiencing positive outcomes in his treatment program and rehabilitation of his mental

health and substance abuse issues.

Georgina mentions in her interview that she dislikes the structure of the program she is currently in but recognizes the positives of structure as necessary for stabilization of her mental health and recovery:

> *"I think the fact that it's all volunteer (addiction services) is a problem. I honestly think if you get caught with a DUI* ***you should be forced to go to, like, a rehab centre and, like, follow through with it****."*

Georgina's comment is most likely a direct result of her mother's lack of commitment to addiction services and recognizing that her mother required a stricter program to make her accountable and to help her recover. Of her own experiences, Georgina says:

> *"I'm not...I'm 8 weeks clean because I can't leave, so that's a positive and I won't go back to that.."*

Georgina recognizes that being in a structured program has helped her to mostly maintain

abstinence but she dislikes the lack of freedom she feels in the process:

> *"So I guess if I was more forced to take control, I would, it would help more. And saying that is* ***scary because I'm like 'No! I don't want to lose control of my life****.'"*

She mentioned earlier in the interview that she has been in control of her own decisions most of her life, due to the lack of parental involvement, and so having that control taken away from her has been a struggle to accept:

> *"But this program is voluntary but your parents kind of decide for you. But my parents don't really have a position of authority in my life-****I kind of call the shots when it comes to me, so, really, this is voluntary for me too.****"*

Georgina was ambivalent about the structure of the treatment: She saw it as

necessary and helpful but at the same time felt constrained in her usual independence.

Penelope mentions that being in the structured program has helped her to maintain her sobriety:

> *"**I stopped doing drugs because I was being tested**. They said if I started doing drugs they'd keep me longer so I stopped doing drugs. I was like 'I don't want to stay longer' so I dropped the drugs."*

Penelope acknowledges that the mandatory drug testing and the current program structure helped her to abstain from drug use and later reveals in the interview that she was relieved she went through the withdrawal process and didn't require drugs to function afterwards. Penelope also acknowledged that the structure of the environment helped to stabilize her mental health symptoms and mentions later in the interview that she feels positive about her future when leaving the program, and that the counseling and abstinence has made her feel good about who she is: *"Like, I'm not high that much and can see the real world better."*

Tasha discussed the benefits of being in a structured program and although it feels overzealous, it has its advantages, especially with keeping the youth abstinent. She brought up, of her own accord, that mandatory drug testing should be done:

> *"It would make people really pissed off, that's a for sure kind of thing. But I mean, **I think it's something that we need at least once every two months** and stuff like that because….where I'm from…you can get drugs at every other house…like, it's bad…it's really bad."*

Tasha is acknowledging that if she were tested, she would abstain more and not

give in to the urge to use because of the reinforcement. She also mentions that the program she is in has helped her to stabilize her mental health and also stay mainly clean for 16 weeks, with only a few slips of using on the weekends. This is the most clean she has been in two years and credits the structure of the program as one of the keys to this success.

Integration. The youth are in a specialized mental health program where their substance use is in some cases being monitored (i.e., mandatory drug screening) but not necessarily being talked about and addressed in their recovery plans. This reflects that integration of addiction and mental health services in Alberta is a slow- going process and that treatment centres still need to make efforts towards integration. The youth were asked if they felt there could be an easier way to access both addiction and mental health services. The youth spoke of the services being in one site together and the benefits they felt would result from co-location.

Brian spoke of the need for addiction and mental health services to be co-located. When asked what would be the ideal treatment for a youth with substance abuse issues and mental health concerns, he spoke of an co-location of service:

> *"Probably in this program, but, like, with, um, AADAC (addiction counsellors) people. Like,* ***part of the building is AADAC and for strictly drug and alcohol abuse and then this place for the mental health and social health****."*

He identified that having two services in one place would benefit the youth in treatment and mentioned that he would prefer to have access to both a mental health therapist and addiction counsellor in his current program.

Georgina was asked if she thought having addiction support in the intensive mental health program would benefit other youth, including herself:

> *"I think so, I think so a lot. They don't…since we're kids and say we're only an addict for 5 months versus someone like my mom who has been dealing with it for 30 years and now can't, like, hold down a job or whatever…it's kind of like, we're not like, as big of a deal. Cause, like, what do you know about addiction?* ***Like, you're 16 and, like, I don't really want to tell you because it's embarrassing…BUT, a lot****."*

Georgina alludes to not being taken seriously when she tried to address her substance abuse issues in the past, due to her age. She was then asked what she thought would be ideal treatment for youth with substance abuse issues and mental health concerns:

> *"…****I think mental health and addiction go hand in hand****. Like, you don't have to have a mental health problem to have an addiction and you don't need to have vice versa, but usually they go hand in hand. So, I find it kind of odd that I have to go, like, my mom has to go to her therapist and then her addiction counsellor****. I feel like they should be together. It would be so much more beneficial.****"*

Georgina than speaks to the barrier she feels if she wants to tell someone that she has

both an addiction and mental health concern:

> "*I guess it's just harder because I feel vulnerable and like I have to tell 20 hundred people.* ***If it's like one person, who knew your story and knew how to cope with it, and all of your problems, it would be so much easier****."*

Tasha explained how uncomfortable it was for her to be referred to an addiction

counsellor after she confided in her mental health therapist about her drug use:

> *"…like, **she doesn't specifically work on drug addiction**. Like, I don't think she really knows what to say to me. The last time I saw her I was, like, 'yeah, I'm going to do drugs, that's the way it is right now.' Like, I can't change right at this minute and I don't want to because it's my decisions and my choice right now, free will of not doing drugs is just not possible and it's not happening. And she was just trying to explain that, like, it's not good and things and, like**, didn't really know how to tell me because she's not that kind of counsellor**."*

She mentioned her drug use to her therapist but did not feel supported due to the lack of knowledge she felt her mental health therapist had on the topic of addiction. Tasha was then referred to an addiction counsellor whom she did not see because she didn't want to have to go to another appointment. This points out a barrier that youth face with parallel services: going from one agency to another is not the most effective. Tasha was asked if it would be useful if the program she was in right now had an addiction counsellor on site:

> *"If they had an addiction counsellor on site here?…it would probably be really useful for us 'cause I remember the first week I was here and I was crying and upset, and I wanted to just smoke a bowl, and I was furious, and no one would talk to me about it because they don't know how to deal with it. **We need someone who knows how to deal with addiction and knows how to talk and ask about it. It's just mental health right now.** They said they'd probably expand so hopefully in a year from now there will be a drug counsellor here for some kids-that would be good."*

Tasha mentions she would talk to an addiction counsellor on site at the current mental health intensive treatment program, despite not having a positive experience with an addiction counsellor previously. She would be in a position where she would try it again, if it were convenient enough.

Rebecca was asked about addiction counsellor access and she mentioned that at her school, a counsellor came every Thursday and was made available to youth who wanted to talk about their substance abuse issues. She also said that a police officer would come as well and talk with the kids if they wanted. However, the youth had to tell their teacher or school counsellor in advance that they wished to speak to the addiction counsellor which made the option feel less safe and less desirable. That being said, Rebecca said that she talked to the police officer a few times and felt it was somewhat helpful: *"Um, they are nice. They're good listeners, they understand, they can give you good advice."*

Long wait times. Some of the youth spoke of how long wait times to get into treatment deterred their motivation to go. In Alberta, most of the wait times are long due to limited specialized services. The youth told me that the wait times did affect their perceived level of care.

Rebecca was asked if the last few years have been a positive experience for her in the Alberta treatment system:

> "*Yeah. But, it also sucks cause it feels like* ***so long of a wait in the hospital and for the facilities they have****, but in the end, I think it will be worth it."*

So although she has been in places for a long period of time and has also had to be on wait lists to get into specialized services, she feels it's been an overall positive experience and will continue to use the services in her recovery.

Brian was asked if he had to wait very long to get access to either mental health or addiction services in the past:

> *"..um****, I did have to wait and I was sceptical about it****-I didn't really want*

to do it at first but I was, like, whatever. It won't hurt so might as well try it a few times to see how it is."

He was also asked if there was a place where he could go to that would deal with both substance abuse issues and mental health problems, whether it would be useful: "*yeah, cause then I wouldn't have had to wait."* Brian acknowledged the wait times that exist for both addiction and mental health treatment services in Alberta. Overall, Brian has had a fairly positive experience in the system and his positive attitude is a reflection of the support he feels he receives from his parents. He puts a lot of their opinions into his treatment decisions and mentioned a few times in his interview that he did not want to let his parents down.

Georgina spoke of how she felt desperate to get into a treatment program when her drug use was most problematic for her:

*"…**they told me I was on a 9 month wait list**. I was really bad into my, like, abusing medication then and I was like 'I'm not going to make it to 9 months. I will be rock bottom and six feet under by then.' So that was kind of disappointing and I was like**, 'get me in now and what do I have to do.' Like, tell me now because I wanted help.** But a lot of places, like, there is such a long wait list because there is a lot of people that need help.."*

Georgina acknowledges that there are long waiting lists everywhere because "*a lot of people need help*." The long wait list for Georgina did not stop her from accessing the treatment services; however, when she felt like she needed them the most, they were not accessible to her.

As mentioned previously, Tatum was the most defiant youth I interviewed about addiction and mental health treatment. It was quite evident

he did not want to be in any program and mentioned often in his interview that he had been either "forced" into programs or "bribed" by his mother. He stated that:

> *"I thought my life was going pretty good because everything was going pretty good. But then, like,* ***they had us on a waiting list for this place for awhile*** *and this has been the only free space they had so my mom really wanted me to go here cause my doctor ordered it. It's not my doctor anymore, but told my mom this is a good place."*

Tatum and his parents had toured the facility earlier on in the year, but due to the long wait list to access this specialized service, went back to his regular routine until a space was available. He was unexpectedly placed in the program when a space opened up and Tatum was not happy with it as he had changed his mind about the treatment program after he went back to what he considered his normal routine.

Treatment Planning. Treatment planning is a very important component for any health care provider: finding a service that fits the clients' needs is important for their success. In terms of concurrent disorders, treatment planning becomes a very important part of recovery for clients because of their specialized needs. The youth mentioned that being matched with appropriate services would be beneficial to their recovery.

Georgina mentioned how she would value having the decision to actively contribute to her treatment plan. She said she would like to have an active voice in where she goes:

> *"I guess it depends on the kid but for me, I don't think they usually tailor their, the, um, what's the word, um, they tailor the treatment so it's most*

*beneficial to me but in a place like this, it's like cookie cutter**. So to me, mental health treatment should be tailored to you.**"*

When probed about this further, Georgina agreed that essentially she would prefer to sit down with a therapist or counsellor and figure out what kind of treatment services she feels she needs and what they think she needs and work together to make a treatment plan.

Brian spoke of how he took a chance in trying a program but was disappointed in the outcome:

*"…cause I kind of wanted to get help and then after, like, that program was done, **it didn't really help that much so then I was sceptical about going into another one**."*

Brian wanted and needed help when he first accessed treatment, but he was not matched to a program that fit him the first time, and this deterred him from going to another program for 1.5 years after, as a result.

Tasha spoke of how it is tough to trust the system right away for fear of being "bounced" around:

*"**I don't think anyone that's been referred into the AHS mental health system, um, feels comfortable with anyone**…like, I know that if you have to go in for depression and all sorts of mental health stuff, **you don't trust them right away. It's not going to happen until after awhile**. Even if you bounce around, there will be that one that will help out and make it a lot easier but all of that takes time."*

Tasha had seen multiple therapists over the years but connected with a few and that made a difference to her. However, she did mention that she was very happy with the counsellor in her current program and hoped to continue to gain much needed insight in her recovery from mental health issues and addiction.

"We Don't Know Where to Get It"

All of the youth interviewed were able to articulate what they liked and did not like in terms of treatment and treatment approaches; however, they lacked knowledge of the addiction and mental health services that existed in their area. This awareness piece is important for prevention and intervention purposes for youth, especially youth with both substance abuse issues and mental health concerns.

Tatum was asked if he would seek out addiction and mental health services in a few years, if things became difficult, but he indicated that he wouldn't know where to go: *"People don't know where to go to get help. People stick to themselves, I've noticed that."* He also stated that he is not comfortable asking for help and would rather try to "*figure it out on my own"* which he attributed to his pride. Later in the interview, he mentioned that instead of trying to access services in the future, he would try to talk to a good friend instead.

Brian was asked if he would have any suggestions for youth who are just starting to struggle with substance abuse issues and mental health:

> *"...for them to think they are not alone and there is a lot of other kids that need help.* ***And they don't know how to get it or want to get it.*** *And a lot of them think they are alone but if they actually think that, they find out that there is a lot of people like them and want to help and need it, then it will make it a lot easier."*

Brian is acknowledging that youth in general do not know where to go to get help for mental health and substance abuse issues but that they need and want

the services. They may also feel isolated, compounding the barrier to accessing treatment.

Georgina was asked about barriers for youth in accessing services:

> ***"I don't think a lot of kids know of the services.*** *Or, like, well, if I talk to this person, then my parents will find out. They don't know what mental health is like. Like, counsellors in school are not qualified, in my opinion. At, like, at all."*

Georgina speaks to the fact that not a lot of kids know about mental health or addiction services. She also mentioned that while youth do have access to a school counsellor who could spread the awareness of services, the credibility of the school counsellors' competencies, in her eyes, are questionable. She further states that awareness of addiction services is important:

> *"I don't know…just knowing it's around. So many of my friends haven't been to mental health and I'm, like, that's a problem.* ***How do you get help when you don't even know where to go****? …Like, so you can't go to your doctor because they don't refer you to the right people and you can't go to the school counsellor because she is useless."*

Georgina speaks to her lack of trust in the competencies of health care professionals and school counsellors—two introductory points of care into the treatment system. She also highlights the need for awareness of services to be brought into the school system.

Penelope was asked whether or not she would feel comfortable accessing addiction services. With her limited experience with addiction, she has formed a negative opinion of treatment and would be scared to access services because: *"I don't really like going to places where I'm locked inside and can't have a cigarette or my phone."* She mentioned that she had been to an addiction

counsellor a few times, because she had to, but was *"stoned out of my mind"* in the sessions. Her comment also conveys the lack of knowledge she has about addiction treatment services in that she assumes all treatment is very structured and controlled.

The Impact of Stigma

All youth were asked of their impressions of addiction and mental health services and it was evident that they all have very strong perceptions of the stigma attached to involvement in either form of treatment service. As a result, their overall opinions and impressions were negative.

Georgina spoke of her impression of addiction and mental health services:

> *"I don't know**. It feels more like an insane asylum then, like, beneficial for kids come first kind of mental health services**….Um….I've seen my mom in a lot of addiction services that didn't do anything for her."*

Brian stated that his first failed attempt at getting treatment left a negative opinion regarding how he saw all treatment:

> *"..I kind of wanted to get help and then after, then, like, that (mental health) program was done, **it didn't really help that much so then I was sceptical about going into another one**."*

As mentioned earlier, Penelope had a negative impression of addiction and mental health services:

> "*Cause I don't really like going to places where I'm locked inside and can't have a cigarette or my phone. **I was scared that they'd put me in a program and send me away**."*

Penelope also mentioned that her impressions of the services were also influenced by what she saw in the movies.

Tasha reflected a negative impression of addiction and mental health services due to lack of consistent counsellors:

> *"Um, pretty shitty, um, cause, like,* ***I've been through counsellor after counsellor since I was like, 6 years old,*** *after my parents like divorced so….yeah…not very good"*

Rebecca reflected on her impressions of addiction and mental health services and admitted that the stigma she has attached is one where only people with severe mental health issues access services: "*Um…, it makes me feel like…there's a bunch of schizophrenic people….around me. Or, just that's where I'm going to…"* She also reflected on her friends knowing she is part of the system, further reinforcing that stigma:

> *"I'm just afraid that, like, they will find out about my psychosis and not being able to understand****. I don't want them to call me a psycho bitch or something.*** *"*

Tatum stated that his impression of addiction and mental health services are stigmatized and that he felt these services were ***"Um, for like, crazy people."*** He had this stigma reinforced with his first experience of the mental health treatment system and stated that the current program he is in has only further reinforced this stigma, in his eyes.

Discussion

My interviews with the youth revealed some insightful details along with prominent themes. The themes that emerged from the interviews all link to some relevant literature in the field, with implications for the provision of "concurrent capable" treatment services.

"Just a Diagnosis"

Tasha, Tatum, Brian and Georgina mentioned that some of the staff they dealt with in their experience lacked the engagement skills, relationship building skills, or even the ability to ask the right questions when they did access treatment. This resulted in an overall negative impression of addiction and mental health services for the majority of them. In their interviews, both Georgina and Tasha reported that they would be willing to share information with clinicians if they were just asked the right questions, referring to the lack of substance use questions from the care providers in mental health. Cotton (1993), as cited by Pazaratz (2000), states that core treatment components like empathy, communication and structure are key ingredients for the success of youth treatment. Pazaratz asserts that youth workers must be flexible and nurturing to build trust and to become emotionally close to the youth. Schon (1993), as cited by Pazaratz (2000), recommends that youth workers need to also be reflective and allow the relationship dynamic to unfold between the staff and the youth before they can select any course of action, and not to base their actions solely on academic knowledge. Further, Pazaratz (2000) states that if

staff demonstrate genuineness, it provides an atmosphere conducive to counselling. These points are all well made and would benefit the development of relationships the youth I interviewed needed to facilitate engaging in treatment, specifically regarding their experiences before their entry into their current specialized program, and helping to break the negative impression of the "medical model" of services that most of these youth presented. Moreover, it is clearly important that all front line clinicians receive basic training in the behavioural competency of relationship building skills, especially when working with youth with concurrent disorders.

The Power of Home

Parenting can act as a protective factor in the development of substance use so parental-type support is very important. According to a qualitative study of adolescent development by Beam, Chen and Greenberger (2002), it is also very important for youth to have a relationship with a non-parental adult (including other family members) to positively influence psychosocial adjustment. Their research on resiliency has shown that non-parental adult support positively affects high-risk adolescents (see also Cowen & Work, 1988; Garmezy, 1987; Luthar & Zigler, 1991; Werner & Smith, 1982). Further, Beam et al. indicate that more than 80% of youth they interviewed reported having a non-parental adult in their life that had influenced them positively by showing respect, providing emotional support, serving as someone to talk to, and supporting various activities in which adolescents were engaged. They also

stated that half of the adolescents reported that these non-parental adults positively influenced them by helping with school, relationship, personal, and financial issues, as well as serving as a companion and role model. Further, they state that the majority of the adolescents interviewed (60%) said they were able to disclose more to their non-parental adult support than to their actual parents. Georgina, Tasha and Penelope all have positive non-parental adults in their life and mentioned in their interviews that they relied on them for support. This theme also further reinforces the importance of relationship building skills in front line clinicians. Youth in need of a positive non-parental relationship reach out when a sense of trust is established. Tasha and Georgina both mentioned in their interviews that they both bonded with a counselor who they had established a relationship with and were able to confide in them and ask for advice. Relationship building skills are imperative in the treatment of youth, especially those with a concurrent disorder.

Francis (2011) reported that exposure to parental substance use predicted substance use in children (Biederman et al 2000). Further, Francis (2011) describes a study done by Merikangas and colleagues (1998) that examined three groups of parents: (1) parents with substance abuse disorder, (2) parents with anxiety disorders, and (3) parents with no history of psychiatric disorders (control group). These researchers found that youth with parental substance use had a higher rate of conduct disorder, smoking, drug use and overall lower functioning then those with parents who had no substance use or psychiatric

disorders. Georgina, Tasha, Penelope and Rebecca all have parental figures that struggle with substance abuse issues and all four youth have conduct disorder. Francis (2011) also reports that low parental monitoring is associated with sexual risk taking behavior, substance abuse, drug trafficking, school absence and violent behaviors *(*Jaccard, 1996; Li et al., 2000; McNeely, Nonnemaker, & Blum, 2002). On the other hand, Francis describes a number of protective factors for youth, including a consistent parental relationship (e.g., Brian), stabilizing influences from grandparents, relatives, or influential teachers, and high religiosity both individually and as a family (Fleming et al., 1997; Gopfert, Webster, & Seeman, 1996; Merrill, Salazar, & Gardner, 2001). According to Francis, the stronger the adolescent-parental bond, the lower the likelihood that youth will engage in risky behavior.

Luther and Zigler (1991) reported that ego-resilient children come from a home that has competent, integrated, loving, patient and compatible parents, and have a good relationship with at least one parental figure in the home to protect against the risk associated with family conflict and child abuse (Hunter & Kilstrom, 1979). In a study done by Mallet, Rosenthal and Key (2005), most youth reported that family conflict preceded their homelessness and drug use and that most of them linked their personal drug/alcohol use to a strong hostility towards their parents or step parents. Further, they reported that poor parenting reflected by a lack of monitoring, low bonding of parent and child, abuse, family conflict and family substance use, along with relaxed attitudes towards

substance use, have all been associated with substance use in youth. They go on to report that several youth specifically indicated that they started using drugs and alcohol as a direct result of their parents' use. Tasha, Georgina, Penelope and Tatum had experienced parental substance use in the household, and low parental monitoring.

Duncan, Duncan and Strycker (2000) state that family variables like support and time spent with family served as a protection against problem behaviour, while peer variables like time spent with friends and friend deviance were risk factors for behavioural problems. Another protective factor identified by Duncan, Duncan and Strycker was organized activities: the more time spent in organized activities, the lower levels of marijuana use and academic failure. Youth who spent more time with family were less likely to engage in problem behaviour, therefore, family time together seems to serve as a protective factor to problematic behaviour. As identified by all youth interviewed, their peers engaged in substance use and this was a major gateway to their own use and subsequent abuse issues.

The youth in my study all recognized their substance abuse as a coping mechanism in one way or another. Willis, Sandy, Yaeger, Cleary and Shinar (2001) state that negative life events positively predict substance use, a relationship supported by other studies identifying life stress as a predisposing factor for substance use (Chassin, Curran, Hussong, & Colder, 1996; Wills et al., 1992). Thus stress and coping processes are significant factors for early

substance use. Willis et al. (2000) also state that research has shown angry or avoidant coping as a risk factor for adolescent substance use while behavioral coping and problem solving can be protective factors for substance use. Willis et al. state that having effective coping skills encourages involvement in school based activities, thereby reducing the potential to fall into a deviant peer group that may reinforce alienation and lack of control (Newcomb & Harlow, 1986; Sussman et al., 1999; Wills & Cleary, 1999). High levels of stress can not only impair cognitive functioning, but can also steer the youth towards immediate gratifications as behavioral problem solving techniques, as evidenced by Penelope and Georgina in my study. Further, Willis et al. state that failure to successfully integrate effective problem solving skills could resort in youth seeking out other peers who are frustrated and angry; this affiliation with a group can encourage negative behaviors including substance use, a common pattern among the youth I interviewed. Willis et al. state that, moving forward, it is important to consider these coping cycles and consider how school or family based interventions may be designed to avert these types of stress cycles and coping. As mentioned prior, the program the youth in my study are currently in has a family-centered model of care. All service providers in Alberta that work with youth should offer family-centred interventions that include discussing parental attitudes about substance use, enhanced parental monitoring and family communication.

"We Know What We Need"

All of the youth were asked if they thought having addiction and mental health services co-located would be beneficial for them and they all agreed it would be preferred. For integration to be successful, Bukstein and Horner (2010) state that the development of a treatment plan addressing both mental health and substance abuse issues needs to be the first step with both disorders being considered as primary and treated that way. Further, they state that integrated services can offer the opportunity to engage and motivate youth while also offering the additional interventions targeting mental health or addiction issues. Consistent screening, assessment and treatment planning procedures throughout AHS needs to be a priority, especially with regards to integrated service delivery.

Some of the youth in my study were asked by therapists and doctors about substance use but not in the detail required to shed light on the severity of the substance problem. They all had mentioned that once rapport had been built, it was easier for them to divulge information on how much they use/how far their substance abuse issues had gone. Bukstein and Horner (2010) state that, at the very least, treatment centers screening for psychiatric evaluations should determine the possibility that substance abuse issues exist. If a positive screen for substance abuse issues emerges, a more detailed assessment should then be done. As Bukstein and Horner state, substance use is one of several adolescent domains of functioning, and should be included in every functional assessment.

The youth in my study identified the long wait lists for specialized programs for mental health and addiction as a barrier to seeking treatment. As stated by Hadland, Kerr, Li, Montaner, and Wood (2009), in their study with concurrent disorder street youth, the most common barrier for accessing services was excessively long wait lists, preventing 66% of the youth from receiving treatment. Other factors included behaviour being incompatible with the program's rules, being rejected for reasons other than a long wait list or behavioral problem, fees of a program that youth could not afford, not providing the type of service the participant was seeking, or the program being too far from the youth's residence. Hadland et al reported that barriers of excessively long wait lists along with lack of knowledge of available programming were the major factors that impeded youth from pursuing services in their study. These two factors were also alluded to during the interviews in my study.

The Impact of Stigma

The negative impression these youth have about the system, and the stigma that has resulted, needs to be addressed in prevention programs and awareness programs across Alberta. Stigma of addiction services, as mentioned by the youth I interviewed, was also reflected in the study done by Hadland et al. (2009). They reported perceptions that

addiction program rules are too strict and the stigma of the potential lack of confidentiality once in the program deterred youth from accessing addiction services.

Eklington, Hackler, McKinnon, Borges, Wright and Wainberg (2012) assert that the

Surgeon General has identified stigma as “the most formidable obstacle to future progress in the arena of mental illness and health” (U.S. Department of Health and Human Services [USDHHS], 1999, p. 291) and put down the reduction of stigma as an important public health goal. Hawkins (2009) states that stigma is attached to both mental health and substance abuse treatment with youth and that this can negatively impact those youth seeking help. Youth may also believe they are fine in comparison to their peers and therefore do not need any help while parents may fear any social or economic repercussions from seeking out treatment. Moses (2010) reported that parents and family members who communicated the message that mental illness was a negative trait or those who chose to not acknowledge the illness increased youth’s perception of stigmatization within the family. This was described by Georgina who mentioned that she was in a home environment that, despite mental health and substance issues being present, was not able to have open discussions about these issues. This may have further impacted her impression and stigmatization of mental health and substance use issues.

Adolescence is a time of emerging identity in the context of changing physical, cognitive and social experiences. Eklington et al. (2012) state that youth who have a psychiatric illness run the risk of being “labeled” as someone who has a “mental health problem” and thus may be more susceptible to

negative evaluations from peers or others (Donenberg & Pao, 2005). Eklington et al. state that youth with a mental illness acknowledged that their social distinction, in larger society, was not a positive one. However, they found that the degree of experienced stigmatization of mental illness also depends on the individual. That is, while youth reported feeling labeled and judged, in the same way, they were also able to find support and acceptance in other areas like peers or family relationships. Perceived support appears to be a factor in how youth deal with stigmatization. Youth in the study did experience internalized feelings of stigma and shame and reported using other coping mechanisms, like substance use, to manage and minimize stigmatization and rejection by others.

Implications/Recommendations

The results of the interviews with the youth made it clear that Alberta Health Services needs to work harder at providing a seamless and integrated approach to addiction and mental health service delivery. We know this is already a priority and some would argue that this approach is already taking place at other service centers across the province. While the following recommendations focus on addiction and mental health services, it should be noted that these recommendations should be applied system-wide throughout the province.

As Bukstein and Horner (2010) state, concurrent disorder youth are among the most difficult populations to treat. While some service providers in the province have started the integration process, there are others that still need to

catch up. It is also clear that the youth have not experienced optimal treatment for their mental health and addiction issues and improvements need to be made. As stated by Bukstein and Horner, necessary interventions that programs need to integrate treating concurrent disorder youth include: (1) psycho-education interventions, (2) problem-solving skills training, (3) interventions to decrease avoidance/increase positive social involvement, (4) motivational interventions, and (5) family skills training (communication and problem solving). Bukstein and Horner recommend that motivational techniques be used across intervention strategies (both with family and adolescents) to enhance coping skills, relapse prevention, self-efficacy expectations and awareness of high risk situations and behaviors. Georgina, Tasha, and Tatum are all benefitting from their current involvement in the specialized program; the program's emphasis on a family-centered model of treatment plays an important role in these outcomes. They are rebuilding their familial relationships, resolving barriers, and working on their own personal growth. Georgina, Penelope and Tasha also spoke of the advantages that strict drug testing procedures had regarding a promotion of their abstinence and Steen (2010) states on that same note that adolescent integrated treatment policies should impose barriers on access to alcohol, cigarettes and marijuana for prevention. Bukstein and Horner (2010) go on to mention that active drug screening helps to keep the theme of abstinence prominent while in specialized treatment.

Yaminer and Bukstein (2008) state that the high rate of co-occurring

psychiatric conditions and substance use disorders in adolescents highlight the need and importance of having comprehensive assessments of an adolescent's functioning across multiple areas. What was discovered in the study's interviews was that this comprehensive assessment, asking detailed questions about both mental health and substance use, was lacking. Substance use was only touched on in most cases, with no exploration of frequency of use and other details. Georgina, Brian, Penelope and Tasha all mentioned that they would have been open to sharing this information if they were just asked the questions, even relieved if they had been asked about the details of their substance use and its severity.

Yaminer and Bukstein (2008) suggest that integrated treatment and continuing

care interventions need to be matched to adolescents' developmental stage and degree of readiness to change for them to have success in being treated for a concurrent disorder. As stated by Georgina, she would have valued the opportunity to give her perspective on what she needed and negotiate with her treatment team. This process would offer necessary engagement along with empowering Georgina to be more active in her recovery and own the process she needed to follow through on. Brian also mentioned that the first program he was referred to was not effective in what he felt he needed. If he had the opportunity to discuss in detail what he thought he needed and compare with what his doctor had thought, perhaps he would have had a positive first time

experience.

Recommendations regarding the push for integration in AHS treatment services can be made with the results of my study in mind:

Ensure basic competencies of all addiction and mental health staff.

Staff need to be engaging, building relationships, asking the right questions and effectively communicating with the youth they are treating. This may also mean that, as a province, we need to develop a treatment model or pathways conducive to treating concurrent disorders, one that ensures all staff have the appropriate specifications and professional competencies to go with it. AHS may also benefit from sponsoring systematic training workshops on the importance of the therapeutic alliance (Safran & Muran, 2000) to establish those critical relationship skills and behavioural competencies needed when treating youth with concurrent disorders.

Ensure family centered therapeutic interventions are happening in addiction and mental health adolescent treatment facilities.

The youth spoke of the impact that their home environments had on them and they are currently in a family-centered program that is addressing their needs. A recommendation for all addiction and mental health service providers is to include family-centered therapeutic interventions into programming. Family-involvement in the treatment process can be a crucial element in long-term success of recovery from addiction and stabilization of mental health concerns.

Ensure that comprehensive screening, assessment, and treatment planning are

***used for concurrent disorders*.**

All of the youth in my study were "suspected" of using substances and, according to each youth, not one of them were asked the frequency, duration and severity of their use, despite being in a specialized mental health program. The same may be said about addiction services in regards to asking about symptom severity and duration of mental health issues; however, determining whether that is the case would require additional study. What we do know is that mental health and addiction go hand and hand, and as Minkoff (2001) states, concurrent disorders have become the "expectation not the exception" for treatment providers. Implementing a comprehensive screening for both addiction and mental health will help to match clients up with appropriate interventions, and also allow for important relationship building.

***Ensure that time is being spent with each youth*.**

It was mentioned that most of the youth felt rushed during the intake and assessment process when they accessed services. Taking time to build relationships and gaining trust from clients is imperative. System constraints pose a challenge to this recommendation due to the lack of supply versus the demand, but it should be placed as a priority for service providers to take the time to build trust and engagement with their clients, and to get them involved in their treatment planning. This also means funding a larger staff complement to meet the demands currently placed on the service delivery is necessary.

***Ensure emphasis on prevention and early intervention is happening*.**

Alberta Health Services has implemented prevention and awareness campaigns throughout the province and we know that they are happening at the school level. However, the youth mentioned the need to further explore this education in the classroom. Perhaps implementing curriculum based on addiction and mental health would be beneficial. As argued by the youth, discussions of sexually transmitted infections are being had in the classroom, so there ought to be discussions on mental health and substance use to educate all children and youth on the signs of mental illness, the effects of substance abuse issues and the consequences associated with each form of disorder.

Ensuring that wait times are being looked at and reduced.

In Alberta, reduction of wait times in emergency units in hospitals across the province is a priority at the moment. A recommendation would be for service providers to look at quality improvement measures to reduce the wait times associated with addiction and mental health services and specialized mental health and addiction services for youth. It was mentioned in the interviews that the contacts the youth had with addiction and mental health services providers often felt rushed. This recommendation is two pronged: to spend more time engaging with youth also means increasing funding for a larger staff complement to meet the demand.

Ensure that more specialized programs become available throughout the province.

While this may be a less feasible recommendation, it is clear that specialized mental health and addiction programs for youth are needed. There

are currently a small number of programs available across the province, hence the long wait lists. Again, the supply cannot meet the demand and this poses a problem. There is a shortage of treatment services for children and adolescents in Alberta, whether these are for mental health or substance abuse issues and this needs to be addressed. According to the youth that I interviewed, there is also little evidence that integrated service delivery is actually happening within existing services, in a way that moves the provision of services forward in the province. Increased funding and establishment of a greater number of service agencies is to be considered and as a province, we need to ensure that, at the very least, clinicians and staff at all addiction and mental health agencies are able to provide interventions in a "concurrent capable" manner.

Limitations of Study

Several limitations of my study are warranted regarding the generalization of the findings. First, the study group may not be representative of the larger population. While this group was a specialized population that did have concurrent disorders, it may not represent the larger population of youth that access treatment in Alberta. However, two of the youth were from rural areas of Alberta and the remaining four were from urban locations. Second, this study used interpretive phenomenology that has a main focus on interpretative coding and analysis. Analysis of observations could be biased and therefore it may have lower credibility with some administrators and programs. That being said, as part of the IPA method to ensure rigor and to avoid carrying any biases

into the analysis, I did recruit a blind reader to ensure neutrality was maintained in the interpretations and analysis. I also did "open-coding", a process that involves writing my initial reactions and biases to the transcript down to allow myself to acknowledge those biases before I started the line-by-line coding process. Third, this study has a low number of participants due to the method chosen, making it difficult to make quantitative predictions and to test any hypotheses that larger quantitative studies can address. Fourth, this study accessed a specialized mental health program that was looking to start the integration process in their current service delivery. It presents only one side of a complex issue and a comparative sample with a focus on addiction treatment settings engaged in an integration of mental health interventions would be helpful.

Future Research

Prevalence of concurrent disorders among youth in mental health treatment is high. Finding effective treatment for youth with a concurrent disorder is a priority and research is happening in the field. More studies evaluating integrated services versus parallel treatment programs for youth with concurrent disorders are needed. Further, studies addressing whether or not wait lists impede a youth's readiness for treatment and treatment outcomes would be beneficial to this field. Ongoing research on the efforts to integrate addiction and mental health services, along with appropriate treatment responses to concurrent disorders, should continue to be a priority in this field.

Final Thoughts

My experience of interviewing articulate youth, who were willing to share with me how it felt to be in the Alberta treatment system, was surprising and insightful. Their perceptiveness into what kind of treatment they needed and what skill set the clinicians they saw should have, was more detail than I anticipated I would receive. What was most interesting though, was that despite the experiences they have had, whether they be negative, positive, effective or ineffective, all of the youth when asked, felt they had gained more awareness and control over both of their mental health and addiction concerns by accessing addiction and mental health services in their journey so far. This, to me, really depicted the resiliency that these each of the youth have, and the hope for the future they have in their recovery. As service providers, more work needs to be done and more attention and care needs to be paid, but it is comforting to hear that the basic levels of care are being delivered, to a population that needs it the most.

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Appendices

Appendix 1 - Interview Guide

Interview Guide

Intent: To obtain narratives on treatment services from adolescents with co-occurring disorders.

How long have you been in treatment?

Have you had a good experience in treatment? What made it a good experience?

Have you had a bad experience with treatment? What made it a bad experience?

How do you know if/that you are getting better?

What helps you to stay well mentally?

What do you consider to be mental health services?

What do you consider to be addiction services?

Have you ever tried to get treatment for addiction?

What has it felt like for you to be in treatment?

Has it been hard for you to be able to get help for your mental health concerns? Were you afraid to ask?

Has it been hard for you to be able to get help for your addiction concerns? Were/Are you afraid to ask?

Have you had any problems accessing mental health or addiction services? If so, what kind of problems have you run into?

Is there any time where you felt it was easy to get help for either? If so, what made you feel like it was easy?

Is there a way that you think would make it easier for you to get mental health help? What about addiction help?

Do you feel like you have gained more awareness and control over your mental health? Do you feel like you have gained more awareness and control over your substance use?

Appendix 2 - Subthemes

Competencies of the work force:

- Engagement with youth T5/p.12/L174; T6/p.16/L258; T2/p.12-13/L135; T3/p.3/L36; T4/p.1/L12; T5/p.6/L86

- Relationship building; T5/p.12/L178; T6/p.2/L24; T2/p.12-13/L135; T4/p.1/L12; T4/p.3/L38; T4/p.13/L110
- Asking the right questions-in Addictions-asking about mental health and in MH asking about addictions.; T2/p.7/L68-69-71; T3/p.5/L68-76; T3/p.8/L111-114; T3/p.9/L136
- Competencies help the kids to gain trust which leads to engagement in the program and process; T2/p.2/L20; T2/p.12-13/L135; T5/p.7/L92
- Collaborative Treatment planning; T2/p.1/L8
- Less medicalization of the system: T6/p.2/L24-30.; T2/p.2/L22; T2/p.16/L169; 5/p.12/L174
- Treating the youth like a person and not a diagnosis; T2/p.7/L75; T3/p.3/L36; T5/p.12/L174
- Establishing a sense of community.
- Wants feedback on insight and awareness; T2/p.2/L18; T2/p.9/L99-103

Resourcefulness

- Seeking out the information they want. T6/p.8/L124; T2/p.14/L149; T4/p.6/L58-60

Trust

- Building engagement to tell care providers about the feelings. T6/p.2/L24-30. ; T6/p.17/L262; T1/p.7/L105; T1/p.10/L149
- Knowing you can ask for a new counselor or therapist if the current one isn't working out.
- Having trust in the system that it will work. T6/p.8/L124; T6/p.17/L268
- Listening T6/p.2/L24-30. T1/p.10/L149; T2/p.3/L32-p.9/L99-103; T4/p.1/L12; T4/p.3/L38; T5/p.8/L115-118

School

- Curriculum to address A&MH. Just like they have STI awareness, have a whole area devoted to awareness of A&MH T5/p.13/L188; T2/p.13/L141

Support

- Being held accountable*T2/p.12/L132-133; T1/p.4/L63
- Stigma of services and treatment; T1-6-L's 2; T6/p.17/L271: T1/p.6/L83; T2/p.1/L4; T2/p.8/L83; T3/p.7/L96-98
- Identity: T1/p.3/L41; T2/p.6/L64; T3/p.6/L88
- Structure is good for youth to stop using the drugs: T1/p.1/L12; T1/p.8/L121; T2/p.4/L38; T2/p.15/L163; T3/p.7/L104; T3/p.8/L116; T4/p.9/L82
- Home life support is a big factor in these youth's lives: T1/p.5/L77-p.9/L132; T2/p14/L153; T3/p.5/L78; T3/p.5/L84; T4/p.11/L96; T5/p.4/L52/ T5/p.5/L66; T5/p.10/L150-152

- Understanding and no judgment from treatment providers; T6/p.17/L271; T1/p.8/L112-117
- Peer support is major T5/pg10/line154; T6/p.15/L228; T3/p.5/L78; T3/p.7/L104; T4/p.11/Ll96; T5/p.10/L154

Access

- Awareness of services-where they are, what they are and how to get them; T6/p.17/L264; T1/p.6/L83; T2/p.8/L87; p.11/L121; T3/p.9/L126; T4/p.8/L72
- Having more one-on-one counseling sessions is generally preferred but access to this option is not available:T2/p.10/L107-110; T3/p.3/L49; T4/p.4/L42; T5/p.10/L141-142
- getting to the right place the first time: proper treatment matching;T1/p.1/L10; T2/p.1/L7-8; T3/p.10/L147; T4/p.12/L110
- Having a safer way to access a counselor vs having to "out yourself": T1/p.4/L57;T3/p.4/L54; T5/p.9/L128
- Enduring long wait times; T5/pg.12/L170; T6/p.11/L176: T1/p.7/L93;95; T2/p.5/L54
- integrated services to stop the bouncing around in the system; T1/p.7/L99-p.9/L126; T2/p.6/L59-60; T2/p.15/L157; T3/p.7/L107; T3/p.10/L147; T4/p.5/L54; T4/p.12/L102; T5/p.9/L122

Awareness and Control

- All youth felt they had gained more awareness and control by accessing A&MH services in their journey so far.

Overall impression of A&MH services

- All youth did not have a supportive opinion or impression when asked about what they think of when they think of either Addiction or mental health services. This image needs to be addressed and worked on.

Note. Coding: T # (transcript number); P # (page number) and L# (line number).

I.e., T1/p.3/L41 = T1 = transcript 1; P.3 = page 3; and L41 = Line 41.

Appendix 3 – Name, Diagnosis, GAIN-SS score

Name **Age** **Sex**	**Axis 1 Diagnosis**	**GAIN-SS - moderate to high score = 5-20**	**Drug of use**
Name: Brian, **Age: 16** **Sex: Male**	Attention Deficit Hyperactivity Disorder-combined type; Anxiety Disorder-NOS; Alcohol Abuse; Mental Disorder-NOS.	GAIN-SS: 10	Alcohol, marijuana
Name: Georgina **Age: 16** **Sex: Female**	Major Depressive Disorder: single episode; Anxiety disorder-NOS;	GAIN-SS: 12	Prescription drugs
Name: Penelope **Age: 15** **Sex: Female**	Attention Deficit Hyperactive Disorder-combined type; Conduct disorder: adolescent onset; Tourette's disorder diagnosis deferred; Bipolar disorder-NOS	GAIN-SS: 13	Heroin, marijuana
Name: Tasha **Age: 16** **Sex: Female**	Major Depressive Disorder-mild; Anxiety disorder-NOS; parent-child relational problems	GAIN-SS: 11	Marijuana, cocaine
Name: Rebecca **Age: 17** **Sex: Female**	Conduct disorder, adolescent onset; unknown substance abuse; parent-child relational problem; diagnosis deferred-Attention Deficit Hyperactivity Disorder combined type; unknown substance induced psychotic disorder-in remission	GAIN-SS: 11	Alcohol, methamphetamines
Name: Tatum **Age: 15** **Sex: Male**	Attention Deficit Hyperactivity Disorder; Oppositional Defiance Disorder; Parent child relational problem	GAIN-SS: 13	Marijuana, alcohol

Appendix 4 - Master Themes

Identity: T1/p.3/L41; T2/p.6/L64; T3/p.6/L88

Medical Model: T6/p.2/L24-30.; T2/p.2/L22; T2/p.16/L169; 5/p.12/L174

Home environment: T1/p.5/L77-p.9/L132; T2/p14/L153; T3/p.5/L78; T3/p.5/L84; T4/p.11/L96; T5/p.4/L52/ T5/p.5/L66; T5/p.10/L150-152

Treatment: T1/p.7/L99-p.9/L126; T2/p.6/L59-60; T2/p.15/L157; T3/p.7/L107; T3/p.10/L147; T4/p.5/L54; T4/p.12/L102; T5/p.9/L122

T1/p.1/L12; T1/p.8/L121; T2/p.4/L38; T2/p.15/L163; T3/p.7/L104; T3/p.8/L116; T4/p.9/L82

Awareness:T6/p.17/L264; T1/p.6/L83; T2/p.8/L87; p.11/L121; T3/p.9/L126; T4/p.8/L72

Stigma: T1-6-L's 2; T6/p.17/L271: T1/p.6/L83; T2/p.1/L4; T2/p.8/L83; T3/p.7/L96-98

Note. Coding: T # (transcript number); P # (page number) and L# (line number).

I.e., T1/p.3/L41 = T1 = transcript 1; P.3 = page 3; and L41 = Line 41.