Increasing Linkages between Addiction and Mental Health Services in Ontario

FINAL REPORT ON

THE CONCURRENT

DISORDERS

SYSTEM MODELS

PROJECT

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The Centre for Addiction and Mental Health (CAMH) is a public hospital that provides direct patient care for people with mental health and addiction problems. The Centre is also a research facility, an education and training institute and a community-based organization that provides health promotion, prevention and treatment system planning services across Ontario. The Centre was created in 1998 through the successful merger of the Addiction Research Foundation, the Clarke Institute of Psychiatry, the Donwood Institute and the Queen Street Mental Health Centre. It operates central clinical and research facilities in Toronto, and its influence extends throughout the province. The Centre has consultants in 12 community offices and 16 satellite locations across the province who support local communities in health promotion, prevention and treatment system planning efforts in mental health and addictions. The Centre also works with government to influence public policy and resource development processes to ensure that it promotes health and works toward eliminating the stigma associated with mental illness and addiction.

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EXECUTIVE SUMMARY

Introduction

Over the past two decades there has been a growing awareness that many people in the addiction treatment system and many in the mental health system suffer from co-occurring substance abuse and mental health problems, known in Ontario as concurrent disorders (CD). Having two distinct systems for mental health and for addictions results in fragmentation. Clients either receive treatment for only one problem at a time, or are turned away from services because they do not "fit" the agency's mandate. A recognition of the high prevalence of this population and the gap in available services has led government to stress the need for the two systems to increase co-ordination across sectors. As a result of these and other factors, a community development process was initiated to develop, implement and sustain a model of co-ordination among addiction and mental health services in two counties in Ontario. The goal was to address service delivery issues for people with concurrent substance abuse and mental health problems. Recommendations were made for other communities embarking on a similar process.

Findings

Since a key principle of community development is to recognize the uniqueness of each participating community, generalizing the findings of the Concurrent Disorders System Models (CDSM) project to other regions is impossible. However, some of the overarching themes that emerged throughout the project were compelling and warrant consideration by others who wish to engage in a similar process.

Key Learnings about Model Components

The models developed in each of the two participating counties consisted of several components. The following results emerged from focus groups and interviews conducted throughout the evaluation of the project, and from data on the implementation of each component.

- The two most successful components of the models were training for front-line workers and support groups for people with concurrent disorders (a life skills group co-led by an addiction and a mental health worker and a self-help group). Both were consistent with identified priorities expressed during the evaluation of the project.
- Networks among workers were considered useful for increasing communication between services and exploring opportunities to pool resources.
- A mental health and addiction Web site was considered useful for those who had visited it, but many did not have Internet access.
- Service agreements led to positive relationship-building but were not implemented to the extent intended.
- Consumers were wary of increased communication among workers as they felt it might compromise confidentiality and client choice.
- Mechanisms for identifying concurrent disorders and client overlap between the mental health and addiction systems were lacking.

Process Considerations

Who to include and their roles

- Limit team membership to addiction and mental health services.
- Ensure that agency representation reflects the level of co-ordination being sought (i.e., management, front-line worker and /or consumer).
- Involve consumers.
- Have an external facilitator.
- Have champions lead the process.

Important distinctions to make

- Refer to the “target population” for components of the model rather than a specific “definition of concurrent disorders”.
- Distinguish between program and system issues.

- Distinguish between cross-sectional co-ordination (for clients attending more than one service at a given point in time) and longitudinal co-ordination (for referrals and discharge processes that affect linkages over time).
- Consider the unique needs of rural areas.

Planning approaches

- Recognize that all communities are unique.
- Acknowledge the diversity of participating agencies.
- Focus the initiative on "enhancing services for people with CD" rather than "co-ordination."
- Address commitment throughout the process.
- Keep the planning phase short.
- Learn from others' experiences.
- Evaluate the initiative.

Conclusion

Both participating counties developed a model of co-ordination tailored to their region's unique needs. Aspects of those models were implemented in varying degrees. The evaluation of the implementation phase revealed that participants in both counties had experienced positive changes in the addiction and mental health systems as a result of the implementation of some components of the models. Some participants expressed disappointment that more change had not occurred. At the time of writing, concurrent disorders networks continued to sustain themselves in both communities. Specific initiatives evolved from these networks including training, public awareness efforts and program planning. The two support groups for concurrent disorders also continued to be sustained, and an additional concurrent disorders group for youth had begun in County A. These changes and the degree of sustainability suggest the usefulness of a community development approach for improving service delivery for people with concurrent disorders.

INTRODUCTION

Project Catalysts

Typically, addiction treatment services and mental health services and supports operate independently of each other. People with both substance abuse and mental health problems, known in Ontario as concurrent disorders (CD),[1] "fall through the cracks" of the two systems because of exclusionary admission criteria, lack of training about integrated treatment approaches, stigma and inconsistent treatment philosophies across workers (Health Canada, 2002; Howland, 1990). During a provincial needs assessment conducted in 1996, the two most frequently cited unmet needs for individuals with CD were the lack of integrated/co-ordinated treatment and community supports, and the lack of focus on collaborative efforts between mental health and addiction agencies (Melinyshyn, Christie & Shirley, 1996). At that time, the need to increase co-ordination across the two systems was also identified throughout the literature (e.g., Baker, 1991; Canadian Mental Health Association, Ontario Division, 1997; Hood, Mangham, McGuire & Leigh, 1996; Ontario Ministry of Health and Long-Term Care, 1999a, 1999b; Ries, 1994). Although research had been conducted on integrated treatment and supports for people with concurrent disorders, most of the CD literature focused on integration within a given program rather than co-ordination across agencies (Health Canada, 2002). Moreover, most integrated programs described in the literature were situated in large metropolitan centres that did not reflect the unique needs of smaller communities. The literature also offered few guidelines for administrators and community developers to understand and lead co-ordination initiatives. The results of the 1996 needs assessment, recommendations from government and the literature, and the gaps in our understanding of co-ordination across addiction and mental health

1 Commonly known in other regions as dual disorders, dual diagnoses or comorbidity.

services led to the Centre for Addiction and Mental Health initiating and supporting the Concurrent Disorders System Models (CDSM) project.

The Concept of Co-ordination

Co-ordination is often viewed as a means to increase continuity of service delivery (Rogers & Mulford, 1982), bridge gaps in services (Beatrice, 1990), increase cost-effectiveness (Davidson, 1976), "cope with shrinking resources...reduce the abuse by clients known as 'double dipping'" (Whetten, 1982, p. 4), reduce competitiveness among agencies (Mulford & Klonglan, 1979), reduce fragmentation and duplication, increase service provision for people with multiple needs and increase accountability (Baker, 1991). However, the literature offers little empirical evidence to support these views. The literature and policy documents do not offer a clear and consistent definition of co-ordination, nor do they describe how to achieve a co-ordinated system of care. One concise definition of co-ordination that developed within the addiction field is "the degree to which collaboration and exchange exist among an aggregation of service providers" (Baker, 1991, p. 13). This definition was used as a guide throughout the CDSM project because it was consistent with views expressed by addiction and mental health workers and consumers in Ontario during the 1996 needs assessment. At the time, mechanisms such as staff training, program updates, information sharing protocols, cross-appointment of staff and co-ordinated training opportunities were identified as ways to increase co-ordination among services (Melinyshyn, Christie, & Shirley, 1996).

Project Description

Purpose

The purpose of the CDSM project was to develop, implement and evaluate a model of co-ordination among addiction and mental health services in two urban/rural counties in Ontario. The intent was to develop a more formal level of co-ordination across agencies than the existing informal networks that already occurred to some extent in each participating county. The overall goal was to enhance service delivery for people with concurrent disorders. Concurrent disorders (CD) was broadly defined as "individuals having both mental health and substance abuse problems" (Melinyshyn, Christie & Shirley, 1996, p. 15). Tobacco use and gambling were not included in this definition. The total cost of administering the project over a three-year period was $250,000. Money was not provided to either participating county to enhance direct service provision.

County characteristics and project teams

The two participating counties had a population between 200,000 and 350,000, each with an urban core of approximately 100,000 people. One of the two counties had five other urban centres with populations ranging from 14,000 to 27,000. The urban/rural breakdown for both counties was 55-65% urban and 35-45% rural. Participation in the project was voluntary and included government-funded transfer payment agencies with decision-making autonomy over their respective policies and procedures. All participating agencies were based in urban centres but were mandated to serve the larger urban/rural catchment area of their county. The project team in County A had representation from a consumer survivor association, an outpatient addiction service, a community mental health agency, the District Health Council, Probation and Parole, a child and youth service and the mental health services at the local hospital. County B's

project team included one consumer and representation from the following services: a withdrawal management service, an outpatient addiction agency, a community mental health agency, and a psychiatric hospital's outpatient mental health service and mental health assessment service.

Process and roles

Community development principles were used throughout the process of model development in each of the participating counties. Community development

> presupposes that community change may be pursued optimally through broad participation of a wide spectrum of people at the local community level in goal determination and action...'Community Development can be tentatively defined as a process designed to create conditions of economic and social progress for the whole community with its active participation and the fullest possible reliance on the community's initiative[2] (Rothman & Tropman, 1987, p. 5).

The "fullest possible reliance" clause is particularly important in the context of the CDSM project. The intent of the project was for each county to be responsible for developing a model of co-ordination tailored to their region's unique needs. The Centre for Addiction and Mental Health (CAMH) hired one full-time project co-ordinator as a consultant external to the participating counties who would facilitate the process of model development and evaluate the initiative. Each participating county already had a local CAMH consultant who typically played a community development role in that region. The role of this local consultant was to assist the project co-ordinator in facilitating the monthly team meetings and to be the local contact for the project. In both counties, attempts were made to increase consumer involvement in the model development phase; however, such efforts had minimal success.

[2] Rothman & Tropman quote from United Nations. (1955). *United Nations, Social progress through community development*. New York: Author.

Project timeline

The community development aspect of the project was divided into two 15-month phases: (1) developing a model of co-ordination tailored to the county's unique needs during three-hour monthly meetings; and (2) the implementation and evaluation of that model. The expectation was that the implementation process would continue to evolve and sustain itself after the formal project was complete.

EVALUATION PROTOCOL

Methodology and Sampling

Three phases of evaluation were conducted and are summarized in Figure 1.

Data Analysis

All focus groups and interviews were audio-taped. Each tape was professionally transcribed and themes were extracted using McCracken's (1988) five stage process of data analysis.

Establishing Trustworthiness (Reliability and Validity)

Ethical procedures were approved for the entire research process. Interview guides were pilot tested and revised accordingly. Lincoln and Guba's (1984) criteria for establishing trustworthiness in qualitative inquiry were used to increase trust in the research process and to increase the reliability and validity of the findings. Each member of the research team wrote a cultural review to raise his/her awareness of the assumptions he/she brought to the data collection and analysis. This helped to ensure that the researchers noted findings both consistent with and contrary to their expectations. Transcripts from the consumer focus groups were coded by both the project co-ordinator and the consumer who led the sessions. Themes were compared to ensure that the consumers' views were reflected as accurately as possible. For the in-depth interviews, participants' feedback on draft reports showed that the findings were viewed as an accurate reflection of the sentiments expressed in each respective county. In addition, peer debriefing among the research team led to detailed discussions and insights about the data collection, data analysis and implications of the results.

Phase	**Purpose**	**Methods**	**Sample**
Baseline data was obtained throughout the model development phase (March 1999 - June 2000)	To obtain data on: • the characteristics of participating agencies • co-ordination among addiction and mental health services prior to the start of the project • participants' views about the process of model development	Initial data collection form administered at the first meeting	19 agency representatives
		Mid-term survey	13 agency representatives
		Periodic verbal feedback (telephone and in-person)	Various agency representatives
		Content analysis	Minutes from planning meetings and various local documents
Pre-implementation data was obtained after the models of co-ordination were developed, but prior to their implementation (May - July 2000)	To obtain information about: • experiences with the treatment/support of concurrent disorders • co-ordination among addiction and mental health services prior to model implementation • how participants would like addiction and mental health services to co-ordinate • participants' views of their county's model and the impact it might have • views of the model development process • recommendations to other communities embarking on a similar initiative	1.5-hour focus groups	16 consumers recruited through frontline workers and posters
		1.5-hour in-depth face-to-face qualitative interviews using McCracken's Long Interview (1988)	15 agency representatives who had been directly involved in developing the model of co-ordination for their county 26 frontline service providers (primarily addiction and mental health workers) who had not been involved in the planning process but who were expected to be affected by the implementation of the model
Follow-up data was obtained 15 months after the models began to be implemented (November - December, 2001)	To obtain information about: • the extent to which participants were involved in each component of the model • participants' views on what had changed • participants' suggestions for the next steps	1.5-hour focus groups	27 consumers (some of whom participated in the previous phase of focus groups)
		30-minute telephone interviews	13 of the 15 agency representatives previously interviewed 21 of the 26 frontline service providers previously interviewed
		Content analysis	Minutes from ongoing meetings

Figure 1. Methodology and Sampling.

FINDINGS

Since a key principle of community development is to recognize the uniqueness of each participating community, generalizing the findings of the CDSM project to other regions is impossible. However, some of the overarching themes that emerged throughout the project were compelling and warrant consideration by others who wish to engage in a similar process. The components of the models developed in each county, the extent to which they were implemented, and views regarding their level of success are described below. This is followed by process considerations for other communities wishing to embark on a similar initiative. Overall feedback about the model implementation is outlined in Appendix A and policy implications are shown in Appendix B.

County A's Model and Its Implementation

As shown in Figure 2, County A addressed three initiatives during the model development phase: a community service co-ordination protocol, training, and a service agreement between local services and an out-of-county residential program. Also shown in this figure are two spin-off initiatives that occurred as a result of the overall project but were not planned within the project team meetings facilitated by the project co-ordinator. After implementation began, a network consisting of many of the project team members was formed to sustain the initiatives.

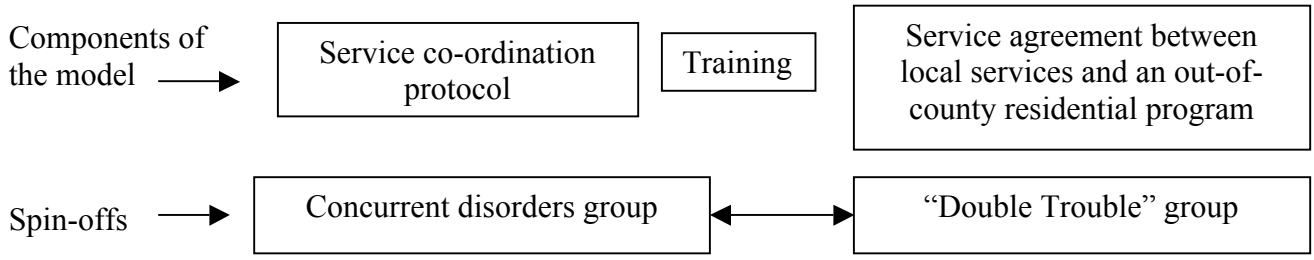

Figure 2. Model of Co-ordination Developed in County A.

Service Co-ordination Protocol: Appendix C shows a formal protocol that was written for service providers to use as a guide when a client had multiple providers. One worker would take on the role of "service co-ordinator"[3] to encourage integrated approaches through case conferences and sharing client information. To facilitate the co-ordination process, the following forms were included in the protocol: screening for CD, names of service co-ordination team members, individual service plans, monitoring, case transfer/closure, and a process review of clients' accomplishments and challenges. This protocol was not implemented as intended because "service co-ordination" was perceived as requiring more service provider time and

[3] The concept of "service co-ordinator" was taken from Illback and Neill (1995).

hence was not feasible without additional resources. However, some of the forms were used for referrals to the newly-formed CD life skills group described below.

Training: In response to a needs assessment that was conducted by the project team (shown in Appendix D), two workshops were held to: (1) inform community service providers about available resources and referral criteria for admission to addiction and mental health programs, and (2) educate addiction and mental health workers about screening and assessing CD. At the time of the follow-up evaluation, training events had continued to occur with high participation rates. Feedback about the training was very positive. In particular, participants appreciated that the events targeted front-line workers and provided a forum for service providers from one system to meet colleagues in the other system.

Service Agreement: Appendix E shows an agreement between addiction and mental health services in County A and a provincial CD residential program located outside of the county. This agreement clarified channels of communication about program changes, and outlined a protocol for smoother referral and discharge processes between County A's services and the residential service. A representative from each relevant service signed the agreement, but communication channels were not implemented as intended primarily because of a change in some of the signatory's roles within their respective agency. Continuing uncertainty about the future of the residential service due to the government's restructuring/deinstitutionalization plans also made it difficult for participants to commit to a specific protocol. However, by involving staff from the out-of-county residential program in the model development phase, front-line service providers in County A became more aware of the residential program's services and its admission criteria. Also, a front-line worker from the residential program was involved in some of the training of

County A's front-line service providers and participated regularly in the county's CD network (a continuation of the model development planning team once implementation began).

Double Trouble Group: This weekly self-help group, held at the consumer survivor association, provided peer support for people with CD. Feedback about this group was very positive because it was a venue where people with CD could go without having to face the double stigma of addiction and mental health, and where they could freely discuss both issues and get support. Consumers found that having a meeting to look forward to helped them maintain sobriety. It gave them something to do instead of drinking on the day of the meeting, and they knew they would feel better after attending. It was particularly helpful to have support from others who had gone through similar experiences. The group was a place to make friends who would not pressure each other into using alcohol or other drugs, which was important to consumers because some of their friends outside the group would sometimes pressure them into using. Having a venue without that pressure made it easier for them to say no to friends who were using alcohol and other drugs. Another benefit of peer support was that those who had many years of sobriety offered useful information about "coping mechanisms," "good skills," and "information."

Concurrent Disorders Life Skills Group: This weekly group was co-led by a service provider from an addiction agency and a worker from a community mental health agency. The purpose was:

- to teach more effective social and coping skills for situations related to substance abuse
- to provide information about the interaction between substance abuse and psychiatric disorders
- to create a supportive milieu in which members felt comfortable sharing their experiences and working toward shared and individual goals (Concurrent Disorders Network, 2001a).

As one of the facilitators stated: "Whatever they need that day is what we talk about, and we try to have written resources and we try to do a little bit of education around whatever it is that

they're struggling with." The group was held at the consumer survivor association, which allowed consumers to avoid the stigma associated with going to a formal agency. Having this group at the same location as the Double Trouble group also facilitated linkages between the groups.

The attendance rate was about five consumers per session. Which five participants attended varied weekly depending on members' level of stability that week. In general, front-line workers found this group to be particularly helpful because it was a referral destination that was more appropriate for people with CD than standard addiction or mental health programs. As one front-line worker stated: "It gives them better access to service and probably better quality of service. The clients feel safer because the group is tailored to their needs and it is a smaller group so they feel more comfortable there." Another benefit of having the group was that the co-facilitators became known as local experts in CD. As one worker stated: "In our agency I think what's happened more is that if people had concurrent clients on their caseload then [name of a co-leader] has become a resource for them." Moreover, some workers had learned more about CD and the group by attending a group session.

Ongoing Network: A network of local service providers working specifically with clients with CD was formed to sustain the project initiatives. The purpose was: (1) to provide education and training for individuals who provide services to people with CD; (2) to develop a network of support and resources; and (3) to develop common evaluation criteria to gather information for use in developing further resources and seeking funding (Concurrent Disorders Network, 2001b). The network accomplished the following tasks during the first 15 months of implementation:

- a training workshop
- improved tools to evaluate CD programs and the network
- participation in a health fair
- continued liaison with the out-of-county residential service

- brown bag network meetings for sharing program updates
- the development and distribution of a brochure with all of the county's CD options.

The network had also expanded to include representatives from four other counties in the same region of the province. This expansion was considered to be positive particularly because

> when you have a broader base to draw from, you can bring in more expensive speakers. We want to bring in the certification program for concurrent disorders. Individually that's pretty costly for one community, and it's way more costly to send someone to Toronto to do it, so if we can work together we can bring somebody down and we'll be able to draw the number of people we need to get to make a workshop viable. That's going to cost us several thousands.

Participants felt that through this network, better partnerships had been formed and the sharing of expertise was helpful. As one worker stated: "once you get over my-turf-your-turf kind of thing … once there's a face there, they're more likely to keep in touch with each other and share resources."

County B's Model and Its Implementation

Figure 3 shows the model components for County B. The brown bag lunches, alliance service agreement and Web site were formal components that were the focus of the planning meetings. The workshop and distribution of information sheets occurred during the model development phase along with the planning of the concurrent disorders work group, which existed in County B before the project started.

Alliance Service Agreement: Appendix F shows the agreement that was developed to "provide agencies with a mechanism for [this] joint planning and sharing of service delivery, specifically for individuals who require services from both the addiction and the mental health systems." The objectives were "to ensure that the network has a clear description of: the services that are provided, the links between agencies, and the role of each agency in the full continuum of health

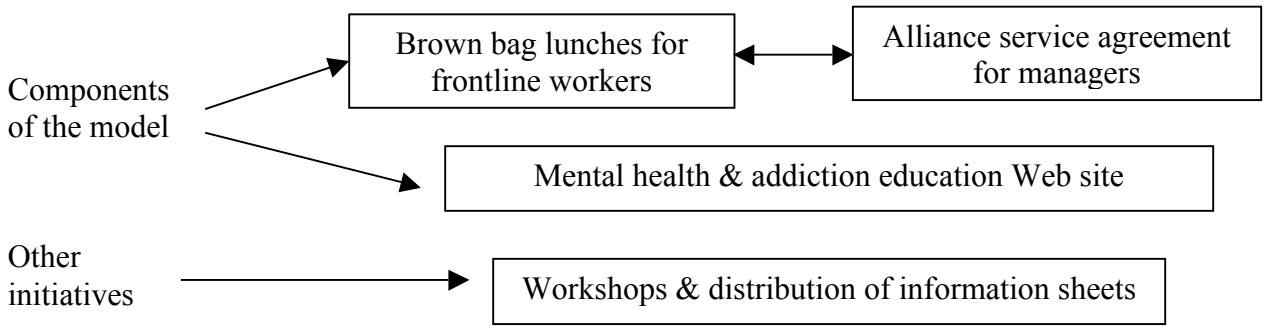

Figure 3. Model of Co-ordination Developed in County B.

and social services." The signatories, the managers of participating services, were to meet quarterly to explore mechanisms of co-ordination such as staff sharing, cross-training and case conferencing. The hope was that signing the agreement would formalize the commitment to make some changes in service delivery. Only two of the four meetings were held in the first year of model implementation primarily because of scheduling difficulties. Meetings continued to be held in the second year after implementation which suggests sustainability. During the meetings, participants spent a significant amount of time updating each other on policy, programming and system changes. One tangible outcome of the alliance was that a psychiatrist from the mental health system had become "a consulting psychiatrist to the outpatient addiction service two half-days per month." Participants felt that they had benefited "terrifically" from this outcome: "[it] has been wonderful, it's been a godsend." At the time of the follow-up evaluation, topics of discussion in alliance meetings included physician involvement in the alliance, more staff sharing and starting a CD group co-led by an addiction worker and a mental health worker. Planning for these initiatives had not yet begun but was expected to occur.

Some participants in the follow-up evaluation felt that the alliance had led to stronger relationships with other services:

> I think it's just the atmosphere of partnership and you know, just the mindset of working together and having community linkages….we've seen an increase, for instance, in our referrals from [name of other agency].

On the other hand, several participants expressed concern about the level of commitment among the signatories. Although participants agreed with the content of the agreement, they expressed disappointment in the alliance protocol, particularly with respect to the lack of attendance at meetings and the lack of follow through on the agreement:

> Generally agencies communicated well before but… I think it's more on paper. Like yes, we have the service agreement in place and this means that you know we'll do this, that and that. But I tend to think maybe it's more lip service than it is actual practice.

Brown Bag Lunches: Brown bag lunches were held bi-monthly in the core urban centre to bring front-line service providers together from both the addiction and the mental health fields. The purpose was for service providers to make connections with other front-line workers, share information and resources, identify educational needs and raise current issues. Because of limited time during the lunch hour, a work group would sometimes be formed to deal with issues that required further examination and the findings would be presented at the next brown bag lunch session.

At the time of the follow-up evaluation, eight lunches had been held. In general, attendance ranged from nine to 14 participants (with only zero to three from the addiction system). Numerous topics were covered including: program changes; training events; concerns regarding clients' loss of monthly government cheques if they attended residential treatment; specific treatment approaches; legal/ethical issues; referral procedures; issues related to interactions between medications and substance use; and the possibility of starting a support group for people with CD co-led by an addiction worker and a mental health worker. Brown bag lunch discussions

led to a successful full-day training workshop on motivating clients to get treatment and strategies for working with clients presenting with CD.

The follow-up evaluation showed that those who attended the lunches liked the sessions and found them to be a good use of time. As one individual stated:

> I've attended nearly all of the meetings and they've been excellent. We've been sharing a lot of case management or presenting cases and… getting feedback for how to handle particular aspects of the case and sharing information about what's happening in their agencies and what the programs are and expressing concern as to, you know, the needs of the population. So it's really been quite productive and, you know, there's been a lot of good communication and more cooperation for when you need to call to a particular agency you know to discuss a client. So that's been excellent.

Although some would have preferred more involvement from the addiction sector, others felt that there was good representation from both the addiction and the mental health fields. Workers particularly appreciated the opportunity to meet with colleagues from other services: "getting to know one another… it's always easier to talk to somebody who you've met face-to-face… then it's easier to refer back and forth or just sort of [do] case management." Participants felt that the length of the meetings was good, that discussions focusing on specific issues were useful, and dividing into subgroups to work on specific tasks was beneficial. Other feedback described the value of receiving a reminder prior to each session; the communication difficulties caused by the number of acronyms used at sessions; and disappointment that the lunches had not led to more staff sharing.

Several front-line workers who participated in the project evaluation recommended that a similar lunch series start in other urban and rural centres around the county to benefit workers in other areas. Identified barriers to participating in the lunches included: travel time and costs; the inability to take on more work; the view that such initiatives were outside their job description;

the view that co-ordination was the role of managers, not front-line workers; and a reluctance to sacrifice their lunch hours.

Mental Health and Addiction Education Web Site: County B's mental health education Web site was expanded to include information about addictions and addiction programs. At the time of the follow-up evaluation, several addiction services had been added and the Web site advertised and provided the schedule for the brown bag lunch series described above. The evaluation showed that few front-line service providers interviewed had access to the Internet at work and therefore had not visited the site. Many even reported that they did not have access to a computer. The few people who had accessed it spoke very highly of it and one individual stated that "just by having the name together [showed] that [the two systems] were working together."

Workshops and Distribution of Information Sheets: Prior to the CDSM project, County B had a work group that planned community awareness initiatives, including an annual CD workshop and the development of "Tip sheets" on CD. This group continued to meet throughout the project and planned its annual workshop, which was very successful. As part of the project, the "Tip sheets" were broadly distributed to front-line workers and physicians around the county. The project evaluation revealed that some front-line service providers found this information sharing to be very helpful. Based on a request from physicians, following a presentation by the project co-ordinator at the local hospital grand rounds, the project team developed and distributed a one-page information sheet containing three telephone numbers for physicians to call if they had patients with suspected substance abuse or mental health problems. Physicians were not included in the evaluation of the project so no information was available regarding the usefulness of these information sheets.

Sustainability and Link between Front-line Workers and Managers: At the time of the follow-up evaluation, sustainability of the model occurred through one individual who organized the alliance meetings and the brown bag lunches. This facilitation role included: booking rooms, sending out reminders of meetings, taking and distributing minutes of meetings, evaluating the progress of the model, and providing feedback from the evaluations to participating members. This individual also had the responsibility of attending both alliance and brown bag lunch meetings to ensure communication between the two groups. Such communication offered front-line workers a safe vehicle to present their concerns to managers. Also, managers were reminded of the importance of the brown bag lunches and of the participants' desire for managers to encourage more front-line staff to attend. Having a communication channel between the lunches and the alliance meetings also gave managers an opportunity to relay information to front-line workers about program and system changes.

Key Learnings about Model Components

The following results emerged from focus groups and interviews conducted throughout the project evaluation and from data on the implementation of each component of the model.

Key Learnings

- The two most successful components of the models were training for front-line workers and support groups for people with concurrent disorders (a life skills group co-led by an addiction and a mental health worker and a self-help group). Both were consistent with identified priorities as expressed during the evaluation of the project.
- Networks among workers were considered to be useful for increasing communication between services and exploring opportunities to pool resources.
- A mental health and addiction Web site was considered useful for those who had visited it, but many did not have Internet access.

Key Learnings (Continued)

- Service agreements led to positive relationship-building but were not implemented to the extent intended.
- Consumers were wary of increased communication across workers as they felt it might compromise confidentiality and client choice.
- Mechanisms for identifying concurrent disorders and client overlap between the mental health and addiction systems were lacking.

Although participants agreed with expert consensus papers and policy documents about the importance of increasing co-ordination across addiction and mental health services, their priorities were to: (1) increase training for front-line service providers in both the addiction and the mental health systems, and (2) provide people with CD with a place to go where they would not be stigmatized and where they could address both issues. The successes of the Double Trouble self-help group and the concurrent disorders life skills group co-led by an addiction and a mental health worker demonstrate that "a place to go" was indeed worthwhile and a viable initiative for enhancing services for people with CD. The need for specialized programs was also identified in the provincial needs assessment conducted in 1996 (Melinyshyn, Christie & Shirley, 1996) and is supported by the literature (e.g., *The dual disorders recovery book*, 1993; Hamilton & Samples, 1994; Minkoff, 1996).

The need for training is also supported by the literature (e.g., Baker, 1991; Howland, 1990; Minkoff, 1994). Both counties developed a network with training as a key component. The feedback about the training was very positive. The networks also provided an ongoing forum for increased communication between services and opportunities for agencies to pool resources. These were considered to be useful initiatives that helped to enhance the system for people with

CD. The mental health and addiction education Web site had limited impact due to a lack of access to the Internet.

Three types of written service agreements were developed: (1) a community service co-ordination protocol; (2) an agreement for increased communication between agencies and improved referral and discharge processes; and (3) an alliance agreement for managers to partake in joint planning and sharing of service delivery. Although some benefits evolved from the development of these agreements (e.g., a CD referral form, ongoing networking with relevant agencies and a psychiatrist attending an outpatient addiction program on a regular basis), each fell short of the initial expectations. In all three instances considerable time was spent on details to formalize the agreement and then the implementation reverted to more informal processes.

Two concerns arose during the evaluation of the project: (1) consumers were wary of increased communication across workers as they felt it might compromise confidentiality and client choice; and (2) mechanisms for identifying concurrent disorders and client overlap between the mental health and addiction systems were lacking. Such mechanisms are necessary to identify gaps in services and to provide information that could be used for program and system planning. One question that arose during the evaluation was the extent to which clients simultaneously attend a program in each of the two systems. Those with a serious mental illness may be more likely to present to the mental health system while those with a less serious mental illness may be found in the addiction system. Gathering information about client overlap would assist communities in deciding which mechanisms of co-ordination would be most useful.

Process Considerations

Overall, participants found the community development approach useful. Recommendations for other communities wishing to develop models of co-ordination among addiction and mental health services in their region are outlined below.

Who to include and their roles

Recommendations
• Limit team membership to addiction and mental health services. • Ensure that agency representation reflects the level of co-ordination being sought (i.e., management, front-line worker and /or consumer). • Involve consumers. • Have an external facilitator. • Have champions lead the process.

Limit membership: In general, community development principles suggest that the more inclusive the process, the greater the range of constituents who will have a sense of ownership over the model and the greater the buy-in for implementing the model (Rothman, 1995). However, for inter-organizational co-ordination, Mulford and Klonglan (1979) recommend keeping the number of players small and including only key services. The results of the CDSM project support the latter view. Participants recommended that the planning team be kept small and consist of consumers, representatives from the mental health and addiction agencies, and local planning bodies such as the District Health Council and CAMH. Agencies outside the addiction and mental health systems play an important role in providing services for people with

CD (e.g., medical field, judicial system, children's services, housing, employment). However, giving them full consideration in the early stages of building linkages across programs could lead to a slowing of the process by multiple agendas and/or unrealistic expectations. Incorporating their input should only occur as required and can be obtained using strategies such as focus groups and surveys.

Representation should reflect the level of co-ordination: The representative from each agency should be chosen carefully to reflect the level(s) of service delivery that is the focus of the initiative: consumer level, service provision level, administrative level, or a combination of these. Those who will be implementing and are affected by the change should be involved in the planning. However, the current shortage of resources in addiction and mental health agencies requires a sensitivity toward the front-line time that workers must forego to sit on committees. Front-line service providers who participated in the evaluation of the CDSM project generally did not want a direct role in the planning aspect of the project; they were content to receive brief updates or be informed of the completed model. Some felt that co-ordination issues were beyond their job description, were the responsibility of management and took time away from direct client service. Although it would be ideal for both a front-line worker and a manager from each participating agency to be involved in the model development process, this usually is not feasible. Finding alternative ways to obtain input from front-line workers may be required. Regardless of who represents an agency, this individual must ensure that all levels of workers at their agency are kept informed and have a vehicle for providing feedback.

Involve consumers: Having consumers directly involved in the planning process was viewed as an essential way to ensure two-way communication and education between agency representatives and consumers. Participants felt that consumer involvement would serve as a

reminder that the primary motivation should be to improve services for people with CD. People with CD are a heterogeneous population so it is important to incorporate the views of a variety of consumers. The project teams in both participating counties attempted to increase consumer involvement in the planning phase by having front-line workers invite their clients with CD to attend monthly meetings. This approach had minimal success. Recommended strategies for recruiting and retaining clients/consumers in this type of process are outlined in Appendix G.

Have an external facilitator: The majority of agency representatives in both counties felt that the facilitator should be a neutral person who is not involved in direct service provision and whose job is specifically to conduct this type of community development initiative. Front-line workers and managers do not have the time required to facilitate such a process and a neutral party is more likely to focus on the needs of the community than on how the protocol might affect his/her agenda, staff, clients or agency policies. A disadvantage of using a neutral person as a facilitator is that this person can easily become a scapegoat or be expected to resolve political and/or historical barriers. The facilitator should avoid getting caught up in local politics by ensuring that everyone's role is clearly defined at the outset and reviewed on a regular basis.

Have champions lead the process: A distinction must be made between facilitator and leader. CAMH's role in the project was to facilitate the process by bringing people together, organizing meetings, facilitating meetings and drawing on other resources where appropriate. The role was not to lead the process or to direct the content of the models that were developed. The expectation was that the community team itself would develop the model. As one respondent stated: "a good facilitator does not lead." Good leadership requires a "champion" or group of champions who are visionaries and who play an active role in doing the required legwork. One of the counties wanted the leadership to come from within the community. The other county

would have preferred the leadership role to be played by an external player such as CAMH, the District Health Council or the Ministry of Health and Long-Term Care.

Important distinctions to make

Recommendations
• Refer to the "target population" for components of the model rather than seeking a specific "definition of concurrent disorders". • Distinguish between program and system issues. • Distinguish between cross-sectional co-ordination (for clients attending more than one service at a given point in time) and longitudinal co-ordination (for referrals and discharge processes that affect linkages over time). • Consider the unique needs of rural areas.

Refer to the "target population" rather than "definition": People with CD make up a heterogeneous population. Numerous combinations of mental health and substance abuse problems exist, and for each combination there is a range of problem severity and possible treatment/supports required (Health Canada, 2002). Each agency, and even different workers within an agency, may define or conceptualize CD differently based on their treatment philosophy and the sub-population of CD they are mandated to serve. Unless all participating agencies already define CD in the same way, recognizing differences and agreeing that each component of the initiative may require a focus on a different sub-population of CD would be useful. Referring to the "target population" for the initiative or for a component of the initiative is more useful than attempting to find a specific "definition" that might delay the process of moving forward and that risks excluding some sub-groups of CD.

Distinguish between program and system issues: It is important to clearly understand and articulate the difference between internal agency capacity building and broader system development. Discussions throughout the process are likely to include a combination of both. Addressing which will be the focus for the initiative is important at the outset to keep the discussions focused and to reduce false expectations.

Distinguish between cross-sectional and longitudinal co-ordination: Gaps in service delivery can occur at a specific point in time (cross-sectional) or over time (longitudinal). Cross-sectional co-ordination refers to comprehensiveness and co-ordination of services when a client simultaneously attends more than one program. Examples include service providers sharing client information, case conferences and agreements about client goals. Longitudinal co-ordination refers to the flow of services and the transition from one service to another over time. It includes protocols for smooth referral processes and discharge plans. During the CDSM project, confusion sometimes arose when some participants were discussing cross-sectional care while others were thinking of longitudinal care. Identifying which type of co-ordination is desired at the outset is important so that participants have a common understanding of the goals of the initiative. If the data are available, determining the extent to which clients attend both systems simultaneously (cross-sectional) and the need for changes to referral and discharge processes (longitudinal) would be useful to assess the need for each type of co-ordination.

Consider the unique needs of rural areas: Although the intent of the project was to encompass urban and rural areas within the county, the models that were developed were most appropriate for urban areas. The cost and time required for travel were considered to be the primary barrier for workers and consumers in rural areas to implement components of the model. In addition, some front-line workers and managers in rural areas felt no need to increase

co-ordination with workers in urban areas because they were satisfied with their own local networks. Therefore the unique needs of workers and consumers in rural areas must be assessed and given specific consideration in the planning phase.

Planning approaches

Recommendations

- Recognize that all communities are unique.
- Acknowledge the diversity of participating agencies.
- Focus the initiative on "enhancing services for people with CD" rather than on "co-ordination."
- Address commitment throughout the process.
- Keep the planning phase short.
- Learn from others' experiences.
- Evaluate the initiative.

Recognize that all communities are unique: The two participating counties differed in various ways, which significantly influenced the process and the models that were developed. Each community brought a different history of relationship-building, ways of operating and degrees of embracing change. Any community development plan must be flexible and the facilitator must emphasize the importance of a process and outcome tailored to the community's unique needs.

Acknowledge the diversity of participating agencies: The baseline evaluation highlighted the diversity of services in the addiction and mental health systems. Agency characteristics varied regarding mandate, funding, sponsorship, size, location, composition of staff, population served,

approaches and philosophy of treatment or support, and screening and assessment tools used. Some questions were even raised regarding whether client characteristics differed across agencies; however, agency data were not available to determine whether this was the case. In using a community development approach, it is important to acknowledge these differences and recognize that they may lead to varying views on the community's needs and how they should be addressed.

Focus on "enhancing service delivery" rather than "co-ordination": The concept of co-ordination is complex and incorporates several dimensions. Many front-line workers felt that the term was abstract and academic, and that the issue should only be addressed by agency management. Some participants equated co-ordination with organizational mergers, which was viewed as threatening jobs. Others had concerns that co-ordination among front-line workers could have a negative impact on clients because some mechanisms of co-ordination, such as sharing client information, could reduce confidentiality and client choice. Although they were asked about co-ordination in the focus groups and interviews, participants spoke primarily about training and a place for people with CD to go where they would not feel stigmatized and where they could address both types of issues. Participants rarely discussed co-ordination initiatives such as case conferences, staff sharing and cross-training. A focus on "enhancing the system in order to improve services for people with CD" would be less abstract and less threatening to stakeholders than a focus on "increasing co-ordination." This broader focus would allow the flexibility to address system changes that may not be viewed as "co-ordination" per se but that are a current priority for the community (such as starting a new service or self-help group). Couching the initiative in terms of "enhancing the system" would be viewed by front-line workers as more relevant to their day-to-day work and to clients and consumers.

Address commitment throughout the process: Commitment means more than being interested in the topic, attending meetings and making recommendations for other agencies to change. Commitment must include preparedness for one's own agency to change. It is useful to consider Prochaska and DiClemente's (1992) transtheoretical model of change in assessing each agency's and the community's readiness to change. Like individual clients, agencies and communities go through stages of change: pre-contemplation, contemplation, preparation, action and maintenance. Commitment means attending meetings on a regular basis. Sporadic attendance can be more disruptive than useful, particularly when topics have to be revisited because someone was absent from a prior meeting. All participants must actively engage in discussions that bring their personal and professional "best advice" for the overall system, not just for themselves or for their agency. Participants should be held accountable for maintaining a two-way system of communication between the process and all relevant stakeholders within their respective agencies, and they should be prepared to make changes themselves.

Keep the planning process short: The optimal length of a process such as this is difficult to determine because each community is unique. However, it is important to recognize that "service co-ordination is usually a slow, evolutionary process" (Baker, 1991, p. *x*). The 15-month planning period associated with the CDSM project was generally viewed to be too long. However, the total time commitment was deemed appropriate (approximately 12 three-hour meetings). Advantages associated with a shorter planning period include more consistency in membership at meetings, greater continuity between meetings and fewer external changes that could interfere with the process. In the project, participants found it helpful to spend time at meetings to inform and update each other on recent program and system changes. This information sharing was necessary and part of the model development process, but it took away

from planning time. The recommendation was for the planning phase to be short and focused with a maximum single meeting length of three hours. A higher frequency of meetings would likely be required if the timeframe were compressed. Time must be allotted (either within the meetings or through some other mechanism) to share updates on program changes. If they occur within the planning meetings, efforts should be made to limit the time spent on updates to avoid overwhelming the discussions and slowing the process.

Learn from others' experiences: As shown in Appendix H and I, each community developed a system logic model (SLM) to identify its respective system's program components, process objectives, outcome objectives and goals for people with CD (Rush & Ogborne, 1991). Some agency representatives found the logic model process useful for identifying issues, learning about the terms used by other agencies and identifying gaps in the system. Others found the process to be academic, abstract and cumbersome. The SLMs that were developed in the two participating counties were similar to other SLMs that had previously been developed in the addiction and mental health fields. Rather than develop a SLM from scratch, the recommendation was for other communities to save time by using existing SLMs as samples and modifying them to reflect the unique needs of their community and/or the CD population. The purpose of this approach would be to identify existing components of the mental health and addiction system for people with CD in their community and to articulate the goals and objectives of the system. This SLM could then be used for discussion about where changes need to occur to "enhance services." After the CDSM project was finished, a chart of possible mechanisms for linking addiction and mental health services at the community level was developed (see Appendix J). Other community development processes could be used to develop a specific workplan. Connecting with other communities who have already gone through this

process would be useful to learn about what did and did not work for them. Some agency representatives in the CDSM project recommended that other communities start with a survey of all participating agencies to determine their region's needs. Then, they would use the results to devise solutions or use models of co-ordination developed by other communities as examples and tailor them to suit their community.

Evaluate the initiative: Evaluating the initiative is crucial to determine the extent to which the initiatives are being implemented and to assess future requirements. In the CDSM project, focus groups and in-depth face-to-face interviews were viewed as good mechanisms to obtain feedback from clients/consumers, front-line workers and managers. Other methods of evaluation include surveys and short discussion groups during staff meetings. It is important to get feedback from a variety of stakeholders including clients/consumers, front-line workers, managers and family members and friends of those with CD. The baseline evaluation showed that agencies in the substance abuse system could not estimate how many clients met criteria for a psychiatric diagnosis, and those in the mental health system could not estimate how many of their clients abused substances. Improvements in identifying people with CD are required in order to assess whether system changes have had an impact on the intended target population.

CONCLUSION

Both participating counties developed a model of co-ordination tailored to their region's unique needs. Aspects of those models were implemented in varying degrees. The evaluation of the implementation phase revealed that participants in both counties had experienced positive changes in the addiction and the mental health systems as a result of the implementation of some components of the models. Some participants expressed disappointment that more change had not occurred. At the time of writing, networks in both counties (the Concurrent Disorders Network in County A and the brown bag lunch series and alliance meetings in County B) had continued to sustain themselves as planned. Specific initiatives evolved from these networks including training, public awareness efforts and program planning. The Double Trouble group and concurrent disorders life skills group in County A also continued to be sustained over time and an additional concurrent disorders group for youth had begun. These changes and degree of sustainability suggest the usefulness of such a community development approach for improving service delivery for people with concurrent disorders.

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Appendix A

Overall Feedback about the Model Implementation

Overall feedback about the changes made during the implementation phase of the project were remarkably similar in the two participating counties. General themes were as follows.

Achieved intentions: Several participants felt that "[the] project has been positive…[I] would recommend it to other communities;" and that "[service providers feel good about the project because they] feel as though something's being done. As one agency representative stated:

> The committee achieved what it had hoped to do and that was to simply identify where clients access the system, where were common entry points and at the very least to let all those people know what the resources were if they couldn't provide them within their agencies, specific to concurrent disorders. And I think that we've achieved that and we established relationships with each other and we're ready to work with each other on behalf of the client.

Increased profile for CD: Overall the project was viewed as having increased the profile of CD. As one individual stated: "I think that the very fact that this client group is being recognized and there's efforts to assist them is totally amazing." As another stated:

> Well, I think that for sure it's got a higher profile. The whole subject area has a higher profile. It's difficult to be around mental health and addictions these days and not hear mention of concurrent disorders….[County B] had a very successful workshop, day workshop on concurrent disorders and I think that the reason for that success was because this whole area has become more a focus for agencies.

Stronger relationships: Many of the front-line workers who participated in the follow-up evaluation phase of the project commented on the model leading to stronger relationships and an increase in working together across agencies: "There's more willingness to work together, yeah from certain agencies, not all." They felt that the relationships and the increase in referrals were "an indication that we're breaking down some barriers. And you know that is essential that this program work closer with [name of other agency]." Some felt that front-line workers were no longer "working in opposite directions or giving conflicting advice." Participants also felt that

workers had a better idea of who to call for input about certain issues that arose. Despite the many positive comments, one respondent felt that although interagency collaboration was improving, there was still room for improvement: “It’s developing because certainly people are working together and collaborating more with different agencies, but I think it’s still on a learning curve.”

Improved service delivery: Some participants felt that clients had directly benefited from the project: “The biggest benefit is the fact that I think some of our clients are now getting better service.” As another front-line workers stated: “I think that clients are quite happy for their workers to talk and clients are willing to sign consent forms for sharing of information.” Others expressed hope that consumers may now feel better understood and less ostracized or turned away from addiction programs because they were taking medication.

Referrals more appropriate: Several comments were made in County A about referrals, such as an increase in confidence in making referrals, awareness of locations to refer clients, more appropriate referrals and more effective referral processes. As one worker stated: “The big thing is not necessarily that I wouldn’t refer to [an out-of-county residential agency] or [a youth agency] before, but I feel much more ease in doing so now because of the relationship that’s built.” Another worker expressed the view that:

> Sometimes you get information from the community that’s not exactly accurate because of their own frustration in dealing with the system. Now that I’ve worked directly with that partner I understand the referral process a lot better. And that way I can meet the needs of my clients a lot better.

Improved identification of CD: Several service providers in County A indicated there was “a stronger move… to recognizing concurrent individuals” and “much more willingness to ask questions about somebody’s substance use.” As one individual stated:

> A case worker here would probably be aware or make a point of being aware of whether somebody is working with an addictions counsellor. Where a year ago [the client] may have been involved in both programs and we may not have known it.

Disappointment that more had not changed: Several respondents expressed disappointment that more had not changed:

> There was all this hope that… we'd be job shadowing, and you know, we'd be running groups together and stuff like that. And offering, you know, concurrent workshops and stuff like that and it's just not happening.

Others felt that front-line workers were still biased against the other system and continued to only address the concern mandated for their agency:

> It still occurs that if there is a common client across the two systems, then workers just focus on their own mandate and don't share client information with other workers or don't even share the approach that they are using with other workers.

One front-line service provider who was interviewed felt that the project raised false hopes and led to an increase in frustration with the system: "When you hope that you might get a piece of something and you don't, then you're more frustrated."

Sub-populations of CD that have not been affected by the model: Some front-line workers in County A felt that the model did not adequately address the needs of people with severe CD. For example, they believed that some people with CD did not want to go to a formal service. Also, the process for admission to the CD life skills group was considered to be "quite formal." As one individual stated:

> If they are presently experiencing some of their psychotic episodes, they find groups difficult because they are very paranoid and very frightened to interact…it seems they will go for awhile, and then they won't go, and go.

Another felt that the model was not inclusive of clients from rural areas.

Aspects of co-ordination could be detrimental: Consumers felt that there were situations where they would not want service providers to share information. For example, rape was

considered very personal and not to be shared. The stigma of substance abuse and mental health issues was another reason to withhold information. Consumers were concerned about losing government benefit cheques or their driver's licence if other workers were informed of their substance use. Consumers were particularly concerned about workers with whom they had previously had a negative experience or workers they were just starting to see. Consumers felt that they would be treated differently if the worker were aware that they had CD. Consumers also wanted to continue to have choices about which services and workers they wanted to see and provide information to.

Appendix B

Policy Implications

Given that the focus of the CDSM project was on co-ordination at the community level, participants in the evaluation were not asked to comment on broader system and policy issues. However, some themes did emerge that have policy implications.

Need for funding: Throughout the project and its evaluation, participants repeatedly commented on the challenge of increasing co-ordination without any additional funds. Co-ordination was viewed as requiring more service provider time. Without the finances to increase staff, many desired initiatives were not feasible.

Support and direction required from the Ministry: One of the counties appreciated being given the control to develop their own model of co-ordination tailored to their region's needs. The other county would have preferred more direction particularly from the Ministry of Health and Long-Term Care but also from their District Health Council and the Centre for Addiction and Mental Health.

Paying consumers: One county felt that consumers should be paid for their participation in such initiatives while the other county preferred that consumers not be paid because it contradicted a culture of volunteerism.

Physician involvement: Both counties stressed the crucial role that physicians play in the care of people with CD. However, participants were frustrated with the lack of physician involvement throughout the project. Given current realities with respect to physician remuneration and the impact this has on meaningful involvement by physicians in this type of process, strategies for effectively engaging physicians should be explored at a provincial level to enable their participation.

The role of Assertive Community Treatment (ACT) teams: Discussions about whether the ACT team should be included in the project occurred in one of the participating counties. Since ACT teams are intended to offer both substance abuse and mental health treatment/support and since they see clients over a long period of time, there did not seem to be a role for the ACT team to engage in cross-sectional or longitudinal co-ordination with other services. While ACT teams were considered to be a useful resource in the community, they only provided service to a small number of the most seriously mentally ill people with CD. Increasing the capacity for ACT teams to serve more people would be beneficial.

Appendix C

CONCURRENT DISORDERS SYSTEM MODELS PROJECT
County A
COMMUNITY SERVICE COORDINATION

Working Draft

INTRODUCTION

Individuals who are referred to a specific agency quite often have complex needs requiring the services of several agencies. In the process of delivering these services, decisions may be made that include referrals to a number of agencies. These factors require that individual cases be coordinated in a manner that promotes the continuity of care throughout the entire health continuum in a manner that optimizes the possibility of positive outcomes.

The underlying concept of Community Service Coordination is to provide a service that is comprehensive, proactive, efficient and effective. It is assumed that by providing such a systematic approach, individuals will receive improved care at all levels. This, in time, should result in a more positive experience on the part of the individual, family, community agencies and case coordinators.

PURPOSE

The Community Service Coordination process was developed by and for service providers, to help integrate activities and to help better service individuals with concurrent disorders (a mental illness and a substance abuse problem). This process can help individuals, agencies and communities work together to improve the planning, delivery and evaluation of services. The guidelines are designed to help you by:

Describing how to Integrate Community Service Coordination
Demonstrating practical tools for a Community Service Coordination process.

OBJECTIVES

The objectives are:
Outline the goal and principles of an integrated approach to community service coordination
Describe a process for integrating community service coordination
Establish a process to deal with community service coordination issues
Identify roles and responsibilities of key people.

DEFINITIONS

Many different terms are used to describe what we have chosen to call client and service coordination. We are aware that terms often imply a particular point of view and that they can change over time. Appendix A provides a list of definitions as they are used in this process.

PRINCIPLES

This is a shared responsibility that:
Ensures that the best interests and wellbeing of the client are foremost.
Enables clients, communities and health care providers to work together to identify needs and effective solutions and responses
Promotes shared leadership, planning, decision making, resources and evaluation
Acknowledges mutual respect for the expertise and contribution of each participant
Recognizes the role of the family, other caregivers and community resources in planning and caring for clients.

ENGAGEMENT

The agency to which the client was referred will do an intake assessment and then assist clients/families with accessing the appropriate services in order to identify a Service Coordinator. The Service Coordinator will be responsible for facilitating the coordination of all services, that form the multi agency team, in an orderly planned process that restores or maintains clients independent functioning to the fullest extent possible.

KEY ELEMENTS OF THE PROCESS

Accountability

All members of the Integrated (multi-agency) Team are responsible for ensuring that each client has one Individual Service Plan for the system, addressing individual client's identified needs. The client must have input into this service plan. All members of the team are responsible for adhering to the Individual Service Plan and documenting implementation, significant events and progress of the plan. Service Providers should also communicate the implementation and significant events to other service providers on the service coordination team.

Role of Service Coordinator

The Service Coordinator will **work with the client** and other service providers to identify expectations for the client's future progress and follow-through with the Individual Service Plan and/or referrals to another agency (Service Provider) to deal with specific identified client needs. The Service Coordinator will also ensure that the best interests and well being of the client and family are foremost. The specific duties include:

Ensuring that there is client and family involvement
Ensuring that an assessment of client needs is undertaken and an Individual Service Plan is developed that clearly identifies the roles of the team members and agencies that are to be involved with the client
Ensuring that a regular process for monitoring is established
Ensuring that contact is maintained between team members and external referrals. This contact may be in the form of verbal phone contact and/or written updates that allow all team members to be aware of important changes in services provided by other team members.
Ensuring that all paperwork and files are accurate and up-to-date
Ensuring that conflict management, negotiation, advocacy functions are done as needed/identified

Organizing and chairing meetings when needed or accompany the client to meetings if necessary.

When a client is transferred to another agency, the Service Coordinator needs to make every effort to identify a Service Provider and share with him/her the client's Individual Service Plan. This would require the informed consent of the client. The Service Coordinator will ensure that discharge and follow-up plans are developed, recorded, implemented and discussed with the client and other service provider(s).

Ensuring progress reviews are conducted on a regular basis. This may include meetings comprised of the various members of the integrated team.

Upon discharge a Case Conference may be arranged that will review and implement a discharge plan. This conference should include both formal and informal supports who have been part of the team and those who will continue to support the individual.

Role of other service Providers

To work collaboratively with the other members of the Community Service Coordination Team to develop the Individual Service Plan.

To maintain communication with the Service Coordinator (client consent is presupposed).

To participate in any needed case conferences and Service Plan evaluation and/or modifications.

To follow the directives of their own agency in respect to documentation and confidentiality

CONFIDENTIALITY

The Service Coordinator and Service Providers will respect the rite of the client to maintain confidentiality. Information that is shared will be done with the knowledge and permission of the client by the use of informed consent. Informed consent may be through the use of Consent to the Disclosure, Transmittal or Examination of a Clinical Record under Subsection 35(3) of the Act (From 14's) or liaison privileges (see Appendix B)

The Service Coordinator and Service Providers will ensure that the client/family understands the content of the documents to be released. The respective service providers will maintain documentation of the information released in the client records.

The client must sign an authorization to release specific information to specific agencies at the initiation of the Service Provider. The written authorization must be dated, signed by the client and obtained prior to the date a disclosure occurs.

The Service Coordinator and Service Providers will facilitate or actually do appropriate follow-up with referral sources deemed necessary.

Records must be stored in a secure manner according to specific agency policy and procedures.

Clients/families have the right to choose not to release information to any source other than the service providers.

The Service Coordinator and Service Providers will release only client-authorized information as requested by client.

If disclosure is required through a court order or subpoena, the agency's senior official must determine the legitimacy of the order; the purpose for the disclosure will first review the order or subpoena and limitations on the information disclosed.

APPENDIX C-1

[Appendix to County A Community Service Coordination]

DEFINITIONS

Service Providers: Formal services offered by agencies that are mandated to provide services to clients.

Informal Supports: Includes family or friends providing support

Client: An individual with a concurrent disorder (a serious mental illness and substance abuse) with complex physical, psychological, social and/or spiritual needs who uses services offered by community agencies.

Coordination: A process of enabling independent organizations and their staff to work together. It involves establishing a common understanding of the services provided by each agency and by determining each agency's accountability and responsibility.

Individual Service Plan: A series of goals, interventions and tangible outcome measures and responsibilities that provide a cohesive and integrated approach that addresses and meets the identified needs of the client.

Service Coordination: Service Coordination is a team approach to providing services. These activities include assessing, planning, coordinating, implementing, monitoring and evaluating services.

Service Coordinator: The Service Coordinator will be designated to coordinate and ensure the organization of and follow through of identified client needs.

APPENDIX C-2

[Appendix to County A Community Service Coordination]

COPIES OF LIAISON PRIVILEGES

Agencies in County A have an obligation to maintain the confidentiality of client information. Confidentiality is important because it enhances the clients' trust and their satisfaction with the support and services they receive. It also demonstrates a commitment to professional standards and behaviour and must be protected.

Liaison privileges exist with the following agencies:

(list agencies)

The purpose of the signed agreement is to allow the staff (who must individually sign and be approved for this privilege) to verbally exchange client information.

Community Service Coordination

Screening Checklist for Clients

	Check if YES
Does the client have multiple and/or complex needs?	
Does the client believe that they have multiple or complex needs?	
One or more services providers, agencies involved and /or needed.	

A YES answer to one or more of the above statements indicates the client may be appropriate for the Community Service Coordination Process.

Community Service Coordination
Individual Service Plan

Name of Client: _____
Service Coordinator: _____ Date Developed: _____
Date of Next Meeting/Review: _____

Service Provider Responsible	**Goals**	**Action**	*** Client Approved**
Progress Update: (Status of Goal, Strengths, Obstacles)			
Modification of Goal			

* Space for client's initials to indicate client's agreement and received a copy of the plan.

Community Service Coordination

Referral

Name of Client: _____

Birth Date (Age): _____

Service Coordinator: _____ Date of Request: _____

Agency referred Client Referred to: _____

Contact person: _____ Phone & extension: _____

Request:

Reason for Referral:

Client Comment:

Appendix D

TRAINING NEEDS ASSESSMENT

Name of your Agency:_____-
_____

Type of Services provided:

_____

_____

Type of clients to whom you provide services:

_____

Please rate your learning need in the following topics from low to high, where 1 indicates a low learning priority and 5 indicates a high learning priority.

Topics	**Low Priority**				**High Priority**
Identification of mental health disorders	1	2	3	4	5
Overview of various mental health disorders	1	2	3	4	5
Information about medications for mental health disorders	1	2	3	4	5
Treatment options for people with mental health disorders	1	2	3	4	5
Crisis intervention	1	2	3	4	5
Community resources for people with mental health disorders	1	2	3	4	5
Referral procedures for people with mental health problems, to agencies in, and outside, this community	1	2	3	4	5
Identification of substance abuse	1	2	3	4	5
Facts and myths about alcohol	1	2	3	4	5
Facts and myths about illicit drugs	1	2	3	4	5
Facts and myths about prescription drugs	1	2	3	4	5
Detoxification – withdrawal symptoms and management	1	2	3	4	5
Community resources for assessment, referral and treatment	1	2	3	4	5
Referral procedures for people with substance abuse problems, to agencies in, and outside, this community	1	2	3	4	5

Other:_____
_____
_____

Appendix E

SERVICE AGREEMENT

BETWEEN

(residential provincial program)

AND

(local community agencies)

1

Purpose

The purpose of this agreement is to enhance communication between services and to ensure smooth and effective referral and discharge processes.

AGREEMENT

Communication

We are committed to ensuring regular communication between (residential program) and the above mentioned (local community) services by:

1. On a regular basis, the Director of (residential program) will forward program changes (including client package, forms, policies and procedures) to the Program Director of (specific local service through which most referrals to residential program would occur).

2. The Program Director of (specific local service through which most referrals to residential program would occur) will be responsible for forwarding this information to the (residential program) liaison representative at the following agencies:

(list other local community agencies who have clients with concurrent disorders)

3. The District Health Council agrees to disseminate this information at meetings of the (name of DHC sub-committee).

4. Representatives from each of the agencies listed in #2 will forward their program changes directly to the Director of (residential program).

5. Any concerns about this agreement will be brought to the Director of (specific local service through which most referrals to residential program would occur) who will call a meeting to have the concerns addressed.

2

Referral and Discharge Processes

The purpose of the process outlined below is to ensure that:

a) referrals are appropriate;

b) the least intrusive and least expensive treatment options are considered;

c) County A's service providers provide clients/consumers with a client package and an explanation of the admission and discharge procedures;

d) other options are considered while the client/consumer is on a waitlist;

e) (residential program) knows which County A service provider(s) to contact to have involved in discharge planning.

1. The preference is that all referrals to (residential program) come from an addiction or mental health service provider in County A, namely the services listed as part of this agreement. Each of these services has a (residential program) liaison representative. Through the communication vehicles listed above, and through training by a (residential program) representative, these services are committed to being up-to-date on how to assess concurrent disorders and how to determine appropriate referrals to (residential program).

In addition, within County A, clients who are being considered for (residential program) will be considered for the local Concurrent Disorders Group as a least intrusive and least expensive alternative to (residential program). In collaboration with the Concurrent Disorders Group facilitators, a decision will be made as to the appropriateness of referring a client to (residential program). Attending the Concurrent Disorders Group will also be an option while the client is on a waitlist for (residential program).

2. Upon making a referral to (residential program), County A service providers will attach to the referral form a crisis and discharge contact list. The purpose of this list is to inform (residential program) service providers of the client's preference for contacts at discharge and if a crisis occurs. This list can include service providers, family members, friends, or anyone else who the client chooses.

3. With (residential program) staff support, the client will contact the County A service provider prior to discharge. The (residential program) staff will fax a one-page discharge information sheet to the County A service provider (which will include the case manager and aftercare worker's phone number). A full discharge report will be forwarded after discharge.

4 . When (residential program) staff assesses a County A resident for (residential program) services, they will also consider the appropriateness of referral to the County A CD Group as a least intrusive alternative to the (residential program).

Signatories

All signatories agree to comply with all the conditions stipulated in the agreement.

(name) _____ _____
(Agency) Date

(name) _____ _____
(Agency) Date

etc.

Appendix F

CONCURRENT DISORDERS ALLIANCE SERVICE AGREEMENT

developed by

THE CONCURRENT DISORDERS SYSTEM MODELS PROJECT - COUNTY B

This document represents an initial agreement among the services listed in Appendix A on the _____day of _____, 2000.

It will be reviewed again on _____ unless an Executive Director of any member of the Alliance requests a revision at an earlier date. The Centre for Addiction and Mental Health will take the lead in organizing these meetings.

Structure of the Alliance

The Mental Health Reform Implementation Plan uses the term "strategic alliances" in discussing a means to "facilitate service integration." According to the Oxford Dictionary, an alliance is a "union" or "agreement to co-operate." Because the purpose of this service agreement is to develop a coordinated system of care for individuals with concurrent disorders, an agreement to cooperate is essential. The addiction rationalization document does not use the term "alliance" but recommends a "network" of services. Similar to an alliance, a network means "a group of people who exchange information, contacts and experience for professional or social purposes" (Oxford). This term is very similar to "alliance" and is also appropriate for developing a coordinated system of care. Although, the title of this agreement uses the term "alliance," "network" and "alliance" will be used interchangeably throughout this document.

As an alliance, we assume that client/consumers often do not know in advance which service will best meet their needs and as a result they may initially present to any one of the services available. One way of achieving a seamless system of care is to engage client/consumers at the first location in which they present rather than turning them away because they don't meet the agency's mandate. Client/consumers may not receive all or even any treatment at this first location but they will be engaged and will have effective referrals to the services that can best meet their needs.

For this reason, there is not one lead agency for the entire addiction and mental health system. Instead, all agencies will be familiar with the expertise of the other agencies and client/consumers will be appropriately referred (including follow-up) to the agency or individual that is the "lead" service for the client/consumer's particular need at that given time. This service agreement allows agencies to focus their respective areas of expertise while at the same time avoiding duplication of services. Each participating agency is considered to have equal input and

decision-making power into the contents of this agreement and how this coordination mechanism is implemented. Members of this agreement will be accountable to the Alliance.

Target Population

This agreement addresses the treatment of individuals with both an addiction and a mental health problem who present to publicly funded services in County B. This population includes the following sub-groups:

1. adults who have been diagnosed with both a psychiatric and an addiction disorder;

2. adults who have symptoms that suggest they may have both types of disorders but have not yet received a formal diagnostic assessment; and

3. adults who may not meet all necessary criteria for both an addiction and a mental health disorder but who are concerned with or are presenting with symptoms of both types of problems (sub-syndromal).

4. family members (any age) of individuals in sub-group 1, 2, or 3.

NOTE: Not all agencies in the Alliance are expected to service all of the above mentioned sub-groups. While the priority of this agreement is individuals who have been diagnosed with both a psychiatric and an addiction disorder, the treatment system must be responsive to and accessible to all people with symptoms of both addiction and mental health problems. For this reason, all agencies are expected to make appropriate referrals (based on the client/consumer's level of need) when such an individual does not fit the mandate of that agency.

Purpose of Agreement

The current Mental Health Reform documents state the expectation that agencies "jointly plan and share service delivery for people whose multiple needs require that they must access services from multiple systems" (MOH, p. 21). The **purpose of this service agreement, therefore, is to provide agencies with a mechanism for this joint planning and sharing of service delivery**, specifically for individuals who require services from both the addiction and the mental health systems.

Consistent with the recommendations in the addiction system's current rationalization document, the **objectives of this agreement are to ensure that the network has a clear description of:**

- **the services that are provided,**
- **the links between agencies and**
- **the role of each agency in the full continuum of health and social services.**

The goals of the agreement are outlined in the County B Concurrent Disorders System Logic Model (attached). These include:

- to more effectively and efficiently service individuals with both a substance use and a mental health problem
- to create a generally reliable structure that provides services that are the least intrusive and are client/consumer-centred
- to increase quality of life (e.g., a home, a job, a friend)
- to more effectively identify when services for both mental health and substance use problems would benefit the client/consumer
- to improve continuity of delivery of client/consumer services (both treatment and support) and continuity of staff contact
- to ensure equal access to services (e.g., child care, transportation)
- to ensure culturally appropriate services

Overall, this service agreement provides a protocol that ensures a seamless system of care with smooth linkages. That is, a system where client/consumers feel as though they are part of one system and that each component of the system works together. As outlined in current reform documents, services "will develop effective working partnerships with other sectors whose services could benefit their clients" (addictions, p. 8) and "services will be linked and coordinated so the consumer is able to move easily from one part of the system to another" (mental health, p. 3).

Commitment

Each member of the Alliance is committed:

- to ensure efficient referral processes and appropriate follow-up by:
  - contacting both the client/consumer and the service provider to whom the client/consumer was referred to assess whether the referral was successful; and
  - as deemed appropriate by the referring service provider, addressing issues that arose if the referral was not successful.
- to ensure that client/consumers have access to the system 24 hours a day by having the phone number of an emergency after-hours contact on their answering machine so that individuals are informed of that option 24 hours a day;
- to communicate program changes to members of the Alliance and to the emergency contact service that is on their answering machine;
- to submit program changes to the [name of county] Mental Health and Addiction Education Web site manager to have them posted on the site;
- to considering client/consumer feedback in planning decisions and program changes;
- to improve coordination of client/consumer care between addiction and mental health agencies with overlapping client/consumer groups. This will be achieved by collaborating using the mechanisms under the "Collaboration" section below;
- to improve treatment planning to increase quality of service to client/consumers;
- to maximize the effectiveness of the participating services;
- to share staff expertise and other resources between agencies;
- to facilitate the opportunity for staff to define the relationship between participating agencies;
- to provide increased support to consumer-run groups;

- to engage in common advocacy where gaps are identified;
- to develop a more comprehensive system for evaluating client/consumer outcome;
- to match client/consumers with community services to meet their specific needs.

Collaboration

The agencies may share client/consumers in common either through referral by one agency to the other or because the client/consumer is simultaneously involved with both agencies as a result of self-referral or referral from a third source. Regardless of how client/consumers come to attend multiple services, they will be informed that each agency is not a stand alone service but an agency with other resources; all agencies are part of one system. The client/consumer is a client or consumer of the system rather than a client or consumer of one particular agency.

The first agency to realize the client/consumer is also involved with another service shall request consent from the client/consumer to share information with that other agency. The client/consumer shall be fully informed of the purpose of the consent and the type of information to be shared.

The agencies will endeavour to communicate with each other regarding the client/consumer on a regular basis, or whenever deemed necessary, for case conferencing, treatment planning or progress updates. This will ensure the provision of coordinated service to the client/consumer. The schedule and type of communication will be decided upon by the assigned staff, but will likely be characterized by periodic telephone conversations.

Mechanisms for building linkages include:

Whenever appropriate managers will encourage staff to engage in one or all of the following:

1) Case Conferencing: when a client/consumer is receiving services at more than one agency, the development of a treatment plan will include input from the client/consumer and all service providers, as well as any other individual who the client/consumer feels should be part of the decision.

2) Staff Sharing: free of charge, a service provider from one agency will work at another agency as consultant or as front-line service provider. This can be at regular intervals such as every Monday afternoon or it can be on an as-needed basis. This service may also be reciprocated by a service provider in the second agency also doing some work at the first agency.

3) Cross-training: service providers at one agency are trained by staff at another agency and vice versa. This includes consultations as well as in-house training.

4) Shared Training: when a training event is organized by one agency, the organizers will invite service providers from another agency. This usually refers to in-house training. No cost would be charged to the second service.

5) Shared Physical Space: an agency offers some of their physical space to service providers at another agency. For example, an agency may offer a room for a self-help group to be held once a week. Another example is when an agency may provide a shared office space (with booking schedule) for a service provider to see a client/consumer in that location because it is more convenient for the client/consumer than having the appointment at the service provider's office.

Administrative/Management Responsibilities

Each partner agency will continue to:

- have its own governing body
- provide for its own liability insurance and protection of other assets
- manage their own staff and operate with their own human resource policies
- offer the services it chooses
- use the admission criteria it chooses

Conflict Resolution

In situations where a staff member from one agency is conducting clinical, consultation, or administrative services in a second agency, that staff member will abide by the policies and procedures of the second agency. Should there be any conflict that arises, the process of resolution is first for those who are directly involved to address the issue. If the conflict cannot be resolved in this manner, then the Executive Director of each agency will meet with the others who are directly involved to address the issue.

Process for Review of Agreement

Each partner agency will ensure that a senior management representative attends a meeting no less than four (4) times annually to foster positive working relationships and to facilitate operation of this agreement.

The purpose of these meetings will be to:

- assess whether the Alliance has achieved its goals and objectives;
- to assess the effectiveness of incorporating client/consumer input into the service delivery system; and
- to modify the attached system logic model as appropriate.

APPENDIX F-1

[Appendix to Concurrent Disorders Alliance Service Agreement]

MEMBERS OF THE ALLIANCE INCLUDE THE FOLLOWING AGENCIES
(In Alphabetical Order)

 (name of agency)

(name of representative)_____ Date: _____
(Signature)

Office locations covered by the Agreement: _____

NOTE: The Alliance is also proposing to include:

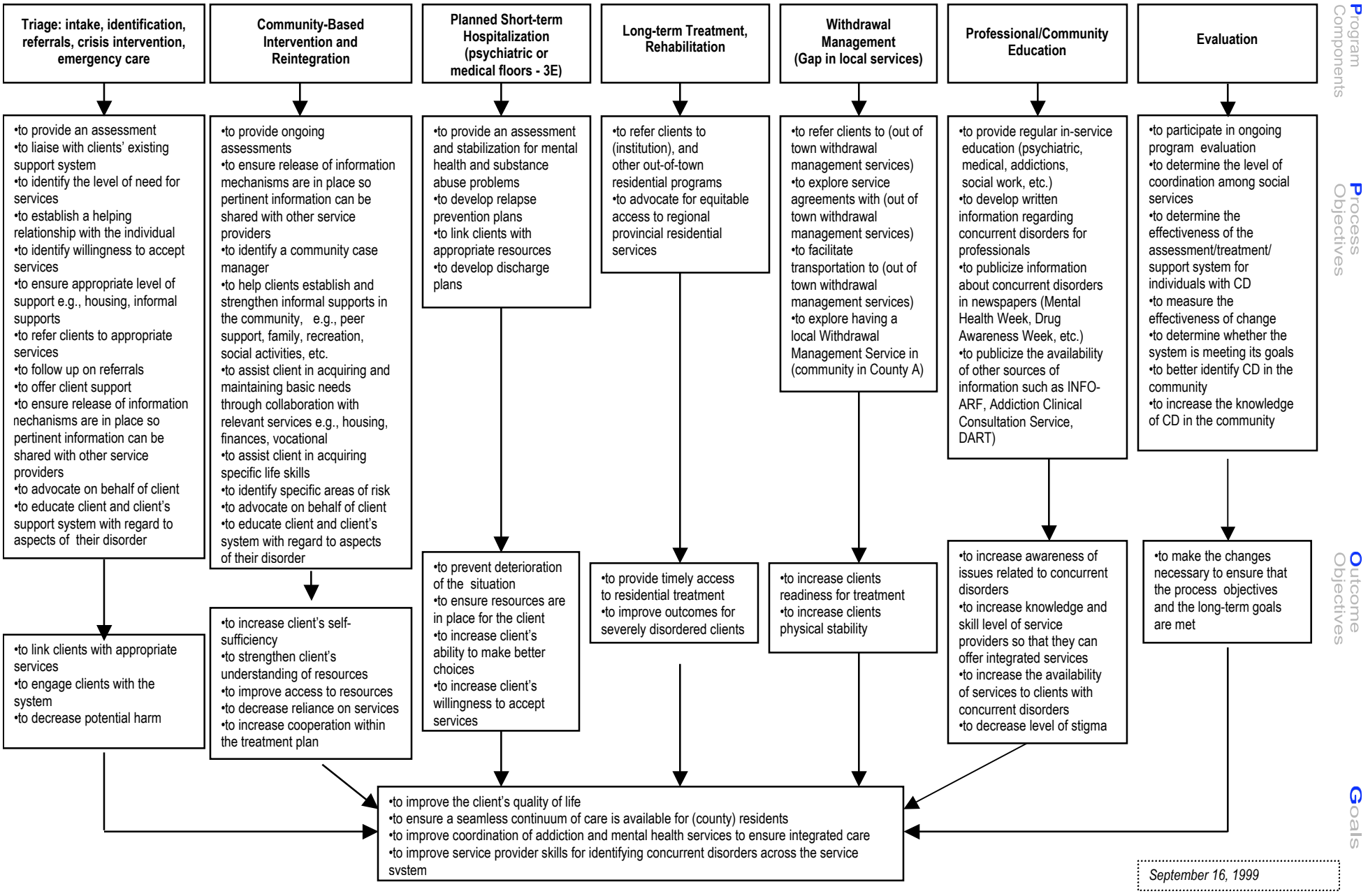
(list other agencies that have not been involved in the process but that the Alliance would like to have sitting around the table)

Appendix G

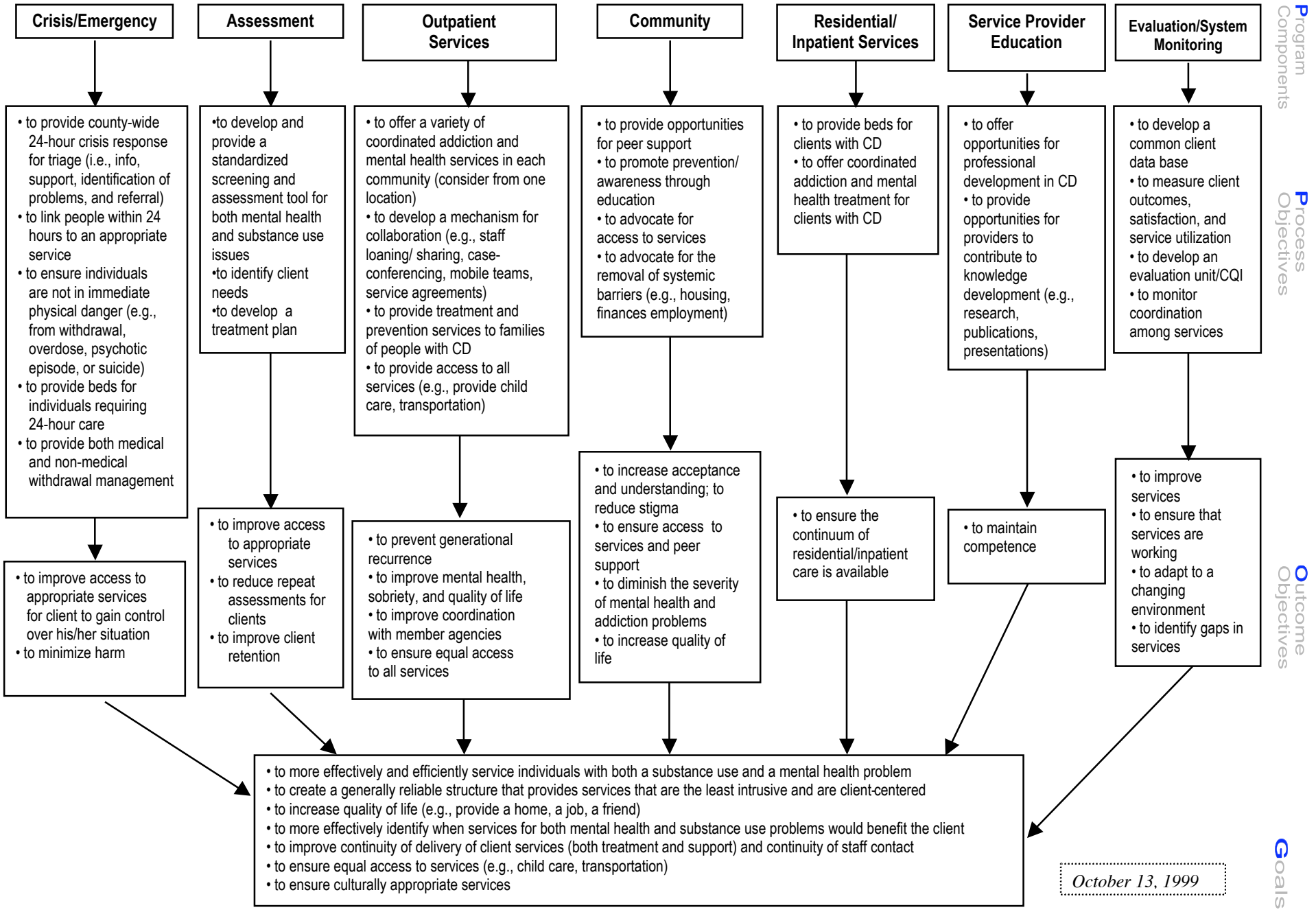
Recommended Strategies for Facilitating Consumer Involvement

- Be clear about the target population and describe it in terms used by consumers.
- Administer a brief survey or interview clients with CD.
- Hold "information sessions" which could be used to recruit client/consumer representatives before the project begins.
- Advertise on posters, in newspapers, Cable TV, through a local speakers' bureau and through the many local consumer networks.
- Reduce barriers to participation by offering transportation and child care for example.
- Treat participants as equals and with respect and understanding include consumers more directly by ensuring they share decision-making power and by providing them with the use of agency resources (e.g., photocopier and fax).
- Explore mechanisms for compensating consumers for their participation.
- Avoid stigmatizing comments and the use of professional jargon.
- Be patient and tolerant of missed meetings.
- Schedule meetings at times when consumers can attend.

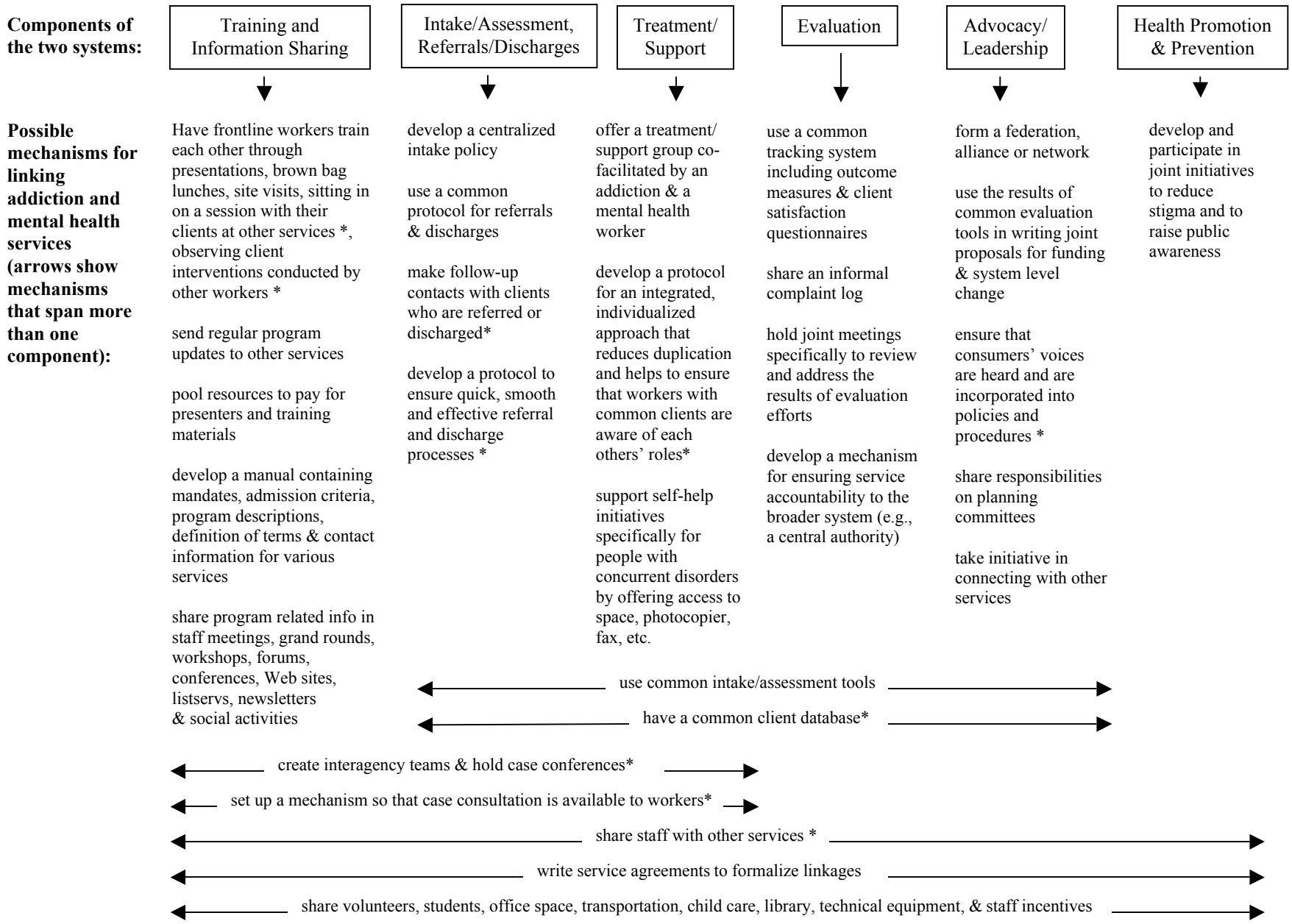
Appendix H County A Concurrent Disorders System Logic



Appendix I County B Concurrent Disorders System Logic Model



Appendix J Possible Mechanisms for Linking Addiction and Mental Health Services at the Community Level



** Consideration must be given to ensure the protection of clients' rights regarding confidentiality and choice*