Capital Health

Release of Concurrent Disorders Report
November 2011

Dear Friends and Partners,

Last year, Capital Health established a task group to find ways to improve care for concurrent disorders clients, individuals living with both a diagnosed mental illness and an addiction. The enclosed report, "A Collaborative Framework: Caring for Individuals Living with Concurrent Disorders," lays the foundation for improved collaboration and care.

There are already many examples of ways in which Capital Health's Mental Health Program (MHP) and Addiction Prevention and Treatment Services (APTS) work well together to support individuals living with concurrent disorders. Traditionally, however, individuals with concurrent disorders have been treated sequentially by our services. This means that the individual was treated first for the mental illness and then later for the addiction issue – or vice versa.

This report recommends working toward a collaborative model of care in which mental health staff provide treatment for mental health issues, while – at the same time – addictions staff address substance use issues. This model will build on the collaboration that is already taking place between our services, while strengthening our ability to provide improved and coordinated care.

Here is a quick look at what is inside the report:

- **screening and assessment tools** to better identify concurrent disorders
- **concurrent disorders training** to build capacity among all APTS/MHP staff
- additional **collaborative initiatives** in a number of clinical areas
- ways to address barriers to **information sharing**
- **community engagement** to ensure individuals and families continue to provide input and feedback
- **identification of future needs** (e.g. specialized concurrent disorders inpatient/day treatment)

Sustainability plans include:

- establishing a permanent **Concurrent Disorders Council** with representation from APTS, MHP, clients and family members.
- appointing a manager and a physician to co-lead this work, using existing staffing, accountable to both APTS and MHP.

Please visit the following webpages to learn more about upcoming events where we will share more details about our plans for concurrent disorders:

- http://www.cdha.nshealth.ca/addiction-prevention-treatment-services/concurrent-disorders
- www.ourhealthyminds.com

Thank you to all who contributed ideas and perspectives on how to improve care. There will be ongoing evaluation during this process, so please continue to send us your ideas.

Sincerely,

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A Collaborative Framework:
Caring for Individuals Living with Concurrent Disorders

The Concurrent Disorders Task Group

of

Addiction Prevention and Treatment Services and
The Mental Health Program,
Capital Health

November 1, 2011

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I. Executive Summary

In Canada, concurrent disorders refer to individuals who have been diagnosed with mental illness and at least one addiction issue. Concurrent disorders – prevalent in those with mental illnesses and even more prevalent in those with substance abuse – are challenging to treat effectively. Moreover, treatment programs in Canada – and elsewhere – have been largely unsuccessful. Barriers to successful treatment have included:

- long-standing cultural differences between addictions and mental health treatment programs;
- philosophical differences relating to best practices for treatment of concurrent disorders;
- lack of support by senior leadership to bring staff together for planning and collaboration related to developing models of integrated care;
- lack of funding for integrated treatment programs.

Despite these challenges, Capital Health made a commitment to our citizens to provide better care for individuals living with concurrent disorders. With strong support from the Vice President, Person-Centred Health and the directors of both Addiction Prevention and Treatment Services (APTS) and the Mental Health Program (MHP), a task group was launched in August 2010 to examine how more effective and sustainable clinical services could be provided to this often neglected and under-serviced group. The task group's mandate was to develop a strategy and submit it to Capital Health's senior leadership by the fall of 2011. The aim: to design a clearly articulated and do-able plan, one that would not require immediate additional resources and that would be sustainable over time.

This report presents the findings of the task group's efforts over the past year. Working groups, established by the overall task group, have made recommendations regarding:

- organizational structures that would sustain this work over the long haul (framework);
- ways of engaging a wide range of stakeholders in this process (engagement);
- immediate and longer-term clinical approaches that could and should be implemented (clinical initiatives);
- improving the ability of both mental health and addiction services to identify those with concurrent disorders (screening and assessment);
- training and capacity building among staff and others.

The task group has also identified current and future challenges and identified a timeline for implementing these initial recommendations, the most important of which is the creation of a permanent council to guide this work as it moves forward in Capital Health district.

Finally, in carrying out its work, the task group became increasingly aware of the need for a specialized concurrent disorders day or inpatient treatment program in Capital Health. It is the task group's hope that, as APTS and MHP together increase the capacity of all staff in identifying and treating concurrent disorders and as collaboration between mental health and addictions continues to grow, our services will be well positioned to establish a specialized integrated program in the future..

In the meantime, it will be the crucial role of the Concurrent Disorders Council to ensure that the level of collaboration that has already taken place between the two services continues to flourish in the coming years, resulting in many tangible examples of improved care for individuals living with concurrent disorders.

II. Introduction

In the spring of 2010, Capital Health's Mental Health Program (MHP) and Addiction Prevention and Treatment Services (APTS) began the work of creating a framework, or a new model of care, for individuals living with concurrent disorders, an especially vulnerable population made up of people who are experiencing both mental health and addiction issues.

Concurrent disorders clients make up a significant percentage of those accessing the services of APTS and MHP. The Centre for Addictions and Mental Health in Toronto, Ontario, has noted that – depending on the setting – prevalence rates for concurrent disorders have been found to range from 20 to 80 percent.[1]

Currently, Capital Health lacks a specialized, collaborative treatment service for Concurrent Disorder clients. In fact, in many cases, clients with concurrent disorders face significant challenges in accessing services and receiving treatment. For example:

- Upon intake, MHP staff may ask that clients deal with their addiction issue prior to receiving treatment.
- Addiction staff may require that clients receive treatment for a mental health issue prior to accessing addiction services.
- Access, treatment and navigation through the system can be extremely complex and frustrating for this vulnerable population, significantly affecting recovery and contributing to relapse.

> • *"Effective intervention for concurrent disorders requires close collaboration between specialized addiction services and mental health providers."*
>
> *- Concurrent Disorders: Cross-Jurisdictional Review*

A collaborative model of care is clearly needed to prevent individuals from being treated separately over time by two different services when their needs could have been better met by a collaborative service that addressed their needs together. From a client perspective, collaboration would result in:

- Improved, more comprehensive and effective care and treatment.
- A more efficient and accessible intake and assessment process that avoids clients being "bounced" from one service to the other.
- Reduced frustration for clients and their families.
- Better support for recovery and a reduction in relapse.

With the needs so obvious, it does not come as a surprise that attempts to collaborate on better care for shared patients and clients have happened numerous times in past decades. Plans had been developed, volumes written, on how to serve this vulnerable population in a different way, but the complexities and staffing resources required to implement these plans proved unsustainable, and – although intentions were good – needed changes to the system did not happen.

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1. [1] Centre for Addiction and Mental Health, "People with Concurrent Disorders," in *Virtual Resource for the Addiction Treatment System, Section 3: Special Populations.*

In addition, former attempts at developing a plan for concurrent disorders failed to put in place a formal mechanism or body to ensure sustainability and accountability over time. No group was tasked with the ongoing work of implementation, monitoring, evaluation and follow up. With the ongoing demands on the system and on individual services and clinicians, past attempts at a formal collaborative model of care for concurrent disorders failed. Collaboration between MHP and APTS did happen, but it was dependent upon the goodwill of individual staff members or teams.

This time, plans are in place to ensure that both appropriate and evidence-based services will be developed, with an ongoing sustainability framework to support them.

What is different this time?

- The task group has received a clear mandate from Capital Health senior leadership.
- This mandate comes with support, encouragement and accountability. Capital Health leaders and board are keenly interested in seeing this work come to fruition, and they will hold both services accountable for achieving improved patient and client care.
- The timing of the task group's mandate coincides with a growing provincial interest in concurrent disorders and how to address current gaps in services provincially for this vulnerable population.
- The province released a cross-jurisdictional review of concurrent disorders programs last year, which contributed to and helped shape the task group's early work.
- The provincial government has made concurrent disorders a priority and hired a coordinator to move the work ahead at the provincial level. The task group has worked collaboratively with government throughout this process to ensure that all efforts are aligned provincially and nationally in terms of standards and best practices.
- This time, APTS and MHP have focused on creating a modest and realizable model of care that uses existing resources, one that will be implemented through realignment of priorities and better sharing of resources.
- Sustainability has been the focus from the very beginning. The task group's first working group to be established -- the Framework Working Group -- identified early on that an ongoing permanent structure would be needed to ensure this work would be sustainable. A Concurrent Disorders Council, with representation from both APTS and MHP and accountable to APTS and MHP directors and the vice president, Person-Centred Health, will move the work forward after the task group disbands. A position appointed to manage the concurrent disorders initiatives and to support and guide the council will add to the strength of this sustainability framework.

The need for an integrated concurrent disorders treatment program

It was the task group's mandate to develop a framework and recommendations using only existing resources. However, in carrying out this work, it became clear to everyone involved that a specialized and integrated concurrent disorders day or inpatient treatment program is needed in Capital Health and the province as a whole.

Currently, no integrated concurrent disorders treatment program exists in Eastern Canada. As a result, this highly vulnerable population lacks access to needed care or must be sent out-of-province to obtain it. As such, the task group recommends that funding for a specialized concurrent disorders day or inpatient treatment program be identified as a funding priority for the coming years.
A concurrent disorders inpatient unit will require approximately $1.3 million per year to support staffing and supplies. A concurrent disorders day program is a second option and would require approximately $500,000. Should such a unit be established and made available to individuals living in the Maritime provinces, it could be a revenue generator for Capital Health and/or for the Department of Health and Wellness.

For more information on this option, please see **Appendix H**: "Estimated Budget for a 10-Bed Concurrent Disorder Program."

Submitted by:

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Approval of Report and Recommendations

This report was approved by:

Barbara Hall

_____ on October 31, 2011.

Barbara Hall
Vice President, Person-Centred Health

▪ *"Substance use and mental health influence one another interactively. Maintaining a dual focus is key to effectively engaging and working with clients with concurrent disorders. The [goal of the treatment team is to] ensure that clients receive care that is effective and coordinated."*

- Centre for Addiction and Mental Health, Concurrent Disorders Services

III. Project Charter[2]

A. Purpose

The mandate of the task group was to create a framework to support collaboration and an integrated approach in the treatment of individuals with concurrent disorders and their families.

The following activities fell within the scope of the task group's work:

- Design an effective model of care for concurrent disorders clients that includes:
  - ✓ Identifying integrated clinical care and practice guidelines.
  - ✓ Building capacity by implementing common education and training programs.
  - ✓ Collaborating on common and integrated research projects.
  - ✓ Incorporating continuity of care and transition of care approaches.
  - ✓ Coordinating a holistic care journey.
- Put into place accountability structures in APTS and MHP to ensure the framework is successfully implemented.
- Carry out evaluation to monitor the progress and success of the framework.
- Create a process to obtain ongoing feedback from staff, community and consumers on the effectiveness of the services.
- Develop a set of principles to guide the process (e.g. change management).
- Create a process to implement the model of care (e.g. pilot initiatives).
- Implement outcome measures within the model.

▪ *Our purpose: create a framework to support collaboration and an integrated approach in the treatment of individuals with concurrent disorders and their families.*

The task group made the following assumptions in carrying out this work:

- Significant change needs to occur to successfully implement the framework.
- There is a current lack of data available on concurrent disorders in Capital Health.
- The parameters of the task group are clearly understood and endorsed by leadership and partners.
- Project resources necessary will be committed and endorsed.
- Competing organizational priorities will be managed by leadership.
- The clinical frontline team will have the authority to contribute to the ongoing evolution of the process model in application.

[2] Complete version of the Project Charter found in **Appendix A.**

IV. Approaches to Treating Concurrent Disorders

The challenges of working with concurrent disorders clients are as old as health care itself. Historically, health professionals have struggled to reconcile various types of treatment, which vary greatly and are based on differing philosophical orientations and approaches. Integrated care for concurrent disorders has been slow in coming and could not be found anywhere in North America until recently. Even now, effective collaboration on models of care between mental health and addictions is rare, and change to the system is painfully slow.

Historically, there have been three primary models of service delivery for concurrent disorders:

A. Sequential Treatment

By far the most popular approach in the latter part of the twentieth century, this remains the model of choice for many professionals.

- In sequential treatment, the individual seeks treatment for one disorder. Then – having successfully addressed that disorder – the client moves on to treatment for the second disorder. The more serious or severe condition, viewed as the primary disorder, is generally tackled first.
- This approach may delay much-needed interventions. Most often, a person's two conditions are interrelated, so it can be nearly impossible to address the issues in isolation from one another. For example, addressing a drinking problem in someone who is profoundly depressed presents a serious clinical challenge. Similarly, treating a depressive disorder in someone who is actively drinking is equally challenging.
- Often, sequential treatment results in neither condition receiving adequate or timely treatment.
- In this type of sequential approach, patients often end up going from one service to the other repeatedly, a frustrating experience that can cause them to give up on treatment entirely.

▪ *Integrated care for concurrent disorders has been slow in coming and could not be found anywhere in North America until recently.*

B. Parallel Treatment

This approach is what APTS and MHP are striving to implement with this proposed framework. Given current fiscal realities, which include no new resources, parallel treatment is the most realistic model of care for Capital Health to implement at this time. However, this does not preclude the option of offering a specialized concurrent disorders inpatient or day program as staff become more highly skilled in concurrent disorders and as funding realities change. It is the hope of both APTS and MHP and the task group as a whole that successful implementation of a parallel model will lead to increased awareness of the need for an integrated concurrent disorders program in Eastern Canada. The recommendations put forward in this report are designed to lay the foundation for a specialized concurrent disorders program at some future date.

In the parallel model currently being proposed, individuals are cared for with a coordinated clinical care approach, one that addresses both mental health issues and addictions concerns together, drawing on the strengths and expertise of both types of clinical approaches. Clinical staff from each service area work together to ensure the best treatment outcomes for clients.

- Mental health issues are tackled by those on the mental health team.
- At the same time, substance use issues are addressed by addictions staff.
- This type of treatment helps improve the individual's likelihood of successful recovery.

- The challenge to success in this model, however, is effective communication between caregivers.
- With multiple professionals involved, an accountability system is needed to ensure that clinicians communicate regularly with one another and not give conflicting advice or messages to clients based on differing treatment practices and philosophies.

C. Integrated Treatment

Specialized concurrent disorders treatment programs that offer fully integrated treatment exist at only a few sites across the country. In the future, APTS and MHP envision such a program located at Capital Health and serving much of Eastern Canada. The task group identified the need for such a program in Capital Health and identified it as a priority for any concurrent disorders' funding made available in the future. Currently, clients must go out-of-province to receive this type of treatment.

In a specialized day or inpatient concurrent disorders program, clients would receive treatment for all their addiction and mental health conditions under the care of a single multidisciplinary team.

- The theory behind this treatment model is that one cohesive team simultaneously addressing all aspects of mental health and addictions may improve outcomes.
- Further study is needed to determine whether this approach truly is more effective than parallel treatment.
- Because services of this nature generally treat patients with more severe and complex conditions, it can be hard to measure effectiveness compared to other models.

V. Working Groups and Recommendations

A. Framework Working Group

1. Mandate

The mandate of this working group was to:

- Create the overarching framework based on the leading evidence regarding concurrent disorders' service provision.
- Create a visual representation of this framework that illustrates the journey that individuals will experience as they move throughout both services.
- Recommend an organizational structure to support and sustain the work moving forward.

2. Approach

In designing this framework, the working group reviewed and incorporated many of the concepts presented in the Tiered Model of Service, outlined in the report *Concurrent Disorders: Cross Jurisdictional Review,* prepared by Pyra Management Consultants, Inc. for the province of Nova Scotia.

According to this report, the Tiered Model of Service is a "conceptual organization of addiction and mental health services … where Tier 1 reaches the most people, with each subsequent tier offering more focused, often more specialized, and generally more intensive services for an increasingly smaller population." This model was based on the work of the National Treatment Strategy Working Group (2008) and the concept of the continuum of care as presented in the Kirby Report, *Out of the Shadows at Last* (2006).

3. The Framework

The working group created a framework that integrates the concept of the tiers from addictions literature with a continuum of care model, well known in both mental health and addictions. The language of this framework was carefully selected to be easily embraced by staff in both services.

In a tiered model of service, clients move seamlessly between the tiers in either direction. Moreover, every entry point into the system is a valid entry point, and, once in the system, clients can easily move between the tiers based on needs. The working group embraced these principles of fluid movement and "every door is the right door" and deemed them crucial to the framework.

Finally, instead of recommending a new *organization* or *program*, this working group recommends the development of a framework that identifies the collaborative space in which the services provide integrated care to a shared client population.

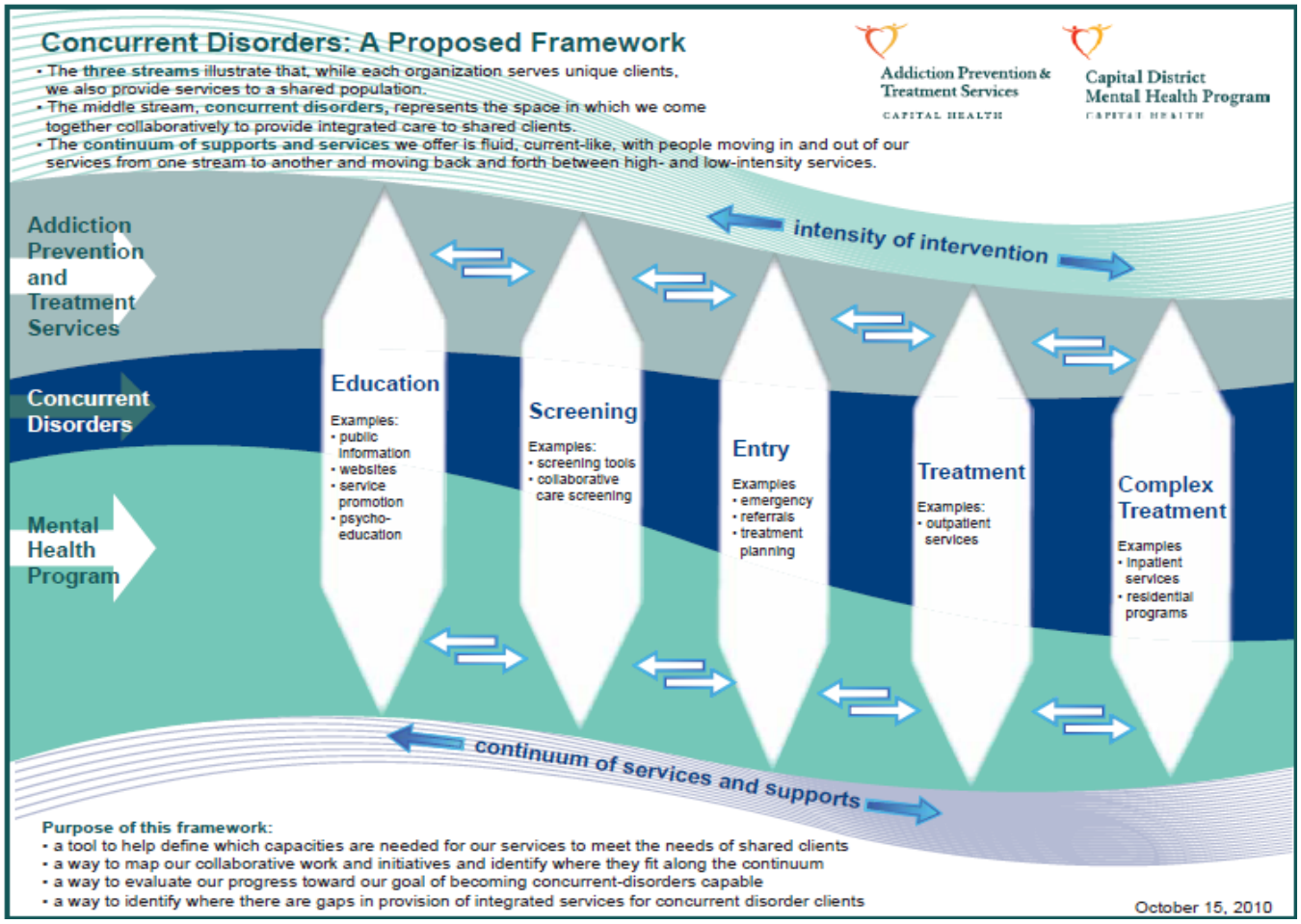
• The proposed framework includes three streams: the outer streams represent APTS and MHP and their unique clients. The middle stream, concurrent disorders, represents the space in which we come together – across the entire continuum of services – to collaboratively provide integrated care to our shared clients.

As the Cross-Jurisdictional Review states, "Treatment services must serve people with addiction concerns alone, people with mental health concerns alone, and people with co-occurring addiction and mental health disorders. Therefore, the tiered model will be developed

with three distinct yet integrated streams that serve clients and families." The framework created by this working group clearly identifies these three streams in the illustration (below):

- The outer streams represent APTS and MHP and their unique clients.
- The middle stream, concurrent disorders, represents the space in which both services come together – across the entire continuum of services – to collaboratively provide integrated care to shared clients.
- The continuum of supports and services offered is fluid, current-like, with people moving in and out of different services from one stream to another and moving back and forth between high- and low-intensity services.
- The intensity of the service grows greater as you move from left to right on the continuum, while the number of clients served by the intervention decreases.

Concurrent Disorder Proposed Framework



4. Proposed Sustainability Structure

Next, the working group tackled the design of a permanent organizational structure that will ensure the sustainability of the concurrent disorders model of care within Capital Health. The task group envisioned a permanent council that would implement the recommendations created by the current task group as well as continue to develop the collaborative model of care for concurrent disorders within APTS and MHP.

A manager of concurrent disorders would be identified to guide and support the council's work as it implements the many recommendations, pilot initiatives and training programs identified in this report.

Critical tasks of the manager and the council include:

- Overseeing existing collaborations and maintaining support for them.
- Implementing and managing priority pilot initiatives as identified by the task group.
- Developing a model for a specialized concurrent disorders inpatient or day program in Capital Health and continuing to present this as a need to partners and funders.
- Exploring future collaborations to improve service.
- Measuring and evaluating outcomes of collaborations and initiatives.
- Supporting implementation of the working groups' recommendations identified in this report.
- Overseeing designated working groups and identifying the need for new ones, as required.
- Producing an annual report to senior leaders and other stakeholders, demonstrating concurrent disorders outcomes.
- Ensuring ongoing engagement of both internal and external stakeholders.

The Concurrent Disorders Council will report to the vice president, Person-Centred Health, through the directors of APTS and MHP. The council will be co-chaired by one representative from APTS and one representative from MHP, each serving two-year terms. The council will have membership as follows:

- Four members from APTS.
- Four members from MHP.
- Four consumer advocate and/or client or family representatives.
- A concurrent disorders manager to serve as ex-officio member.

Membership will be for three years, with staggered terms. The APTS and MHP representatives are to be comprised of frontline clinical and non-clinical staff.

RECOMMENDATIONS

Framework Working Group:

1. Accept the collaborative framework illustrated above as the basis for the concurrent disorders model of care within Capital Health. The framework consists of three streams made up of:
    - APTS programming directed to unique addictions clients.
    - MHP programming directed to unique mental health clients.
    - Collaborative concurrent disorders initiatives directed to shared clients.
2. Implement concurrent disorders initiatives across the continuum of services and supports, striving for representation in each of the framework's identified areas, including:

- Education
- Screening
- Entry
- Treatment
- Complex treatment

3. Appoint a Concurrent Disorders Council to sustain the proposed framework, implement the recommendations of this task group and identify ongoing concurrent disorders needs. The details of the council are explained above and outlined in the document, *Concurrent Disorders Council Terms of Reference*, found in **Appendix B**.

B. Engagement Working Group

1. Mandate

This working group's mandate was to engage mental health and addictions staff, consumers, clients, service providers and community stakeholders in discussions about concurrent disorders to help APTS and MHP identify how to better meet the needs of individuals living with both mental illness and addictions.

2. Approach

The Engagement Working Group designed a series of events and communications with staff, community partners and public stakeholders to gather input and share ideas for improving care for concurrent disorders in Capital Health.

3. First Voice Representation in Task Group Membership

Susan Kilbride-Roper provided the perspective of first voice in the task group. Her involvement was crucial in planning respectful, outcome-driven engagement events. Susan was able to help identify who needed to be invited, what topics to open for discussion and where to hold each event in order to ensure a diverse representation and to hear from a wide variety of perspectives.

4. Staff Engagement

The first engagement event focused on hearing from staff of APTS and MHP. Collaborative Day, held in February 2010, brought together more than forty staff from each service to explore how APTS and MHP could come together differently to deliver services to people living with both mental illness and addiction. This staff event was an important first step in opening the lines of communication between two services that had a history of being isolated from one another. The intended outcome was to build closer working relationships and begin to talk about what an effective model of care for concurrent disorders clients might look like.

Wayne Skinner and Debbie Katz Ernest, experts in the area of concurrent disorders programs at the Centre for Addiction and Mental Health in Toronto, facilitated the day. One visioning exercise helped staff identify the attributes of an ideal care journey for individuals living with concurrent disorders.

▪ *Staff saw the need for improved access, and coordinated access points, so that "every door is the right door." Wherever the client enters the system, they would be supported in getting where they need to go to receive the best type of treatment.*

Staff identified that both MHP and APTS needed to be more aligned with primary care professionals, especially in the areas of training and collaboration. Staff saw the need for improved access, and coordinated access points, so that "every door is the right door." Wherever clients enter the system, they would be supported in getting where they need to go to receive the best type of treatment. Staff raised the need for care to "respect the dignity of those we serve, to be person-centred, culturally sensitive and respectful of diversity."

Staff asked for improved and increased communication between and across services. They identified the importance of providing clients with a coordinated care journey so that clients would no longer be "bounced" from one service to the other.

Another Collaborative Day exercise asked staff to identify "just one thing" they would change about the system in the coming year to make it better for individuals living with concurrent disorders. Topping the list:

- Training in concurrent disorders for frontline staff in both services
- Common information systems (MHP and APTS currently use different health information systems)
- A single access point for concurrent disorders clients
- Shared assessments
- Collaborative treatment and groups
- Increased referrals and information sharing
- More collaboration at community locations

5. Citizen/Client Engagement

Building on the success of Collaborative Day in 2010, APTS and MHP expanded engagement the following year to include community partners, citizens, clients and family members. February 10, 2011, marked the first-ever Community Conversation on Concurrent Disorders. Approximately 100 individuals gathered to learn more about the firsthand experiences of individuals living with concurrent disorders, to identify what is not working currently and share ideas for improvement.

Dr. Ron Fraser, clinical academic leader, APTS, presented "Better Care for Individuals Living with Concurrent Disorders," an overview of best practices for a concurrent disorders model of care.

A first-voice experience was presented by Susan Kilbride-Roper. Susan is a consultant with the Empowerment Connection, a patient rights advisor with the Mental Health Program and a member of the APTS-MHP Concurrent Disorders Task Group.

A panel discussion addressed the questions: "What isn't working about care for individuals living with concurrent disorders now?" and "What does better care for individuals living with concurrent disorders look like?"

Panelists included Beverley Crawley, a mental health nurse with the Mental Health Court; Dave Anderson, an addictions counselor; Brigitte Neumann, a family member; Dr. Ajantha Jayabarathan, a family physician; and Patti Melanson, a nurse with the Mobile Outreach Street Health program.

- *In response to the question, **"What does better care look like?"** citizens and stakeholders replied:*
  - *Family power and respect*
  - *Self-help groups*
  - *Coaching and mentoring*
  - *Compassion*
  - *Good communication between partners*
  - *Improved collaboration with primary care; doctors being a bridge to treatment*
  - *A treatment plan that goes with you wherever you go*
  - *Employment, housing and food: addressing the social determinants of health*

The panel was followed by a question-and-answer period, during which the audience could ask questions of the panelists, who were joined by Dr. Ron Fraser (APTS) and Dr. Scott Theriault (MHP). The event closed with a networking lunch.

During the question-and-answer period, members of the audience were encouraged to raise issues and voice their concerns. Many in the audience had had negative experiences in trying to access services for themselves or a loved one. They talked about needing to find a balance between respecting confidentiality requirements and being able to share information that would help family members and caregivers support their loved ones. Others talked of the need for a multi-partnered approach to dealing with concurrent disorders, noting that the issues involved extend far beyond mental health and addictions treatment and include other areas such as income assistance,

employment and availability of safe, affordable housing. The need to be able to access timely treatment and integrated or collaborative care and treatment was also identified as a priority.

As a result of this event clients, community members and partners had the opportunity to identify their interest in becoming involved in future committees and focus groups related to concurrent disorders. APTS and MHP now have a robust list of individuals who are available to assist the Concurrent Disorders Council as it begins to implement some of the recommendations and initiatives outlined in this report.

In addition, the task group decided to hold the Community Conversation on Concurrent Disorders annually to ensure that the voices of those living with concurrent disorders – and those that care for them in the home and the community – are heard by the health care system. This yearly gathering will also serve as an evaluation tool, helping to determine whether the outcomes of this task group's work are improving access, treatment experiences and quality of care.

RECOMMENDATIONS

Engagement Working Group:

1. Organize a yearly event as one of the methods to evaluate whether care is improving and to identify any emerging needs and barriers.
2. Continue to involve concurrent disorders clients and their family members in focus groups, committees and planning.
3. Invite some of the individuals who have indicated an interest in further involvement to join the permanent Concurrent Disorders Council and subcommittees and/or working groups when they are formed.
4. Continue to share the information gathered at the 2010 and 2011 engagement events to raise the profile and understanding of concurrent disorders within Capital Health and in the community.
5. Use existing communications channels within APTS and MHP to share information about concurrent disorders to inform staff, learners, clients, citizens and other stakeholders.

C. Clinical Initiatives Working Group

1. Mandate

The mandate of the Clinical Initiatives Working Group was to look at potential collaborative efforts that would result in better care for concurrent disorders clients, using existing resources. Although no new resources would be available, the working group did look at shifting resources, exchanges of staff and collaborating to do work differently.

2. Approach

Given the fiscal realities, and the certainty that creating a new specialized, integrated concurrent disorders program would not be an option at the present time, the Clinical Initiatives Working Group concluded that a spirit of reciprocity would be crucial for the successful implementation of any new initiatives. Reciprocity would ensure that each service contributes equally to the creation of new initiatives and services.

RECOMMENDATIONS

Clinical Initiatives Working Group:

1. Practice reciprocity in all current and future concurrent disorders Clinical Initiatives so that resources provided by one service are matched with similar resources from the other service.

2. Implement the eight **priority pilot initiatives** outlined below, as identified by the working group.
    a. Bungalows
    b. Urgent Care – Consultation Liaison
    c. Psychiatry at Withdrawal Management Service – Consultation Liaison
    d. Co-facilitated Group Therapies
    e. Facilitated APTS-MHP Assessments
    f. Personality Disorders Program
    g. Reproductive Mental Health
    h. Peer Support Groups

3. Description of Priority Pilot Initiatives

a. Bungalows

The new community living bungalows at the Nova Scotia Hospital provide an excellent opportunity to provide a long-term residential rehabilitation experience for individuals suffering from severe and persistent mental illness and co-occurring substance use disorders. The working group envisions one of the bungalows set aside for the concurrent disorders population, providing intensive, prolonged rehabilitation for this extremely difficult-to-treat population. This could offer some patients living with concurrent disorders an excellent opportunity to receive focused and intensive treatment, provided the funding partners – the Department of Health and Wellness and the Mental Health Foundation of Nova Scotia – were in agreement with exploring this option.

Currently no services of this type are available anywhere in Eastern Canada. Portage in Montreal has a program for those suffering from chronic psychotic disorders called the Mentally Ill Chemical Abuse (MICA) Program, with 20 beds where clients stay up to a year and then live in step-down apartments for another one to three years. This working group envisions creating a similar program within Capital Health and recommends pursuing provincial funding for this as a specialized service. Should funding be obtained at some future point, the bungalow for concurrent disorders would be under the direct administration of MHP, with APTS providing collaborative and specialized therapeutic programming to deal with addiction-related issues.

Even without a dedicated bungalow for a concurrent disorders inpatient program, many options exist for integrating such programs within the existing bungalows. The Mental Health Program's Recovery and Integration Steering Committee has already made a number of recommendations for working with concurrent disorders clients in the bungalows. These are outlined in **Appendix C.**

b. Urgent Care – Consultation Liaison

Currently, urgent care services in the Halifax Infirmary-QEII-Abbie J. Lane complex lack formalized access to addictions expertise and consultation. The working group recommends that APTS assign a staff person to carry out consultation liaison activities to support staff in these facilities. This individual would provide liaison activities as follows: three half-days per week to urgent care; two half-days per week to the medical-surgical floors teamed with the MHP consultation liaison psychiatry; and two half-days providing liaison activities and potential programming on psychiatric inpatient units.

c. Consultation Liaison Psychiatry at Withdrawal Management Services

In exchange for the APTS liaison person (as described in b. above), Consultation Liaison Psychiatry would provide a half-day psychiatric consultation service for APTS clients in Withdrawal Management programs at the Nova Scotia Hospital. This would also be an excellent opportunity for psychiatry residents to fulfill part of their Royal College requirement in addictions training.

d. Co-facilitated Group Therapies

The working group recommends that there be facilitated concurrent disorders groups on the inpatient psychiatric units as well as the Community Mental Health Program and Community-Based Services of APTS. Each group would be co-facilitated by therapists designated by MHP and APTS. The APTS group co-leader would be comfortable in addictions issues, while the MHP designated co-leader would have a comfort level with psychiatric issues. Each co-facilitator would have the opportunity to learn from their peer and the needed expertise in each area would be available when dealing with complex cases. Similar programming could be arranged at the East Coast Forensic Hospital.

e. Facilitated APTS-Mental Health Assessments

The working group recommends facilitated access to assessments in both APTS and MHP. Both services will set aside a number of designated concurrent disorders assessment slots on a weekly basis at all the major outpatient clinics. For example, APTS at Dartmouth Community-Based Services would provide two or three assessment slots each week to accommodate referrals from a Community Mental Health Clinic such as Belmont House. The MHP clinician would accompany the client to the APTS assessment, thereby better understanding assessment outcomes and treatment plans. The same would be true for MHP. Community mental health clinics would set aside designated assessment slots for APTS clients, and the APTS clinician would accompany the client to better understand the mental health assessment and treatment plan.

f. Personality Disorders Program

The working group recommends that a concurrent disorders component be included in the new Borderline Personality Long-Term Therapy Program currently under development in MHP. Weekly concurrent disorders group therapy sessions would be co-facilitated by an MHP therapist in collaboration with an APTS clinician. Any borderline personality disorder clients who were identified as having significant addictions issues would be expected to participate in this program as part of their ongoing rehabilitation.

g. Reproductive Mental Health (IWK)

The Reproductive Mental Health Program works with women who are new mothers, intervening early in order to prevent problems in subsequent generations. The working group recommends that APTS continue to provide this important program with consultation liaison support as well as co-facilitating groups with their therapists. In exchange, Reproductive Mental Health will provide psychiatric consultation to the Matrix program, a specialized addiction program for women, and the Compass Program, a structured treatment program, both at APTS.

h. Peer Support Groups

Currently, few peer support groups exist within APTS and MHP at Capital Health. Much potential exists to increase the number of these groups, based on the 12-step self-facilitated program. Twelve-step groups are an evidence-based approach to concurrent disorders, and 12-step programs such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) are proven to be highly effective.

This working group recommends that 12-step groups begin to be offered within MHP and APTS inpatient services. For example, evening 12-step groups could be offered to interested clients on MHP psychiatric inpatient units such as 6 and 7 Abbie J. Lane and within APTS' Withdrawal Management programs.

APTS and MHP will liaise with AA and NA to recruit individuals who are motivated to start and lead inpatient groups, designing groups that will fit well within the respective program settings. NA and AA also have some specialized self-help groups for individuals with concurrent disorders (known as "Double Trouble" groups) that may be suitable options as well.

Offering peer support groups onsite in APTS and MHP inpatient services gives clinicians some control over content presented, helping to address challenges that may exist, such as the perspective on the use of psychotropic medications, which unfortunately has, at times, been discouraged in AA groups.

Moreover, other forms of peer-support groups could be developed within both services. A new working group reporting to the Concurrent Disorders Council will need to be established to look at the role of peer support groups within APTS and MHP and to oversee any peer-support groups that do develop.

D. Screening and Assessment Working Group

1. Mandate

This working group recognized that building an effective, sustainable model of care for concurrent disorders clients starts with the screening and assessment tools used by clinicians in APTS and MHP. Staff in both services are keenly aware of the need to identify concurrent disorders when this condition presents in either service. The key is to find tools that do not add unnecessary complexity and time to the intake process, which would prohibit sustainability of use in the workplace. Therefore, this working group's mandate was to identify the easiest to use and most effective method(s) and/or screening and assessment tools, enabling both APTS and MHP staff to consistently screen for and identify concurrent disorders.

2. Approach

The committee researched and reviewed a number of concurrent disorders screening tools most commonly used by other services across Canada. Based on research and the realities within both MHP and APTS, the task group has selected the following screening tools:

- A combined mental health screening tool (GAIN SS) to be used by both APTS and MHP.
- One mental health screener (PsyCheck) was chosen to be used by APTS clinicians with their clients, and one addictions screener (ASSIST) was chosen for MHP staff to use for their clients.

The approach included piloting of these screening tools at one APTS location (1673 Bedford Row in Halifax) and one MHP location (Dartmouth Community Mental Health at Belmont House).

Two other sites (APTS' 99 Wyse Road site and Bayers Road Community Mental Health) were selected to provide control information regarding clients and referral data. Once the pilot tools and sites were selected, a consultant was contracted to coordinate the pilot project and evaluate the data.

The goals of the APTS/Mental Health Concurrent Disorders Pilot Screening Program, still underway, are to:

- Identify APTS clients who require immediate clinical attention for a mental health concern.
- Identify MHP clients who require immediate addiction services.
- Identify tools that are helpful in identifying those clients.
- Collect data to bring about evidence-based changes in practice and enhance client recovery.

RECOMMENDATIONS

Screening and Assessment Working Group:

1. Based on the outcomes of the pilot program described above and on feedback provided by the consultant coordinating the project, implement the use of selected concurrent disorders screening and assessment tools to be used consistently by staff in both respective services.

E. Training and Capacity Building Working Group

1. Mandate

The mandate of the Training and Capacity Working Group was to develop concurrent disorders competencies for both APTS and MHP staff.

2. Approach

Early on, the working group determined that a curriculum guide – defining the curriculum competencies, the learning objectives and the prescribed outcomes – was needed. A comprehensive curriculum guide was drafted (see **Appendix G**) in response to this need.

The curriculum guide's target audience includes all clinical staff in APTS and MHP. Staff from both services will be provided with the basic learning curriculum. Depending on the area of work and the acuity in the populations being served, intermediate or advanced learning may be required.

3. Competencies

What would concurrent disorders competencies look like within each service?

- Concurrent disorders-capable mental health clinicians would have core competency skills to screen, assess, clinically support and collaborate with APTS for additional treatment planning in specialized services for those clients who also had substance use disorders.

- Concurrent disorders-capable addictions clinicians would have core competency skills to screen, assess, clinically support and collaborate with MHP for additional treatment planning for specialized services for those clients who also had presentations of mental illness.

The working group designated three different levels of training, with detailed learning plans, to develop needed concurrent disorders competencies among all staff.[3] The three levels, which will vary according to service area and clinicial work, will include basic *(*for all service providers in APTS and MHP, unless predetermined by service area clinical program that they already meet the requirements); intermediate (to be determined as per program requirements); and advanced (to be determined as per program requirements).

BASIC includes being able to:

1. Provide a comprehensive definition and demonstrate a working knowledge of concurrent disorders.
2. Screen for mental health and substance use problems using standardized measures.
3. Form a preliminary impression of the nature of the presenting problems.
4. Use basic engagement skills including, but not limited to, stabilization, outreach, and assistance with practical needs and building the therapeutic alliance.
5. Use basic interviewing skills such as asking open-ended questions, making reflective listening statements, summarizing and making statements of affirmation.

[3] *Adapted from concurrent disorders competencies and learning plans created by the Centre for Addictions and Mental Health (CAMH) and the Connecticut Department of Health.*

6. Use de-escalation (i.e. crisis stabilization) skills when needed (e.g. voice modulation and modeling a calm stance, assessment of immediate situation and current resources both formal and informal, normalization and validation, and the instilling of hope by clear statements of intent to help).
7. Demonstrate knowledge of crisis management procedures:
    a. Knowledge of referral processes and being able to use them with clear understanding and direction when needed.
    b. Knowledge of the behaviour/physiological signs of intoxication and withdrawal from various substances and the signs of potential risk of harm to self or others.
    c. Knowledge of crisis management procedures if someone is intoxicated or in withdrawal from substances and/or reporting suicidal ideation and/or homicidal ideation.
8. Coordinate care in a directive case-management approach when multiple providers are concurrently involved in care.
9. Have a basic knowledge of medications used to treat mental illness and addiction issues.
10. Know the signs and symptoms of mental illness and addiction issues and apply this knowledge to concurrent disorders practice.
11. Understand wellness and recovery models for patients who are assessed to have concurrent disorders.
12. Display patience, persistence and optimism.

INTERMEDIATE includes (in addition to the basic competencies listed above) being able to:

1. Conduct integrated assessments.
    a. Knowledgeable of the drug classes and mental health diagnostic categories used in the DSM IV.
    b. Determine severity/acuity of disorders.
    c. Knowledge of current “street” names of the various drugs.
    d. Knowledgeable and competent in various models of assessment (e.g., stage of change, mental health status).
    e. Demonstrate, via documentation, mental health and substance use disorder diagnoses.
2. Perform integrated and collaborative treatment/recovery planning with a focus on shared decision-making (i.e., client, clinician, other services).
3. Conduct engagement, education, and treatment for both mental health and substance use disorders.
    a. Use more advanced interviewing strategies such as motivational interviewing and cognitive behavioral therapy approaches.
    b. Know the basic concepts of social learning theory.
    c. Assess stage of change/mental health status, which is the basis for various therapies.
    d. Be able to modify counseling strategies for individuals with concurrent disorders.
4. Understand the recovery and rehabilitation models of both Mental Health and Addictions (psychiatric rehabilitation, consumer co-op models, harm reduction principles, self-help groups) and link individuals with concurrent disorders to models/groups that are welcoming, knowledgeable and concurrent capable.

ADVANCED includes (in addition to both the basic and intermediate competencies listed above) being able to:

1. Use integrated models of assessment, clinical intervention, treatment planning and recovery.
2. Understand group processes and facilitate groups (e.g., process groups, skills groups, interactive psycho-education groups).

   a. Work individually with families and/or facilitate a multi-family psycho-education/support group.
3. Provide interventions for families and other supports.
4. Demonstrate an understanding of use and impact of psychotropic medication.
5. Support quality and continuous improvement efforts, including a focus on incorporating evidence-based resources, and best practice tools in providing integrated care.
6. Leadership in advanced competencies and clinical skills
   a. Leading and/or facilitating peer supervision
   b. Providing mentoring for peers in basic and intermediate competencies

RECOMMENDATIONS

Training and Capacity Building Working Group:

1. Provide all APTS and MHP staff with the basic level of competency training for concurrent disorders.
2. Provide some APTS and MHP staff with intermediate and advanced competency training, based on needs within individual service areas and prevalence of concurrent disorders within that service.
3. The Training and Capacity Building Working Group continue its work under the supervision of the Concurrent Disorders Council and in cooperation with clinical practice educators in APTS and MHP to develop a sustainable training model by which all staff will have the opportunity to obtain and maintain needed training and skills.

VI. Current and Future Challenges

A. Information Technology

1. The Current Situation

Currently, APTS and MHP function using different health information systems. APTS uses a web-based database system called ASsist, which captures client specific demographic, health and treatment information relating to addictions. The built-in daily service records of ASsist capture client and clinician specific information at the group or individual encounter level.

The ASsist system is provided and maintained by the Department of Health and Wellness and is a standalone system. In other words, it does not "talk" with other Capital Health applications such as STAR Patient Processing, Pathways Healthcare System (PHS) or Horizon Patient Folder (HPF), all of which are used by MHP.

Due to these differing health information systems, information on APTS clients in ASsist cannot automatically be shared and viewed by MHP and vice versa. Clinicians may, however, obtain read-only accounts in either system in order to view information on their clients. However, access to read-only accounts is not readily available to a broad range of clinical staff.

▪ *It is very likely that many clients being served in the new collaborative initiatives resulting from this task group's recommendations will access parallel services from both APTS and MHP.*

The implications of the present system are that:

- Accessing clients' information through the creation of "read-only" accounts is time-consuming and resource intensive and currently not available to all clinicians.
- Collecting data on concurrent disorders clients is challenging because information on a single client being seen by both services must be pulled separately from two different systems and then combined for analysis.

2. Proposed Solution

With the new collaborative initiatives being recommended in this report, it will be essential to allow APTS and MHP to share information more effectively and to develop health information systems that will support this collaboration. It is possible to create an "artificial link" between the two health information systems. Currently, the creation of the artificial link is dependent upon a clinician's judgment and is determined on a case-by-case basis.

With the implementation of this framework, MHP and APTS will need to expand and formalize the linking of the two systems to ensure that all clinical staff have access to the information they need to effectively communicate across programs with other clinicians when working with concurrent disorders clients. Linking of MHP and APTS systems will require an investment of human and financial resources.

RECOMMENDATIONS

Information Technology:

1. Create better and more easily accessible linkages between APTS and MHP health information systems using existing options such as the expansion and formalization of a system to create “artificial links.”
2. Examine data from both systems to provide information about factors and common services provided to concurrent disorders clients.

3. Resources for Implementing Solution

Under the supervision of the Concurrent Disorders Council, staff in the area of decision support at MHP and APTS research and statistical officers can help move this project ahead and ensure that links are created between the two systems, facilitating information sharing and collaboration.

B. Research and Evaluation

1. Outcomes

The APTS-MHP Concurrent Disorders Task Group has identified both short- and long-term indicators of success for the concurrent disorders framework, including:

a. Short-term outcomes:

1. Tangible examples exist of new approaches in working with Concurrent Disorder clients in both MHP and APTS.
2. Training opportunities for concurrent disorders are regularly made available to and utilized by staff in APTS and MHP.
3. A comprehensive framework for concurrent disorders is in place, one that is reflective of best practices and developed for service delivery.
4. Numerous small success stories about improved service to concurrent disorders clients and their families have been communicated to staff, stakeholders and community.
5. Tangible evidence exists to show that individuals, families, care providers, community organizations and other stakeholders have been consulted in developing a model of care for concurrent disorders clients and their families.

b. Long-term outcomes:

1. Measures have been developed and put in place to demonstrate that people's treatment needs are being met (e.g. improved quality of life, quantitative evidence, and harm reduction).
2. Barriers to clients accessing and navigating services have been successfully addressed.
3. Clients have access to information and education to make decisions about treatment for concurrent disorders.
4. Staff members demonstrate increased competencies and comfort in working with concurrent disorders.

2. Research and Evaluation Initiatives

Currently little data exists on concurrent disorders clients in Capital Health. The new Concurrent Disorders Council will need to create a working group to focus on Research and Evaluation. The priority task of this working group will be to gather information on the clients who currently access both services. These benchmark values are needed in order to evaluate the success and outcomes of any new concurrent disorders initiatives moving forward.

RECOMMENDATIONS

Research and Evaluation:

1. The new Concurrent Disorders Council will create a working group to focus on research and evaluation.
2. The priority tasks of this working group will be to:
- Collect baseline data.
- Develop a system to gather information and report on the outcomes identified above, and determine other outcome measures, for clients who access both services for concurrent disorders.
- Work with the Engagement Working Group to gather and interpret anecdotal evidence from consultations with internal and external stakeholders and use this as one of the measurements going forward.

C. Health Human Resources

The task group considered the adequacy of mental health and addictions human resources capacity within our services.

In many health care jurisdictions, the educational backgrounds of the workforces of mental health and addictions systems, even within the same community, are quite distinct. Capital Health is no different. Competent practitioners offer both services, but these practitioners have quite different educational backgrounds and often have little or no knowledge about the other service. More importantly, many do not know how to access the other's services.

Acknowledging these realities, The APTS-MHP Concurrent Disorders Task Group identified a number of health human resource considerations that will need to be further explored by the Concurrent Disorders Council once it is established. They include:

- How to provide ongoing information and education that will allow staff to understand both services and the programs offered in each.
- How to put in place effective communications channels to increase awareness of each other's clinical expertise, services offered and treatment approaches.
- How to ensure that training is delivered at the right level to the right people.
- How to initiate succession planning to ensure sustainability of collaborative roles in both services.
- How to develop methods to nurture effective collaboration between and among teams.
- How to identify as soon as possible any union-related issues or challenges that may arise as this framework and its recommendations are implemented.
- How to create effective collaboration among staff from APTS and MHP in areas where closer integration of work is needed to implement concurrent disorders initiatives.

D. Space and Facilities

1. The Current Situation

Currently, APTS and MHP programs are located throughout the entire Capital Health district in many different types of facilities in many different locations, both urban and rural.

Each hospital site or treatment facility requires highly complicated mechanical, electrical, and telecommunications systems, and specialized knowledge and expertise are needed to evaluate any potential changes to these space and facilities.

> ▪ *"A functional design can promote skill, economy, conveniences and comforts; a non-functional design can impede activities of all types, detract from quality of care, and raise costs to intolerable levels."*
>
> *- Hardy and Lammers*

2. Potential Changes

When implementing the concurrent disorders initiatives outlined in this report, APTS and MHP must carefully consider the role of space and facilities. According to the literature, there are six issues that should be considered when planning for program changes:

- Current trends
- Key planning issues
- Space planning approaches
- Achieving optimal performance
- Facility layout considerations
- Potential facility planning pitfalls

a. Current Trends

Currently, in both APTS and MHP, there is limited usable space in its present form available for existing programs. As a result, if offices, clinical assessment areas or clinical interview space are needed to carry out new concurrent disorders work, APTS and MHP will need to plan how to access adapt current spaces and facilities. Alternatively, using existing spaces during evening hours may provide additional options for some concurrent disorders programming.

b. Key Planning Issues

APTS and MHP will need to initiate a planning process to determine where concurrent disorders initiatives will be located and what type of spaces will be needed. In this planning process, there are four different types of spaces that will be examined: fixed spaces, workload dependent spaces, variable spaces and optional spaces.

- **Fixed spaces** are spaces that generally do not vary in either number or size, regardless of the overall scope of activities of the department or functional component.
- **Workload dependant spaces** are spaces such as procedure rooms and patient care spaces that are typically dependent on the projected workload.
- **Variable spaces** are spaces that vary in size depending on the total number of procedure/patient care spaces programmed.

- **Optional spaces** are spaces that depend on the scope of services, specific operational concepts, administrative policies and desired level of amenities.

Until the various concurrent disorders initiatives are implemented, it will be difficult to understand the full scope of services and the space and facilities that will be required. In the beginning, some services may need to be offered on a trial basis in pre-selected areas.

c. Space Planning Approaches

Sharing existing spaces well will require careful planning and collaboration on the parts of APTS, MHP and Capital Health. Collaboration on space and facilities will be essential in order for concurrent disorders initiatives to be successful now and sustainable in the future. Both services will need to work together to plan for future space and facility needs, given available resources through effective facility planning and capital investment.

d. Achieving Optimal Performance

The purpose of this concurrent disorders framework is to improve services to concurrent disorders clients and their families. In order to achieve optimal outcomes for individuals and increase the effectiveness of staff in treating concurrent disorders, APTS and MHP will need adequate spaces and facilities to carry out needed services.

e. Facility Layout Considerations

Each APTS and MHP facility currently has a different design. Service areas within APTS and MHP that will become home to concurrent disorders initiatives will need to be looked at individually to determine how best to utilize the resources available in each available space.

f. Potential Facility Planning Pitfalls

Older buildings, lack of funding, small treatment rooms and lack of space within Capital Health will make it challenging, in some circumstances, to implement new initiatives.

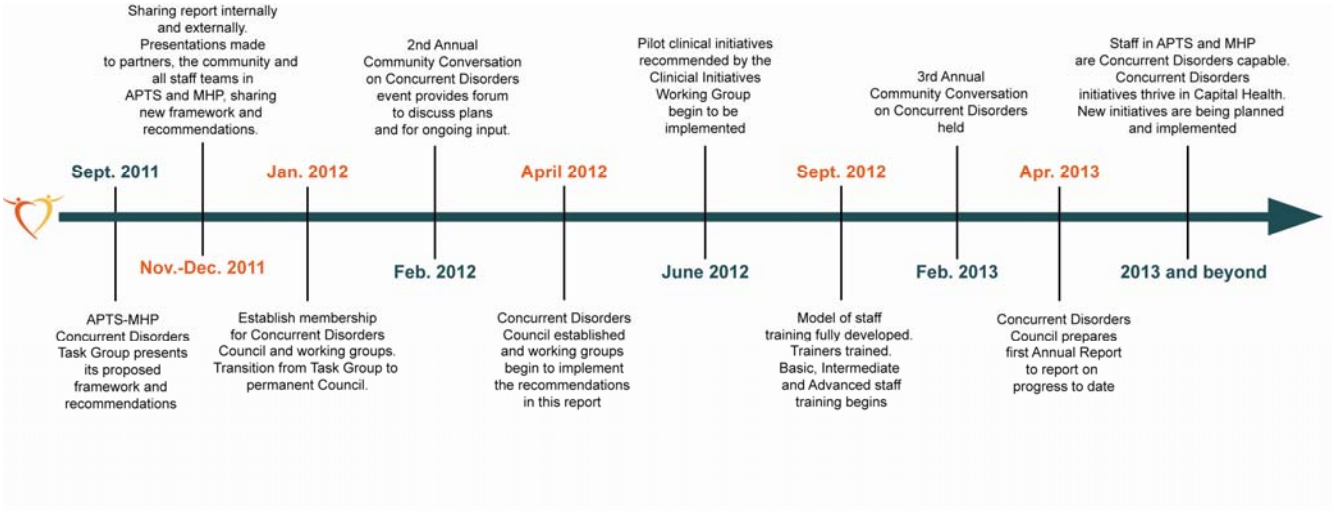
Careful consideration of space and facilities needs is crucial for each program site where concurrent disorders initiatives will be implemented. Careful planning can help ensure that minimal costs are incurred to the organization and that space is adequate to meet the needs of both services and support the success of collaborative work.

VII. Timeline and Implementation

The task group concludes its mandate with this report. Upon approval of this report and its recommendations, the current task group will transition its mandate to the permanent Concurrent Disorders Council, which will take up its work where this report leaves off.

The following timeline represents the best estimate of how the recommendations in this report will be implemented over the coming two years.

Beyond that, APTS and MHP are confident that the Concurrent Disorders Council will continue to support and expand the concurrent disorders model of care within Capital Health, refining its mandate and vision as collaborations and initiatives evolve in this quest to provide improved care to concurrent disorders clients and their families.



VIII. Conclusion

With this report, the task group's work draws to a close, but the work of providing better care to individuals living with concurrent disorders has really just begun. The recommendations contained in this report mark only the modest beginnings of a larger transformation that will take many years – and the sustained commitment of Capital Health staff and leadership – to bring to fruition.

While the task group's work was limited to looking at collaboration between mental health and addiction services, much more work needs to be done to ensure even broader collaboration takes place to address concurrent disorders, involving primary health care providers, community organizations, government, social services and other partners.

The work of the task group has already resulted in stronger working relationships between staff in both the mental health and addictions programs. Working group meetings presented many tangible opportunities for staff from both APTS and the MHP to model effective collaboration, looking beyond organizational and departmental boundaries to remove barriers to treatment and address challenges to integration, all with the goal of providing better care to shared clients.

Finally, during the course of the task group's work, staff in both services benefitted from opportunities to hear the voices of concurrent disorders clients and those who care for them. As the task group's recommendations begin to be implemented and further plans are developed, it will be essential to continue to involve those most affected by these services in committees, working groups and decision-making related to concurrent disorders. Ongoing engagement, paired with effective and consistent monitoring and evaluation, will ensure that this framework, and any initiatives born of it, truly will result in better care for a vulnerable population.

IX. Appendices

A. **Project Charter**

B. **Concurrent Disorders Council Terms of Reference**

C. **Community Living Initiative – Recommendations for Working with Individuals Experiencing Concurrent Disorders**

D. **Concurrent Disorders Curriculum Guide**

E. **Estimated Budget for a 10-Bed Concurrent Disorder Program**

APPENDIX A:
Project Charter

1. PROJECT IDENTIFICATION	
Project Name	**Addiction Prevention and Treatment Services and Mental Health Program Task Group**
Executive Sponsor	Barbara Hall – Vice President, Person Centered Care
Project Sponsor/s	Peter Croxall - Director, Mental Health Program (MHP) Trevor Briggs - Director, Addiction Prevention and Treatment Services (APTS)
Project Leads	
Version	**6.0 September 2010**

2. PROJECT BACKGROUND

Capital Health's Mental Health Program and Addiction Prevention and Treatment Services (APTS) have been asked to create a model of care for individuals with concurrent disorders, an especially vulnerable population made up of people who are experiencing both mental health and addiction issues.

Concurrent disorder clients make up a significant percentage of those accessing the services of APTS and Mental Health Program. In fact, more than half of those seeking assistance for an addiction also have a mental illness, while between 15-20% of those seeking assistance for a mental health concern are also harmfully involved with substances and/or gambling.

Currently, Capital Health lacks a specialized, collaborative treatment service for concurrent disorder clients. In fact, in many cases, clients with concurrent disorders face significant challenges in accessing our services and receiving treatment. Upon intake, Mental Health staff may ask that clients deal with their addiction issue prior to receiving mental health treatment. On the other hand, addiction staff may require that clients receive treatment for a mental health issue prior to accessing addiction services. Overall, access, treatment and navigation through the system can be extremely complex and frustrating for this vulnerable population, significantly affecting recovery and contributing to relapse.

It is clear that the Mental Health Program and APTS need to design an effective model of care for this population. From a business perspective alone, improved services for concurrent disorder clients make good financial sense. A collaborative model of care will prevent individuals from being treated separately over time by two different services when their needs could be better met by a collaborative service that addressed needs simultaneously.

From a client perspective, collaboration will result in improved, more comprehensive and effective care and treatment. It will also provide a more efficient and accessible intake process that avoids clients being "bounced" from one service to the other. There will be reduced frustration for our clients and their families. Recovery will be supported and relapse reduced.

3. PROJECT PURPOSE

To create a framework to support collaboration and an integrated approach in the treatment of individuals with concurrent disorders and their families.

4. PROJECT SCOPE

In Scope:

- Review effective models of secondary prevention and early intervention for concurrent disorders
- Design an effective model of care for concurrent disorders clients that includes
  - ✓ Identifying integrated clinical care and practice guidelines
  - ✓ Building capacity by implementing common education and training programs
  - ✓ Collaborating on common and integrated research projects
  - ✓ Incorporating continuity of care and transition of care approaches
  - ✓ Coordinating a holistic care journey
- Put into place accountability structures in APTS and the Mental Health Program to ensure the framework is successfully implemented
- Carry out evaluation to monitor the progress and success of the framework
- Create a process to obtain ongoing feedback from staff, community and consumers on the effectiveness of the services
- Develop a set of principles to guide the process (i.e. change management)
- Create a process to implement the Model of Care (i.e. pilot projects)

Out of Scope:

- Project does not include merging Addiction Prevention and Treatment Services Program with the Mental Health Program.

5. PROJECT MILESTONES			
Name	**Description**	**Date**	**Responsible**
1. Collaborative Day	A day designed specifically to highlight the need to have both programs working together to improve the care for patients living with concurrent disorders	Feb. 2010	Addiction Prevention and Treatment Services, Mental Health Program
2. Task Group established	Task group members selected and first meeting held.	Feb. 2010	Addiction Prevention and Treatment Services, Mental Health Program
3. Task Group reviews criteria for success of Concurrent Disorder programs	Task group reviews national and provincial findings and recommendations of staff made at Collaborative Day	June 2010	Task Group members
4. Project Charter completed	Project Charter is approved, outlining work that will be done.	July 2010	Project working group
5. Task Group looks at literature review of models of care; finalizes terms of reference	Working Group presents literature review of models of care for Concurrent Disorder programs	July 2010	Task Group members
6. Task Group clarifies expectations for Working Groups	Defines expectations and sets rules of engagement (1-pager developed to be provided to Working Groups prior to recruitment of volunteers)	Aug. 2010	Task Group members
7. Working Group Recruitment	Chairs and members recruited and identified; first meetings convened	Sept.-Oct. 2010	Task Group members
8. Communications Plan complete	Communications Plan developed to identify key audiences, strategies, tools, how we will communicate accomplishments, etc.	Oct. 2010	Communications Advisors
9. Coordinator position	Individual recruited/identified to coordinate Concurrent Disorder model of care framework	Fall 2010	APTS and Mental Health Program
10. Working Groups present priorities to Task Group	Identify priorities and action plans	Nov. 2011	Working Groups

11. Working Groups identify pilot project and present to Task Group	Identify priorities and action plans	Dec. 2011	Working Groups
12. Working Groups update Task Group	Update re: activities, plans, prototypes, small wins	Jan. 2011	Working Groups
13. Collaborative Day/Concurrent Disorders Conference	Conference provides a forum to engage and ask for input from citizens and stakeholders as working groups of the APTS-MHP Concurrent Disorders Task Group develop their recommendations, action plans, and initiatives.	Feb. 10/2011	Collaborative Day Working Group
14. Working Groups present Preliminary Recommendations	Working Group Recommendations identified	March 2011	Working Groups
15. Framework document drafted	Based on recommendations from Working Groups, Task Group drafts framework document identifying how Mental Health Program and APTS will support collaboration and an integrated approach to addressing the needs of individuals with concurrent disorders and their families. Draft document circulated to staff, citizens and stakeholders for feedback/input	April-June 2011	Task Group members and Working Group volunteers from APTS and Mental Health Program
16. Framework document finalized and presented	Task group completes final edits to Framework documents and presents completed document to senior leadership	July - August 2011	Task Group members and Working Group volunteers from APTS and Mental Health Program

6. ROLES AND RESPONSIBILITIES	
Role and Resource Name	**Responsibility**
Executive Project Sponsor - Barbara Hall	Provide executive leadership endorsement for the project to ensure ongoing commitment of resources and alignment with the goals of Capital Health and the Patient Centred Care portfolio.
Project Sponsors – Peter Croxall and Trevor Briggs	Provide leadership support to the project lead and the team to make the required decisions. To advocate the collaborative work relationship between both services. Provide network connect between functional areas of mental health services within CDHA. Ensures resources are available.
Project Coordinator	Manage all aspects of project and facilitate implementation.
Task Group Members	
Mental Health Program	
Peter Croxall	
Susan Hare	
Kim Fleming	
Kim Munroe	
Maureen Wheller	
Scott Theriault	
Joanne Watkins	
Addiction Prevention and Treatment Services	
Trevor Briggs	
Shaun Black	
Rachel Boehm	
Mary Cripton	
Jill Robertson	
Ron Fraser	
Consumer Advocates / Family Advocates	
Susan Kilbride-Roper	
Project Manager	

7. WORKING GROUPS		
Name of Working Group	Lead	Members
Framework	Susan Hare	Susan Hare, Shaun Black, Ron Fraser, Mary Cripton, Rachel Boehm, Maureen Wheller
Collaborative Day	Maureen Wheller/Rachel Boehm	Shawn Jolemore, Susan Kilbride-Roper, Maureen Wheller, Rachel Boehm
Clinical Initiatives	Mary Cripton	Ron Fraser, Scott Theriault, Co-chairs, Shawn Jolemore, Lead Mary Cripton, Kim Fleming, Brenda Flemming, Jill Robertson, Danny Patterson, Gregg Lambert
Training/Capacity Building	Mary Cripton	Mary Cripton, Kim Munroe, Co-Chairs. Scott Janssen, Nancy Snow, Jill Robertson, Mary Pyche
Screening and Assessment Tools	Peter Croxall/Trevor Briggs	Trevor Briggs, Peter Croxall, Co-Chairs, Michelle Baird, Laura May Wilbur, Carol White, Andrew Starzomski

8. PROJECT BUDGET		
Budget Item	**Amount**	**Funding Source**
Collaboration and Retreat Days	Various	APTS and MHP to cost share

9. KEY ISSUES/RISKS	
Severity (H, M, L)	**Description**
M	Patients not being served by both services, when needed
M	Patients are confused as to how to access services
M	Patients are not able to access the service they need
M	Patient information is not being shared between services

10. PROJECT ASSUMPTIONS

The following assumptions have been made:

- Significant change needs to occur to successfully implement the framework
- Data availability (lack of data)
- Parameters of task group are clearly understood and endorsed by leadership and partners
- Project resources necessary will be committed and endorsed

10. PROJECT ASSUMPTIONS

- Competing organizational priorities will be managed by Leadership
- The clinical front line team will have to authority to contribute to the ongoing evolution of the process model in application

11. PROJECT'S CRITERIA FOR SUCCESS

This project will be successful when:

Short-term criteria:

1. Tangible examples exist of new approaches in working with Concurrent Disorder clients in both Mental Health Program and APTS.

2. Training opportunities for concurrent disorders are regularly made available to and utilized by staff in APTS and the Mental Health Program.

2. A comprehensive framework for concurrent disorders is in place, one that is reflective of best practices and developed for service delivery.

3. Numerous small success stories about improved service to Concurrent Disorder clients and their families have been communicated to staff, stakeholders and community.

4. There is tangible evidence that we have consulted with individuals, families, care providers, community organizations and other stakeholders in developing a model of care for Concurrent Disorder clients and their families.

Long-term:

1. Measures have been developed and put in place to demonstrate that people's treatment needs are being met (e.g. improved quality of life, quantitative evidence, harm reduction).

2. Barriers to clients accessing and navigating services have been successfully addressed.

3. Clients have access to information and education to make decisions about treatment for concurrent disorders.

4. Staff demonstrate increased competencies and comfort in working with concurrent disorders.

Appendix B:
Concurrent Disorders Council Terms of Reference

Purpose
To leverage the existing models of care in both the Mental Health Program (MHP) and Addiction Prevention and Treatment Services (APTS) to improve the services for individuals with both mental illness and substance abuse problems. The Council is a decision making body and will be made up of ten individuals with equal representation of frontline clinical and non-clinical staff from the two services, two consumer representatives as well as the Concurrent Disorder Coordinator.

Critical Team Tasks
• Oversee existing collaborations and maintain support for them • Promote successful pilot areas, if appropriate • Explore future collaborations that will improve service • Measure/evaluate existing collaborations • Support implementation of the Working Groups recommendations • Oversee existing working groups and identify new ones as required • Produce an annual report on the deliverables of the council and its working groups

Team members
Council members (including consumer representatives) will serve staggered three-year terms. The co-chairs (one from APTS and one from the MHP) will serve three-year terms. The staff person assigned to manage concurrent disorders will be an ex-officio member of the council. Communications advisors will support the council on communications-related matters.

Team Responsibilities & Expectations	
Team Values: • Honest communication, forthrightness, professionalism, politeness, and respect for each other's opinions • Promoting mutual trust • Commitment to team success • Commitment to project timelines and deadlines (individual and team) • Encourage solutions and alternatives to be put forward when problems are identified	**Team Meetings:** • Clearly defined purpose and desired outcomes (included in agenda) • Duration: up to 2 hours • For the first year, the Council will meet every two weeks. Afterwards, it will meet monthly • Decisions will be made by majority (6 members or more) • Start meetings on time regardless of who has shown up at start time

Communication Plan
The Concurrent Disorders Council will report to the directors of the MHP and APTS through its chair(s). The Directors of the MHP and APTS are responsible for reporting on the actions and findings of the Council to the VP, Person Centred Health.

APPENDIX A: Concurrent Disorders Terms of Reference Working Groups

Concurrent Disorders Council Working Groups

In implementing the recommendations of this report, and in further developing the concurrent disorders model of care within Capital Health, the Concurrent Disorders Council will designate the following working groups:

1. Clinical initiatives
2. Research and evaluation
3. Community engagement
4. Training and capacity building
5. Others as required

(Oct. 2011)

Appendix C:

Capital District Mental Health Program
Recovery & Integration

Recommendations for working with individuals experiencing concurrent disorders

Steering Committee of the Recovery and Integration Re-Organization

- To conduct concurrent disorders groups in the community for clients in the Community Living Initiative (the Bungalows) on The Nova Scotia Hospital site, East Coast Forensics Hospital and the Hubs – as part of the Recovery and Integration Reorganization within the MHP.

- Utilize better concurrent disorders screening tools at intake and engage in ongoing screening for concurrent disorders issues in the Bungalows and Hubs – potentially being involved in part of the Concurrent Disorders Task Group Screening Pilot.

- Training for all staff in recovery and integration in providing ongoing support for individuals with concurrent disorders issues: e.g. knowledge of the Stages of Change Model and use of Motivational Interviewing techniques. Advanced training for staff in pharmacology and drug interactions for the severe and persistent population.

- Skills training for staff in Recovery and Integration and APTS to work collaboratively in an integrated manner.

- In order to support the workload of both Recovery and Integration and APTS staff, continue to embed APTS staff at the Hubs, and place Recovery and Integration staff at APTS for ½ day/week or more to enhance opportunities for cross-training, early screening, consultation, collaboration, etc. to support the best outcomes for patients.

7 July 2011

Appendix D:

Concurrent Disorders Curriculum Guide

Concurrent disorders refer to the co-existence of both a mental illness and a substance use problem.

Background

A client with concurrent disorders has the coexistence of both a mental illness and a substance abuse issue. Literature suggests that the prevalence rates range from 20% to 80% of the population being treated. We know conclusively that people experiencing mental illness have much higher rates of substance abuse than people in the general population. Similarly, individuals with a substance use disorder have much higher than expected rates of mental illness. We also know that current approaches to treatment and support for either mental illness or substance use disorders is less effective for people who are experiencing both.

It is very important for mental health programs and addictions programs to initiate a comprehensive approach to treating clients with concurrent disorders in a **standardized way**. Additionally, due to the prevalence of concurrent disorders, it is important to ensure that service providers have the education they need in order to provide services to clients that meet their needs.

Depending on where staff work, and the population served, education may be provided at a basic (minimum for all mental health and addictions workers), intermediate and/or advanced level. This curriculum guide will assist in ensuring that standardized education requirements are met at all three levels of learning.

Target Audience

All service providers working within the Capital Health Mental Health Program and Addiction Prevention and Treatment Services will be provided with the basic learning curriculum. Depending on the area of work and the populations being served, intermediate or advanced learning may be required.

Concurrent disorders-capable mental health clinicians would typically be able to assist clients who also had substance use disorders of low severity. Similarly, concurrent disorders-capable addictions clinicians would typically be able to assist clients who had mental health disorders of low severity, at a minimum.

Basic: All service providers in Mental Health and Addictions Programs.
Intermediate: To be determined as per program requirements.
Advanced: To be determined as per program requirements.

Overall Structure of the Training

Staff participate in the appropriate level of training (basic, intermediate or advanced), depending on their learning requirements. At these sessions, staff participate in a combination of learning, interaction and evaluation, covering such areas as:

- introduction to the objectives for the learning being provided
- evaluation of learning outcomes
- recognition of previous learning

- introduction of new resources and information

Guiding Principles

- Employ a wellness and recovery perspective
- Adopt a holistic viewpoint for problem solving and critical thinking
- Develop a collaborative client-centered approach to service delivery
- Involvement of family and significant others is essential
- Address specific real life problems early in treatment
- Plan for the client's cognitive and functional impairments
- Use support systems to maintain and extend treatment effectiveness for concurrent disorder
- Information sharing guidelines support involvement of the individual's circle of care (copy of the Guidelines to be included in the Appendix)

Learning Plans[4]

Basic Learning Plan

Overview and Purpose **To provide the service provider with a basic level of knowledge and experience in the treatment of concurrent disorders.**
Basic Outcomes: 1. Screen for mental health and substance use problems using standardized measures. 2. Form a preliminary impression of the nature of presenting problems. 3. Use basic engagement skills. • Stabilization, outreach, assistance with practical needs, building the therapeutic alliance • Basic motivational interviewing skills: ask open-ended questions; make reflective listening statements; summarize and make statements of affirmation 4. Employ de-escalation skills when needed. 5. Demonstrate knowledge of crisis-management procedures. • Know the behaviour and physiological signs of intoxication and withdrawal from various substances, and the signs of risk to self or others • Follow the crisis-management procedures if someone is intoxicated or is in withdrawal from substances, and/or reporting suicidal ideation and/or homicidal ideation 6. Knowledge of referral processes and able to use them assertively when needed.

[4] *Adapted from concurrent disorders competencies and learning plans created by the Centre for Addictions and Mental Health (CAMH) and the Connecticut Department of Health.*

7. Coordinate care in a directive, case management approach when multiple providers are involved in care.

8. Demonstrate patience, persistence and optimism.

9. Obtain a basic understanding of medications used to treat mental illness and addiction issues.

10. Provide a comprehensive definition of concurrent disorders.

11. Understand the signs and symptoms of mental illness and addiction issues.

12. Understand wellness and recovery models for patients who are identified as having concurrent disorders.

Curriculum Competency	**Learning Objective**
1. Definition of concurrent mental illness and substance use disorders	▪ Definition of concurrent disorders ▪ Basic information on biological and environmental risk factors related to development of mental health and substance use disorders
2. Signs and symptoms of substance use and common mental health disorders, and their interaction	▪ DSM IV TR definition of substance abuse disorders, criteria for dependency versus abuse, physiological effects of substance use, withdrawal, criteria and physiological concept of withdrawal management ▪ The associated major signs and symptoms of the most common mental health disorders as presented by the DSM-IV TR ▪ Basic information on how mental health disorder signs/symptoms interact and affect signs/symptoms of substance use disorder and vice versa
3. Basic medication knowledge	▪ Basic concept of medication versus “drug” within the context of maintaining “drug-free,” basic/general information about medications for major disorders
4. Wellness and recovery options	▪ Basic information on principles of treatment including need to address, blend and integrate treatment for both substance use and mental health disorders ▪ Working knowledge of the model and framework for understanding and initiating change ▪ Demonstrate basic knowledge and understanding of motivational interviewing

	techniques ▪ Demonstrate basic knowledge and understanding of Consumer Model of Care (Psychiatric Rehabilitation)
5. Relapse prevention and knowledge of coping and healthy living skills	▪ Basic relapse prevention education and skills related to substance use and mental health disorders within the context of relapse prevention (including warning signs) ▪ Basic information about effects and interaction of physical wellness and mental health and/or addiction disorders and vice versa and the role of healthcare and nutrition in recovery ▪ Demonstrate a basic understanding of the referral process for clients with concurrent disorders to obtain the services that they require ▪ Understand principles of harm reduction and relapse prevention
6. Screen for mental illness and substance use problems using standardized measures	▪ Understand how to complete a concurrent disorders screening tool ▪ Basic information on interpreting assessment data obtained from screening tool
7. Form a preliminary impression of the nature of the presenting problems	▪ Understand how to complete a concurrent disorders screening tool ▪ Basic information on interpreting assessment data obtained from screening tool ▪ Recognize the signs and symptoms of concurrent disorders through recognition and screening
8. Use basic engagement skills	▪ Able to use engagement skills such as stabilization, outreach, assistance with practical needs and building the therapeutic alliance ▪ Able to use some basic motivational interviewing skills: asking open-ended questions, making reflective listening statements, summarizing and making statements of affirmation
9. Use de-escalation skills, as required (crisis stabilization)	▪ Understand the use of body langage, voice modulation, calmness and validation during the

	crisis experience from a strengths-based perspective
10. Understand crisis-management techniques	▪ Demonstrate an understanding of crisis management ▪ Complete a Non-Violent Crisis Intervention (NVCI) course ▪ Understand current Capital Health crisis response policies

Intermediate Learning Plan

Overview and Purpose **To provide the service provider with an intermediate level of knowledge and experience in concurrent disorder.**	**Intermediate** **Must complete the following objectives in addition to Basic objectives**

Intermediate Outcomes:

1. Conduct integrated assessments, including being:

- knowledgeable about the drug classes and mental health diagnostic categories used in the DSM IV TR.
- able to apply knowledge and skills to conduct comprehensive assessments
- able to determine severity/acuity of disorders
- knowledgeable of current street names of the various drugs
- able to assess for stage of change and insight
- complete an assessment of function (GAF)
- document mental illness and substance use disorder diagnoses

2. Perform integrated and collaborative treatment (recovery) planning

3. Provide education, and treatment for both mental health and substance use disorders, including being able:

- to utilize more advanced interviewing strategies
- to utilize more advanced therapeutic models and strategies
- to demonstrate dynamic counselling approaches and strategies

4. Use treatment strategies compatible with each stage of change or level of insight

5. Understand the recovery and rehabilitation models of both Mental Health and Addictions (Psychiatric Rehabilitation, Consumer Co-op Models, Harm Reduction principles, self-help groups) and link individuals with concurrent disorders to models/groups that are welcoming,

knowledgeable and concurrent capable	
Curriculum Element	**Objective**
1. Definition of concurrent mental health and substance use disorders	▪ Education on how to use strengths-based recovery-oriented language and models
2. Signs and symptoms of substance use and common mental health disorders and their interactions	▪ Education on diagnostic issues including stabilization, remission and the ability for a diagnosis to change in relation to a co-occurring substance abuse disorder ▪ Education in specific content for specific disorders and co-morbidities with attention to the integration of both substance use and mental illness
3. Medications	▪ Information on the appropriate use of medications, side effects, interaction with substances and the importance of communication with an individual's prescriber
4. Wellness and recovery options	▪ Education in how to find 12-step or other types of support groups specific to the individual's needs and in strategies for coping or managing challenges and using resources ▪ Knowledge of education and skills related to both disorders individually and as they interact with each other ▪ Knowledge in developing and utilizing coping skills for both mental health and substance use disorder signs and symptoms ▪ Detailed knowledge of healthcare risks related to both concurrent disorders as well as the role of nutrition and physical wellness in recovery ▪ Knowledge of resources available to clients who have concurrent disorders ▪ Demonstrate intermediate skills in motivational interviewing techniques ▪ Knowledge of recovery resources available within Capital Health and the community ▪ Demonstrate knowledge of treatment strategies including: medication, psychotherapy, holistic/alternative, professionals, family members, self-help, natural supports, peer, 12-step support,

	etc. ▪ Understand the recovery and rehabilitation models of both Mental Health and Addictions (Psychiatric Rehabilitation, Consumer Co-op Models, Harm Reduction principles, self-help groups) and link individuals with concurrent disorders to models/groups that are appropriate, knowledgeable and concurrent capable
5. Conduct integrated assessments	▪ Demonstrate knowledge of how to complete a concurrent disorder assessment tools. ▪ Able to conduct mental health or addictions assessment interchangeably and when needed. ▪ Understand the importance of developing integrated treatment plans

Advanced Learning Plan

Overview and Purpose **To provide the service provider with an advanced level of knowledge and experience in concurrent disorder.**	**Advanced** **Must complete the following objectives in addition to the Basic and Intermediate objectives.**
Advanced Outcomes 1. Use integrated models of assessment, intervention and treatment • Understand group processes and facilitate groups (e.g., process groups, social skills groups, stage-wise groups and interactive psycho-education groups) 2. Provide interventions for families and other supports • Work individually with families and facilitate a multi-family psycho-education/support group 3. Demonstrate an understanding of psychotropic medication as well as their interactions with substances 4. Support quality improvement efforts, including a focus on incorporating changes in evidence-based best practices, resources, and tools in the provision of integrated services for people with concurrent disorders 5. Provide leadership and facilitate a peer supervision model that includes a mentoring role as per the core competencies	

Curriculum Element	Objective
1. Use integrated models of assessment, intervention and recovery.	▪ Understand group processes and facilitate groups (e.g., process groups, social skills groups, stage-wise groups, interactive psycho-education groups) ▪ Understand principles for facilitating groups
2. Provide interventions for families and other supports.	▪ Work individually with families ▪ Facilitate a multi-family psycho education/support group ▪ Demonstrate an understanding of how to integrate families/significant others/others affected and support systems formal and informal into the treatment plan
3. Demonstrate an understanding of psychotropic medications	▪ Able to develop medication learning plans for patients with concurrent disorders ▪ Articulate medication regime to clients.
4. Support quality efforts and tools in the provision of integrated services	▪ Available to assist in the development of concurrent disorders screening and assessment tools ▪ Collaborating and conducting clinical research in concurrent disorders
5. Provide peer supervision and a mentoring at basic and intermediate levels	▪ Develop facilitation and peer leadership skills in mentoring and peer supervision models

Appendix E:
Estimated Budget for a 10-Bed Concurrent Disorder Program

Estimated Budget for a 10-Bed Concurrent Disorder Program			
Staff	**FTE**	Estimated Budget	
Team Leader	1	$	89,000.00
Staff Nurse (RN)	4	$	319,272.13
Licensed Practical Nurse (LPN)	4	$	220,000.00
Care Team Assistant	2	$	80,242.44
Occupational therapist	0.5	$	40,941.11
Clinical therapist	1	$	86,000.00
Addiction Counsellor	1	$	76,000.00
Social Worker	1	$	89,827.80
Admin Support (secretary C)	1	$	43,000.00
Psychiatrist	0.2		
FTE Total excluding psychiatry		**$**	**1,044,283.48**
Supplies			
Drugs		$	80,000.00
Medical surgical supplies		$	3,700.00
General supplies		$	14,000.00
Laundry and Linen		$	1,600.00
Stationary/photocopying/printing		$	9,900.00
Computer leases and printers		$	2,200.00
Phone rental including cell phones		$	4,500.00
Travels		$	6,085.00
Training Cost		$	3,500.00
House Keeping supplies		$	725.00
Meals (including labour)		$	105,000.00
Sub Total (Supplies)		**$**	**231,210.00**
Total Operating Costs		**$**	**1,275,493.48**

Notation: The following associated costs are not included:

- .2 FTE psychiatrist position
- Building/lease cost
- Housekeeping/labour cost

Submitted by Dorothy Edem