Mental Health and Addiction Services

System Level Standards for Concurrent Disorders 2012

NOVA SCOTIA

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Glossary

Agency of First Contact:
whichever agency—Mental Health or Addiction Services—has first contact with the client.

Brief Intervention:
those practices that aim to investigate a potential problem and motivate an individual to begin to do something about the problem, either by natural, client-directed means or by seeking additional treatment.

Circle of Care:
term of reference used to describe the health information custodians and their authorized agents who are permitted to rely on an individual's implied consent when collecting, using, disclosing, or handling personal health information for the purpose of providing direct health care. This includes physicians, nurses, specialists/other health-care providers referred by the physician, and health-care professionals selected by the patient, such as a Pharmacist or Physiotherapist. (Personal Health Information and Protection Act, 2004)

Collaborative Treatment:
treatment that is characterized by decision-making shared among service providers involved in the person's care, the client, and their concerned significant others, or by a team of clinicians that works collaboratively to ensure that care is coordinated among service providers.

Community Service Providers:
the referring agencies and service providers, outside of Mental Health and Addiction Services, who contribute to the overall health and functioning of the individual.

Concerned Significant Others:
those individuals identified by the client as being an integral part of their support system; may include family members, friends, and/or others.

Concurrent Disorders:
co-occurring mental health disorder(s) and substance use problem(s).

Continuity of Care:
the process by which the client and service providers are cooperatively involved in ongoing health-care management supporting client recovery.

Cultural Competence:
the ability to provide care to individuals with diverse values, beliefs, and behaviours, including tailoring service delivery to meet each individuals' social, cultural, and linguistic needs.

Evidence-based:
making decisions about how to promote health and provide care by integrating the best available research evidence, practitioner expertise, and knowledge of the local context, with the needs, values, and preferences of those accessing services and supports.

Parallel Treatment:
treatment that is characterized by simultaneous but separate treatment of the mental health disorder and substance-use problem by different service providers, without coordination or collaboration.

Partner Program:
refers to either Addiction Services or Mental Health Services; if Addiction Services is the Agency of First Contact, the partner program is Mental Health Services and vice versa.

Person-centred:
respecting a person's values, preferences, and expressed needs when planning treatment.

Protective Factors:
in this context, anything that prevents or reduces vulnerability for the development of a concurrent disorder. These can be fixed (age, sex, family history) or modifiable (employment, housing, family discord).

Recovery:
the process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential.

Risk Factor:
in this context, anything that increases an individual's chances of developing a concurrent disorder. These can be fixed (age, sex, family history) or modifiable (employment, housing, family discord).

Self-management:
clients being actively involved in their health care, utilizing a variety of creative and individualized strategies to deal with their health problems in their daily lives so as to live as normally as possible despite their symptoms.

Service Level:
the level at which clinical care and psychosocial support is delivered.

Sequential Treatment:
a treatment plan in which one of the concurrent disorders is mitigated or resolved before beginning treatment for the other.

Social Determinants of Health:
the conditions in which people are born, grow, live, work and age, including the health system. Examples include income and social status, social support networks, education and literacy, employment, personal health practices, and coping skills.

System Level:
structures and processes that provide the infrastructure for the organization and delivery of services and supports for people with concurrent disorders and their concerned significant others. This includes supports such as policy, leadership, funding, performance measurement and accountability, information management, human resource management, and research and knowledge exchange.

Introduction

Our current health-care system is challenged to address the needs of people experiencing substance-use problem(s) and mental health disorder(s), a situation commonly referred to as concurrent disorders. The addictions and mental health components of the system often use different treatment philosophies and are structured in such a way that clients are frequently only treated for one of their problems/disorders, or they experience parallel treatments with little or no continuity of care or collaboration. Individuals experiencing concurrent disorders do not compartmentalize their problems, therefore the system(s) treating them should not. Keeping the client and his or her concerned significant others at the center of system planning is vital.

In 2007 a Provincial Health Services Operating Review highlighted gaps in the treatment of people with concurrent disorders in Nova Scotia. The Department of Health and Wellness (DHW), the District Health Authorities (DHAs), and the IWK Health Centre (IWK) are committed to providing comprehensive quality care for people experiencing concurrent disorders and their concerned significant others. A Provincial Concurrent Disorders Project Working Group (herein referred to as "the Working Group") was struck to provide guidance and oversight to the planning and implementation of initiatives to enhance services and supports for individuals experiencing concurrent disorders. The Working Group has established a comprehensive, multi-year plan to meet this mandate.

Effective intervention for concurrent disorders requires close collaboration between Mental Health and Addiction Services. Representatives from provincial Mental Health and Addiction Services co-led an initiative, in consultation with the DHAs and the IWK, to develop these Joint Provincial Concurrent Disorders Standards (herein referred to as "Concurrent Disorders Standards"). To inform the Concurrent Disorders Standards development process, a situational analysis of current services and supports related to concurrent disorders provided by Mental Health and Addiction Services in Nova Scotia was conducted, as well as a cross-jurisdictional review of relevant policies, guidelines, and standards. Using this information as a foundation, as well as key references from the literature regarding promising and emerging practices, a draft set of Concurrent Disorders Standards was developed by representatives of Mental Health and Addiction Services staff from across the province. These system standards support collaborative care.

An extensive multi-phased consultation process was undertaken. The Concurrent Disorders Standards were first reviewed by two nationally recognized experts. This was followed by joint DHA-level consultation sessions with Mental Health and Addiction Services staff. An online survey was developed to give Mental Health and Addiction Services staff the opportunity to provide further feedback. In addition, separate focus groups for clients and their concerned significant others were conducted, along with several individual interviews.

A number of stakeholder surveys were also completed. This important feedback was summarized and analyzed, and formed the basis for a series of revisions to the original Concurrent Disorders Standards document.

This document is intended as a guide to enhance care along the full continuum of supports and services for individuals experiencing concurrent disorders and their concerned significant others. The Concurrent Disorders Standards encourage a culture shift at all levels of Mental Health and Addiction Services. This will require a shared vision supported by common values and leadership that consistently champions this shared vision. Sufficient resources must be invested to support all stages of the change process at all levels, from planning to implementation, and performance monitoring. Open, ongoing, two-way communication will facilitate understanding and opportunities for collaborative problem-solving.

Individuals experiencing concurrent disorders come from all walks of life. Mental illness and problematic substance use cross all boundaries, including gender, income, race, geographical location, sexuality, and language. It is important to consider the impact and influence that these demographic characteristics have on mental illness and problematic substance use, as well as what this may mean for the etiology, development, and treatment of individuals' problems. The Working Group and those participating in the consultation process identified gambling as a distinct and important issue requiring a more thorough understanding of the literature related to problem gambling and co-occurring mental health disorders. A review of the literature has been commissioned to gather information related to concurrent problem gambling and mental health disorders. The evidence collected will inform next steps in addressing co-occurring problem gambling and mental health disorders. This could include adding gambling-specific standards at a later date.

Prevention and health promotion are not specifically addressed in this document as they are not specific to concurrent disorders. Prevention and health promotion should target all populations and be attended to throughout the continuum of Addiction and Mental Health Services.

As evidence in the field of concurrent disorders evolves, these Concurrent Disorders Standards will be changed to reflect this new knowledge.

Purpose of Concurrent Disorders Standards

New system-level standards are needed for the purposes of:

- setting a foundation for improvement, recognizing that full implementation may take time
- reducing undesired service variations
- focusing attention on intended outcomes and activities required to achieve them

Guiding Principles

The Joint Provincial Concurrent Disorders Standards are based upon the following guiding principles. The standards support the implementation of services and supports that:

- are person-centered
- are evidence-based
- acknowledge concurrent disorders as the norm, not the exception
- where appropriate, involve concerned significant others
- are culturally competent
- support self-management
- support strengthening of protective factors and strategies to address risk factors
- respect and value the unique contributions of Mental Health and Addiction Services
- are practical and sustainable
- focus on the social determinants of health

A Model for Providing Collaborative Concurrent Disorders Services and Supports

In 2007 a National Treatment Strategy Working Group launched A Systems Approach to Substance Abuse in Canada: Recommendations for a National Treatment Strategy (herein referred to as the "National Treatment Strategy"). The National Treatment Strategy provides direction and recommendations to strengthen services and supports. Many jurisdictions across Canada (e.g. New Brunswick, Alberta, and Ontario) have leveraged the recommendations in the National Treatment Strategy to inform their Mental Health and Addiction Services strategic plans.

Many of the principles outlined in the National Treatment Strategy complement those guiding these standards. The systems approach, as described in the National Treatment Strategy, has much appeal because it is premised on the "any-door-is-the-right-door" notion, allowing individuals to access the continuum of services and supports that best meet their needs and strengths. Clients and their families must feel welcome at all possible points of entry.

A second key concept of the National Treatment Strategy is that client problems cannot be solved by one champion, one government, one organization, or even one sector. Instead, the individual accessing services is a client of the overall system and not of any one particular service provider. Effective treatment does not begin or end at the doors of the Mental Health and Addiction Services, but should include multiple sectors based on client need. Research has shown that individuals experiencing concurrent disorders are more likely to require other services including (but not limited to) primary care, social assistance, education, housing, and justice/corrections. Focusing on specialized addiction and/or mental health services in isolation reduces the ability to address the determinants of health. As such, the National Treatment Strategy emphasizes effective linkages between services and sectors. These Concurrent Disorders Standards not only encourage enhanced collaboration between Mental Health and Addiction Services but also require staff to strengthen relations with other community service providers who may be involved with the client.

The National Treatment Strategy is based on a five-tiered framework. Services and supports in the lower tiers, such as activities that draw on natural networks of support (e.g. peer support groups), are open to all and are intended to meet the needs of greater numbers of people. The upper tiers are designed to meet the needs of smaller numbers of people with more severe mental illness and substance-use problems. It is important to note that individuals with substance-use problems and mental health disorders often access services and supports from more than one tier, either sequentially or simultaneously.

The National Treatment Strategy considered evidence generated from population surveys and various treatment settings, which indicated that substance abuse and mental health disorders frequently co-occur. This population is more likely to experience physical illness and require a range of social supports. In all circumstances it is necessary to consider the acuity (the severity/what level of treatment is needed), chronicity (the longevity or duration) and overall complexity of a case. The last is characterized by the interplay between acute, chronic, and other serious issues such as unemployment, homelessness, and disengagement from family. To have a positive impact on treatment outcomes over the long run, models of care must attend to the "whole person." This can only happen if models of care and supporting policy are comprehensive in scope.

Implementation of Concurrent Disorders Standards

The System Level Standards for Concurrent Disorders are mandatory. DHAs/IWK may take a phased approach to implementing the standards. Full implementation of these standards is expected to take three to five years. DHAs/IWK are expected to develop an implementation plan one year post-launch of the standards. The plans will vary based on each area's current capacity related to concurrent disorders, and each DHA and the IWK may place more or less emphasis on specific standards in any given year. It is not expected that all standards will be fully implemented in the first year.

Monitoring implementation is an important component of quality assurance. This process can help the DHAs/IWK and DHW identify where additional supports and services may be required. In order to measure progress toward implementation, indicator(s) were developed for each standard. Appendix A, Concurrent Disorders Standards—Monitoring Report, provides a template designed to enable the DHAs and the IWK to monitor the extent to which progress is being made towards implementing the System Standards for Concurrent Disorders. This tool will be administered one year post-launch of the Standards. Appendix B, Concurrent Disorders—Phase II Monitoring Report, has been developed to guide future standard measurement. Phase II reporting will not be required until such time as full standard reporting capability has been established. This is dependent upon the completion of a new client information system for Mental Health and Addiction Services.

The remainder of this document presents the Concurrent Disorders Standards. Each section will include:

- the title of the category
- a description of the category
- the objectives to be met
- the standards themselves

Joint Provincial Concurrent Disorders Standards

1.0 Screening

Description

Screening in this context is the process that determines the likelihood that a person has a concurrent disorder. The purpose of screening is not to diagnose but to establish whether the individual may have a mental health disorder and substance-use problem that requires a more in-depth assessment. Integrated screening is the process of screening for mental health disorders and substance-use problems, each in the context of the other. The literature strongly supports an integrated approach. Screening provides a benchmark that can be used to monitor progress, and it can be re-administered in response to changes observed by the service provider over the course of treatment.

Objectives

- To ensure that clients, other than noted exceptions, presenting to either Mental Health or Addiction Services are being screened for concurrent disorders
- To determine the likelihood that a client presenting to either Mental Health or Addiction Services is experiencing a concurrent disorder

Standards

1.1 Each DHA and the IWK have an agreed-upon screening protocol that delineates when and how Mental Health and Addiction Services clients will be screened for concurrent disorders.

1.2 Mental Health and Addiction Services staff responsible for screening will participate in collaborative training sessions on the administration of the agreed-upon screening tool(s).

1.3 Clients are screened at initial intake/assessment for concurrent disorders using evidence-based screening tool(s) agreed upon by Mental Health and Addiction Services within each DHA and IWK. Exceptions include, but are not limited to, children and youth under the age of 12 and individuals attending the following programs: Driving While Impaired, Tobacco Cessation, Early Autism Program, and Concerned Significant Other/Parent Group.

2.0 Referral

Description

Referral is the process of directing someone to another person or agency for help or information. The term "referral" comprises both the act of guiding individuals to another service provider and the actual documentation requesting services. As clients with concurrent disorders often face a disproportionate burden of health, social, and economic challenges, no single organization can meet all of their needs. The ability to connect clients with other community service providers allows the client access to relevant supports and services throughout the health-care system and the larger community.

Objectives

- To ensure seamless and timely access for those individuals who may benefit from the services and supports provided by the partner program
- To give preferential treatment to clients who have been screened as having the potential for a concurrent disorder

Standards

2.1 There is a documented referral protocol within each DHA and IWK to refer clients to partner programs.

2.2 If a concurrent disorder is confirmed through assessment by the partner program, that program will determine client level of urgency and prioritize the client for treatment within that level (i.e. if the partner program determines that this client falls within the "urgent" category, he/she will be prioritized at the top of the "urgent" wait-list; if the partner program determines that this client falls within the "emergent" category, he/she will be prioritized at the top of the "emergent" wait-list).

3.0 Assessment, Treatment Planning, and Discharge Planning

Description

Assessment is the process of gathering information about a person within a service in order to determine whether there is a substance-use problem and/or make a mental health disorder diagnosis. The assessment, which may include social and biographical information, direct observations, and data from specific psychological tests, is usually the first stage of a treatment process.

Treatment planning is the documented process of identifying the presenting problem(s), the goals of treatment, and the methods and strategies that will be used to achieve these goals. Treatment plans include consideration of the client's strengths, needs, goals, and expectations, and may also address income, social support networks, education, employment, and coping skills. Where appropriate, concerned significant others should be involved in treatment planning.

Discharge planning includes the activities that facilitate client movement from one level of care or service to another, or to home. Discharge planning begins on admission, and the goal is to ensure appropriate supports and services are in place prior to discharge, resulting in enhanced continuity of care for clients.

Objectives

- To assess clients who present with the potential for concurrent disorders
- To ensure close collaboration between Mental Health, Addiction Services, and relevant community service providers when working with clients with concurrent disorders and, where appropriate, concerned significant others

Standards

3.1 Assessments are conducted to determine the existence and/or severity of concurrent disorders.

3.2 If further assessment determines that there is a concurrent disorder which requires treatment by Mental Health and Addiction Services, a joint treatment plan will be developed in collaboration with the client and, as appropriate, with their concerned significant others.

3.3 The discharge plan will include the supports and services necessary to sustain the overall health and well-being of the client. These connections will be established prior to discharge.

4.0 Continuity of Care

Description

Refers to the delivery of a "seamless service" as experienced by clients and concerned significant others throughout their care journey. Coordination of care and the sharing of information among service providers are essential components. Continuity of care provides clients with ease of access and navigation within and between the tiers of services and supports offered by Mental Health and Addiction Services and relevant community service providers.

Continuity of care begins with first contact and continues throughout the care journey. As such, implementation of these Concurrent Disorders Standards related to screening, referral, assessment, treatment, and discharge planning will increase coordination and collaboration, and improve the clients' experience.

Objectives

- To improve the clients' experience of access and navigation when they require the intervention of two or more services
- To improve the coordination of services and supports offered by Mental Health and Addiction Services
- To improve the coordination of services and supports offered by community service providers
- To ensure that staff within the partner programs have timely access to relevant client information
- To ensure that community service providers have timely access to relevant client information

Standards

4.1 Mechanisms for collaborative care between partner programs are established in each DHA and IWK to ensure seamless service throughout the continuum of care.

4.2 To ensure continuity of care for clients, Mental Health and Addiction Services will establish documented processes/protocols for informed consent, communication, screening, referral, and discharge planning with identified community service providers.

5.0 Capacity Building

Description

Capacity building is the process of increasing the ability of an individual, organization, or community to address health issues and concerns. With respect to concurrent disorders, this includes the development of knowledge, skills, attitudes, resources, networks, and leadership necessary to increase understanding and decrease the stigma. The process of capacity building relies heavily on collaboration and partnership, which must begin with Mental Health and Addiction Services.

It is the obligation of Mental Health and Addiction Services to work collaboratively with each other and with community service providers to enhance services and supports related to concurrent disorders. As no one agency can provide all necessary supports and services, preventing and treating concurrent disorders requires a broad population health approach. This involves partners from many sectors, including but not limited to primary care, community services, justice, education, public health, housing, and communities.

Objectives

- To increase the capacity of Mental Health staff to work with individuals who are also experiencing substance-use problems, and to increase the capacity of Addiction Services staff to work with individuals also experiencing mental health disorders
- To increase the capacity of community service providers to integrate knowledge of concurrent disorders within their respective health promotion and prevention programming, as appropriate
- To support community service providers to intervene early with persons at risk for concurrent disorders
- To increase knowledge and understanding of concurrent disorders among community service providers, thus increasing the likelihood that individuals experiencing concurrent disorders and their concerned significant others will access community resources
- To increase the competency of community service providers to conduct screening for concurrent disorders

Standards

5.1 Mental Health and Addiction Services develop mechanisms to build capacity through cross-training opportunities.

5.2 Mental Health and Addiction Services facilitate education opportunities with community service providers to increase understanding of concurrent disorders.

5.3 Mental Health and Addiction Services collaboratively participate in anti-stigma and anti-discrimination initiatives with primary-care and relevant community service providers.

5.4 Mental Health and Addiction Services staff provide training opportunities for community service providers to increase competency in screening for concurrent disorders.

5.5 Mental Health and Addiction Services staff provide training opportunities for community service providers to increase competency in brief intervention for concurrent disorders.

6.0 Organizational and Staff Competencies

Description

Organizational competencies are the combination of skills, information, performance measures, and organizational culture necessary for the achievement of its goal, which in this case is improving the quality of services and supports for individuals experiencing concurrent disorders and their concerned significant others.

Staff competencies are specific measurable skills, knowledge, attitudes, and values needed to effectively perform a particular function or role. Basic competencies should be maintained throughout the entire organization. These include the recognition of the social, political, economic, gender, diversity, and cultural contexts within which each individual presents, as well as the impact that these may have on problem etiology, progress, treatment, and recovery. They are typically learned and developed through work, education, training, and other life experiences.

They serve as an evidence-based framework that identifies the specific abilities required by the Mental Health and Addiction Services workforce to ensure consistent service delivery and care for individuals with concurrent disorders. Identifying and developing staff competencies specifically related to concurrent disorders will be essential for improving outcomes for this population.

Objective

- To promote quality practice through the development and adoption of organizational and staff competencies for concurrent disorders

Standards

6.1 Staff competencies for concurrent disorders are embedded in the job descriptions, interview guides, selection process, and performance evaluations of staff according to their scope of practice.

6.2 Mental Health and Addiction Services staff explore opportunities to conduct cross-training to address identified gaps.

6.3 Identified Mental Health and Addiction Services staff are oriented to the services and supports of the partner program.

7.0 Monitoring

Description

This is the process of monitoring the extent to which progress is being made towards implementing the Concurrent Disorders Standards. Monitoring the implementation is an important component of quality assurance and accountability. Monitoring can help identify where additional supports and services may be required to meet the standards.

Objectives

- To assess the extent to which the Concurrent Disorders Standards are implemented in all DHAs and the IWK
- To monitor adherence to the Concurrent Disorders Standards
- To develop an outcomes monitoring system for concurrent disorders clients

Standards

7.1 All DHAs and the IWK have a documented implementation plan.

7.2 Once implementation has begun, Mental Health and Addiction Services will report annually on their progress towards full implementation.

7.3 All DHAs and the IWK have a documented process for outcomes monitoring for concurrent disorders.

Appendix A:
Concurrent Disorders Standards—Monitoring Report

Purpose

The following template has been designed to enable the District Health Authorities (DHAs) and the IWK to monitor the extent to which progress is being made towards implementing the System Standards for Concurrent Disorders. Monitoring implementation is an important component of quality assurance and can help each respective area and the Department of Health and Wellness (DHW) better understand where additional supports and services may be required.

Given that the DHAs and the IWK may take a phased approach to implementing the standards, each DHA and the IWK may place more or less emphasis on specific standards in any given year. It is not expected that all standards will be fully implemented in the first year.

The Monitoring Report will be submitted to DHW one year after the launch of the Standards.

Instructions

- Gather key individuals in both Addiction Services and Mental Health who have a role in providing support to people with concurrent disorders or who are responsible for activities related to concurrent disorders. Consider including representatives from different levels or areas of service delivery.
- Have the group work through the tool (i.e. assess and note the level of implementation for each item).
- Record the results on the tool.
- In the "Comments" section please describe activities you have undertaken and/or plan to undertake in order to meet the indicator.
- Attach supplementary information that further describes the process and achievements to date.

How Results Will Be Used

Completion of this tool will provide information that can be used collectively to identify successes, gaps, and challenges related to implementation of the standards. This can help determine what resources DHAs/IWK need in order to fully implement the policy. In addition, government departments and DHAs/IWK will be able to use this information in future planning related to concurrent disorders.

How Results Will Be Shared

A provincial summary report will be written and shared with DHAs/IWK and key DHW staff. The report will not identify or name DHAs or IWK nor be used to compare DHAs/IWK.

Indicators for Measurement One Year Post Standard Implementation

Please note the status of the indicator within your jurisdiction as follows:
N = not implemented P = partially implemented F = fully implemented

Category: 1.0 Screening

Indicator	Status (N, P, F)
Standard 1.1: Each DHA and the IWK have an agreed-upon screening protocol which delineates when and how Mental Health and Addiction Services clients will be screened for concurrent disorders.	
1.1a. One or more evidence-based screening tools for concurrent disorders are agreed upon. *Please explain (list tool(s) used)*:	
1.1b. Policies and procedures have been developed that states for whom, when, and how screening for concurrent disorders will take place. *Please explain:*	
Standard 1.2: The Mental Health and Addiction Services staff responsible for screening participate in collaborative training sessions on the administration of the agreed-upon screening tool(s).	
1.2 Training is offered in the administration of the agreed-upon screening tool(s). *Please explain:*	

Category: 2.0 Referral

Indicator	Status (N, P, F)
Standard 2.1: There is a documented referral protocol within each DHA and IWK to refer clients between partner programs.	
2.1 Policies and procedures have been developed for referral within and between Mental Health and Addiction Services. *Please explain:*	

Standard 2.2: If a concurrent disorder is confirmed through assessment by the partner program, the partner program will determine client level of urgency and prioritize the client for treatment within that level (i.e. if the partner program determines that this client falls within the "urgent" category, he/she will be prioritized at the top of the "urgent" wait-list; if the partner program determines that this client falls within the "emergent" category, he/she will be prioritized at the top of the "emergent" wait-list).	
2.2a. Policies and procedures have been developed to prioritize clients with concurrent disorders for treatment. *Please explain:*	

Category: 3.0 Assessment, Treatment Planning, and Discharge Planning

Indicator	Status (N, P, F)
Standard 3.1: Assessments are conducted to determine the existence and/or severity of concurrent disorders.	
3.1 Policies and procedures are in place to ensure that assessment takes place following a screening that indicates the possibility of a concurrent disorder. *Please explain:*	
Standard 3.2: If further assessment determines there is a concurrent disorder which requires treatment by Mental Health and Addiction Services, a joint treatment plan will be developed in collaboration with the client and, as appropriate, with their concerned significant others.	
3.2 Policies and procedures are in place to ensure joint treatment planning takes place. *Please explain:*	

Category: 4.0 Continuity of Care

Indicator	Status (N, P, F)
Standard 4.2: Mental Health and Addiction Services will establish documented processes/protocols for informed consent, communication, screening, referral, and discharge planning with identified community service providers to ensure continuity of care for clients.	
4. 2 Policies and procedures are in place to facilitate information-sharing with community service providers. *Please explain:*	

Category: 5.0 Capacity Building

Indicator	Status (N, P, F)
Standard 5.1: Mental Health and Addiction Services develop mechanisms to build capacity through cross-training opportunities.	
5.1a. Annual plans have been developed for cross-training opportunities for Mental Health and Addiction Services. *Please explain:*	
5.1b. Identified staff members requiring cross-training have received that training. *Please explain:*	
Standard 5.2: Mental Health and Addiction Services facilitate education opportunities with community service providers to increase understanding of concurrent disorders.	
5.2a. Plans for identifying training needs of community service providers are developed. *Please explain:*	

5.2b. Training is provided to meet the identified needs of community service providers (e.g. general knowledge, screening, referral, brief intervention, etc.). *Please explain:*	
5.2c. Training opportunities for community service providers are evaluated. *Please explain:*	
Standard 5.3: Mental Health and Addiction Services collaboratively participate in anti-stigma and anti-discrimination initiatives with primary-care and relevant community service providers.	
5.3 An annually updated plan to initiate, participate, and/or contribute to anti-stigma and anti-discrimination initiatives is developed collaboratively. *Please explain:*	
Standard 5.4: Mental Health and Addiction Services staff provide training opportunities for community service providers to increase competency in screening for concurrent disorders.	
5.4 You may expand on your response to indicators 5.2a and 5.2b	
Standard 5.5: Mental Health and Addiction Services staff provide training opportunities for community service providers to increase competency in brief intervention for concurrent disorders.	
5.5 You may expand on your response to indicators 5.2a and 5.2b	

Category: 6.0 Organizational and Staff Competencies

Indicator	Status (N, P, F)
Standard 6. 1: Staff competencies for concurrent disorders are embedded in the job descriptions, interview guides, selection process, and performance evaluations of staff according to their scope of practice.	
6.1a. Job descriptions include staff competencies for concurrent disorders. *Please explain:*	
6.1b. Staff selection processes include staff competencies for concurrent disorders. *Please explain:* **6.1c. Performance evaluations include staff competencies for concurrent disorders.** *Please explain:*	
Standard 6.2: Mental Health and Addiction Services staff explore opportunities to conduct cross-training to address identified gaps.	
6.2 You may expand on your response to indicators 5.1a and 5.1b:	
Standard 6.3: Identified Mental Health and Addiction Services staff are oriented to the services and supports of the partner program.	
6.3 Identified staff members are oriented to the services and supports of partner programs. *Please explain:*	

Category: 7.0 Monitoring

Indicator	Status (N, P, F)
Standard 7.1: All DHAs and the IWK have a documented implementation plan.	
7.1 Implementation plan is updated annually. *Please explain:*	
Standard 7.2: Once implementation has begun, Mental Health and Addiction Services will report annually on their progress toward full implementation.	
7.2 Progress on implementation of the concurrent disorders standards is reported to DHW annually.* (*using the template provided by DHW) *Please explain:*	

Appendix B:
Concurrent Disorders Standards—Phase II Monitoring Report

Purpose

The following template has been designed to enable the District Health Authorities (DHAs) and the IWK to monitor the extent to which progress is being made towards implementing the System Standards for Concurrent Disorders. Monitoring the implementation is an important component of quality assurance and can help each respective area and the Department of Health and Wellness (DHW) better understand where additional supports and services may be required. This tool has been developed to guide future measurement and will not be required until such time as full standard reporting capability has been established.

Instructions

- Gather key individuals in both Addiction Services and Mental Health who have a role in providing support to people with concurrent disorders or who are responsible for activities related to concurrent disorders. Consider including representatives from different levels or areas of service delivery.
- Have the group work through the tool (i.e. assess and note the level of implementation for each item).
- Record the results on the tool.
- In the "Comments" section please describe activities you have undertaken and/or plan to undertake in order to meet the indicator.
- Attach supplementary information that further describes the process and achievements to date.

How Results Will Be Used

Completion of this tool will provide information that can be used collectively to identify successes, gaps, and challenges related to implementation of the standards. This can help determine what resources DHAs/IWK need in order to fully implement the policy. In addition, government departments and DHAs/IWK will be able to use this information in future planning related to concurrent disorders.

How Results Will Be Shared

A provincial summary report will be written and shared with DHAs/IWK and key DHW staff. The report will not identify or name DHAs or IWK nor be used to compare DHAs/IWK.

Category: 1.0 Screening

Indicator	Percent (number)
Standard 1.3: Clients are screened at initial intake/assessment for concurrent disorders using evidence-based screening tool(s) agreed upon by Mental Health and Addiction Services within each DHA/IWK.	
1.3 Percentage (and number) of clients who are screened in accordance with screening policies and procedures. *Please explain:*	

Category: 2.0 Referral

Indicator	Percent (number)
Standard 2.2: If a concurrent disorder is confirmed through assessment by the partner program, the partner program will determine client level of urgency and prioritize the client for treatment within that level (i.e. if the partner program determines that this client falls within the "urgent" category, he/she will be prioritized at the top of the "urgent" wait-list; if the partner program determines that this client falls within the "emergent" category, he/she will be prioritized at the top of the "emergent" wait-list).	
2.2b. Percentage (and number) of clients with a concurrent disorder prioritized for treatment within the level of urgency in which they are placed. *Please explain:*	

Category: 3.0 Assessment, Treatment Planning, and Discharge Planning

Indicator	Percent (number)
Standard 3.2: If further assessment determines there is a concurrent disorder that requires treatment by Mental Health and Addiction Services, a joint treatment plan will be developed in collaboration with the client and, as appropriate, with their concerned significant others.	
3.2b. Percentage (and number) of clients involved in both partner programs who have a joint treatment plan developed. *Please explain:*	
Standard 3.3: The discharge plan will include the supports and services necessary to sustain the overall health and well-being of the client. These connections will be established prior to discharge.	
3.3 Percentage (and number) of discharge plans that identify the services and supports necessary to sustain the overall health and well-being of the client and make these connections prior to discharge. *Please explain:*	

Category: 4.0 Continuity of Care

Indicator	Percent (number)
Standard 4.1: Mechanisms for collaborative care between partner programs are established in each DHA/IWK to ensure seamless service throughout the continuum of care.	
4.1 Percentage (and number) of clients with potential for a concurrent disorder receiving treatment from both services. *Please explain:*	

Category: 5.0 Capacity Building

Indicator	Percent (number)
Standard 5.1: Mental Health and Addiction Services develop mechanisms to build capacity through cross-training opportunities	
5.1b. Percentage (and number) of staff who participate annually in cross-training opportunities. *Please explain:*	

Category: 7.0 Monitoring

Indicator	Percent (number)
Standard 7.3: All DHAs and the IWK have a documented process for outcomes monitoring for concurrent disorders.	
7.3 A documented policy/protocol exists for outcomes monitoring for concurrent disorders. *Please explain:*	

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