Mental Health and Addictions Care Collaboration in Renfrew County
Working Session Report - June 22nd 2017 v1

Table of Contents

1. Concurrent Clients within Mental Health and Addiction Programs in Renfrew County

Baseline Data: "Lay of the Land" Spring 2017

	Caseload	*# with concurrent disorders*	*# connected to other*	*% with concurrent*	*% receiving concurrent services*	*Number with potential "unmet needs"*	*% with potential "unmet needs"*
Addiction Programs	550 [a]	257 [a]	106 [a]	46.7% [a]	41.2% [a]	151 [a]	58.8% [a]
Mental Health Services of Renfrew County [d] (including ACTT)	742	196[c] (166 excluding ACTT)	75[g]	26.4%	45.2%[g]	91[b,c,g]	54.8% [b,c,g]

Notes:
a = estimates
b = Renfrew County Assertive Community Treatment Team (ACTT) has a concurrent disorder specialist on staff
c = MANY IN LONGER TERM SUPPORTS (CASE Management) ARE IN REMISSION, ABSTAINING OR ATTENDING AA; MANY CRISIS CLIENTS HAVE SUPPORT IN MAKING REFERRAL BY WORKER
g = does not include ACCT numbers

Analysis:

This population could benefit from an intervention that builds on "sharing information; case conferencing; sharing care plans"

This population could benefit from an intervention that builds on "identifying; inviting and engaging clients" into a collaborative care approach.

2. Collaboration Perspectives

The participants identified the following ideas regarding what collaboration means to them. The ideas have been grouped to assist in the development of an evaluation framework as the project moves forward into the desired future state.

Scope

- Client centred
- Ideally beyond just Renfrew Mental Health and Addiction organizations – including Alcoholics Anonymous (A.A.), Ontario Disability Support Program (ODSP), Family Doctor, Justice, and Royal
- A continuum approach across various levels and identifying what makes sense now:

Communication ⟷ Integration

Methods/Tools	Activities	Outcomes
• Face-to-face interactions • Keeping information straight (not getting lost between organizations) • Role definition (not doing everything yourself) • Flexible/nimble approaches to client needs • Communication • Cooperation • Stepping over boundaries of money/funding (integration?)	• Learning from each other (cross training) • Learning best practices • Learning what other people/services do • Role definition • Client goal identification • Coordinated Care Plan development • Case Conference	• Not getting lost in the system • Client not having to go back to "square one" – not retelling the story over and over (streamlined and shared assessments) • Common understanding of best practices • Client goal achievement • Removed Barriers

3. Current State and Desired Future State

READ ME

There are 2 high-level process maps included within this document:

1A. ***Renfrew County Common Concurrent Disorder Client – Current State***
Identifying client flow from intake, assessment, treatment, and transition for addictions clients accessing mental health services and vice versa

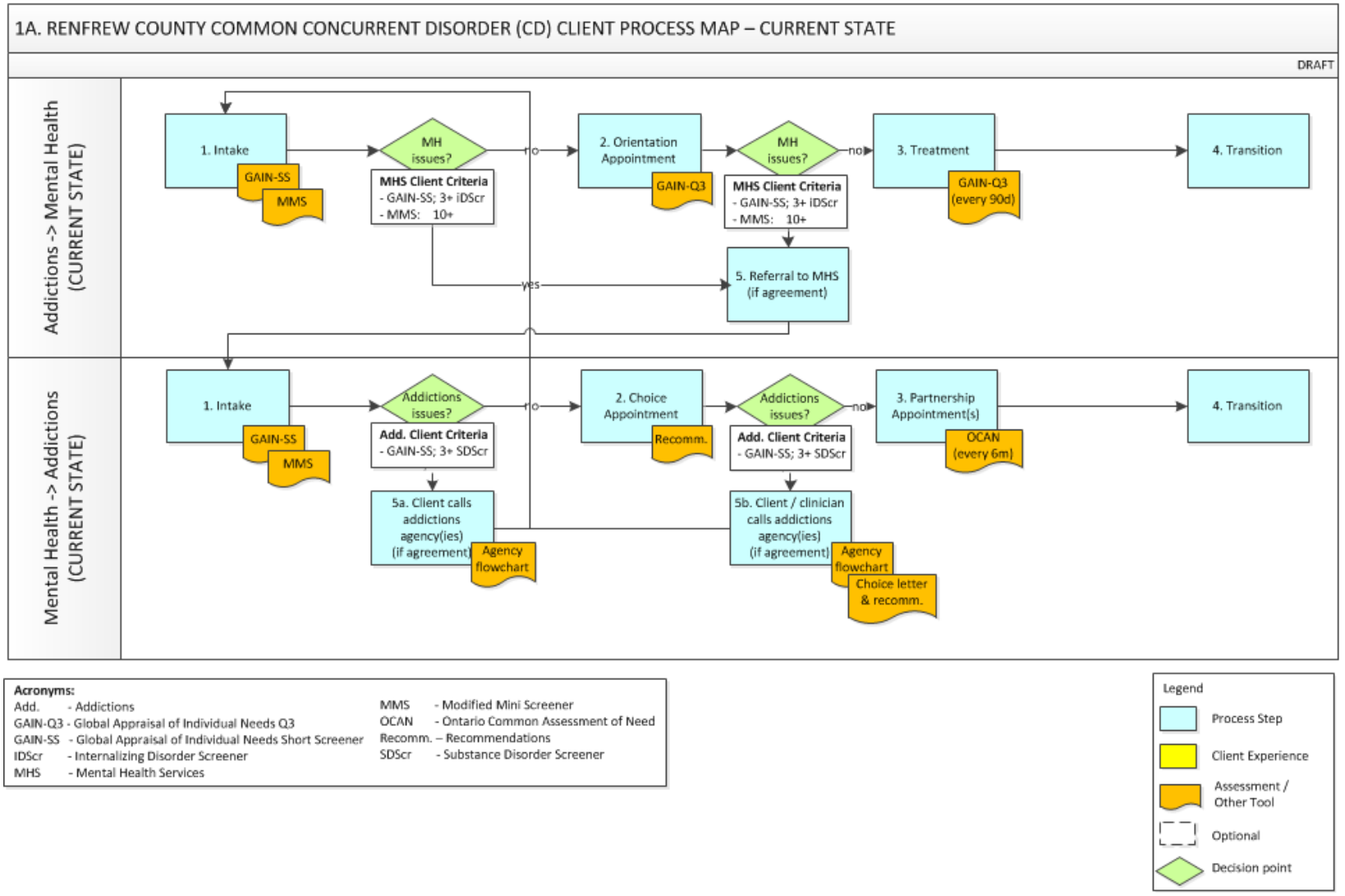
1B. ***Renfrew County Common Concurrent Disorder Client – Desired Future State***
Identifying client flow from intake, assessment, treatment, and transition for addictions clients accessing mental health services and vice versa

Each high-level process map includes a legend listing acronyms and symbols used in the map

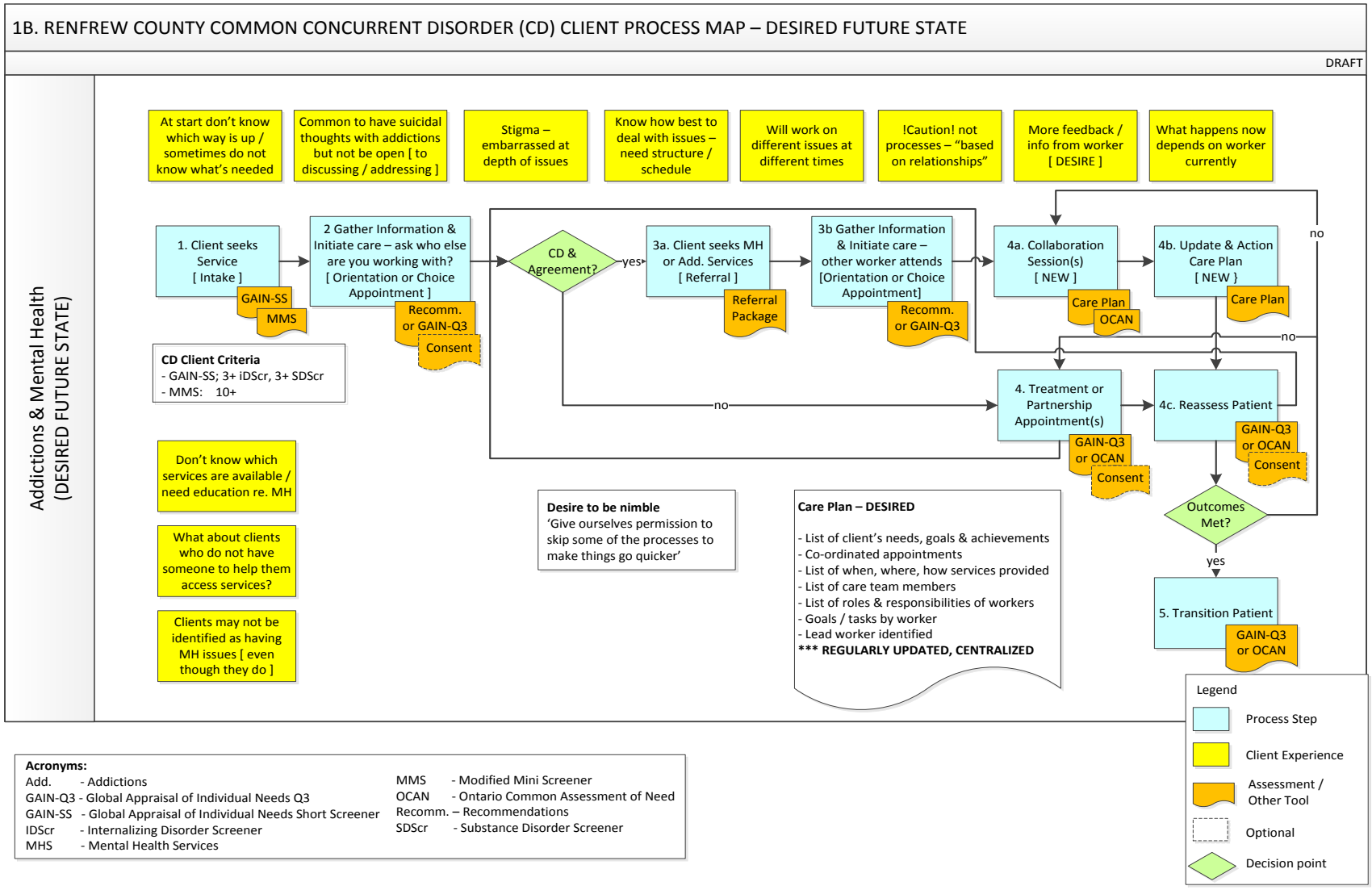
Each process map includes process steps (blue rectangle), decision points (green triangle), client experience (yellow rectangle), and assessment / other tools (orange document-shape)

Each process step is numbered, optional steps have dashed lines

These draft process maps were developed by individuals with lived experience, family members, front-line workers, and administrators based on conversations at the Apr. 25th, May 30th, and June 22nd working sessions around collaboration.


1A. RENFREW COUNTY COMMON CONCURRENT DISORDER (CD) CLIENT PROCESS MAP – CURRENT STATE
DRAFT
Addictions -> Mental Health (CURRENT STATE)
1. Intake
GAIN-SS
MMS
MH issues?
MHS Client Criteria
- GAIN-SS; 3+ iDScr
- MMS: 10+
no
yes
2. Orientation Appointment
GAIN-Q3
MH issues?
MHS Client Criteria
- GAIN-SS; 3+ iDScr
- MMS: 10+
no
5. Referral to MHS (if agreement)
3. Treatment
GAIN-Q3 (every 90d)
4. Transition
Mental Health -> Addictions (CURRENT STATE)
1. Intake
GAIN-SS
MMS
Addictions issues?
Add. Client Criteria
- GAIN-SS; 3+ SDScr
no
5a. Client calls addictions agency(ies) (if agreement)
Agency flowchart
2. Choice Appointment
Recomm.
Addictions issues?
Add. Client Criteria
- GAIN-SS; 3+ SDScr
no
5b. Client / clinician calls addictions agency(ies) (if agreement)
Agency flowchart
Choice letter & recomm.
3. Partnership Appointment(s)
OCAN (every 6m)
4. Transition
Acronyms:
Add. - Addictions
GAIN-Q3 - Global Appraisal of Individual Needs Q3
GAIN-SS - Global Appraisal of Individual Needs Short Screener
IDScr - Internalizing Disorder Screener
MHS - Mental Health Services
MMS - Modified Mini Screener
OCAN - Ontario Common Assessment of Need
Recomm. – Recommendations
SDScr - Substance Disorder Screener
Legend
Process Step
Client Experience
Assessment / Other Tool
Optional
Decision point

Mental Health and Addictions Care Collaboration in Renfrew County
Working Session Report - June 22nd 2017 v1



Acronyms:

Add. - Addictions	MMS - Modified Mini Screener
GAIN-Q3 - Global Appraisal of Individual Needs Q3	OCAN - Ontario Common Assessment of Need
GAIN-SS - Global Appraisal of Individual Needs Short Screener	Recomm. – Recommendations
IDScr - Internalizing Disorder Screener	SDScr - Substance Disorder Screener
MHS - Mental Health Services	

4. Referrals

Participants identified the following as important components of / considerations when referring to Mental Health and Addictions (MHA) and other services.

MHA Services:

- Common referral package between organizations – leverage existing Addictions referral package *(IDEA)*
- Include latest screeners in referral package
- Identify urgency of client's needs for services *(how?)*
- Beyond just a fax…
- Call Lisa (MH intake worker) -> choice appointment
- Acknowledge that we never have all the information needed

Other Services:

NOTE: Although the group did not identify specific items around referrals to other services, it should be noted that inclusion of this should be considered in the future.

5. Care Plan

Participants identified the following as important components of / considerations for a care plan. The components have been grouped to assist in the development of the care plan (tool) as the project moves forward into the desired future state.

Client-Centred:

- List of client's needs
- List of client's goals and achievements
- Shared outcomes
- Safety of client and workers is important

Appointments:

- Co-ordinated appointments
- Date of next meeting / session set at current meeting / session
- List of when, where, and how services are provided

Care Team:

- List of care team members (and contact info)
- List of roles and responsibilities of workers

- Goals / tasks by worker
- Community-based workers *(DESIRE)*
- Involve family members in the care plan (if makes sense for client) *(CLIENT)*

Lead (Worker):
- Lead identified at 1st meeting – may change over time / be re-assessed
- For addictions case manager is first point of contact for client (= lead)
- Worker with best rapport may take the lead role
- Lead sees the client most often
- Clients need a lead *(CLIENT)*
- How closely to define lead – more collaborative vs lead role? *(CONCERN)*
- Use older protocol to identify the lead
- If client from Choice Appointment, MH worker will not be the lead
- Need to follow best practice

Relationships:
- Workers need to stay connected with clients
- Relationships are very important *("more important than process")*

Mechanics:
- Centralized care plan – *need to determine tool to be used*
    - Do we (can we) use the Health Links tool (CHRIS)?
    - Can OCAN be used as a collaborative care plan?
        - Does this work for addictions? Addictions uses GAIN-Q3
- Regularly updated – *need to determine how & who*
    - Who updates the care plan? Is it the lead?
    - How can we make it not taxing?
- Need to figure out how this will work / integrate with existing care plan(s) / tools
- Needs to include latest assessments

6. Collaborative Care Sessions and Choice Appointments

Participants identified the following as important components of / considerations for collaborative care sessions. The components have been grouped to assist in the development of the collaborative care session (process) as the project moves forward into the desired future state.

Terminology:
- Not 'care' or 'case' conference – sounds one-off – more like collaboration

Purpose:

- Identify lead and other roles
- Identify recovery success – next steps and when
- Develop / clarify (centralized) care plan

Information Gathering:

- Gathering of relevant information; assessments; health records, social history / social determinants; and services being accessed

Mechanics:

- Face-to-face ideal but may not be practical due to time / distance
- Location needs to be comfortable for client – and safe for all

When It Works Well:

- Transparent
- Client knows the case manager – trust is already built
- Brings together the relevant information
- OCAN / GAIN-SS does not matter to client
- Have information on how best to deal with issues / have structure
- A care plan that is centred around the client and their needs
- Communication, rapport, open-minded
- MH needs might not emerge at start – client open to self-realization
- Client is the centre of every process and involved in massive, difficult changes
- Care plan can help with providing structure
- Needs to happen multiple times
- Collaborative

Choice Appointments – MH Services:

- Within 2 weeks
- Identify depth of needs – both immediate and other
- Guided conversation around services and options through completion of OCAN
- Gather consents / permission(s) for release of information
- Client is expert on their needs
- Addictions worker also comes to Choice Appointment / warm hand-off *(IDEA)*

Other:

- Overlap with Health Links?

7. "Pulse of the Group" – What is exciting; what is concerning

The participants identified that the enthusiasm during the session was uplifting and they are looking forward to the development and use of a coordinated care plan that can be used in both mental health and addiction settings.

Family members and those with lived experience felt it was nice to be heard and be part of activating positive change. Full participation of front line staff and clients was seen as crucial input in identifying what could be done and where priorities should lie.

There is a desire to move forward, especially around the quick wins that were identified during the session and leveraging champions. Ideally this work should build on the principles of Health Links.

Group participants were comfortable being involved as the project moves forward and especially highlighted the benefits of client and family member participation in this work.

In terms of concerns, the first concern was finding the time for collaborative care sessions and figuring out how to make a collaborative approach flow in a timely fashion.

Successful communication approaches and information sharing was deemed crucial to the success of any collaborative care approach. Technology was identified as enabling communication and information sharing, but also challenging to get a platform that would work easily and consistently with all organizations.

Participants would also like to ensure that the change process is documented in a concrete manner, along with a clear and measurable definition of success.

Another concern that was brought forward is the change process that Mental Health Services of Renfrew County is already in the process off. There is concern about adding more change to an already change weary organization.

If was recommended that minimum first steps be clearly identified and agreed on.

8. Next Steps and Quick Wins

Quick Win?	Action	Leads / Champions	Time-Frame	Outcome / Deliverable
Yes	Shared agreement on minimum first steps	RCATS+[1]	Summer	Clear path forward
Yes	Common referral package used by both mental health and addictions	Yves?/ Gillian?	Summer / Fall	Standard referral tool
Yes	Draft collaborative care plan tool based on feedback from session and Health Links	??	Summer	A draft tool to be tested
Yes	Identify common clients between Mackay Manor's Addictions Supportive Housing (ASH) program and MH case management. Identification of common approaches.	Liana / Elizabeth	Summer / Fall	Identification of clients who would benefit from a coordinated care approach Documentation of common approaches.
	Start coordinated care through a pilot (revisit process flow and identify what that looks like within the pilot)	Gillian?/ Sarah?	Fall	Refined process flow # clients in a coordinated care model Identify resource requirements and efficiencies
	Evaluation Framework	??	Summer / Fall	Clear monitoring and definitions of success for project.

[1] Renfrew County Addictions Treatment Services Plus (Mental Health) members include Mireille Delorme, Kim Macleod, Lise Laframboise, Tom Carroll

9. Participant Feedback

The following are highlights from the session evaluations:

- 15 participants completed the survey;
  - 5 (33.3%) were front-line workers;
  - 4 (26.7%) managers / administrators
  - 3 (20.0%) were individuals with lived experience / family members;
  - 3 (20.0%) other
- 14 (93.3%) participants were highly satisfied / satisfied with the session; 1 (6.7%) did not respond
- 14 (93.3%) participants strongly agreed / agreed that the session had a strong client and family member perspective
- 14 (93.3%) participants strongly agreed / agreed that their participation in this project will have a positive impact for individuals with mental health and substance use issues
- 15 (100.0%) participants strongly agreed / agreed that we have the right people to support the success of this project
- What aspects of the session did you enjoy the most?
  - "Discussion around practical 'how-to' approaches. Seeing progress towards practical and specific tools not focused on ideology"
  - "I really feel that gets discussed is valued and head. And that's so very important. I also feel that takeaways me actioned - that we truly do have a part in activating change"
  - "Really excited about referral form to addictions. Collaborating with other agencies and clients to improve our services. Clarification of what other organizations do"
  - "The variety of points of views. Especially from the client/family perspective"
- What aspects of the session did you enjoy the least?
  - "A big part of the session was around the 'mechanics' of care. I feel we could have spent a little more time exploring and trying to better understand from the clients perspective"
  - " I think there should be a representative form health links at the table"
  - "to compressed, need more time"
- How will we know that mental health and addictions service in Renfrew County are collaborating well?
  - "When we start to do this consistently with all clients instead of on occasion with only certain workers"
  - "The quality of recovery in the clients involved"

    - The client will testing that the feel treated by 'one' team rather than different organization. We meet the client recovering goals + outcomes"
- Are we missing anyone?
    - "Health links Rep"
    - "More client and family members"

10. Participants

First Name	Last Name	Job Description	Organization
Yves	Arseneau	Opioid Case Manager	Addictions Treatment Service, Renfrew County
Marci		Family Member	Addictions Treatment Service, Renfrew County
Kim	MacLeod	Service Director	Addictions Treatment Service, Renfrew County
Melanie	Caulfield	Project Manager	Champlain Pathways to Better Care
David	Hesidence	Project Director	Champlain Pathways to Better Care
Alice	Hutton	Lead Facilitator/Planner	Champlain Pathways to Better Care
Tom	Carroll	Executive Director	Mackay Manor
Andy		Lived Experience	Mackay Manor
Liana	Sullivan	Lead Case Manager/Clinical Supervisor	Mackay Manor
Colleen		Lived Experience	Pathways Alcohol & Drug Treatment Services
Lise	Laframboise	Executive Director	Pathways Alcohol & Drug Treatment Services
Gillian	Mckay		Pathways Alcohol & Drug Treatment Services
Laurie	Bishop	Case Manager	Pembroke Regional Hospital
Meghan	Campbell	Student	Pembroke Regional Hospital
Mireille	Delorme	Director, Mental Health Services	Pembroke Regional Hospital
Brittony	Osler	Occupational Therapist	Pembroke Regional Hospital
Sarah	Selle	Community Case Worker	Pembroke Regional Hospital
Cheryl	Summers	Clinical Manager	Pembroke Regional Hospital