A Standard Approach to Concurrent Capable Practice Framework

Understanding Concurrent Capability

What is Concurrent Capability?

Concurrent capability is the ability of healthcare providers to screen, assess, and treat individuals experiencing a concurrent disorder in a welcoming, trauma-informed, and recovery-oriented manner.

Defining Concurrent Disorders

The term "concurrent disorders" was used in the Health Canada document *Best Practices for Concurrent Mental Health and Substance Use Disorders* (2002) and is now widely used across Canada.

Definitions of concurrent disorders have included a wide-reaching and diverse range of disorders, including physical health and behavioural addictions. AHS, Addiction and Mental Health (AMH) have adopted this term to refer to the entire continuum of challenges faced by a person with mental health and substance use disorder or a behavioural addiction.

AHS, AMH Definition:

A concurrent disorder is a term that describes a situation where a person is experiencing a mental health **and** substance use disorder or behavioural addiction at the same time.

Continuum and Level of Services

Substance use disorders, behavioural addiction, and mental health disorders can be complex and vary in severity and consequences. A wide range of levels of service is needed, from high-intensity inpatient medical service to periodic outpatient treatment.

Concurrent capability develops along a continuum from concurrent capable programs to concurrent enhanced care. Components and criteria have been developed to describe both "concurrent-capable" and "concurrent-enhanced" care. Many services within AMH are already working in concurrent-capable and concurrent-enhanced ways.

(Substance Abuse and Mental Health Services Administration, 2020)

Concurrent Capable Programs

Concurrent capable programs assume every person seeking assistance will likely have concurrent challenges. Healthcare providers may assess and treat the primary issues for the individual and deliver integrated services to support the individual's full range of care requirements (Substance Abuse and Mental Health Services Administration, 2020). When integration is not possible, care coordination with other services or programs is vital in ensuring individuals receive the right care when needed.

Program design

It is essential to look at all aspects of a program's design and function to ensure integrated policies, procedures, and practices are embedded in its operations.

Integrated program design includes:

Access - The program has a "no wrong door" stance and emphasizes welcoming and engaging all individuals and families regardless of their condition (substance use, behavioural addiction, or mental health concerns).

Screening and Brief Intervention - The program uses a standard approach to screening for concurrent disorders and completes a brief intervention when possible.

Assessments - Assessments are ongoing, recovery-oriented, and comprehensive. They document the individual's current and past information, strengths, skills, talents, and support in identifying their treatment goals.

Program Collaboration and Partnership - The program consults and collaborates with internal and external programs, services, and providers to share knowledge. The program has established guidelines for care coordination and collaborative service planning, including documentation procedures for individuals and families who attend another program/service.

Person-Centred, Integrated Treatment and Recovery Programming and Planning -

- Provides or supports goal-oriented intervention planning
- Focus on readiness for treatment and match interventions accordingly
- Supports or provides pharmacotherapy - whether prescribing is done on or off-site, there are procedures, forms, and materials to help individuals learn about medications, communicate openly with prescribers, and take medication as prescribed
- Develops and provides education and resources to individuals
- Develops and implements group session programming as needed

Ongoing Development of Treatment/Recovery Relationships - by all those involved in a person's care (internal or external to the program).

Well-Developed Treatment/Recovery Program Policies – the program identifies how they will support:

- Reduced use of harmful substances
- Abstinence goals

- Return to use
- Criminal justice aspects
- Discharge/transition planning, including guidelines, practices, and forms, continuous matching of readiness for treatment and continuing care requirements.

Staff Competency and Training – the program provides opportunities for learning/training and supports developing individualized learning plans needed for concurrent capable programming and treatment for both non-clinical and clinical care.

Quality Improvement and Data – is a collaboration between leadership, supervisors, clinical and non-clinical staff, individuals, and families to design and implement a vision of person-centred, trauma-informed, culturally safe, recovery-oriented, concurrent capable care. Gaps in service are addressed, and there are new opportunities to create quality care.

Program Philosophy - the program operates under a written vision, team charter, or goal statement that officially communicates its commitment to implementing person-centred, trauma-informed, recovery-oriented, and concurrent capable care

Program Policies – the program follows and has guidelines/protocols for AHS and AMH policies, including confidentiality, the release of information policy, and clinical record keeping and documentation.

Concurrent-Enhanced Program Design

Concurrent-enhanced program design is similar to concurrent capable programs with integrated programming provided by healthcare providers with a higher degree of competence and scope of practice in delivering integrated treatment (Substance Abuse and Mental Health Services Administration, 2020). Healthcare providers in these programs are trained to recognize the signs and symptoms of multiple disorders. Concurrent-enhanced programs must also address concurrent disorders through their policies, procedures, and practices.

Enhancing Concurrent Capability

Why is enhancing concurrent capability important?

When an individual experiences a mental health **and** substance use disorder or behavioural addiction at the same time, these problems can influence each other in their development, severity, response to treatment, return to use and/or previous circumstances. The treatment can be less effective when healthcare providers attempt to treat without recognizing and responding to the symptoms for all areas of concern. The high prevalence of concurrent disorders in mental health and addiction settings means we should consider people coming into service with both conditions as the expectation and not the exception.

The capacity of a system to organize concurrent-capable services, as a minimum standard, is critical to strengthening the efficiency and efficacy of service delivery to the addiction and mental health population.

What are the goals of concurrent-capable care?

- Improved service for addiction, mental health, and concurrent disorder individuals and their families throughout all stages of their journey within our systems of care.

- Effective and efficient interaction and intervention for addiction, mental health, and concurrent disorder individuals and their families.
- Standardization of care, regardless of the point of entry into the system, embodying the concept that "every door is the right door."
- Further integration and improved collaboration within and between AMH teams, programs, and services.

The Standard Approach to Concurrent Capable Care Framework

AMH developed a standard approach to concurrent capable care framework to support enhancing concurrent capability (Alberta Health Services, 2016). This standard approach has six guidelines or processes for identifying the knowledge, skills, attitudes, and service integration practices required to implement concurrent capable care - each guideline is considered a standard for practice and was developed in alignment with the AHS Patient First Strategy.

See the algorithm on the next page.

A Standard Approach to Concurrent Capable Practice

First contact with person

EVERY DOOR IS THE RIGHT DOOR…

Concurrent Capable Addiction Services

Concurrent Enhanced Programs Integrated AMH Teams

Concurrent Capable Mental Health Services

WELCOME AND **ENGAGE**

Observe and gather information on appearance, behavior and cognition (ABC) and review history, while establishing rapport and engaging individual/family

SCREEN FOR CONCURRENT DISORDERS

Using a reliable tool (GAIN-SS, DSM-V CC, etc.) to identify the presence of a mental health, addiction or concurrent disorder

BRIEF INTERVENTION:

- Solution focused
- Single session or more (5-10)
- Crisis intervention

KEEP AND CONSULT

Consultation, collaboration and coordination with other service (addiction or mental health) and other involved service providers

WARM HANDOFF:

- Mental Health
- Addictions
- Concurrent Enhanced Service
- Community supports

COMPREHENSIVE ASSESSMENT

INTEGRATED TREATMENT PLANNING

COMPREHENSIVE INTERVENTIONS

TRANSITIONS IN CARE

- Recovery oriented, collaborative process that is person-centred, trauma informed and strengths based
- Involves person/family and other services providers in care coordination
- Reassessment is ongoing throughout the recovery journey with shifts in treatment planning as needed

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Six Guidelines

The six essential guidelines or ‘standards’ of AHSs standard approach to concurrent capable care include:

Standard 1: Welcome and Engage individuals into our service. This guideline establishes the foundation for our contact and provides an opportunity to observe and gather details on a person's appearance, behaviour, and cognition. Reviewing potential safety risks and collateral information from reports, notes, previous assessments and diagnoses, prescribed medications, and treatment history will support the standard.

Standard 2: Screening determines a person's needs and whether further assessment and treatment are required, including decisions on keeping a person in care or consulting other providers. Screening tools depend on program or service protocols, clinical judgment, and immediate safety needs. They may include using a validated and reliable tool, such as the GAIN-SS (CAMH modified). When the results indicate an immediate concern or further exploration of need, the following steps should be taken:

- A brief intervention
- Consultation and collaboration with an appropriate colleague
- A more comprehensive assessment that targets concerns from screening
- A coordinated referral/warm hand-off that matches a person to a program or service that provides the required level of care needed (e.g. concurrent enhanced addiction or mental health service).

Standard 3: Comprehensive Assessment involves engaging in a process with the person to gather more detailed information. It may include consultation or collaboration with the other services and can depend on where the person entered the system.

Standard 4: Integrated Treatment Planning is developing a treatment and well-being plan based on screening and assessment findings. Planning includes selecting supports and interventions for substance use, gambling, and mental health concerns (concurrent disorders) that can be implemented simultaneously during treatment. The process also includes monitoring, evaluating, planning for discharge, and updating the treatment plan to reflect evolving needs and goals. Plans are developed in collaboration between a healthcare provider, the individual, and others involved in their care to reflect a person's needs, motivation, strengths, and goals.

Standard 5: Comprehensive Interventions are the combination of treatments, therapies, and strategies built into the integrated treatment plan.

Standard 6: Transitions in Care is the final guideline in the process. Transitions occur between facilities, people, and providers, levels of care, across the continuum of care, and between programs. Transitions in care should be considered and occur to ensure that the individual receives the most appropriate care, resulting in improved health outcomes.

Creating Expectations and Setting Standards

The Patient First Strategy places individuals and their families at the centre of managing their own health and wellness. The guidelines/standards in the concurrent capable approach are developed from this perspective because individuals are active participants in their care. Using

these guidelines/standards, AHS AMH affirms its commitment to individuals, families, healthcare providers, and services.

Learn More:

- To learn more about concurrent disorders and other training related to concurrent capability, see the PACES Learning Pathway.
- The Handbook for Individuals and Families has been developed to help individuals and their family members know what to expect from Addiction and Mental Health Services through standards and key indicators related to their care.
- For resources related to patient and family-centred care, visit Insite.

References

Alberta Health Services. (2016, June). *Enhancing Concurrent Capability (ECC) Toolkit.* Retrieved March 2020, from Alberta Health Services: https://www.albertahealthservices.ca/info/Page14889.aspx

Health Canada. (2002). *Best Practices: Concurrent Mental Health and Substance Use Disorders.* Retrieved from Government of Canada: https://www.publicsafety.gc.ca/lbrr/archives/cn73942091-eng.pdf

Substance Abuse and Mental Health Services Administration. (2020). *Substance Use Disorder Treatment for People with Co-Occurring Disorders. Treatment Improvement Protocol TIP 42.* Retrieved from SAMHSA: https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-01-004_Final_508.pdf