Recovery Alberta
MENTAL HEALTH AND ADDICTION SERVICES

Concurrent Capable Program Review

Participant Handout

Creating welcoming, trauma-informed, recovery-oriented, and concurrent capable services for individuals and families experiencing addiction and mental health concerns.

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Contact

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Welcome

Thank you for participating in this baseline self-assessment program and practice review with your team today. The Concurrent Capable Review Service (CCPR) is designed to help interested programs organize a baseline self-assessment of their concurrent capability. It is part of a continuous quality improvement process in which programs plan steps of progress toward concurrent capability and a recovery-oriented system of care. When repeated regularly, the review will help programs measure change processes and progress and support continuous learning.

Standard Approach to Concurrent Capable Care

Recovery Alberta healthcare providers utilize tools and resources to support integrated addiction and mental health services. The Standard Approach to Concurrent Capable Practice Framework (on the next page), and the Handbook for Individuals and Families guided the development of the CCPR Toolkit. These resources provide individuals, their families, and healthcare providers with expectations and key indicators related to their care.

For more information on Enhancing Concurrent Capability, please see here

For more information on a Standard Approach to Concurrent Capable Practice, please see here

Background

In 2009, Alberta Health Services announced a province-wide system of addiction and mental health services that would respond to the unique needs of three groups of people:

- those with mental illness or mental disorders
- those with substance use and/or gambling concerns (behavioural addiction)
- those with both.

In 2024, Recovery Alberta was established as a new provincial health agency, created to provide comprehensive and accessible recovery oriented care to Albertans.

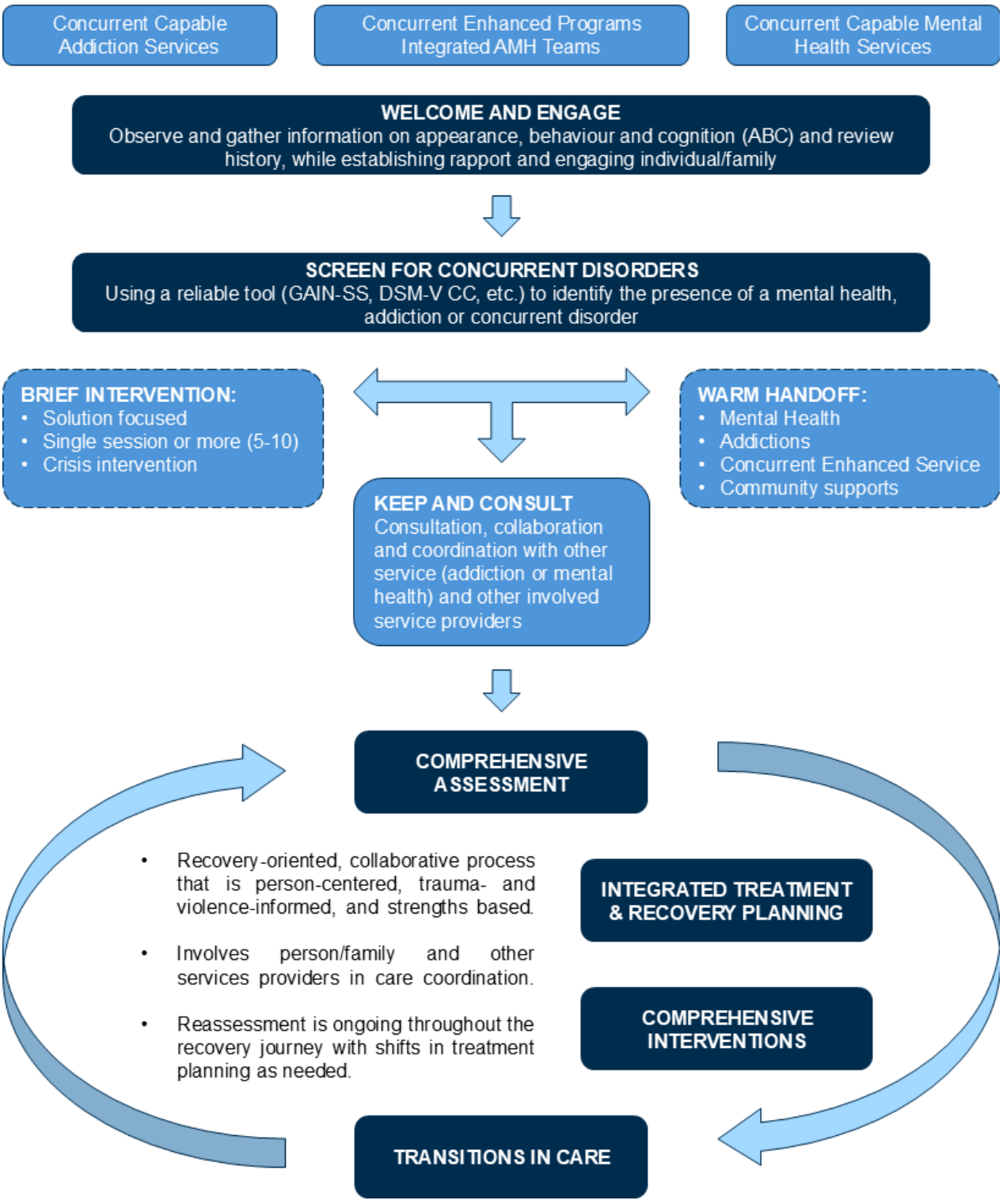
The Standard Approach to Concurrent Capable Practice Framework was developed to help individuals, their families, and healthcare providers understand what to expect from Addiction and Mental Health Services through standards and key indicators.

The Goal:
To create welcoming, trauma-informed, recovery-oriented & concurrent capable services for individuals and families.

A Standard Approach to Concurrent Capable Practice

First contact with person

EVERY DOOR IS THE RIGHT DOOR…



Definitions

Concurrent Disorders - A combination of mental health disorders, substance use, and/or gambling. Also termed Concurrent issues, Concurrent Conditions, Co-occurring Disorders and Dual Diagnosis (Alberta Health Services, 2018).

Concurrent Capability - The ability to identify, manage and treat people who present with concurrent disorders (mental health conditions and substance use and/or gambling concerns) (Alberta Health Services, 2018).

Likert scale

The Likert scale is used to score each statement in every review section. Here are some key points:

- It is a five-point scale.
- It allows each participant to indicate how much they agree or disagree with each statement.
- It provides five possible answers so each person can indicate their strength of agreement regarding the statement.

1. Not at All
2. Slightly
3. Somewhat
4. Mostly
5. Completely

Review Sections

1 Welcoming and Engaging

1. Written and online information about accessing services welcomes individuals and families with concurrent disorders into service and offers hope for recovery.
2. Access to services is prompt and offered in a coordinated manner. People are supported through delays they may experience while getting to their preferred services.
3. The program environment (i.e., signage to find the program, reception area, waiting room, hallways, meeting spaces, pictures/posters, brochures, flyers, etc.) creates a welcoming atmosphere that supports engagement and recovery for individuals and families with substance use, gambling, and mental health conditions.
4. People and their family members receive welcoming access to service regardless of their stage of change regarding their mental health, substance use and/or gambling concerns.
5. Access to educational information about trauma, recovery and building resilience, substance use, addiction and/or gambling and mental health conditions is available.

6. Healthcare providers introduce themselves, explain their role, consent for treatment, the limits of confidentiality, how to include family and other support persons in the recovery planning process and the process of filing a complaint if there are concerns about how a person is treated while accessing services or the kind of services they received.
7. Healthcare providers actively listen to people seeking services, answer their questions, and collaboratively explore which resources will work best for them, considering their stage of change, cultural beliefs, and lifestyle.

2 Standardized Screening and Brief Intervention

1. In a welcoming and respectful manner, standardized screening tools are used to screen everyone seeking services for concurrent substance use, gambling behaviours, mental health conditions (including trauma), medical conditions, and areas with increased health or well-being risks. This information is used to inform recovery planning.
2. People seeking services feel engaged in the screening process, understand the purpose of the questions, and how their answers help connect them to the most appropriate service(s).

3 Comprehensive Assessment

1. Initial assessments gather and document information about each concurrent substance use, gambling and/or mental health condition, active or stable.
2. Assessment is an ongoing process in which information is gathered and reviewed regularly to understand people's evolving concerns and goals.
3. Assessments focus on people's current strengths, skills, supports and periods of well-being to provide a positive, recovery-focused approach to recovery planning.
4. Assessments regularly gather and document information about the stage of change (i.e., pre-contemplation, contemplation, preparation, action, maintenance, return to use) people are in regarding each condition for which they receive services.
5. With consent, healthcare information may be shared with the care team and/or family members to support people's recovery.

4 Integrated Treatment and Recovery Planning

1. People's hopeful goals, personal needs, recent successes, and strengths are included in their recovery plan.
2. For each concern, a stage of change is identified, stage-matched interventions are explored, and achievable steps to help the person feel and be successful are agreed to.
3. Person-centred plans focus on building skills and support. When required, the plan is modified and positive feedback for small steps of progress in the recovery journey is used.
4. People are active participants in care. They know their rights and responsibilities, and their preferences and goals in their recovery journey are respected. Family members may be included.
5. When exploring potential resources to support recovery, the risks and benefits of each alternative are explained.

6. Recovery plans include biopsychosocial and spiritual goals to ensure people feel empowered to meet their basic needs and address substance use and/or gambling and/or mental health concerns.
7. When possible, a copy of the recovery plan is provided to people and/or family members and others in the care team.

5 Comprehensive Interventions

1. Education and resources about mental health, substance use, gambling, concurrent disorders, recovery and building resilience are available and accessible (i.e., placement for pick up, various languages based on community demographics).
2. Stage-matched group or individual sessions provide psychoeducation to empower choice and decision-making. Examples include:
3. Education about psychiatric medications includes information about taking medication as prescribed and/or using it safely if continuing to use other substances.
4. Recovery skills manuals are available in substance use or gambling residential treatment to teach about managing trauma symptoms.
5. Sobriety skill-building manuals are available while receiving inpatient mental health treatment.
6. People feel involved in implementing their recovery plan. They learn skills, practice good self-care, and have the necessary information about connecting with mutual support groups and community resources to improve their quality of life and maintain well-being.
7. Family members understand how to access community support and resources that promote their well-being and recovery.
8. Healthcare providers provide strengths-based, recovery-oriented, trauma-informed services for people who continue to use substances, do not take medication as prescribed, or are not following other aspects of their recovery plans. Negative consequences or punishment are not used.
9. The program responds positively when individuals ask for help when they are having difficulty maintaining their recovery or beginning to experience increased symptoms of mental health conditions.

6 Transitions in Care

1. Transition plans, procedures, practices, and forms identify specific stage-matched recommendations for each issue the person seeks treatment for.
2. For each transition in care, people are included in warm handoff communication between the sending and receiving healthcare providers, whether in person or by phone.
3. A multidisciplinary team of healthcare providers works collaboratively to coordinate care, provide care and help people make transitions to ensure suitable supports are in place to help them achieve their recovery goals at all stages.
4. With consent, other care team members may share information regarding care and progress.
5. People often have multiple priorities, so services are coordinated to match their goals for recovery.
6. Healthcare providers help people navigate the health and social services support systems to ensure they become connected with community services they need (i.e.,

housing, food security, showers, finance, legal, education, dental, optometry). A written list of community resources and contact information is provided.
7. People, family members and the larger care team know how to re-engage with services when needed.
8. The program invites people and family members to provide feedback on their service experience to foster continued program development and improvement.

7 Program Collaboration and Partnership

1. The program is connected to and collaborates with local partner agencies offering community-based health and social services.
2. Addiction or mental health staff promptly consult a collaborative program partner when requested.
3. Healthcare providers participate in scheduled addiction and mental health services interagency care coordination meetings to address the complex needs of people and their families.

8 Concurrent Capable Competency Development

1. Specific recovery-oriented concurrent disorder competencies for all staff are included in position descriptions.
2. The program has and implements its written scope of practice for concurrent disorder competency for all healthcare providers based on their position within the program and professional designation, if any. This may be done through local procedures, supervision, and group and individual learning activities for all staff working in and leading the program.
3. Administrative and clinical supervisors use their knowledge and skills to help staff become more welcoming, recovery-oriented, and concurrent capable.

We hope you had great conversations, learned a lot from hearing your ideas and feel prepared to improve services because of this review process.