

# ***Concurrent Disorder Services in Ontario: An Environmental Scan***

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## About the Authors

**Canadian Mental Health Association (CMHA), Ontario** is a leader in the evolution of Ontario's mental health and addictions system by contributing our knowledge, resources and skills to provincial policy development and implementation, promoting mental health in collaboration with others, and championing equitable access to mental health services.

**Addictions & Mental Health Ontario:** In support of building a more comprehensive and responsive system for the treatment of addictions and mental health in Ontario, Addictions Ontario (AO) and the Ontario Federation of Community Mental Health and Addiction Programs (OFCMHAP) have come together to build a new association: **Addictions and Mental Health Ontario**. Our goal is to ensure that all Ontarians can access the services and supports they need to address addiction and mental health issues, fostering dignity and accountability to those it serves.



**Canadian Mental  
Health Association**  
Ontario



## Acknowledgements

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Finally, we would like to acknowledge the contributions and support by the Project Advisory Committee:

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**Ontario Federation of Community  
Mental Health and Addiction Programs**  
*Sharing Resources, Exploring Common Issues*

*Together we have become*

***Addictions & Mental Health Ontario***

# Concurrent Disorder Services in Ontario: An Environmental Scan

## Summary Report

### Background

There are currently no provincial directions on delivering services to people with concurrent disorders, despite the fact that Ontario has focused much attention on integrating the mental health and addictions system.<sup>1</sup>

The prevalence and impact of concurrent disorders varies largely by not only substance of use (e.g. alcohol vs. illicit drugs), but also by specific mental health diagnosis. It was identified that 37% of those diagnosed with an alcohol disorder are also likely to have a co-occurring mental health disorder during their lifetime; whereas the likelihood of co-occurrence for those abusing substances beyond alcohol is estimated to be 53% (Concurrent Disorders Policy Framework, 2005). It is important to note the variation of co-occurring disorders by medical diagnosis as well. Skinner et al. (2004) identified:

- Among people who have had an anxiety disorder in their lifetime, 24% will have a substance use disorder in their lifetime.
- Among people who have had major depression in their lifetime, 27% will have a substance use disorder in their lifetime.
- Among people who have had schizophrenia in their lifetime, 47% will have a substance use disorder in their lifetime.
- Among people who have had bipolar disorder in their lifetime, 56% will have a substance use disorder in their lifetime.

Antisocial and behavioural issues are associated with having a concurrent disorder; as are legal and/or justice involvement (Rush et al., 2008). Data from North America suggest that 10-20% of people experiencing homelessness have co-occurring mental health and substance use disorders, although some believe that the actual prevalence is much greater (O'Campo et al., 2009).

Rush et al. (2008) states that *“People with co-occurring disorders are more likely to seek care, accounting in large part for the higher prevalence of co-occurring disorders in mental health, substance use, and more generic health care services. This higher utilization translates into higher health care as well as costs in many other sectors (e.g., welfare). That said, a very significant percentage of people with co-occurring disorders do not seek any help at all and those that are engaged with community services are more likely to report inadequate and unsatisfactory treatment and support.”*

Systemic, administrative and attitudinal barriers often confront people with concurrent disorders who do seek services and supports. In both the mental health and addictions sectors treatment outcome studies have consistently reported the negative impact of concurrent disorders on treatment retention and effectiveness (Rush et al., 2008).

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<sup>1</sup> For the purposes of this project and report, concurrent disorders is defined as co-occurring mental health and substance use problems.

Concurrent disorders impact individuals, families and society, as well as the health and social services system. The Canadian Mental Health Association, Ontario and Addictions & Mental Health Ontario have prepared this agenda-setting report to identify priority issues in planning, delivering and monitoring services for people with concurrent disorders that require attention in Ontario to ensure a high-quality health system, responsive to clients and accountable to funders.

## Approach

The goal of this project was to conduct a scan to profile system issues that should be addressed in Ontario to set in motion the impetus for enhancing services to people with concurrent disorders.

An Advisory Committee was convened that engaged select front line service providers in the mental health and addictions sector to inform this scan (Appendix I). Specifically:

- A policy focused review was conducted of reports and recommendations prepared over the past 15 years by non-governmental organizations, advisory bodies to government, and provincial and national directions in mental health and addictions that address the delivery of services for people with concurrent disorders (Appendix II).
- Key informant interviews were conducted. Key informants were suggested by the project advisory committee. Selection criteria included knowledge of current and historical issues related to concurrent disorders from a policy, system planning and provincial perspective. A key informant finding report was also prepared (Appendix III).
- Key themes from the policy review and key informant interviews were synthesized to identify key issues requiring further attention. A survey was then prepared and sent to 270 mental health and addictions agencies in Ontario to validate and expand on priority issues identified thus far. Survey findings were analyzed and a report on the findings was developed (Appendix IV).
- Lastly, existing concurrent disorders data sources available in Ontario were identified and key issues summarized (Appendix V).

## Key Findings

### 1. Definition of Concurrent Disorders

There is currently no consensus regarding what conditions should be included under “concurrent disorders.” Concurrent disorders are variously defined by diverse health service providers and sectors. A lack of common definition has implications for scoping policy directions, eligibility for services, responsiveness to client needs, collaboration and identifying core competencies for staff.

A common definition of concurrent disorders was identified as an issue that requires further attention. Variances in current definitions include whether behavioural addictions such as gambling, shopping and sex are included. Another significant factor is whether tobacco dependence is included in the definition.

### 2. Lack of Directions

#### 2.1. Provincial

There is currently lack of provincial direction to address services for people with concurrent disorders. This is particularly disconcerting given recent attention on mental health and addictions policy and the release of a new 10-year mental health and addictions strategy for Ontario. There have also been no recent provincial investments made towards concurrent disorders service delivery.

Provincial leadership through the Concurrent Disorders Ontario Network (CDON) supported by the Centre for Addiction and Mental Health (CAMH) was active from 2005 to 2010. There is no official information on why CDON is no longer in existence however key informants did recall that the funding and resources for CDON were not maintained by CAMH to resource CDON. No other network or group has taken over the provincial leadership role or even components of CDON’s work.

Lack of directions in Ontario has resulted in inconsistencies across the province on when, what and how concurrent disorders services are provided. With no provincial mechanism in place to give direction to delivering services for people with concurrent disorders, there is consequently no monitoring of existing programs. The Multi-Sector Service Accountability Agreements (M-SAAs) lack indicators that have the potential to monitor need and coordinate services for people with concurrent disorders within LHINs. This situation needs to be remedied under Ontario’s Action Plan for Health Care, with the ultimate goal of providing the *right care at the right time in the right place*.

#### 2.2 Local

As there are no provincial directions, there has been variable Local Health Integration Network (LHIN) planning for concurrent disorder services. Some LHINs include services for concurrent disorders within their Integrated Health Service Plans (IHSPs) while others do not. These inequities are reflective of differing levels of satisfaction expressed by health service providers with their LHIN’s planning for concurrent disorders. Inequitable local capacity restricts access to services and supports that are key to addressing the needs of clients with concurrent disorders.

Eligibility requirements further compound access issues. In general, addiction agencies will more often accept clients with mental health services while mental health services are less likely to accept clients with addiction issues.

However, key informants identified that there is much good work happening at the local level by health service providers with respect to concurrent disorders. Local stakeholders, for example, are setting up local inter-agency committees to address the needs of people with concurrent disorders. There are new practices emerging. Cross training within addiction and mental health services has also been deemed successful. As previously mentioned, this is often occurring without provincial direction and sometimes without LHIN guidance.

### **3. System and Service Coordination**

System navigation is a challenge for many people with concurrent disorders. Further attention to accessing and transitioning through the continuum of care for people with concurrent disorders is required. These problems are compounded for clients with more complex needs, such as people who have a dual diagnosis and a concurrent disorder; or those in conflict with the law.

System and service coordination also requires attention in emergency departments. Addressing emergency department visits by people with concurrent disorders is required. Key informants identified that people with concurrent disorders use emergency departments because adequate community supports are not in place and as a result emergency departments deal with the overflow.

System and service coordination is an issue that requires attention for people with concurrent disorders who use multiple services, simultaneously or episodically. The connection between services, lack of capacity to meet needs, sharing information between services and shared care for this population is a challenge.

### **4. Integration**

Integration has been identified as a priority across Ontario, although how integration is defined varies from region to region. As of yet, there is lack of clarity by funders, health sectors and some health service providers in the province regarding how service coordination/integration can support increased responsiveness to people with concurrent disorders (although models have been proposed, including by CDON). In addition, it is not yet clear how the current focus in some LHINs on organizational integration through amalgamations and mergers would inform the planning and delivery of concurrent disorders services. The impact of integration on concurrent disorders services does not seem to be a point of discussion or planning.

Inter-sectoral integration between the mental health and addictions sector and other sectors to address individuals with concurrent disorders was also identified as an important issue, particularly within the justice system.

## **5. *Inter-sectoral Differences***

Organizational culture, funding requirements, and accountability mechanisms as well as service differences and territoriality are issues that require further attention for planning and delivering services to people with concurrent disorders, according to key informants. These issues have been identified as a challenge to cooperation amongst the mental health and addictions sector. Differences in backgrounds, training and approaches must be recognized and overcome in order to support collaboration of mental health and addiction service providers to address the needs of individuals with concurrent disorders.

## **6. *Funding***

Federal and provincial reports on mental health and addictions have discussed the need for appropriate and adequate funding in order to provide concurrent disorders services. However, funding is a challenge for concurrent disorders services as there have been a lack of investments, given no provincial directions or planning. Many agencies are providing concurrent disorder services without dedicated funding. They are not receiving funding from either their LHIN or other sources. Agencies reported that 25% of the services that they provide for concurrent disorders are not funded.

## **7. *Data Collection***

Data is a key source of information to plan and monitor services for people with concurrent disorders. There are significant differences in how the community mental health sector and the addictions sector collect data on concurrent disorders services. Existing data sources cannot be linked. Currently, there is no central repository to compile all concurrent disorders service data on which to inform future rounds of health system decision-making.

## **8. *Standards***

Developing program standards for concurrent disorders were identified as a priority by health service providers. Program standards were also identified as being an important bridge across the mental health and addictions sector.

## **9. *Evidence-based Practice***

Health service providers support the need for more evidence-based services. Existing evidence has been identified however there needs to be more of a focus on providing services to people with concurrent disorders. There has been some movement within the mental health sector for increased evaluation of programs however this requires more attention in the addictions sector.

## **10. *Training***

Service providers are seeking professional development on core competencies to deliver programs to people with concurrent disorders. Access to training was identified in our survey as the top priority for enhancing service delivery to people with concurrent disorders.

Availability of clinical supervision to health service providers was deemed inadequate, and this was identified as being both a human resource and professional development issue. Lack of

standardization in training and the lack of definition of core competencies have led to human resource challenges, as there are variations amongst staff's knowledge in concurrent disorders.

It was also highlighted that attention should be given to distinguishing between concurrent disorder-capable and concurrent disorder-enhanced. Concurrent disorder-capable are skills that all health service providers in the field should have. They should be "capable" of screening for mental health and addiction conditions, collecting data and developing treatment plans. Concurrent disorder-enhanced means staff have more in-depth expertise in providing concurrent disorders interventions.

## **11. Human Resources**

Agencies are experiencing human resource shortages that impact the delivery of concurrent disorder services. This is attributed to lack of funding to hire dedicated concurrent disorders staff, difficulty in recruiting staff at a competitive wage, as well as lack of staff that is trained to work with this clientele.

## **12. Special Populations**

Three priority populations were identified by our key informants and health service providers as requiring special attention when planning the delivery of concurrent disorders services. These three populations are:

- Youth
- Seniors
- Aboriginal Peoples

### **Youth**

While the needs of youth with concurrent disorders were identified as a priority, of particular urgency is to address the needs of transitional-aged youth. Concurrent disorder issues frequently emerge in adolescence and early adult years. A key concern is that when youth transition into the adult system, the adult system is not adequately responsive to meet age-specific needs. This population is a high user of the health system and can present with complex needs.

### **Seniors**

Seniors are another population that require priority attention when planning concurrent disorders services. There is very little attention being given to seniors with concurrent disorders.

### **Aboriginal Peoples**

Aboriginal peoples require priority attention when planning concurrent disorders services. The prevalence rates of mental health issues, co-morbidity and suicide amongst this population is a major concern. Aboriginal peoples experience increased levels of stigma, and require culturally competent care.



## Next Steps

The Canadian Mental Health Association, Ontario and Addictions & Mental Health Ontario have prepared this agenda-setting report to identify priority issues in planning, delivering and monitoring services for people with concurrent disorders that require attention in Ontario.

Ontario's Comprehensive Mental Health and Addictions Strategy includes the goal "to provide timely, high quality, integrated, person-directed health and other human services." Key methods to achieve this goal include strengthening and integrating mental health and addictions services and enhancing the capacity of the health system to provide integrated services.

Ontario is currently setting priorities for year 4 and beyond of the strategy. Our next step will be to raise awareness of community mental health and addictions service issues in order to set in motion actions to support implementation of the strategy.

Our associations are ready to meet with policymakers and decision-makers and engage the community mental health and addictions sector, as well as other advisors, to improve the planning, delivery and monitoring of high-quality services for individuals with concurrent disorders in Ontario.

### **Recommendation:**

That the Ministry of Health and Long-Term Care and Local Health Integration Network (LHIN) representatives work collectively with the Canadian Mental Health Association, Ontario and Addictions and Mental Health Ontario to remedy issues in community-based services for individuals with concurrent disorders that have been identified in this report.

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## Appendix I

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## Concurrent Disorders Document Review

### Background

This section summarizes reports over the last 15 years by non-governmental organizations, advisory bodies to government and provincial and national directions in mental health and addictions that address the delivery of services for people with concurrent disorders.

#### ***Concurrent Disorders Policy Consultation Document (1997)***

The Concurrent Disorders Task Force of the Canadian Mental Health Association, Ontario developed a policy paper and recommendations to improve services to people in Ontario with concurrent disorders in 1997. The report reviewed definitions, prevalence rates, system issues and service gaps. Key issues included lack of information and understanding of concurrent disorders, stigma, prevention, and obstacles to service delivery at both the program and system level.

Individuals with concurrent disorders were identified as a priority population. People experiencing homelessness, ethno-racial populations, transitional-aged youth, women, seniors, Aboriginal persons and people in conflict with the law were highlighted as especially under-serviced.

The report recommended development of continuing education for health professionals based on defined core competencies; routine standardized screening; application of best-practice approaches in community-based treatment; increasing familiarity of health professionals with self-help programs; and improved co-ordination and collaboration within and between the mental health and addictions services, primary care and hospitals to enhance continuity of care.

#### ***Making It Happen (1999)***

*Making It Happen* comprised both a framework and an implementation plan developed by Ontario's Ministry of Health to provide direction on the reform of mental health services. It defined a continuum of care for comprehensive and integrated treatment, rehabilitative and support services. These directions included a major focus on building capacity in community-based care. *Making It Happen* identified people living with concurrent disorders as a priority population with complex needs requiring specialized services, while recognizing that some coordinated service delivery was already taking place at the local level.

*Making It Happen* acknowledged that addiction and mental health service systems had historically operated separately due to differing philosophies and service approaches. As such, Section 4.3 in *Making It Happen* included a placeholder for future consideration of common

policy directions in Ontario for concurrent disorders; but not before parallel implementation of the distinct mental health and addiction strategies released at that time.

### ***Setting the Course. A Framework for Integrating Addiction Treatment Services in Ontario (1999)***

Ontario's Substance Abuse Bureau prepared *Setting the Course*, a review and framework to guide the evolution of Ontario's addiction treatment system. The report indicates that addiction services that once primarily focused on alcohol abuse were now encountering more complex presenting problems, including individuals with serious mental health conditions.

Four strategies were recommended: Collaborate with other health and social service agencies to assist them in early identification and referral of clients experiencing substance misuse; develop service agreements with these community-based agencies to create an integrated network of services; enhance the ability of existing addiction services to respond to diverse client needs; and expand the array of services available for client populations using evidence-based treatment approaches.

The report also supported enhanced coordination of care to better meet the clients served by parallel addiction and mental health services. Identified strategies included expanding cross-training and review of service eligibility criteria in order to reduce the likelihood of individuals being excluded from sector specific services. In addition, it recommended that a more in-depth needs assessment be undertaken for specialized community-based and residential treatment services for individuals with concurrent disorders.

### ***The Time Is Now: Mental Health Implementation Task Force Final Report (2002)***

*The Time Is Now* was the final report from the nine regional Mental Health Implementation Task Forces, established by the Ministry of Health and Long-Term Care to develop regional and local recommendations based on *Making It Happen*. This report recommended that a mental health framework be developed for special populations, including individuals with concurrent disorders in order to set out directions for "sectoral integration of services."

Many of the regional reports address in detail how to improve the planning and delivery of local services to better meet the needs of individuals with concurrent disorders. According to the reports, this is particularly the case for people who are homeless, youth, First Nations' people, and those in contact with the law.

### ***Best Practices: Concurrent Mental Health and Substance Use Disorders (2002)***

The Centre for Addiction and Mental Health (CAMH) prepared this *Best Practices* report under the direction of Health Canada's Federal/Provincial/Territorial Committee on Alcohol and Other Drug Issues. The target audience is managers and front-line service providers in mental health and addiction agencies, individual practitioners, health planners, program developers, researchers and policy-makers.

The report defined concurrent disorders and sets out best practices for integrated service delivery. It synthesized the expanding body of available evidence, combined with advice from both the project's expert panel and users of services. This best practices document for people with concurrent disorders is intended to provide a comprehensive, integrated approach to screening, assessment, and treatment and support.

The report also underscores the necessity to address best practices for system integration. However, it acknowledged that the state of "knowledge and practice wisdom" to address system barriers and challenges was not yet sufficiently developed to offer best practice strategies. Within these considerations, it still identifies objectives that could support system level integration: users of services and their families be meaningfully involved in planning; enhanced knowledge transfer; more inter-agency planning at the local level; and training and education of service providers involve a mix of approaches including formal curricula development, cross-training, continuing education and credentialing.

### ***Concurrent Disorders Ontario Network Policy Framework (2005)***

The Concurrent Disorders Ontario Network (CDON), a group of service providers with ex-officio participation from the Ministry of Health and Long-Term Care prepared the first policy framework in Ontario to address concurrent disorders in 2005.

The report supports system coordination and integration through a conceptual framework intended to enhance accessible and seamless services to people with concurrent disorders. It recommends that coordination be improved through shared-services, multidisciplinary teams and inter-agency agreements. It recommends the development of health promotion and prevention interventions to assist with early identification and intervention, as well as access to comprehensive assessment, referral and treatment.

CDON recommends the introduction and application of best practices to guide the delivery of services in Ontario; and references Health Canada's Best Practice Guidelines (2002). It recommends expanded training and education of staff, together with identification of core competencies. It also recommends the need to develop indicators at the service and system level to monitor treatment services and client outcomes.

At the time of its publication, CDON indicated that the time was right with the introduction of a new regionalized health system approach in Ontario, LHINs, to collectively plan, fund and

monitor health services for people with concurrent disorders to implement the specific strategies identified in their report.

### ***Out of the Shadows at Last (2006)***

Under the leadership of Senators Michael Kirby and Wilbert Keon, The Standing Senate Committee on Social Affairs, Science and Technology released its final report, *Out of the Shadows at Last* after two years of pan-Canadian public hearings and expert consultations to examine Canada's health system with respect to mental health and mental illness. The report addresses concurrent disorders within its section on addictions, while acknowledging that more in-depth investigation is required to adequately address this topic which fell beyond their investigative mandate. *Out of the Shadows* recognizes that people with concurrent disorders often fall through the cracks due to differing philosophies and treatment approaches between the mental health and addiction sectors. It recommended that services for people with concurrent disorders be evidence-based, comprehensive and integrated. This includes the availability of intensive, specialized services and supports to address complex needs.

The Senate Report recommended that a Mental Health Transition Fund be established in Canada, funded by the federal government on a per capita basis to accelerate the transformation of the mental health system. And that this Fund provide \$50 million per year through transfer payments to the provinces and territories for outreach, treatment, prevention programs and services to people living with concurrent disorders.

### ***Toward an Effectively Integrated Health System in Ontario (2009)***

Prepared by the Centre for Addiction and Mental Health, this report discusses the impact of people with concurrent disorders on emergency room (ER) wait times and alternate levels of care days (ALC). From a systems perspective, the report links a resolution of this situation to increasing action to deliver population-based services and supports for people with concurrent disorders. The report recommends strategic planning and investments in four key areas to achieve significant and sustainable progress:

- providing community-based alternatives: comprehensive, available, accessible and effective services for people with concurrent disorders
- improving processes within ERs for effectively managing visits related to concurrent disorders
- enabling faster identification of and appropriate discharge and referral of ALC patients with concurrent disorders
- developing reliable indicators and reporting on time spent in ERs and number of ALC days for patients with concurrent disorders

The achievement of these objectives are detailed through a list of strategies that focus on service provider training, expanding the availability of a comprehensive array of integrated

services and supports, enhanced screening processes, and an infrastructure to support data collection, reporting and monitoring for concurrent disorders.

### ***Every Door is the Right Door (2009) and Respect, Recovery and Resilience (2010)***

These reports, an interim and final, were prepared by the Minister's Advisory Group on Mental Health and Addictions, a broad-based group comprised of individuals with lived experience, family members, health providers and researchers, convened by the Minister of Health and Long-Term Care to advise on the development of a new, integrated mental health and addictions strategy for Ontario. This milestone was the inaugural shift in policy intended to address mental health and addictions together. Both of these reports focus on the need to deliver integrated and person-directed services for mental health and addictions, and include recommendations for concurrent disorders.

*Every Door is the Right Door* envisions a seamless, integrated system with increased capacity to detect and manage concurrent disorders. Acknowledging there are already promising practices occurring in some regions at the local level, the advisors prescribe that in a transformed system, any individual in Ontario presenting to addictions services will be screened for mental health problems while anyone presenting to a mental health service will be screened for problematic substance use and problem gambling. Specialized services for people with concurrent disorders will be available and provided, as part of a comprehensive continuum of care.

The final report of the Minister's Advisory Group, *Respect, Recovery and Resilience*, identified similar goals and objectives as other reports preceding it over the past decade that have recommended how to improve services for people with concurrent disorders. The group: envisions a comprehensive, integrated and coordinated mental health and addiction sector with appropriate, responsive and effective coordination occurring with hospitals and primary care; supports mental health and addiction providers improving their knowledge and skills associated with defined core competencies and delivery of evidence-based, recovery-oriented service; recognizes that guidelines and standards inform the delivery of services; and recognizes that people with lived experience and their families are integral to planning and monitoring to ensure the existence of high quality services.

### ***Concurrent Disorders: Substance Abuse in Canada (2009)***

In 2009, the Canadian Centre on Substance Abuse prepared a detailed report by clinicians in the field on the etiology of concurrent disorders, identifying important areas for action and recommending a national response to individuals having a concurrent disorder. They urge the development of a national framework to establish an integrated and consistent approach to services and supports for people affected by concurrent disorders. Specific areas of attention include: the development of integrated clinical practice guidelines and standards; common



educational objectives with specialized training programs that include a focus on integrated service delivery; and a priority focus on youth and early identification.

***Select Committee on Mental Health and Addictions Interim Report (2010) and Final Report: Navigating the Journey to Wellness (2010)***

The Select Committee on Mental Health and Addictions, an all-party committee of the Ontario legislature was struck in 2009 to investigate ways to identify issues and gaps, innovative approaches and leverage existing opportunities to enhance mental health and addiction services in Ontario. This legislative committee convened and carried out its work via public hearings at the same time that the Minister's Advisory Committee was preparing their advice. It was expected from the onset that both reports would inform Ontario's new mental health and addictions strategy in-development.

The Committee offered several recommendations on concurrent disorders, including: the need for equitable access to specialized concurrent disorder services in all areas of the province; better integration of services; and enhanced training to providers. It also recommended the creation of a new umbrella organization, Mental Health and Addictions Ontario, to provide leadership at the provincial level with a mandate that included ensuring adequate capacity to serve individuals with concurrent disorders.

***Open Minds, Healthy Minds (2011)***

Ontario's 10-year mental health and addictions strategy makes some reference to concurrent disorders, although limited. *Open Minds, Healthy Minds* recommends that integrated mental health and addictions services be provided to individuals with concurrent disorders to improve outcomes and quality of care. The report recommends that this is achieved through the development of core competencies, standardized roles and responsibilities as well as scopes of practice to ensure individuals are receiving the appropriate care. Best practices and standards are also recommended to ensure a minimum quality of care and standardization in the field to support concurrent disorders as well as other specialized populations.

The report also recommends that a quality-improvement approach be developed to ensure integrated care. This approach will include service collaboratives for better coordination, measuring performance improvement through program standards, accreditation, as well as common intake and assessment.

***Changing Direction Changing Lives. The Mental Health Strategy for Canada (2012)***

With a mandate to improve mental health and support the creation of a mental health system that can best meet the needs of people with mental health problems and illnesses, Canada's new mental health strategy gives only limited attention to addressing the needs of people with

concurrent disorders. Goal 4 of the strategy is “to provide timely, high quality, personal directed health and other human services.” In order to achieve this goal, the strategy recommends that best practices and standards across sectors be developed and implemented to better meet the needs of individuals with concurrent disorders.

## Key Informant Interviews

### ***Recruitment of Key Informants***

Key informants were suggested by the project advisory committee. Selection criteria included knowledge of current and historical issues related to concurrent disorders from a policy, system planning and provincial perspective.

Ten interviews were conducted between January 23, 2012 and March 2, 2012.

### ***Methodology***

Information was collected through semi-structured interviews with key informants. The interview tool included open-ended questions (see Appendix B) and was administered in person or by telephone. The interview tool was adapted for context and suitability as needed.

For the purposes of the key informant interviews, we did not define concurrent disorders; as our initial assumption was that there is not agreement on what should be included and excluded in the definition.

### **Current and Historical Initiatives**

Key informants identified a number of current and historical initiatives at the provincial and local level that impact the planning and delivery of concurrent disorders in Ontario.

### **Provincial**

Key informants believe that there are currently no provincial directions specifically concerning concurrent disorders, and as such there is no consistency across Ontario. At the local level, there are variations on what type of work is being done to address the issue and how high a priority concurrent disorders work is.

### ***Concurrent Disorders Ontario Network (CDON)***

Key informants indicated that from 2005 to 2010 provincial leadership for concurrent disorders was provided through the Concurrent Disorders Ontario Network (CDON), supported by the Centre for Addiction and Mental Health (CAMH). It was suggested by some key informants that concurrent disorders and specifically CDON ceased to be a provincial priority, although no one could recall exactly why CDON discontinued its work. Some key informants believed that CDON ceased to be active because funding was not renewed; and with no resources to support the project internally from CAMH, the network became inactive. Since the demise of CDON, no other network or group has taken provincial leadership. Consequently, key informants working in the field indicate there is no clear vision or demonstrated commitment for concurrent disorders provincially. And, there have been no provincially designated investments for concurrent disorders services. There is a sense that the area of concurrent disorders is not in an active evolution/developmental mode as it once was.

Key informants considered CDON an influential group while it was active. It was seen as helpful from a systems perspective, as it enabled stakeholders to come together provincially and share lessons learned back to the field. The CDON advisory group provided over-arching coordination and communication across the province on concurrent disorders, including an online resource. It was able to develop the Concurrent Disorders Policy Framework (2005) that recommended policy directions for Ontario, which included Best Practice guidelines. CDON applied the Framework and provided training to the field when it was active. No further provincial developments have occurred since the termination of CDON.

### ***GAIN Tool***

Key informants identified the GAIN Short Screener (GAIN-SS), which is part of the Global Appraisal of Individual Needs (GAIN) family of screening and assessment measures, as a useful tool for planning the delivery of concurrent disorder services in Ontario. Key informants identified that the GAIN-SS is being piloted in the Champlain LHIN, South West LHIN and Central West LHIN with promising results screening for concurrent disorders.

One local initiative for GAIN-SS is taking place in the Champlain LHIN, where it is being used in emergency departments and police services to screen people for concurrent disorders.

### ***Drug Treatment Funding Program***

Various initiatives under the Drug Treatment Funding Program (DTFP) were recognized for their potential impact on the planning and delivery of concurrent disorders in Ontario. These initiatives are not just applicable to addictions, but focus more broadly on mental health and problem gambling. It was recognized that concurrent disorders are on the radar for DTFP but there is no policy framework at this point. Key informants identified concurrent disorders as originally being on the list through the DTFP but because of timing they were not able to be implemented.

### ***Local Integration Health Networks***

Key informants identified the Mental Health and Addiction Local Health Integration Network Leads (a group of 15 system planners with the mental health and addictions portfolio) that meet every month via teleconference to provide updates on what each LHIN is doing in this area and this is having an impact the planning and delivery of concurrent disorders in Ontario as these discussions include a focus on concurrent disorders.

## **Local**

### ***Variation***

Key informants indicated that many communities are addressing concurrent disorders, however, services are being delivered differently across Ontario. It was recognized that there is good work occurring in many local areas.

A key influencer in concurrent disorders planning and delivery of services is the variation in LHIN directions. Pressures to integrate services in some LHINs are creating imperatives for the change. For example, changes in senior leadership within health service provider agencies may

be viewed by LHINs as opportunities to reconfigure mental health and addiction agencies through mergers and/or amalgamations.

It was identified by key informants that historically in some smaller communities addressing mental health and addiction issues together has occurred due to lack of capacity to address them any other way. In smaller communities the variety of services and number of organizations are limited.

It was also recognized that in some communities, regardless of size, mental health and addiction agencies are developing protocols for integrated service delivery as needed to deliver better client services. In some cases, agencies are beginning to voluntarily integrate at the corporate and governance level in order to provide more integrated services.

### ***Integration***

Another key theme that emerged from key informants is that integration (loosely defined) is a major issue across the province that impacts the planning and delivery of concurrent disorders. It was identified that many integration initiatives are happening; however the impact of these integration efforts on concurrent disorder services is unclear. Key informants felt that it was doubtful that the impact of integrations on concurrent disorders services was even a discussion point. They also wondered how effective integration initiatives have been for mental health and addiction services in general.

Key informants felt that integration has meant different things across LHINs. In some areas it has been mergers and changes in administrative processes – i.e. Algoma, or Centre for Addiction and Mental Health (CAMH). The question of “*Does integration really mean merger?*” was raised several times. In other communities, integration is perceived to refer to the development of inter-agency service agreements (functional integration).

### ***Past Projects***

Past projects on concurrent disorders were identified by key informants as impacting the planning and delivery of concurrent disorder services in Ontario. One project mentioned was *Under One Roof*<sup>2</sup>, an initiative promoting a housing-first model. Another project mentioned was *Beyond the Label*<sup>3</sup> which was an educational kit developed to increase awareness and understanding of stigma on people with concurrent disorders.

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<sup>2</sup> The District of Thunder Bay Social Services Administration Board (2010). Draft Housing Strategy - Under One Roof. [www.terracebay.ca/uploads/documents/LIVE/Draft\\_Housing\\_Strategy\\_PDF.pdf](http://www.terracebay.ca/uploads/documents/LIVE/Draft_Housing_Strategy_PDF.pdf)

<sup>3</sup> Centre for Addiction and Mental Health (2005) Beyond the Label: An Educational Kit to Promote Awareness and Understanding of the Impact of Stigma on People Living with Concurrent Mental Health and Substance Use Problems. [www.camh.ca](http://www.camh.ca)

## **Current Enablers for Providing Concurrent Disorder Services**

Key informants identified a number of factors that were working well in the planning and delivery of concurrent disorder services.

### ***Local Planning***

Key informants identified local planning as working well with the planning and delivery of concurrent disorders services. It was felt that there was progress in planning between mental health and addiction service providers at the local level.

### ***Best Practices***

There has been movement towards greater use of evidence-based practice within the sector. Key informants felt that this needs to be expanded to also include evidence-informed practices. There have been international advances in research and models for service that need to be utilized. It was identified that provincial leadership needs to be taken to move the field beyond evidence-based screening into clinical intervention that is evidence-based.

### ***Knowledge Exchange***

Key informants identified that knowledge exchange in the field is progressing. Conferences like Making Gains, as well as other knowledge exchange mechanisms such as the Evidence Exchange Network (EENet) formally known as the Ontario Mental Health and Addictions Knowledge Exchange Network (OMHAKEN) has increased forums for communication. It was suggested if a conference on concurrent disorders were to take place in the near future, there are many best practice examples that health service providers could present, including exemplars of integrated/collaborative practice. Key informants identified a need for the expansion of knowledge exchange strategies to reach service providers who currently or in the future wish to address the needs of individuals with concurrent disorders.

### ***Drug Treatment Funding Program***

Key informants identified the Drug Treatment Funding Program (DTFP) as an example of an initiative that is an enabler. It was felt that it was making good progress in screening and assessment and that it had good leadership. It was mentioned that the current DTFP strategy, which engages stakeholders from multiple sectors – health, justice and/or social services at the community level – is an example of an initiative that is working well.

### ***Awareness of Issue***

Key informants felt that service providers are now more aware of concurrent disorders; and this has generated increased examination and support for concurrent disorder services. In particular, there is more recognition from mental health service providers that some clients may be using substances.

## **Challenges Providing Concurrent Disorder Services**

Key informants identified a number of factors that are challenges for planning and delivering concurrent disorders services.

### ***Provincial Leadership and Direction***

A central challenge identified by key informants is the lack of provincial leadership and direction in Ontario. They also felt that there is no clear vision and follow up commitment or funding investments for concurrent disorders treatment across the province. It was identified as being essential to addressing outstanding needs pertaining to concurrent disorders. Key informants also felt that there does not seem to be a sense that concurrent disorders work across the province is in an active evolution/developmental mode as it once was. The momentum and priority for concurrent disorders has decreased.

It was mentioned that service providers, funded by different ministries, have not had common practices for effective collaboration, which has created complications for planning and delivering optimal services. Currently, there are different reporting strategies and operating protocols across Ministries, which can misalign the planning and delivery of concurrent disorders services. It was felt that the majority of planning concurrent disorder services has been left up to organizations at the local level.

### ***System Design***

Key informants identified that currently there is no system design for concurrent disorders services. This poses challenges and has led to a fragmented system with no integrated design. Key informants felt that currently people are not moving through the system as seamlessly as they should be and are dealing with barriers to get appropriate services. The lack of access to appropriate services has made it difficult to screen people. It was also felt that there are many service barriers within agencies and many agencies get caught up in their own mandates and do not look outside of that. These factors have led to a lack of a continuum of care.

### ***Cultural Differences & Territoriality***

It was identified by key informants that cooperation between the mental health and addiction sectors has been a challenge at times due to cultural differences, arising from different backgrounds, training and approaches. The mental health sector typically relies on more of a clinical model and more extensive formal education for entering the field. The addiction sector was viewed as moving in that direction but currently has less formalized training for entry. Given these conditions, it was recognized that fears exist that if mental health service providers start providing addiction services, then addiction providers may lose their roles.

Another challenge that was identified by key informants was that of philosophy pertaining to the delivery of concurrent disorder services. There is variation, as some providers use a harm reduction approach and others do not.

### ***Using Evidence***

Key informants suggested that they support more evidence-based services. They felt that there is existing evidence available but there needs to be more of a focus on providing services that are evidence based. There has been some movement for more evaluation of existing mental health programs, but there was no knowledge of anything similar taking place within the addictions sector. Key informants felt there must be more of a focus on outcomes and monitoring of who goes in/out of these programs as this may provide good evidence of the people/populations that are being served.

### ***Training***

Key informants identified that because there are no identified core competencies in the delivery of concurrent disorders services, it is a challenge for the field. They felt that the level of active clinical supervision in the sector is not very high. This was identified as a human resource issue but also a professional development issue. The lack of standardization in training and definition of core competencies has led to the human resource challenges as there is variation amongst staff's knowledge on concurrent disorders.

### ***Adult and Children System***

Another issue that was identified as a challenge within the planning and delivery of concurrent disorders services was the lack of effective transitions between the youth and adult mental health and addictions systems. Key informants felt that there needs to be better connectivity between the youth and adult mental health services as there are silos right now and there needs to be better transitions between the services.

### ***Funding***

Another challenge key informants identified was the lack of investments to increase availability of services for people with concurrent disorders. Many organizations do not have any funding or an adequate amount of funding to provide the services that are needed.

### ***Definition***

Key informants identified the lack of a clear definition of what conditions are covered under "concurrent disorder" as problematic. Concurrent disorders are defined differently by different providers and between sectors. This has implications for policy directions, eligibility for services, responsiveness to client needs, collaboration, and defining core competencies of staff.

### ***Client Involvement***

Another challenge identified by key informants was the lack of involvement and participation by people with lived experience in the planning process. People with concurrent disorders are not engaged in service planning.



## **Priority Issues for Concurrent Disorders Services**

Key informants identified the following priority issues related to the planning and delivery of concurrent disorders services in Ontario.

### ***Concurrent Disorders Network***

The need for provincial leadership was identified as a key priority. Key informants felt that resurrecting the Concurrent Disorders Ontario Network (CDON) was the best way to address, guide and champion the planning and delivery of concurrent disorders in Ontario. It was mentioned that CDON already had terms of reference (TOR) that could be reviewed and updated for current relevancy.

### ***System Navigation***

Key informants described system navigation as a priority issue in Ontario related to the planning and delivery of concurrent disorders services. It was felt that transitioning and navigating through the service system can be difficult for clients. These problems are compounded for clients with more complex needs. There should be priority given to service system responsiveness to individuals with concurrent disorders who have avoidable emergency department visits, or clients within the justice system. These are two priority populations where system navigation needs improvement.

Another priority identified by key informants was the issue of eligibility for services. It was felt that addiction agencies will often accept clients that may not be accepted into mental health services and that often individuals coming into the addictions system have mental health issues but may not be eligible for community mental health programs. Eligibility requirements itself were seen as problematic because recognizing whether it is an addiction first or mental health condition can be a challenge. Key informants felt there needs to be more recognition and assistance in identifying this as an issue.

There continues to be system navigation issues for individuals who use multiple services, sometimes at different intervals and sometimes simultaneously. Key informants identified that there is not enough connection between these services and that sharing information and caring for these individuals can be a challenge.

### ***Tools***

Tools were identified by key informants as a priority issue in Ontario related to the planning and delivery of concurrent disorders services. It was identified that there needs to be coordination and a streamlined assessment process with tools used in concurrent disorders services. Key informants identified many different tools and initiatives being used for mental health specific and addiction specific services. For example, the Ontario Common Assessment of Need (OCAN) for mental health and Admission Discharge and Assessment Tools (ADAT) for addictions, respectively.

## ***Evaluation and Best Practices***

Key informants described the need for more attention on evaluation of concurrent disorder services and there needs to be more attention given to best practices.

They indicated that there is no mechanism for sharing of lessons learned from integration processes. Integration of services is either voluntary or directed but there is little information available on what is effective and what is not.

## ***Language and Definition***

Language and definition were identified by key informants as a priority issue in Ontario related to the planning and delivery of concurrent disorders services as there is no clear definition of concurrent disorders and what is included in the definition. This is an issue that requires further exploration and attention.

## ***Integration***

Key informants identified the need for better system planning in order to plan more integrated services. It was suggested that a common understanding is needed as there are differences on what people understand integration to be. They agreed that integration needs to happen for better services, mental health and addictions services need to be connected to one another, and the system can be stronger through networking.

It was said that integration is not just about addictions and mental health, but rather broader in scope, including a focus on acute care, long-term support and integrating services to get people the services they need. The justice system was seen as a priority for concurrent disorders and it was felt that unless it becomes a stronger priority people will not get the services they need and will continue to flow through emergency services and will not get the transitional support that is necessary.

## ***Standards***

Health service providers are seeking program standards to inform their work. These standards need to bridge across mental health and addictions sectors.

## ***Training***

Training was identified as a priority issue by key informants. They felt there needs to be more attention given to staff capacity by either dedicating staff or getting more human resources to deliver concurrent disorders services. It was felt that existing staff also need to achieve more of a comfort level about working with clients with concurrent disorders. Increasing staff capacity would require support for professional development and training in concurrent disorders.

It was suggested that there is a distinction between concurrent disorder-capable and concurrent disorder-enhanced. It was felt that everyone should be “capable” of screening for mental health and addiction conditions, collecting data, and developing treatment plans. However, concurrent disorder-enhanced means staff have more in-depth expertise in providing concurrent disorders interventions.

## **Emergency Departments**

Addressing emergency department (ED) visits by people with concurrent disorders was identified as a priority issue by key informants. It was felt that unless proper supports were put into the community, there would be overflow into emergency departments and that people would not get the support they needed to reduce ED visits.

## **Priority Populations**

There were three priority populations that were identified by key informants as requiring additional attention when planning the delivery of concurrent disorders service. These populations are youth, seniors and Aboriginal peoples.

### ***Youth***

Key informants felt the needs of youth with concurrent disorders were a priority and an even bigger priority population was transitional-aged youth. Concurrent disorder issues frequently emerge in adolescence and early adult years. The problem was viewed by key informants as a structural issue within the system because there are challenges within services about when someone is no longer a youth and needs to move into adult services. The adult services are often not designed to meet the needs of young adults or to address their age-specific issues. This population is a high user of the system and present with the most complicated cases.

### ***Seniors***

Key informants identified seniors as another population that required priority attention when planning concurrent disorders services. It was felt that there has been no attention paid to seniors with concurrent disorders.

### ***Aboriginal Peoples***

Key informants identified Aboriginal peoples as requiring priority attention when planning services. It was felt that the prevalence rates of mental health issues, co-morbidity and suicide amongst this population was a major concern. It was recognized that Aboriginal peoples experience increased levels of stigma and require culturally competent care.

## **Windows of Opportunity**

Key informants were asked to identify where they saw windows of opportunity to address priority issues. They raised the following:

### ***Available Reports***

Key informants identified multiple reports that have been released in Ontario that address the priority issues raised in this report. Ontario's new mental health and addictions strategy, "*Open Minds, Healthy Minds*" includes a focus on prevention and supporting resiliency in youth,

particularly in school settings. It was identified that the strategy has not addressed substance abuse to the same degree as mental health. Many stakeholders are waiting for the development of standards and guidelines, as part of the implementation of the new 10-year strategy and that would be the opportunity to address concurrent disorders.

### ***Local Health Integration Networks***

Key informants identified Local Health Integration Networks (LHINs) as a venue that is already moving forward with addressing enhanced health outcomes and performance monitoring. More work could be done within LHINs, both regionally and collectively, to improve services for people with concurrent disorders.

It was also mentioned by key informants that some LHINs have formally adopted the Concurrent Disorders Policy Framework developed by CDON and that this could be expanded across all LHINs.

### ***Networks and Organizations***

Key informants suggested that the different networks across the province were windows of opportunity. They felt that there was a need to leverage existing initiatives that are demonstrating some level of success. It was often mentioned that there is huge opportunity to build on the work already done by the Concurrent Disorders Ontario Network (CDON). There are regional mental health and addiction networks that work on these issues. There are some opportunities to address concurrent disorders with the Local Health Integration Networks on health outcomes, performance measures, repeat emergency visits and other key LHIN issues.

It was also suggested that the current scan being conducted by the Canadian Mental Health Association, Ontario and Addictions and Mental Health Ontario was a good opportunity to raise priority issues in concurrent disorders.

Another specific group that was mentioned as a model for concurrent disorders was the Community Networks of Specialized Care for dual diagnosis. It was suggested that this might be another forum to address concurrent disorders.

### ***Technology***

It was suggested by key informants that there are opportunities to address priority issues through the use of technology. There is an opportunity with telemedicine to reach people that are more isolated in remote communities, particularly youth.

### ***Evaluation***

Key informants felt that evaluation was a key opportunity to address priority issues. It was suggested that at a system and policy level there needs to be an emphasis on evaluation and measurement. Using the findings from the Drug Treatment Funding Program was also mentioned as needed.

### ***Post-Secondary Settings***

It was suggested that post-secondary institutions were an ideal setting to support training of health service providers in the area of concurrent disorders.

## Appendix A

### Key Informants

1. Alice Bellavance, Executive Director, Brain injury Services of Northern Ontario
2. Anne Bowlby, Manager, Mental Health & Addictions Unit, Community & Population Health Branch, Ministry of Health & Long-Term Care, Community & Population Health Branch
3. Annette Katajamaki, Executive Director Network Co-Chair, Canadian Mental Health Association
4. Dr. Brian Rush, Senior Scientist and Head of the Health Systems and Health Equity Research Group in the Social and Epidemiological Research Department, Centre for Addiction and Mental Health
5. Christine Bois, former co-chair of the Concurrent Disorders Ontario Network, Centre for Addiction and Mental Health
6. Donna Pettey, Director of Operations, Canadian Mental Health Association, Ottawa branch
7. Dr. Paul Mulzer, psychiatrist
8. Glenna Raymond, Strategic Advisor, Ontario Shores Centre for Mental Health Sciences
9. Marion Quigley - Executive Director Network Co-Chair, Canadian Mental Health Association, Sudbury/Manitoulin Branch
10. Sylvie Gunther, former co-chair of the Concurrent Disorders Ontario Network, Centre for Addiction and Mental Health
11. Vicki Huehn, Executive Director, Frontenac Community Mental Health and Addiction Services
12. Wayne Skinner, Deputy Clinical Director in the Addictions Program, Centre for Addiction and Mental Health
13. Carol Zoulalian - Director of Member Services, Houselink Community Homes

## Appendix IV

### **Concurrent Disorders Survey – Community Mental Health and Addictions Providers**

#### ***Background***

The concurrent disorders survey was sent to the 270 mental health and addictions agencies that are members of Addictions & Mental Health Ontario and the Canadian Mental Health Association, Ontario. The survey was distributed in July of 2012 and all responses were collected by the end of August 2012.

The response rate to the survey was 53% (n=142). The survey response rate appears to have been based on self-selection. One hundred and forty agencies indicated they provided services to individuals with concurrent disorders and completed the survey. Two of the respondents only filled out the identifying part of the survey, as they do not provide services to individuals with concurrent disorders.

The survey was sent to all members of both organizations however the issue of concurrent disorders was not relevant to all the members and therefore they did not fill out the survey.

## Agency Demographics

Respondents were located across the 14 Local Health Integration Networks (LHINs). The greatest number of respondents were from the North East LHIN at 16% (23). The fewest number of respondents were from the Erie St. Clair, Central West, South East and North Simcoe Muskoka LHIN, each at 3% (4).

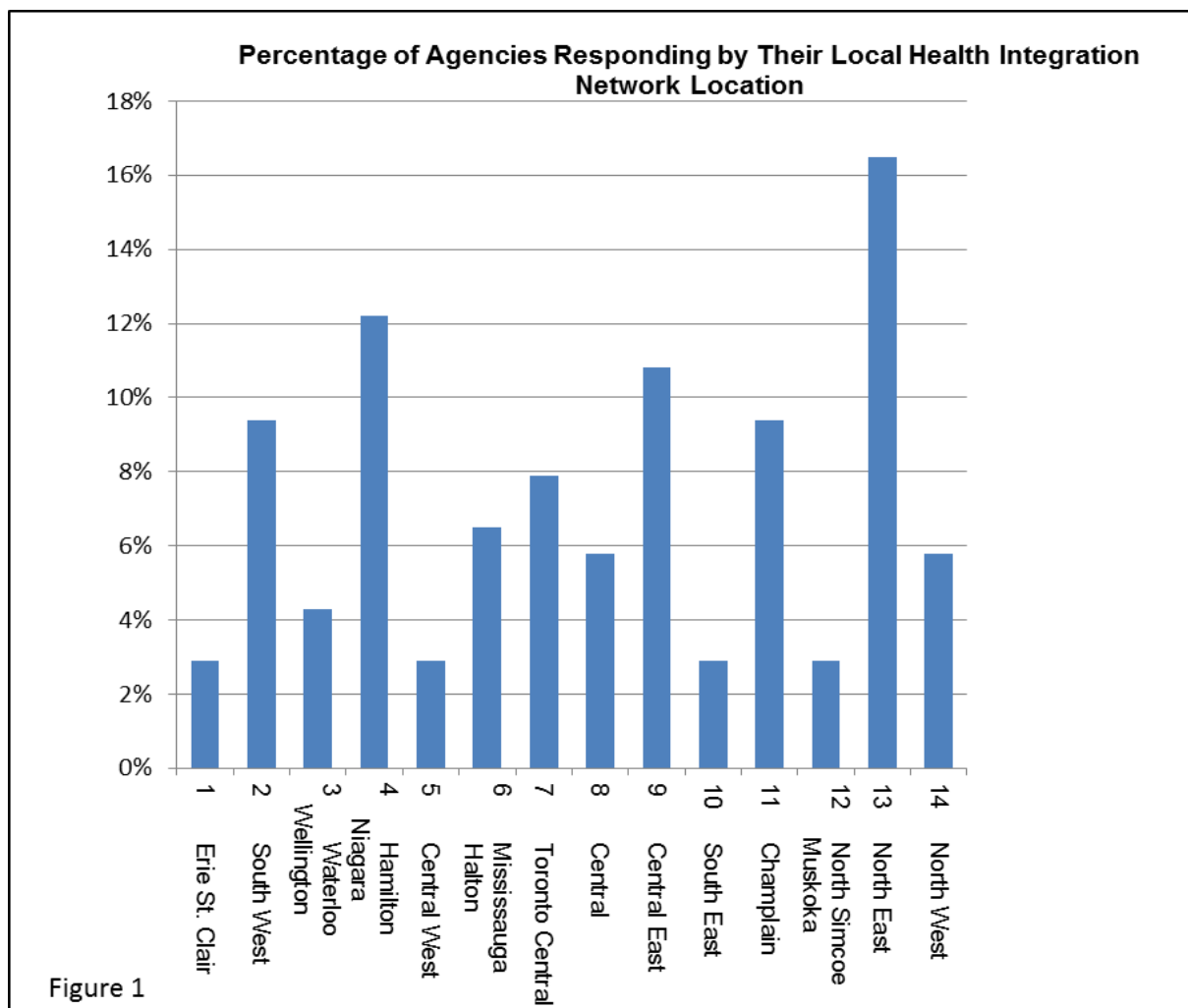
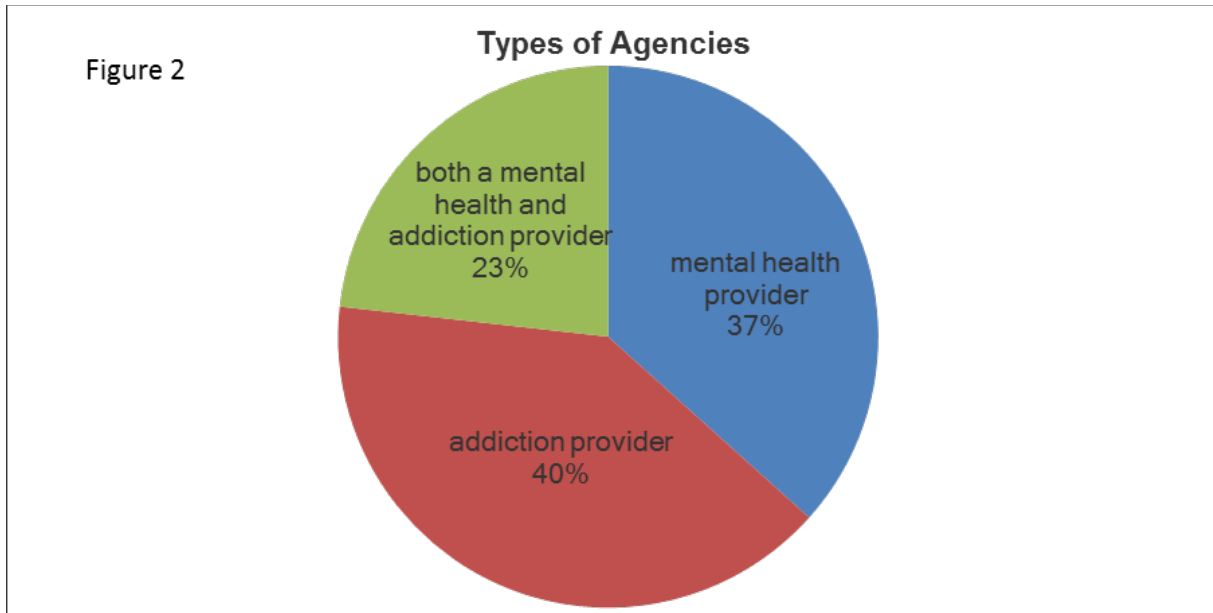


Figure 1  
3 skipped the question

There was a similar percentage of agencies identifying as either an addiction provider (57%) or a mental health provider (52%). Thirty-three agencies identified as both a mental health and addiction provider.





140 agencies identified their agency to be providing services to people with concurrent disorders.

*\*\*The number of survey respondents was n=140 for the following answers\*\**

### **Definition of Concurrent Disorders**

More than two-thirds of agencies reported having a working definition of concurrent disorders (70.4%). Agencies that had a definition of concurrent disorders consistently defined having both mental health and addiction components.

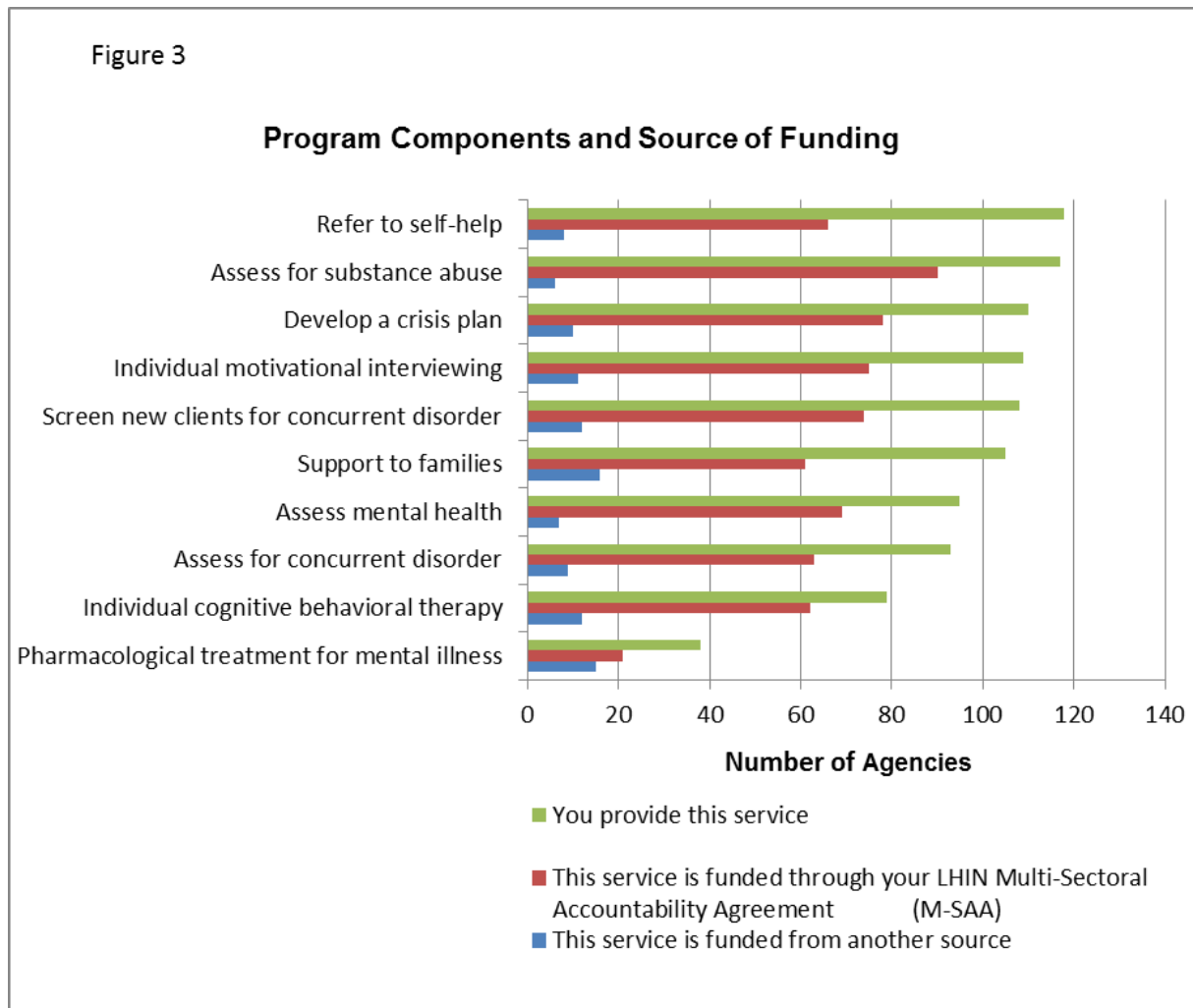
- 71% (100) of agencies have a working definition of concurrent disorders
- 49% (68) of agencies included behavioural addictions such as gambling, shopping and sex
- 24% (33) of agencies included tobacco dependence in their definition

### **Types of Services Provided and Funding Source**

Agencies reported the type of services they provided and how they were funded for it. Some agencies who indicated they provided services for clients with concurrent disorders reported they were not funded for these programs within their Local Health Integration Network Multi-Sectoral Accountability Agreements (M-SAAs). Some of these services are funded through other sources. Approximately 25% of services are not funded through any source to provide the services listed above.<sup>4</sup>

<sup>4</sup> Respondents were asked to indicate if certain services were funded by their LHIN or another source of funding. The 25% of un-funded services is our average estimate based on the difference between all the funding that was available and what was unfunded.

The two services that were the most under-funded (did not receive funding through M-SAAs or other sources of funding) were cognitive behavioural therapy and pharmacological treatment.



2 skipped the question

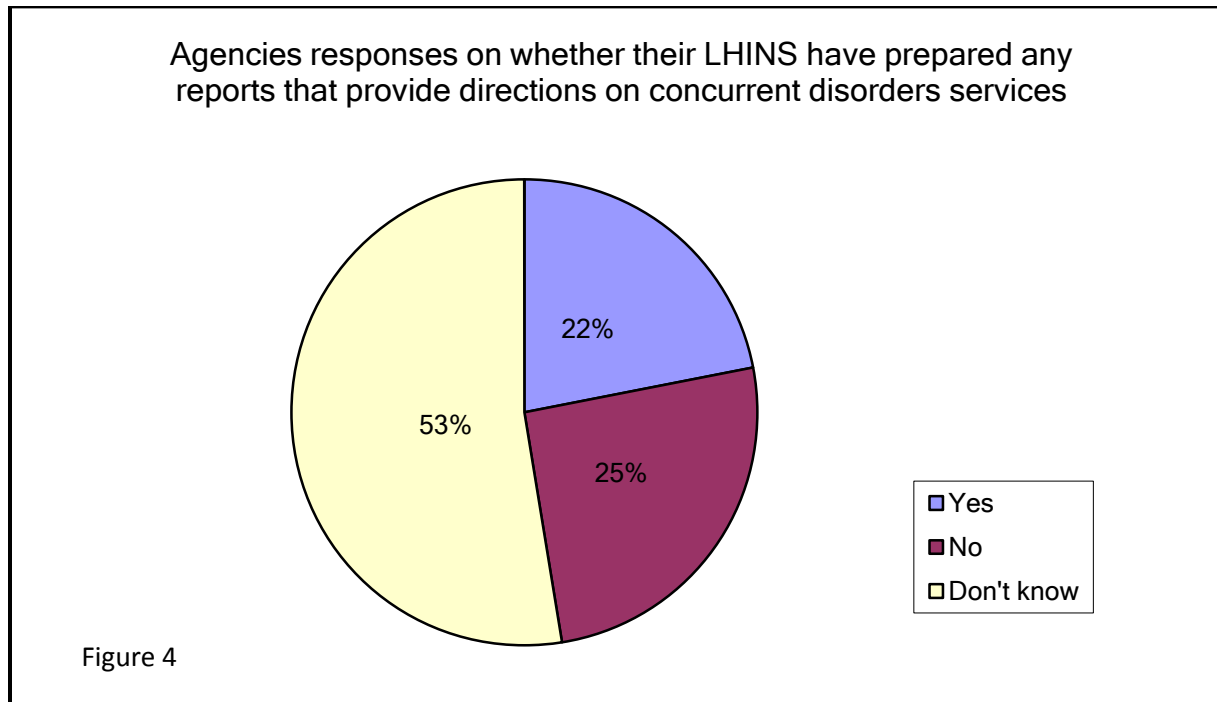
### System Navigation

System navigation was identified as being a challenge for clients with concurrent disorders:

- often 49% (68)
- sometimes 32% (45)
- seldom 4% (6)
- never 0%
- don't know 4.3% (6)
- 15 skipped question

### **LHIN Directions and Planning for Concurrent Disorders**

The number of agencies that responded that their LHINs had prepared any reports that provided direction on concurrent disorders services were 22% (27). A large percentage of agencies 53% (66) did not know whether there were any such reports.



*17 skipped the question*

Less than half of agencies reported that their LHIN had a formal planning table in their LHIN to address concurrent disorders 46% (58).

**Percentage of agencies that that indicated there was a formal planning table that addresses concurrent disorders in their LHIN**

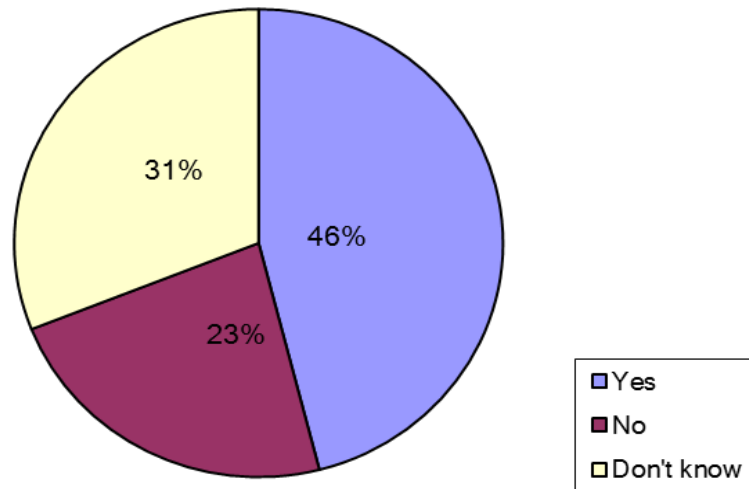


Figure 5

16 skipped the question

41% (52) agencies reported that their LHIN's Integrated Health Service Plan (IHSP) set out expectations for planning/monitoring services for people with concurrent disorders and 25% (32) reported that their LHIN's IHSP did not do that.

**Percentage agencies that reported that their LHIN's Integrated Health Service Plans that set out expectations for planning/monitoring services for people with concurrent disorders**

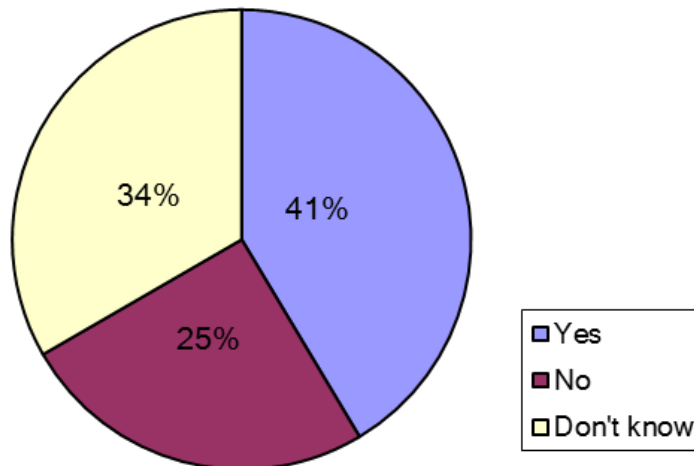
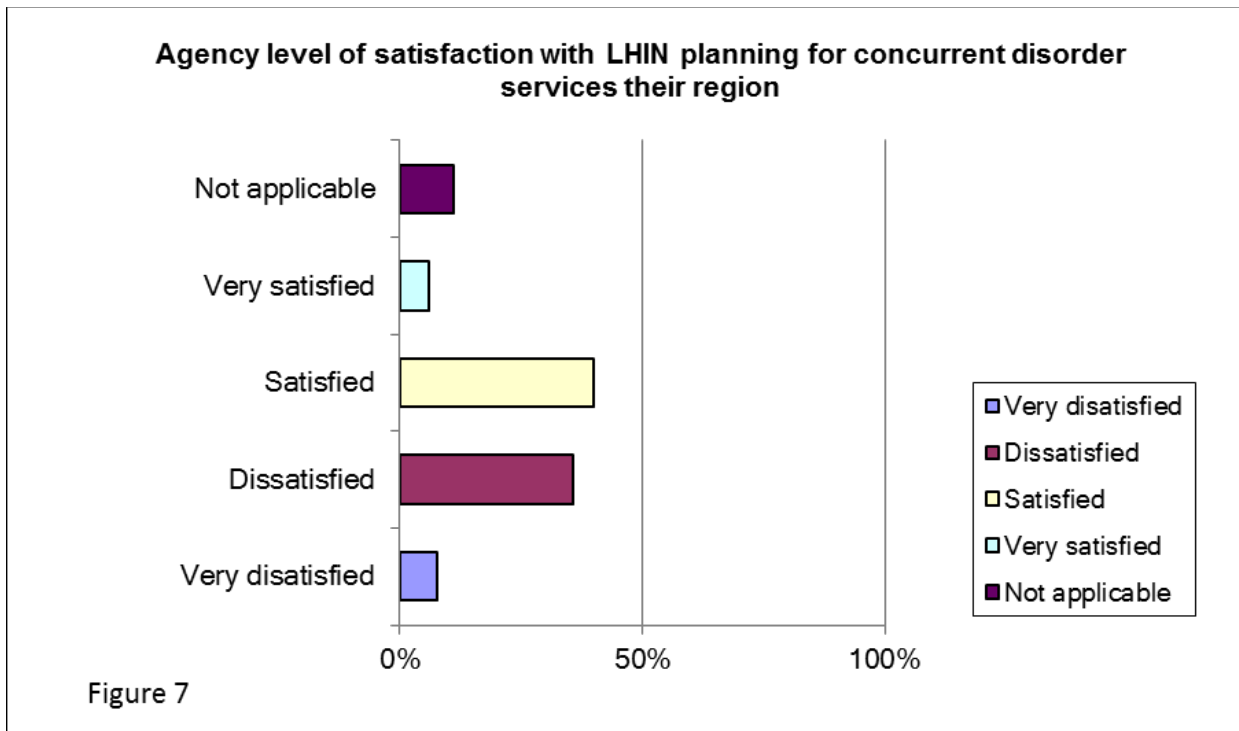


Figure 6

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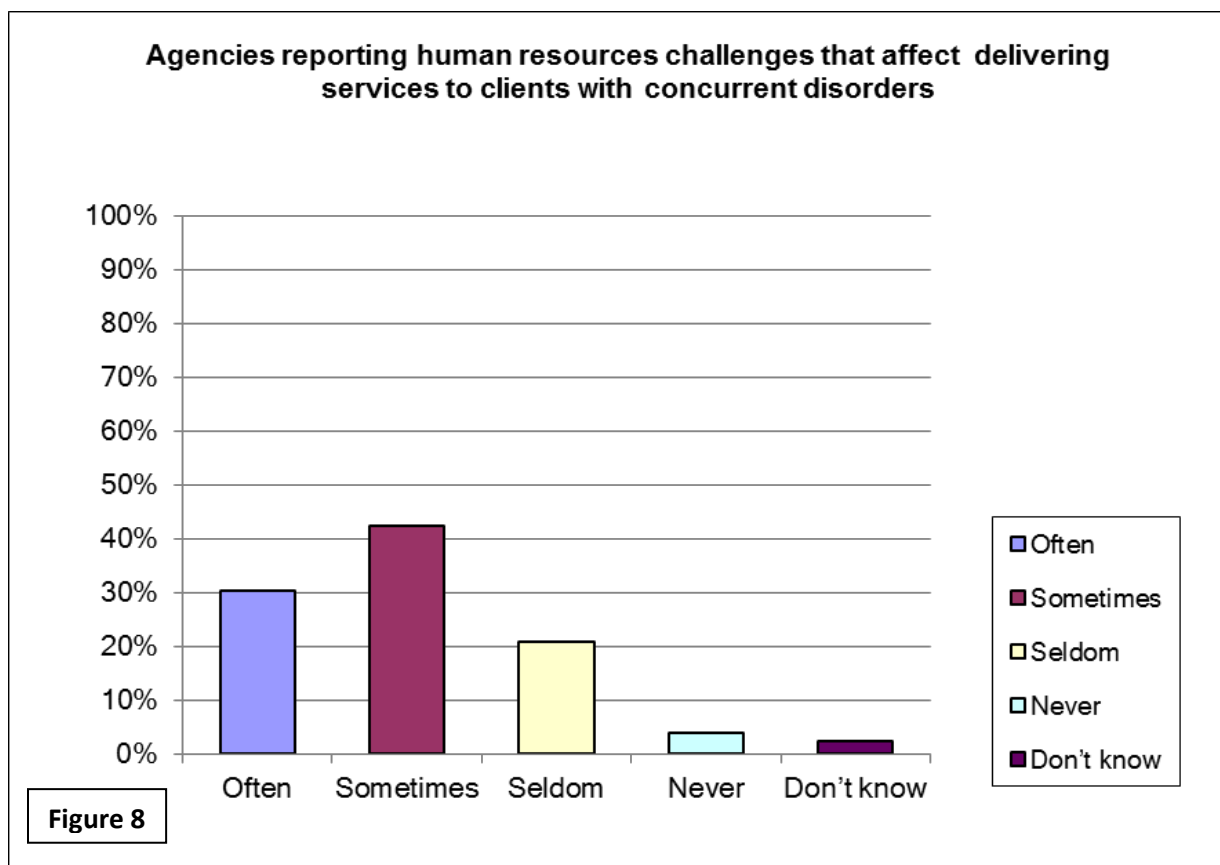
Agency responses varied on their level of satisfaction with LHIN planning for concurrent disorder services in their region.



24 skipped the question

## Human Resources

Agencies responses varied on whether they experienced human resource challenges in delivering services for people with concurrent disorders.



17 skipped the question

The top three reasons for human resource shortages were:

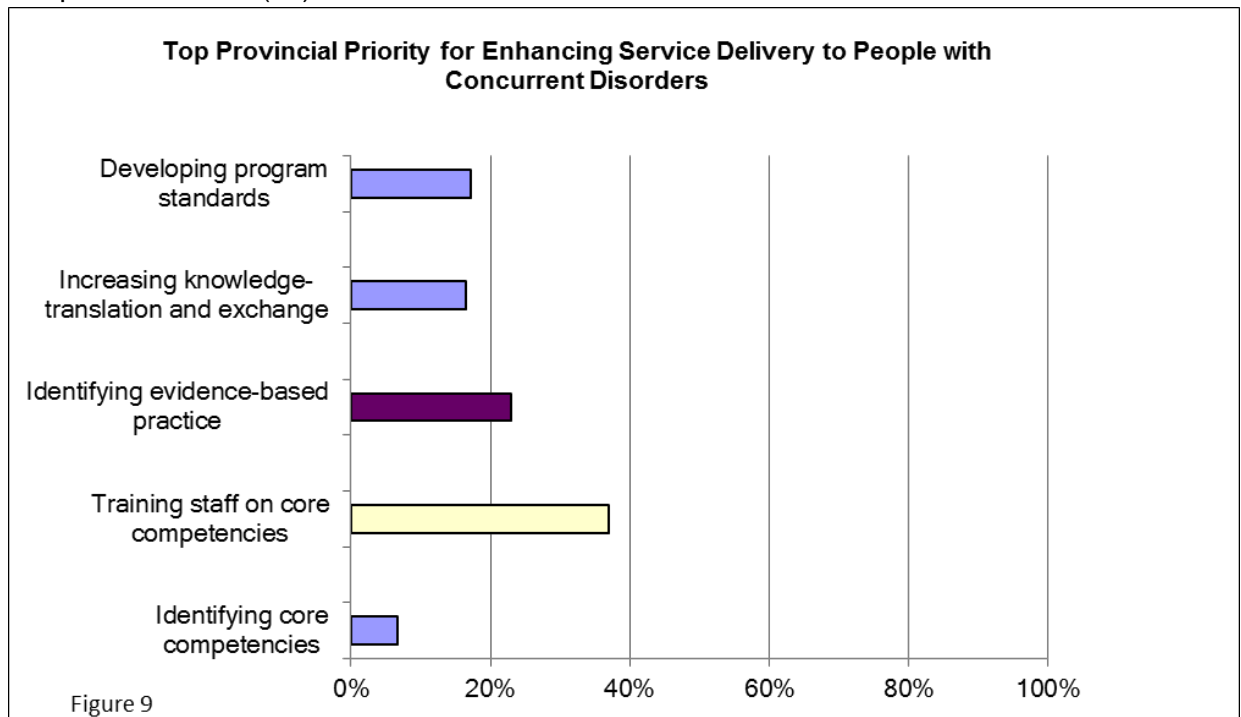
- no funding to hire a dedicated concurrent disorders staff person 46% (61)
- difficulty recruiting staff at a competitive wage 36% (51)
- lack of staff trained in working with this client population 36% (50).

## Provincial Priorities

Agencies reported the following high priority issues that required attention in Ontario:

- defining core competencies for concurrent disorder services
- training staff on core competencies
- identifying evidence to inform practice
- enhancing knowledge translation and exchange of evidence-based practices
- developing program standards.

The top priority for enhancing concurrent disorder services in Ontario was training staff on core competencies 32% (45).



20 skipped the question

## Issues of Data

Data is a crucial source of information to monitor service use, identify unmet needs and support health system planning. There are many different sources of data that capture information on concurrent disorders' services and client demographics. This includes data collected from both the addictions and mental health sector.

## Provincial

### Identified Challenges

In Ontario, there is no central repository that holds all the different types of concurrent disorders data that is collected. There are many different categories of data, each data set has limitations and there is no mechanism to connect all the existing data.

There are also significant differences in how the community mental health sector and the addictions sectors collect data. It is therefore difficult to compare how the two sectors are serving people with concurrent disorders.

### **CONNEX Ontario**

In Ontario, CONNEX collects a wide range of data related to concurrent disorders programs. CONNEX provides information on hospital and community-based services, using data from the Drug and Alcohol Helpline database, the Mental Health Helpline database and the Ontario Problem Gambling Helpline database.

CONNEX can report whether mental health programs accept clients with concurrent disorders. It can also identify whether addictions and problem gambling services accept clients with mental health conditions. This information can be reported at the provincial level by the Local Health Integration Network, organization, or by type of service.

CONNEX is not able to provide data on the number of concurrent disorder health service providers. It also does not collect data on units of service and is not able to provide data on the capacity of programs to serve clients in a reporting period.

CONNEX does not maintain current wait-list information, but it does capture previous estimated wait times for services experienced by individuals with a concurrent disorder if the mental health and addiction providers report this information. Currently, not all LHINs include this as an obligation with Multi-Sectoral Accountability Agreements (M-SAA).

### **DATIS**

In Ontario, the Drug and Alcohol Treatment Information System (DATIS) collects data on clients with concurrent disorders that use hospital and community-based addiction services. The collection of this data is obligatory on addiction service providers as a requirement of their M-



SAA under LHINs. However, concurrent disorder program providers are not obligated to provide similar data on their clients.

Concurrent disorders specific client data collected upon admission for DATIS are: age, gender, income, education level, residence by LHIN, by county, and by postal code. DATIS data also captures clients identifying concurrent disorders as a secondary issue and also upon discharge where clients are referred to for concurrent disorders services.

DATIS works with all health service providers that are required to submit data by providing on-going training and regularly reviewing the data quality.

### **Common Data Set – Mental Health**

The Common Data Set – Mental Health (**CDS-MH**) captures required information from all community mental health agencies funded by the Ministry of Health and Long-Term Care. It includes basic demographic data and clinical characteristics of clients, as well as type of services provided by the organization, referred to as functional centres. CDS-MH includes data for concurrent disorders as a diagnostic category and as clients' presenting issues.

### **Ontario Common Assessment of Need**

The Ontario Common Assessment of Need (**OCAN**) is a standardized, decision-making tool that collects data on clients within the mental health and addictions sector. Information is collected on addictions needs as well as mental health needs from a consumer perspective (self-reported) and from a health service provider perspective with consumer input. OCAN identifies client needs during the assessment period in order to match needs to existing services. Aggregate data derived from OCAN has the potential to inform organizational, regional and provincial level planning and decision making. OCAN collects data from both a client and provider perspective, and includes questions on alcohol and drug use.

OCAN is not a mandated tool for health service providers to use. However, some Local Health Integration Networks have included it in their Multi-Sectoral Accountability Agreements and the Ministry of Health and Long Term Care has recommended its use in all Common Data Set – Mental Health reporting completed by community mental health agencies across Ontario.

OCAN has been implemented in approximately 60% of community mental health agencies across Ontario. It is only implemented in a few addictions agencies and reporting is not developed or planned for these implementations.

### **Management Information System**

The Management Information System (MIS) database captures financial and administrative information from community mental health and addictions agencies as well as other health service providers. There is no information provided on client characteristics (including concurrent disorders) as none is collected through MIS.

### **National**

There are no national protocols for collecting standardized data on concurrent disorder services.

## **Canadian Institute for Health Information**

Canadian Institute for Health Information (**CIHI**) takes a national focus, collecting, analyzing and reporting standardized data across Canada for comparison across provincial/territorial jurisdictions. They also function as a repository for some unique data sets in Canada which they house and report. CIHI does not have any pan-Canadian data from the community mental health and addictions sectors.

CIHI has released an analytical piece on concurrent disorders in-patient data with the Canadian Centre on Substance Abuse (CCSA). One objective of the analysis is to identify the characteristics (e.g. demographics, service utilization, etc.) of individuals hospitalized for concurrent disorders. A second objective is to better understand the impact a person living with a concurrent disorder has on hospital mental health services compared to a person having a mental illness or substance use disorder alone (e.g. length of stay and re-admission rates). The report does not include emergency department visits. The report was released in March of 2013.