INTEGRATED
SCREENING & ASSESSMENT
FOR
MENTAL HEALTH AND ADDICTION SERVICES CONCURRENT DISORDERS

JANUARY 2007
SCREENING & ASSESSMENT

ENGAGEMENT

SAFEY

NO WRONG DOOR

History
Symptoms
Stressors
Support
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ACKNOWLEDGEMENTS:

The following have contributed to the development of this document:

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INTRODUCTION

In March of 2001 Mental Health and Addiction Services signed a Letter of Understanding committing these organizations to working more collaboratively in meeting the needs of clients with Dual Disorders. One initiative of this collaboration was the implementation of a committee with representatives from each organization called the Mental Health and Addiction Services Dual Diagnosis Committee (MHADD). The vision of MHADD was “Ensuring integrated case management for dual diagnosis clients”. The goals of the committee were to provide direction for the development of an integrated case management model, establish standards, process and structure for dual diagnosis training, and explore the benefits of a shared information system for Mental Health and Addiction Services. The MHADD Committee and associated activities provided opportunities for Mental Health and Addiction personnel to engage in philosophical and clinical discussions necessary to ensure a true integrated approach would be available to clients.

In July of 2002 a restructuring of Saskatoon Health Region Services introduced the Primary Health Care Group which included both Mental Health and Addiction Services. This development led to the amalgamation of Mental Health and Addiction Services in December 2002. Throughout this time the MHADD committee activities continued with several staff training initiatives and the development of a draft Integrated Concurrent Service Model. Subsequent to staff feedback sessions regarding the draft, the Concurrent Model Working Group (CMWG) was established to develop the clinical guidelines supporting the implementation of an Integrated Service Model for Concurrent Disorders.

CONCURRENT MODEL WORKING GROUP OBJECTIVES:

1. Establish a collaborative working environment based on mutual respect and shared responsibility.
2. Establish healthy interdisciplinary communication that stimulates creativity.
3. Ensure clinical guidelines contained in the model are based on best practices and evidence based research.
4. Ensure that the Model is practical in application and useful to clients with concurrent disorders.
5. Ensure focus is on the client, there is a consistent approach and no “wrong door”.

‘ NO WRONG DOOR’¹

This phrase is used by Dr. Kenneth Minkoff, MD, a renowned speaker/writer on providing a comprehensive, continuous, integrated system of care to people with co-occurring substance abuse and mental health issues. It concisely reflects a recommended approach for the development of policies and procedures. The direction is to facilitate a welcoming approach across programs and a universal screening for co-occurring disorders at initial contact throughout the system. In addition, the focus is to eliminate arbitrary barriers to initial evaluation and engagement. ‘No Wrong Door’ procedures help clients (regardless of presentation and motivation) access suitable services as soon as possible. (Minkoff, 2001)
BACKGROUND AND RESEARCH BASE:

A team of mental health and addiction staff within the Saskatoon Health Region (SHR) have been meeting to address the issue of Concurrent Disorders. They have referenced research and evidence based materials, attended conferences and shared learning. Through the combined work of the group the current approach in SHR is to enhance services to the client population by ensuring that all clients are screened for both disorders. A flow chart has been developed describing an Integrated Concurrent Service Model (see Page 5).

The document titled BEST PRACTICES: Concurrent Mental Health and Substance Use Disorders, Health Canada, 2001 provides a comprehensive resource of the rapidly growing research literature and expert opinions on this topic. The document has been extensively referenced by Mental Health and Addiction Services staff in the Saskatoon Health Region.

The prevalence estimate of concurrent problems in the client population seeking treatment at a mental health or addiction service settings is sufficiently high to warrant comprehensive screening. There is variability between studies on the prevalence of concurrent disorders in the client population due to studying different sub-groups of people in different settings with different methods. The Best Practices document reviews studies that indicate a range from 38% to 77%. Improved outcomes are noted for clients when the concurrent disorders are identified. Therefore, the recommendation is to consider and screen for the presence of a concurrent disorder with all clients at intake, initial assessment, admission and/or ongoing services.²

The CMWG developed a screening document which outlines a process to be utilized by staff in all mental health and addiction settings. It will aid in the regional objective to address concurrent mental health and addiction issues for the client population.

Additional sources of information are listed in an attachment to this screening and assessment document. The recommended readings are readily available and may be used by mental health and addiction personnel to enhance their knowledge. (See Appendix B)
RECOMMENDATIONS

While the primary objectives of the CMWG were to develop clinical guidelines, they were also encouraged to provide the recommendations that would assist with the implementation of the model. The following recommendations are respectfully submitted on behalf of the CMWG:

1. That there is a formal launch of this document, once approved by management, to highlight this initiative.

2. The local experts and interested stakeholders should be brought together with this committee to prepare presentations for in-service sessions. Pilot the use of the manual and contents on a small scale and revise as necessary.

3. Use in-service sessions to orientate staff to the contents and use of the manual. For in-service session it is recommended that local site expertise be used validating their role and knowledge. There would need to be a combination of mental health and addiction services personnel at each session.

4. Develop a schedule and provide resources for integration.

5. This manual could be promoted and coordinated with other initiatives (local and provincial) that are related to Mental Health and Addiction Services. This manual is timely as it connects with the Provincial Cross-Training Initiative, Project Hope initiatives, and the development of a new mental health facility within SHR.

6. The Integrated Team Service Model (Appendix A) be considered as an option for service implementation.
INTEGRATED CONCURRENT SERVICE MODEL

**ADS - Welcoming and screening for addiction and mental health issues**

**MH - Welcoming and screening for addiction and mental health issues**

**Screening** – for severity of addiction and psychiatric diagnosis

**Periodic screening for MH issues**

**Periodic screening for Addiction issues**

**Both Issues but requires detox or holding**

**Both Issues but has severe acuity**

**GENERALIZED & ONGOING INTEGRATED ASSESSMENT**

**Area or Issue:**

π

π

π

**INTEGRATED CASE**

**Action:**

π

π

π

**Outcomes/Evaluation**

**Working**

**Discharge Planning and Support Systems**

**Not Working**
CLINICAL PRACTICE GUIDELINES

There are clinical guidelines recommended by Minkoff (2005)\(^3\) that aid the development of a therapeutic alliance between clients and clinicians. A few of these points are noted below and more detail may be obtained by referencing the original sources.

Welcoming

- This involves empathy, non-judgmental approaches. A welcoming approach tells the client that they are in the right place regardless of the difficulties they are currently experiencing i.e., ‘No Wrong Door’ philosophy.
- The physical setting supports a welcoming environment for concurrent disordered clients by having posters and pamphlets on display about various conditions. For example, an addiction office may display information about mental health concerns and a mental health office may display information about substance use.

Access

- Clients are able to access service regardless of presentation. At the beginning of treatment it is expected that clients may present as intoxicated, disheveled, disorganized etc.
- Access is helping the client get to the right help or service at the right time for them even when they present in a location that does not best suit their present need.
- When clients have difficulty making and keeping appointments, connecting to a counsellor, even if brief, when they do present is effective. For example, when a client drops in at the office setting with no scheduled appointment, an available counsellor will see them no matter how briefly.
- Arranging appointments at locations easily accessible for the client is also recommended.
- There should be no arbitrary length of abstinence or mental health stability for access to co-morbid evaluation. Initial service only requires that a client be able to engage in a reasonable conversation. Though clients are struggling, they are able to process and provide the clinician with varying amounts of information.

Safety

- This means maintaining safety for clients and staff.
- Staff have confidence dealing with problematic clients when there are safety protocols in place.
- Clients need to be aware that their mental health and substance abuse concerns will be heard and managed by clinicians with the most up to date protocols. (Access to psychiatry and psychotropic medication protocols, withdrawal management protocols [Sask. AMAC] will be utilized).

The therapeutic alliance is a process of connecting and understanding between the counsellor and the client that leads to active treatment and continuing care. (Skinner 2004)\(^4\). Though clients may present in a malfunctioning manner, with welcoming and accessible services they can be engaged in ongoing services to ameliorate their disorders.
GUIDELINES FOR USE OF THE MANUAL

1. COUNSELLOR NEEDS:

- To have knowledge of the prevalence of concurrent disorders in mental health and addiction settings thus validating the need to screen and assess for concurrent disorders. (Resources listed in Appendix B)

- To have an understanding of how the two services currently function.

- To know how to assist or to refer a client, who is identified as possibly having a concurrent disorder, regardless of the setting in which the issue is identified.

2. USE OF A SCREENING INSTRUMENT:

Formal instruments can assist in the identification of concurrent disorders.

When using a screening instrument, remember that the person may not be able to be open and honest yet within the therapeutic alliance. They may not have enough knowledge to know that their issue or substance use may be a concern or problematic. They may present themselves in a positive light or minimize their situation or symptoms.

In addition, some people may not understand the questions or may misinterpret the questions. This is particularly the case if the person being interviewed is in their second language, has an intellectual disability or disorder that affects the way information is processed such as a learning disability or a fetal alcohol spectrum disorder. They may not be sufficiently free of substances/symptoms to be able to process the questions. They may require stabilization if a crisis or mental health episode exists or detoxification/‘clean time’ if substance use is a concern.

A formal screening tool is simply one source of information. Information gathered from the person and from other people who know him/her is equally important.

3. PROGRAM SPECIFIC

Counsellors need to use tools that are appropriate for their client population. Throughout it is important to always use counsellor judgment.
RECOMMENDED SCREENING METHODS AND INSTRUMENTS

Screening for Substance Use Disorders (SUD):

Index of suspicion:

There are clinical, behavioural and social indicators that raise suspicion for a SUD. These may include housing instability, difficulty budgeting resources, social problems, legal problems, employment difficulties, cognitive impairments, violence, suicide ideation and/or attempts.

Asking a few questions:

Have you had problems related to alcohol or drug use? Have others (friends, relative, health workers) ever been concerned about your use? Have you ever said to another person “I don’t have a problem” when you actually questioned yourself that you may.

Screening Instruments: (See Appendix C)

CAGE-AID – CAGE
   Adapted to Include Drugs and includes a reference for use with seniors.

CRAFFT
   Similar to the CAGE and adapted for adolescents.

T-ACE
   A widely used screening tool. This tool has been selected and recommended for women in the prevention literature on Fetal Alcohol Spectrum Disorder.

TWEAK
   Another tool similar to the CAGE but with wording that counsellors may select as appropriate for their clients.

*Clinical judgement is needed to determine the client’s readiness when using these tools.*
Screening for Mental Health Problems:

Index of suspicion:

A simple ABC approach to conducting a mental status exam can reveal the behavioural, clinical and social indicators of a possible Mental Illness (MI).

- **Appearance**,
- **Alertness**,
- **Affect (mood)**,
- **Anxiety**

- **Behaviour**: Movements, purpose, organization, speech

- **Cognition**: Orientation, calculation, reasoning, coherence (including incoherent ideas, hallucination and delusions)

Asking a few questions:

Have you ever been given a mental health diagnosis by a qualified professional? Have you ever been hospitalized for a mental health related illness? Have you ever harmed yourself or thought of harming yourself?

Screening Instruments:

A need exists for the development of a brief screening instrument. Research for an instrument that screens for concurrent disorders is occurring in Canada and the US. Counsellors are urged to be alert to new developments. It is the intention of this committee work that the availability of new instruments be communicated throughout the Mental Health and Addictions services in the Saskatoon Health Region as they are developed and found to be credible.

In the interim, the Mental Health Screening Form III (MHSF-III)\(^5\) is presented for use by addiction personnel. “Yes” responses indicate only a possibility of a current problem and review by a mental health specialist is recommended. (Appendix C)
RECOMMENDED INTERVIEW PROCESS

Use the following process/list as a guide during the screening interview. Use counsellor judgement about how to ask these questions. In many cases, answers will emerge during general discussion and it may not be necessary to ask each question directly. The use of open-ended questions, probing statements and strength-based questions is recommended.

SETTING

It is recommended that office settings have information on mental health issues and addictions represented in the waiting rooms readily visible as clients enter. This first step in letting the clients know the services are interconnected, helps set a tone of openness, reduces stigma and sends the message to clients it is acceptable to talk about both issues.

Daley and Zuckoff (1999) list a number of treatment and system variables that when addressed in the office setting, enhance client compliance with a concurrent disorder treatment program. Included in these are recommendations to provide a welcoming overall atmosphere and to have a treatment philosophy that supports dealing with concurrent disorders. 6

INTERVIEW

The following questions and statements are laid out for initial brief screening as part of the ‘Integrated Concurrent Disorders Service Model’. However, parts of the format may be applicable at later sessions with clients in either a mental health or addiction setting and are referred to as ‘Periodic Screening’ in the model/flow chart. A number of the questions and statements may be important to cover or review with people who are ongoing clients of the service.

1. What brought you here today?

2. SITE SPECIFIC: The counsellor describes what that office and the MH/ADS setting offers. “Here is how I work – I may consult with others – I may make referrals.” Client’s rights are outlined in site consent forms.

3. What do you hope to achieve by coming here (what are your priorities, goals, expectations)? How can we help you?

4. What have you tried before to deal with this concern/problem/issue? To ensure a client-friendly approach the counsellor may provide openings for the discussion of issues by making statements such as: Sometimes people have trouble managing their lives, trouble being able to work, to get out of bed etc. Has this happened to you? Have you ever experienced these difficulties?

- Have you had any contact with Mental Health &/or Addiction Services in the past?
• Have you ever talked to others about emotional/mental health/alcohol or drug problems?
• Have you ever been in hospital or a residential place (inpatient, detox.) for these concerns?

5. Counsellor’s observation:
*Pay attention to the client’s physical and mental status presentation. Include the use of smell in the observation as it may alert the counsellor to the client’s substance use &/or a client’s inattention to personal hygiene.*

6. Living Circumstances:
*The intent is not to get a detailed living history but rather to collect basic information about where the client is living, with whom, and how the client feels about these living arrangements. Basic knowledge about the client’s living circumstances will help you better understand the client’s situation.*

• What are your current living circumstances?
• Who is living in the same place?
• How do you feel about these living arrangements?
• Where are you living?
• Are there other people who play an important role in your life and do not live in your household?
• What kind of supports do you have?
• How often do you use them?

7. Safety Issues
*The intent of these questions is to determine whether the client’s present situation is safe, physically and emotionally, and whether the client presents a danger to self or others. These questions will help you determine if any crisis exists that must be dealt with immediately.*

• What are your current ‘stressors’?
• What puts pressure on you? Do you feel like you are under pressure, can you describe?
• Do you have any concerns for your physical or emotional safety?
• Do you feel safe? Are you safe? Are people around you safe?
• Is there enough food, clothing, heat, water, in your home?

8. Resources:
*The intent is to identify client strengths and areas of resilience.*

1. Who are your supports? When was the last time you saw this person? How often do you connect with this person?
2. What do you do that helps your situation/concern?
3. What do you do to care for yourself?
4. What’s working for you now?
5. What are some of the things you do to help yourself each day?

9. Are there any other health problems that you are dealing with or for which a physician is treating you?
Are you taking any medications? (prescription, non-prescription)

10. Possible additional questions specific to a Substance Abuse or Mental Health concern or both:

• Describe your alcohol and drug use. Have you ever had blackouts? Passed out?
• How has this alcohol/drug use affected your life?
• Tell me what happens when you stop drinking/using?
• Have you ever attempted to stop on your own?
• Explore for withdrawal and craving concerns to determine if there is a risk of seizures, hallucinations or withdrawal difficulties for which the person may need medical or social supports.
• Have you ever attended or are you currently attending any support groups (e.g. 12 Step Meeting, Alcoholics Anonymous, Narcotics Anonymous, Gamblers Anonymous, Al-Anon, Schizophrenia Support group, BiPolar Affected Disorder Support group, Obsessive Compulsive Disorder Support group)? If you have, when was the last time you attended? Explore further if pertinent.
• Are you working with or have you worked with other helping professionals? If so, who, where and when?
• Have you ever attended another treatment program or centre, or been in hospital for mental health concerns or substance use problem? If so, where and when?
• Have you ever felt extremely depressed, felt really down, hopeless? Presently? How long at one time? Was that when you were drinking, using drugs or in withdrawal?
• Have you ever experienced anxiety or panic attacks? Can you describe it? Were you using substances at the time?
• Have you ever thought of harming yourself, or had thoughts of suicide? If yes, when? Were you using substances at the time?
• Have you ever been violent or aggressive towards someone else? In the past? Presently? Were you using substances at the time?
• Was there abuse in the family? Do you mind telling me what kind? Does it affect you now? (This question should be prefaced with the understanding that it is the client’s choice to answer the question and they don’t need to supply details.) Do memories of past violence or trauma effect your life today (e.g. nightmares, shut down emotions)? Is there a history of mental illness or substance usage?
• Do you see a psychiatrist or other health professional for mental health issues?
• What is your daily routine? Has it changed in the last while? Are you able to do the same things you could six months ago? A year ago? Two weeks ago?
• Have you any legal concerns or problems (legal charges or civil court)?
• Have you experienced a head injury?
EDUCATION ABOUT THE EFFECTS OF MENTAL HEALTH OR SUBSTANCE USE CONCERNS:

Education about the effects of mental health or substance use concerns is an important part of the screening process. Typically, education is provided not as a single lecture, but in bits and pieces throughout the screening when it seems appropriate. Some education may be given verbally to the client or handouts may be reviewed with the client. Factual information about mental health and addiction concerns will help clients put their own situation into context and to accurately assess what is going on in their lives.

SUGGESTIONS TO COUNSELLOR’S REGARDING INTRODUCING A SCREENING INSTRUMENT INTO THE INTERVIEW PROCESS:

A flexible approach based on clinical judgment is recommended. The questions from a screening interview may be interwoven throughout the interview. A counsellor may state that we ask these questions of all clients seeking service to ensure we get an accurate picture of their situation, thus help them to get the most appropriate service.

Some sample statements are:

- I am gathering information about your situation and will ask you a series of questions.
- Are you okay/comfortable with my asking questions about _______
- Do you mind if we ask you some questions about your emotional well being or about your use of substances (alcohol/drugs)?
- If a counsellor encounters resistance they may say – “I would like you to think about this request and we’ll get back to it at another session.”
OUTCOMES OF SCREENING

ACTION

- When considering and choosing a course of action, counsellors need to be cognizant of the client’s readiness to change as outlined in the Transtheoretical Model of Change.

- Possible Counsellor Responses:
  “This is what I see might work now.”  “From what you have told me I see two things happening.”

- If the counsellor’s recommendation is declined, attempt to elicit some commitment for change or a willingness to address the issue that brought them there.

- Confirm an action plan if/when the counsellor and client are in agreement.

- Document results and ensure follow-up.

* See Page 16 for Definitions
OPTIONS

1. **Current Crisis Exists:**

   Address crisis and arrange with client to address on-going issue(s) at a later date. Counsellors are urged to seek clinical supervision as needed.

   - Substance abuse withdrawal or intoxication may need to be referred to hospital emergency departments for medical management, a detoxification centre or for home management if appropriate supports exist.
   - Immediate mental health crisis may be referred to the emergency departments, psychiatric units as per current protocols.
   - For other safety concerns address by referrals to family services, justice services (police) or temporary housing/food needs.

2. **Alcohol/drug use is a factor.**

   Rule in the motivational assessment process for substance use and engage with the client to continue with this process either at the current setting or refer to the intake unit at community addiction services.

3. **Mental Health concerns are noted.**

   Addiction Services may refer to the Intake Unit of the Mental Health system. If the client is in a mental health setting, the client will continue to access services at that location. Alternatively, a referral to the appropriate setting can be facilitated. This may involve coordinating services between community and residential settings.

4. **Concurrent problems are identified.**

   The client may continue to receive a service at the current location and the counsellor will plan services in conjunction with the alternate service. The client may be referred to an identified concurrent disorder counsellor if there is one within their own agency. As the system moves towards or develops an integrated service model, clients will have increased opportunities to receive a comprehensive service within one location. Service settings are urged to identify a concurrent disorder knowledgeable counsellor within their setting from whom counsellors may seek clinical supervision. Clinical supervision will assist with ensuring appropriate identification in the screening and then service planning.

5. **Unsure if concurrent problems exist with client:**

   Counsellor continues providing service for the presenting issue. Ongoing screening for concurrent problems continues at future appointments. The counsellor flags issues/areas for follow-up. Ongoing Screening may involve using a more in-depth instrument such as the Michigan Alcohol Screening Test (MAST) DAST for drug use, ‘BASIC 24’, Psychiatric Sub-scale of the Addiction Severity Index (ASI) or other psychological tools which have been approved at the site specific location. See Appendix B for information about these tools.
TERMS DEFINED

1. Parallel Service – This is simultaneous treatment existing or acting together at the same time.

2. Sequential Service – This is when one treatment follows the other treatment through a referral to another agency or a specialized unit.

3. Integrated Service – “…mental health treatments and substance abuse treatments are brought together by the same clinicians/support workers, or team of clinicians/support workers, in the same program, to ensure that the individual receives a consistent explanation of illness/problems and a coherent prescription for treatment rather than a contradictory set of messages from different providers (adapted from Drake and Mueser)”

As systems are changing to better meet the needs of this client population various forms of integration are occurring and the differences between the three above-mentioned terms are no longer so distinct.

Integrated Case Management – This is a process to ensure that the client’s complex needs receive responsive, holistic approaches within an effective service of various agencies such as mental health services, addiction services, social agencies, employment, housing, and family services. There is usually an identified case manager to monitor and coordinate the case plan.
ASSESSMENT

Building upon the foundational principles and following screening, an integrated, longitudinal, strength-based assessment may be commenced. It is important for a clinician to be aware of the increased risks associated with this client population. Risk factors include homelessness, victimization, suicidal ideation/attempts and/or self harm. Generally, clinicians need to be more accepting of the many challenges experienced by the client and to adjust their approaches accordingly. This includes having flexibility in their schedule to see clients when they do present, not expecting compliance with the treatment plan, seeing a client who is not entirely substance free and acknowledging the client’s inability to focus on the therapeutic issue when basic needs are unmet.

Comprehensively assessing clients needs involves many areas of the client’s life and is referred to as a bio-psycho-social-spiritual approach.

Ideally, each client entering the Mental Health and Addictions system, where there is an ongoing expectation of service, will be afforded a comprehensive needs for service assessment and an individual service plan. The needs for service assessment may be part of an intake assessment or may occur when it is clear that the client is prepared to engage in services. The careful determination of needs for service ensures a consistent, comprehensive, and balanced approach to assessment and intervention. The development of the individual service plan, sometimes referred elsewhere as the care plan, ensures that clients and clinicians work collaboratively to set meaningful goals and, as a communication tool, provides the means to ensure service coordination and continuity of care across services.

Within the Saskatoon Health Region, the Individual Service Plan Committee, made up of both Mental Health and Addiction Services staff, through a consensus building process, has developed a series of documents designed to facilitate a comprehensive needs for service assessment and the development of a consistent individual service plan that potentially could be used routinely across all of Mental Health and Addiction Services.

Please refer to two documents in Appendix D. These are the ISP Worksheet and the ISP Template.

The Needs for Service Categories for Adults are:

The careful determination of needs for service ensures the possibility of a consistent, comprehensive and balanced approach to assessment and intervention. Ideally, needs for service are determined in dialogue with the client or patient, or if this is not possible, with the immediate family or caregiver.

Needs for service will change over time reflecting improvement in mental health or success with recovery or, conversely, with deterioration in mental health and increased impairment and disability. The latter is frequently accompanied by social disadvantage, diminished access to resources, and difficulty functioning independently in the community.

Depending on the needs identified, the focus of intervention may be on the patient or client, on their immediate environment, or on a combination of both, for example, on improving their comfort in social interaction or developing their ability to negotiate to meet their needs.
Just as an overwhelmingly stressful living situation can contribute to the inability of a person to cope with untoward life events, a positive and supportive environment can contribute to the successful management of symptoms and a sustained recovery. Identifying past successes, building on strengths, and honouring coping skills are practical pathways to establishing therapeutic alliance and setting appropriate outcomes for intervention.

All of the following needs for service categories are to be considered when developing a holistic and comprehensive plan of intervention, recognizing that certain categories will be more relevant than others, and that the immediate focus of intervention will not necessarily take into account all of the needs identified. Note also that the “areas to consider” are illustrative rather than all-inclusive. A specific program may need to broaden or narrow the focus of what is to be considered depending on its mandate and the nature of the intervention that is being considered.

1. **Emotional and Mental Well being**

   Acute symptoms are manifest in abrupt changes in thinking, reasoning, perception, mood and behaviour. Major mental illness, trauma, and enduring stress can significantly interfere with purposeful and productive activity and significantly impair social and intimate relationships. Anxiety and depression may precede, accompany, or be the consequence of deficits in emotional, spiritual and mental well being.

   **Areas to consider**
   - Mental status including
     - Appearance - Behaviour
     - Speech - Thought (form & content)
     - Appetite - Sleep
     - Affect - Mood
     - Perception - Orientation
     - Cognition - Memory
     - Insight - Judgement
   - Psychiatric history
   - Medical history
   - Social and family history
   - Personal issues, sexuality, sexual orientation
   - Suicidal thoughts, plans, attempts
   - Impact of positive symptoms such as
     - Intrusive thoughts
     - Mania
     - Hallucinations
   - Impact of negative symptoms such as
     - Emotional blunting
     - Absence of pleasurable experiences
     - Problems of volition, motivation
     - Cognitive difficulties
2. **Substance Use and Problem Gambling**

This section encompasses substance use/abuse/dependency, problem gambling, nicotine and other addictions (sometimes called ‘process addictions’ and may include sexual activity, food, and internet).

Substance abuse/dependency, gambling and other addictions impact physical, emotional, mental, social and spiritual well being (bio-psycho-social-spiritual), significantly interfere with purposive and productive activity, and impair social and intimate relationships. Anxiety and depression and other emotional difficulties may precede, accompany, or be the consequence of substance use, gambling or other addiction.

**Areas to Consider**
- Reason person is presenting for service (internal or external motivation)
- Appearance and behaviour – assess for degree of current impairment, distress
- Types and amounts of substances used and when (licit &/or illicit substances)
- Types and frequency of gaming activities (licit &/or illicit)
- Past history of substance use, gambling or other addictions
- Problems/consequences experienced due to current or past substance use, gambling or other addiction
- Past and current need for medical or social detoxification due to substance use
- Past and current need for supports when ceasing or cutting down on gambling activities
- Prior addiction related services and/or recovery attempts
- Existence of protracted withdrawal symptoms due to substance use
  - Poor memory, lack of concentration, difficulty retaining new information
  - Insomnia, anxious or depressed feelings, restlessness
- Need for ongoing assessment and recovery services

3. **Danger to Self or Others / Personal Safety**

The safety of clients, family members, and service providers is a significant concern when assessing the appearance of symptoms, arriving at a diagnosis, or implementing a treatment plan in the community. The potential of the client to self-harm or to be violent to others and their vulnerability to physical, emotional or sexual abuse requires rigorous assessment.

**Areas to Consider**
- High risk behaviour such as
  - Intentional self harm, cutting, purging
  - Driving while impaired
  - Having unprotected sex
  - Wandering in traffic
- Risk of suicide (thoughts, plans, attempts)
- Risk of violence toward others (thoughts, plans, history)
- Contingency plans to manage high risk behaviour
- Vulnerability to being harmed/exploited by others (history)
- Physical safety and emotional security of children or other family members
- Safety of immediate physical and emotional environment
4. **Spirituality**

Spirituality is a critical life factor for many people who engage with Mental Health or Addiction Services. As identity, worldview (how we fit in the world), goals, and aspirations are all closely tied to belief systems and cultural practices, sufficient exploration needs to occur to determine that treatment and intervention are clearly understood and that the outcomes that are selected are meaningful and acceptable to the patient/client. Failure to recognize that spiritual/religious practices for some may either contribute to their difficulties or conversely are critical to their sense of positive mental health and recovery, can relegate treatment planning and intervention irrelevant and ineffective. This is an area that requires considerable maturity on the part of clinicians, particularly in relation to the recognition of appropriate boundaries and the demonstration of respect for belief systems that may be very different than their own.

**Areas to Consider**
- Sense of purpose, feeling of connection to others, society, culture
- Belief in a higher power, cultural practices, religious affiliation
- Worldview, personal values, philosophy
- Religious practices, reliance on ritual, prayer, elders

5. **Stressful Life Events / Trauma**

People who have experienced mental illness and/or substance use/problem gambling often have a diminished capacity to cope with everyday life without experiencing significant stress. Many events and life transitions are stressful in themselves as they are perceived as unpredictable or with uncertain outcomes. In addition, many people are limited in their ability to cope with stress by their early experience of trauma just as the coping ability of others has been enhanced by resolving these experiences. Relapse and the re-emergence of symptoms can be brought on by stressful life events or prevented or ameliorated by the adherence to effective coping strategies.

**Areas to Consider**
- Significant sources of stress in the present and normal coping strategies, positive and negative
- Recent untoward events resulting in death or loss
- Capacity to identify effective and ineffective strategies for managing stress
- Availability of buffering or supportive experiences
- Willingness to engage in problem solving and to reach out for support
- Unresolved trauma that contributes to current stress or limits coping strategies

6. **Physical Health**

People who experience serious mental illness and/or substance use/problem gambling have higher rates of physical morbidity and associated mortality than the general population. Sometimes, because of their illness or lifestyle, these individuals do not access preventative health services, overlook health problems and avoid medical treatment. In addition, some treatments for mental illness, of themselves, lead to long term health risks. Substance (licit and illicit) use can compound health problems.
Areas to Consider
- Current health status (how recent and outcome of general health review)
- Presence of chronic illness, disability, chronic pain
- Commitment/motivation to pursue a healthy lifestyle or aspire to self-care
- Connection to physician and health care team
- Degree of exposure to health risks
  - Smoking
  - Substance use, abuse, dependency
  - Poor nutrition, housing, unsafe environment
  - Not accessing screening (for cancer or heart disease)

7. Medication Management

Compliance to a prescribed medication regime is critical to effectively managing the symptoms of recurrent and persistent mental disorder. Medication is also a useful adjunct to other interventions for people who are incapacitated by stress or overwhelmed by feelings of depression. Medication management, however, is significantly more complicated for individuals who also have a history or current pattern of substance use.

Areas to Consider
- Current compliance to prescribed medication regime
- Risk for future non-compliance
- Understanding of how the medication works, possible side effects and contraindications
- Family/caregiver support for compliance or non-compliance
- Impact of substance use on prescribed medication/likelihood of misuse

8. Daily Living Skills

The ability to maintain independent living skills can influence the housing and social relationship options for people with a mental illness and/or substance abuse/dependency. Some clients are unable to use these skills for short periods during acute illness, during intensive substance use, or while engaged in problem gambling and need time limited support during a recovery period. Others will have longer term difficulty with everyday household tasks and general survival in the community. Developing daily living skills may be very important to some people and a low priority for others. Due to acute symptoms or residual issues, some clients may have great difficulty learning and following through with applying daily living skills, even when motivated. The option of providing basic support instead of training in daily living skills must be considered in the light of the client’s own goals and the likelihood of a positive outcome.

Areas to Consider
- Level of concern/distress about performance of daily living skills
- Expectation/requirement to care for others (children, spouse, parent)
- Presence/absence of relevant skill sets
- Capacity/opportunity to learn daily living skills
9. **Personal Response to Illness, Substance Use, Abuse, Dependency**

The experience of mental illness and or substance use, etc. can have a major affect on how people perceive themselves and their hopes and dreams for the future. Mental illness and/or substance abuse/dependency involve some degree of stigma in almost every culture. The social and personal implications associated with being diagnosed as mentally ill or substance dependent are vast and the person’s response to these can influence their path to recovery or independence and self-sufficiency.

**Areas to Consider**
- Willingness to accept illness/problems
- Degree of distress related to loss of function/aspirations
- Consequences of illness/problems/substance use such as
  - Embarrassing behaviour
  - Estrangement from friends/family
  - Financial losses, disruption of employment and social connections
- Ego strength, self-esteem, motivation
- Willingness to assume responsibility, strive for independence/self-sufficiency
- Ability to engage in problem-solving, utilize available support
- Confidence/confusion about self-management

10. **Family and Caregiver Concerns**

Families often experience major grief, personal turmoil, and significant disruption to family life when a family member is diagnosed as mentally ill or substance dependent. Families almost always need support and timely information in order to adjust to what is occurring and to what they do not understand. Specific information about the illness/condition, the treatment process, the service system and the availability of community support is critical to a positive outcome.

**Areas to Consider**
- Attitudes to and understanding of client’s illness/problems/substance dependency
- Impact of client’s symptoms/behaviour on parents/spouse/children
- Degree of connection/estrangement
- Pre-existing tensions and strengths within the family
- Patterns of guilt/blame/ and of taking/avoiding responsibility
- Need for support and information
- Willingness to remain connected
- Ability to access resources
- Special needs of children of mentally ill, substance dependent, problem gambling parents
11. **Friendships / Social Relationships**

Social competence has been associated with better recovery from serious mental illness, substance dependency and problem gambling. Social relationships and, in particular, friendships, are one of the most important areas of need that may require a specific focus for intervention. Isolation, loneliness, and difficulty being with others in a comfortable way, are not predictors of a positive outcome or full recovery.

**Areas to Consider**
- Size and quality of friendship network
- Level of satisfaction and reliance on social relationships/activities
- Quality of intimate and sexual relationships
- Comfort and ability to perform socially

12. **Recreation / Leisure**

The Recreation and Leisure experience has an impact on the physical, emotional, mental, social and spiritual wellbeing of an individual. Recreation and leisure activities that are interest driven are important for maintaining a sense of purpose, individuality, and enjoyment. Engagement in purposeful activity is a highly valued goal.

**Areas to Consider**
- Awareness of recreation and leisure education activities
- Level of participation in meaningful activity
- Focus on needed social and coping skill development
- Reliance/importance of structure/routine
- Connection to community resources
- Barriers to engagement/participation
  - Stigma/fear/discrimination
  - Cost/availability of transportation

13. **Work / Education**

Employment and career options are frequently limited for people with mental illness or who have engaged in substance use and/or problem gambling because of the episodic nature of illness and recovery and the difficulty of maintaining fulltime employment or pursuing fulltime educational goals.

**Areas to Consider**
- Personal interests, motivation, current skills
- Capacity for new learning/problem-solving
- Cognitive ability, memory, concentration
- Impact of symptoms/problems on abilities and motivation
14. **Income**

People who experience mental illness and/or substance dependency are often severely economically disadvantaged for long periods of time. Lack of access to flexible options in the paid workforce often results in poverty. In addition, clients often have extra health care costs associated with their illness/substance dependency. The need for supported accommodation cuts into disposable income. Recreation and leisure pursuits and attempts at more independent living, necessary for personal recovery, are often expensive and financially inaccessible.

**Areas to Consider**
- Financial comfort (enough to go around, pay the bills)
- Ability to manage finances, budget
- Potential for exploitation (by friends, family, strangers)
- Spending patterns (for example, during a manic phase)
- Coping strategies, contingency plans
- Need for advocacy/trusteeship

15. **Housing**

Stable and suitable housing with appropriate support is associated with improved outcomes for people with mental illness, substance dependency and/or problem gambling. Inappropriate living situations can significantly contribute to stress and lead to chronic health problems.

**Areas to consider**
- Fit of the housing selected with the client’s needs/preference/income
- Accommodation to disability, culture, gender
- Safe, secure, pleasant (or not)

16. **Legal / Advocacy Issues**

Because of the level of social and economic disadvantage frequently experienced by people with mental illness, substance dependency, and/or problem gambling combined with diminished problem solving capacity and increased impulsivity, these clients are frequently in trouble with the law or in the midst of legal issues that are difficult to resolve. In addition, because of the stigma associated with being a member of a marginalized population, they may be deprived of jobs, housing, or income that most people take for granted. The need for advocacy is prominent for those who have diminished capacity to fend for themselves or who experience systemic discrimination in the community.

**Areas to Consider**
- Existence of unresolved criminal or civil legal matters
- Need for a formal advocate or guardian
- Existence of or need for a Community Treatment Order
- Need for education or advocacy in relation to
- Rights in relation to health care
- Rights in relation to certification or determination of capacity
- Legal issues related to housing or employment
- Help to address income security issues
- Unresolved divorce, separation or custody issues

INDIVIDUALIZED SERVICE PLAN

An Individualized Service Plan (ISP) is developed once needs have been identified. Assessment is an ongoing process and needs change, which includes changing the ISP, it is not a static document. A sample format of the ISP Worksheet (used by counselor and client together) and ISP Template (for communication between services providers) is attached. (Appendix D)

* ‘Needs for Service Categories for Adults’ and the ‘Individualized Service Plan’ were originally developed by Psychiatric Services Branch, Victorian Government Department of Health & Community Services, Australia.
RELATIONSHIP BETWEEN MENTAL HEALTH DISORDERS AND SUBSTANCE USE DISORDERS

As counsellors work with clients in mental health and addiction settings serious thought needs to be given to how the presence of one disorder interacts with the other. This may be done by considering the following questions:

1. Does the client accept that they have both conditions? The counsellor may ask the client about the connection.

2. Does one condition exacerbate the other? How do they impact one another for example, are symptoms exacerbated during withdrawal, does one condition ease off, get better or worsen while the other is being treated?

3. Historically, how have the two conditions interacted?

4. Are other service providers aware of the connection?

5. Do both need to be addressed with sequential, parallel or integrated services?
SERVICE SELECTION

The Reis’ Typology (Minkoff, 2005)\(^9\) (Skinner 2005)\(^10\) is a recommended reference for determining the best service for the client. This typology forms a quadrant chart for easy reference. The abbreviations for the following chart are MI - Mental Illness, SUD – Substance Use Disorder. However, Saskatoon Health Region uses Mental Health NOT Mental Illness. Mental Health, for the purposes of this document, includes a continuum of mental issues/concerns related to a person’s well-being through to a diagnosable mental illness)

<table>
<thead>
<tr>
<th>MI High</th>
<th>MI Low Severity</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUD High</td>
<td>SUD High Severity</td>
</tr>
<tr>
<td>[ Serious &amp; Persistent Mental Illness with Substance Dependence]</td>
<td>[ Psychiatrically Complicated Substance Dependence]</td>
</tr>
<tr>
<td><em>Service: Integrated Care</em></td>
<td><em>Service: Collaboration</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MI High Severity</th>
<th>Both Low Severity</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUD Low Severity</td>
<td></td>
</tr>
<tr>
<td>[ Serious &amp; Persistent Mental Illness with Substance Abuse]</td>
<td>[ Mild Psychopathology with Substance Abuse]</td>
</tr>
<tr>
<td><em>Service: Collaboration</em></td>
<td><em>Service: Consultation</em></td>
</tr>
</tbody>
</table>

*Consultation* refers to a process that involves informal links between mental health and addiction service personnel along with additional human services as may be needed for the client. Rather than separate services, the plan is coordinated and facilitated through consultation and acceptance of the role of each service. This may involve parallel or sequential plans. *(See Terms Defined P. 16)*

*Collaboration* refers to formal links between mental health and addiction service personnel who work together to develop and implement a recovery plan. This may involve sequential or parallel planning with the client.

*Integration* refers to the provision of addiction and mental health services in a single treatment setting to meet the often multiple and high needs of the client.
ADDITIONAL ASSESSMENT PROCESSES

Counsellors have received education and training in interviewing, counseling and assessment skills. The following processes are references to aid and guide clinicians in structuring the process. Clinicians may reference the materials and the sources to enhance their capability to work with concurrent disorders.


The manual describes the Motivational Assessment Process (MAP). The MAP is a process that addiction counsellors throughout Saskatchewan can use to assist individuals whose lives are affected by substance use. The process is based on current research indicating that motivation to change is enhanced by therapeutic interaction between the counsellor and the individual and that motivation develops as trust grows and deepens. The process is holistic. It recognizes that social, psychological, biological and spiritual factors contribute to substance dependency, and addresses family, community or lifestyle issues that support or get in the way of recovery. The process recognizes that mental health issues, cultural issues, physical disabilities and cognitive disabilities affect an individual’s substance use and recovery. Research has shown that substance abuse or dependency may exist along with concurrent disorders such as mental health issues/concerns. In these situations, the two disorders interact and each affects the status of the other. The manual addresses these factors. The manual provides counsellors with examples of questions and phrases that may be used when interacting with a client.

2. **Integrated Longitudinal Strength Based Assessment – ILSA**

Dr. Kenneth Minkoff and colleagues recommend this process for clients with concurrent disorders. It comprehensively incorporates information for both disorders. It emphasizes onset of the disorders and how they interact. It covers the effects of treatment interventions (mental health and substance abuse) and factors that contribute to relapse in both disorders. The ILSA is under development and a full description of this resource is expected to be available in mid-April 2006.
INTEGRATED CASE MANAGEMENT

Work with clients may be done in a parallel, sequential or integrated manner using integrated case management strategies.

Some clients have complex social, economic and personal issues and require the responsive, holistic and effective services of several agencies. Integrated case management is the recommended approach for effectively meeting these needs.

Health Canada’s Best Practices Guideline #21 (Roberts et al., 1999) states:

... there is consensus in the literature that clients are better served when they can access a range of flexible and individualized services spanning the specialized and non-specialized sectors, linked through some form of coordination and case management and accounting for the needs of special populations.

Principles of Integrated Case Management

The principles of integrated case management are as follows:

Client-Centred Approaches
- recognize and respond to client needs and expectations
- respect client dignity, responsibility and self-determination
- ensure clients are informed, provided with options, and encouraged to participate in making decisions
- respect the importance of confidentiality, where sharing of information is client-directed on a need-to-know basis only

Holistic Approaches
- acknowledge that no single group can address all the needs of one individual or family
- emphasize the complete and interrelated nature of clients’, families’ and communities’ needs and strengths
- recognize the interdependent nature of all human services

Integrated Approaches
- promote coordination of planning, decision making and resources through a multi-sector and multi-disciplinary team approach
- foster good communication, cooperation and collaboration through a multi-sector and multi-disciplinary team approach
- foster good communication, cooperation and collaboration between service providers, clients and communities
- reduce service fragmentation to improve effectiveness and continuity
- meet client needs in a comprehensive, coordinated and integrated manner

Accessibility and Equity
- ensure access to timely and appropriate services
- foster a respectful, barrier-free environment, where individuals have opportunities for equitable access and equitable benefit
Shared Responsibility and Mutual Respect
- enable clients, communities and human service providers to work together to identify needs and effective solutions and responses
- promote shared leadership, planning, decision making, resources and evaluation
- acknowledge mutual respect for the expertise and contribution of each participant
- recognize the role of the family, other caregivers and community resources in planning and caring for clients
- ensure that the rights of the client and others are protected

Accountability and Affordability
- promote efficient, effective and equitable use of resources to achieve positive outcomes
- provide opportunity and information for human service providers to plan collectively for clients
- provide a framework for accountability to the people and communities being served

Preventative Approaches
- provide opportunities for education of clients, communities and services providers
- promote early intervention aimed at preventing crises

**Integrated Case Management Process**

Integrated case management involves the following activities, which are usually sequential:

- Initiate an integrated case management process
- Identify a lead case manager
- Assess the individual
- Plan for recovery
- Monitor and evaluate throughout the recovery process
- Provide assistance as needed
- Transfer responsibility to client/other agencies and close the case

With integrated case management, documentation is critical for planning, monitoring and meeting client needs. When transferring to another agency, be sure to transfer relevant documentation such as file notes and case notes in accordance with your health region policy. Since several agencies are involved, accurate records must be maintained to ensure that all partners have relevant information. It is recommended that the following information be collected:

- A list of all agencies and/or persons involved and the contact number for each
- The client’s consent for each service and goal
- A list of goals, actions and responsibilities of each participating service agency
- Case transfers or closures
- Evaluation dates and outcomes
- A list of successes and challenges (Government of Saskatchewan, 1998).
COMMITTEE RECOMMENDATIONS

In order to implement the process of concurrent screening and assessment within Mental Health and Addiction Services in the Saskatoon Health region, the committee makes the following recommendations:

1. That there be a formal launch of this document, once approved by management, to highlight this initiative.

2. The local experts and interested stakeholders should be brought together with this committee to prepare presentations for in-service sessions. Pilot the use of the manual and contents on a small scale and revise as necessary.

3. Use in-service sessions to orientate staff to the contents and use of the manual. For in-service session it is recommended that local site expertise be used validating their role and knowledge. There would need to be a combination of mental health and addiction services personnel at each session.

4. Develop a schedule and provide resources for integration.

5. This manual could be promoted and coordinated with other initiatives (local and provincial) that are related to Mental Health and Addiction Services. This manual is timely as it connects with the Provincial Cross-Training Initiative, Project Hope initiatives, and the development of a new mental health facility within SHR.

6. The Integrated Team Service Model (Appendix D) be considered as an option for service implementation.
APPENDIX A

INTEGRATED TEAM SERVICE MODEL

Through the review of current best practices, research-based writings and group discussions, the MHAS Concurrent Model Working Group recommends that an integrated team be developed within Saskatoon Health Region to meet the needs of clients with severe, persistent concurrent disorders that cause major dysfunction in the clients’ life.

Health Canada’s Best Practices (Rush et al 2001) on concurrent disorders define treatment integration as “…. mental health treatment and substance abuse treatments are brought together by the same clinicians/support workers, or team of clinicians/support workers, in the same program, to ensure that the individual receives a consistent explanation of illness/problems and a coherent prescription for treatment rather than a contradictory set of messages from different providers (adapted from Drake and Mueser) [p. 15]).

Health Canada’s Best Practices (Rush et al 2001) recommends an integrated treatment approach for clients with the following diagnosis: co-occurring severe and persistent mental illness: schizophrenia, bipolar disorders, post traumatic stress syndrome, some personality disorders. (BP p. 54) As information is presented in guideline form and research is on going, clinical judgment on an individual case basis is needed to determine which clients require an integrated treatment approach or plan. “ …..this treatment plan may involve addressing the substance use and mental health disorders either concurrently or sequentially, but always in the context of a consistent and coordinated approach tailored to the unique needs and capacities of the individual.” (BP p. 80)

Team Description

The following is a description of an integrated team based on the format outlined in National Program Standards for ACT Teams, June 2003 (Assertive Community Treatment – ACT).

The clients that would require this service are currently on clinicians’ caseloads in MHAS. They are frequently seen by other services such the Brief Detox. Unit and Crisis Management Services. These clients cannot manage or comply with a recovery plan and need regular, consistent contact. There is a harm reduction focus of this client service. The Team offers the client skills/services so that the crises decrease and some form of stability can be maintained.

1. Client Criteria for Referral and Discharge

The admission criteria will include, but not be limited to, those clients who are diagnosed with mental health issues that are considered to be severe and persistent (i.e. schizophrenia, bipolar disorders, or complicated post traumatic stress disorder) and who are abusing or are dependent on substances (Health Canada, 2001 and Skinner, 2005)13. Clients, who have concurrent disorders outside of these diagnoses, will be considered for admission to the integrated team service when the following factors are noted.

- The client struggles with engagement in traditional services
- The client consumes large amounts of health care services
- The traditional mental health and addiction services have proven to be ineffective
- The client is unable to perform activities of daily living due to their mental health and substance use circumstances.
The team will, based upon thorough assessment and regardless of mental health diagnoses, determine with the referral agent and the client the most appropriate level (Reis’ typology) and type of service (serial, parallel or integrated).

Client’s discharge from the program will be dependent on numerous factors, including

- the client’s goals have been achieved and a more stable level of functioning has been noted,
- the client is able to function in their work/education and social life and perform activities of daily living without team support,
- or, if the client consistently declines the service or moves out of the health region.

Clients discharge will be supported by team members, the client themselves and interested stakeholders if at all possible.

As relapse is part of recovery for both disorders, treatment services may be long term.

2. Description of the Integrated Team

The integrated team will provide services to people with severe, persistent mental health disorders and substance dependency. The approach is client centered, oriented to recovery, empowers clients to be part of a collaborative process and individualizes the services to meet client needs. The consumer is a client of the team not one individual counsellor. The team will be located so as to increase engagement with the client population. The team will have the ability to have creative approaches in managing these clients. The team offers the majority of the service and has connections with the community to facilitate additional needs such as housing and income. The team will have an emergency response component through varied staffing hours and connecting with Mobile Crisis for late night emergencies. The team ensures there is a process of continuous care for the client during the service and upon discharge/referral from the service.

The actual client numbers are not known at this point, but it is believed that they are already on current caseloads. It is recommended that the caseload numbers be 8 – 10 clients per staff members and with gradual admission for the start up period. There will be a psychiatrist as part of the team but the team will liaise with the client’s current psychiatrist if they have one.

Staffing

- Team Leader/Clinical Supervisor/Liaison
- RPN/RN (1-2) – injection, medical management role
- Addiction Counsellor (1-2)
- MH Social Workers (1-2)
- Psychiatrist (minimum .5)
- Clinical Psychologist – Masters Level (possibly part time)
- MH Therapist
- Admin Support (screening calls, connect clients to team)
- RT and OT
• Peer Support Person – a person who has received this type of service in the past and is currently stable. They aid by providing experience that counsellors do not have and by ensuring client self-determination.
• Family Service Worker/Therapist
• Optional staff positions:
  - Research person (outcomes) – needs to be part of the team from the start to collect data pre and post service.
  - There is a possible need for a person dedicated to keeping the linkages and liaisons with the community and for education to MHAS on case managing clients in an integrated way. This role could be combined with the research function. Alternatively, this role may be the responsibility of the whole team and directed by the Team Leader.

3. Linkages

Potential referral sources and resources/client supports:

- MHAS services
- Rural MHAS teams (referrals both ways, consultation both ways)
- ER MH staff (works 3-11) and ER’s
- Pharmacy
- Employment counsellors/day jobs, DCREE Income & Security Worker (need strong easy access)
- Housing (includes MH Approved Home Operators, Housing Coalition)
- Mobile Crisis, Crisis Management
- Family Physicians
- ABI
- Early Intervention
- Faith based organizations
- 12 Step programs
- Cultural organizations
- Crocus Coop
- Salvation Army
- CMHA
- Larson House
- Food banks
- Criminal Justice
- Public Health (outreach, needle van, communicable disease)
- CPAS
- CBO’s
- CNIB
- Abilities Council
- Service Clubs
- Businesses (donations and employment opportunities)

Stakeholders Advisory Group

This group would include MHAS management, family members and clients. The feedback from family members and clients ensures that the team remains client focused. It is recommended that 51% of the membership be family members and clients. This would aid with the outcome procedure to know if the clients perceive that they are getting better.

4. Policy and Procedure Requirements

The initial starting point of the team is to develop policies, procedures, communication routes, build linkages and attend to team building.
5. **Program Organization and Communication**

- **Hours of Service:** Recommend plans for 24/7 coverage. The team would cover for certain hours and then have plans with Mobile Crisis and Crisis Management to cover the other hours.
- **Have someone on duty that takes after hour calls from ER, Crisis, for updates/consultations and communication (rotate this duty)**
- **Day/evenings full complement. During Nights there would be the linkage with Crisis Management. Weekend’s portion of the team available from 8 a.m. to midnight.**
- **Ideally, a variety of locations around the city could be utilized by the team as this clientele has functional difficulties getting to offices.**
- **Cell phones would be needed for communication and safety issues.**
- **There are transportation issues for the clients so bus tickets/passes need to be available.**
- **Transportation for staff is a requirement.**
- **Funding for clients to move out of unsafe homes to safer homes needs to be available. (See Linkages)**

6. **Outcomes**

The following items would indicate successful outcomes for the service.

- **Clients experience a reduction in risk factors and/or symptoms.**
- **The client is compliant with the prescribed medications, keeps appointments, and manages their work, social life and self-care.**
- **The client has reduced or no justice system involvement**
- **There are less admissions to intensive care units at hospitals**
- **There is decreased contact with the team (not as a result of getting sicker) or an increase in contact with the team (client willingness to engage)**
- **There is a significant decrease in substance use.**
- **Improved family environment is noted.**
- **Increase of Activities of Daily Living (ADL) is noted.**
- **The client is involved in a recovery program**
- **The client is living independently or moving into a group home**
- **The client has paid employment and/or volunteer work.**
- **Data analysis (quantitative and qualitative) will provide information on outcomes.**
- **Assessing client satisfaction is a key factor to obtain as an outcome measure.**
APPENDIX B

Recommended Readings:

- BEST PRACTICES: Concurrent Mental Health and Substance Use Disorders 2001 Health Canada, Ottawa
  - Rational For Best Practice Guidelines (Prevalence Studies) – P. 14 – 25
  - Best Practice in Screening for Substance Use and Mental Health Disorders – P. 28 – 39
  ISBN: 0-662-31388-7

- Centre for Addiction and Mental Health, Toronto, Ont.
  www.camh.net

- Co-occurring Mental Health and Substance Use Disorders Initiative [Winnipeg Region] Addiction Foundation of Manitoba www.afm.mb.ca/codi.html

- Substance Abuse and Mental Health Services Administration,(SAMSHA) U.S. Established 2003 www.samhsa.gov/centers/csat2002 Treatment Improvement Protocols #42

- Canadian Centre for Substance Abuse www.ccsa.ca

APPENDIX C

CAGE-AID\textsuperscript{14}

The CAGE is one of the oldest brief screening instruments. It is a simple 4-item yes/no substance screen that focuses on the consequences of use rather than the quantity or frequency of substance consumption.

CAGE-AID Test ( CAGE \textit{Adapted to Include Drugs})

<table>
<thead>
<tr>
<th>C</th>
<th>Have you ever felt you should \textbf{cut down} on your drinking or drug use?</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Have people every \textbf{annoyed} you by criticizing your drinking or drug use?</td>
</tr>
<tr>
<td>G</td>
<td>Have you ever felt \textbf{guilty} about your drinking or drug use?</td>
</tr>
<tr>
<td>E</td>
<td>Have you ever had a drink or used drugs first thing in the morning (an \textbf{eye opener} or early morning drink) to steady your nerves or get rid of a hangover or residual drug effect?</td>
</tr>
</tbody>
</table>

Scoring:

A “yes” to any of these questions indicates further assessment and intervention.

**Seniors** – It is recommended that the CAGE be used in conjunction with personal interviews with this client population. Through the personal contact, seniors become willing to disclose information that they perceive may reflect negatively upon themselves. Two additional suggestions are to insert the CAGE questions within other questions about alcohol consumption and to lower the cutoff score to one positive response.\textsuperscript{15}
### APPENDIX C

**CRAFFT\textsuperscript{16} (for adolescents)**

<table>
<thead>
<tr>
<th>C</th>
<th>Have you ever ridden in a <strong>car</strong> driven by someone (including yourself) who was high or had been using alcohol or drugs?</th>
</tr>
</thead>
<tbody>
<tr>
<td>R</td>
<td>Do you ever use alcohol or drugs to <strong>relax</strong>, feel better about yourself, or fit in?</td>
</tr>
<tr>
<td>A</td>
<td>Do you ever use alcohol or drugs while you are by yourself <strong>alone</strong>?</td>
</tr>
<tr>
<td>F</td>
<td>Do you ever <strong>forget</strong> things you did while using alcohol or drugs?</td>
</tr>
<tr>
<td>F</td>
<td>Do your <strong>family</strong> or <strong>friends</strong> ever tell you that you should cut down on your drinking or drug use?</td>
</tr>
<tr>
<td>T</td>
<td>Have you ever gotten into <strong>trouble</strong> while you were using alcohol or drugs?</td>
</tr>
</tbody>
</table>

**Scoring:**

2 or more positive items indicate the need for further assessment.
APPENDIX C

T-ACE

The T-ACE is a widely used screening tool. In addition, this tool is recommended for use with women as a starting point to prevent or reduce the harm of substance use that may pose a risk to the fetus/offspring.

The T-ACE questions are:

<table>
<thead>
<tr>
<th>Tolerance</th>
<th>How many drinks does it take to make you feel high/feel the effects of alcohol? Record the number of drinks _________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annoyed</td>
<td>Have people annoyed you by criticizing your drinking? Yes _____ No _____</td>
</tr>
<tr>
<td>Cut Down</td>
<td>Have you felt that you ought to cut down on your drinking? Yes _____ No _____</td>
</tr>
<tr>
<td>Eye Opener</td>
<td>Do you ever have an eye-opener (a drink first thing in the morning) to steady your nerves or get rid of a hangover? Yes _____ No _____</td>
</tr>
</tbody>
</table>

Scoring:

T question: ___ score 2 points if the person indicates 3 drinks or more.

A, C and E: ___ score 1 point for a positive (yes) response.

Two or more points equal a risk of a drinking problem.
## APPENDIX C

### TWEAK

| **Tolerance** | How many drinks does it take to make you feel high?  
| Two or more drinks = 2 points |
| **Worry** | Have close friends **worried** or complained about your drinking in the past year?  
| Yes = 1 point |
| **Eye-Opener** | Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?  
| Yes = 1 point |
| **Amnesia** | Has anyone ever told you about things that you said or did while you were drinking that you did not remember?  
| Yes = 1 point |
| **K cut-down** | Have you felt you ought to **cut down** on your drinking?  
| Yes = 1 point |

**Scoring:**

Two or more points equals risk of a drinking problem.
APPENDIX C

SIX “FLAG” QUESTIONS

If enough of the subtle signs of problem gambling are present, a helper could open up the gambling issue with some initial gambling questions.

If two or more of these are flagged by positive response, further assessment would be indicated.

1. Do you ever gamble?

2. Have you ever felt the need to cut down on your gambling?

3. Have you ever felt annoyed by criticisms of your gambling practices?

4. Have you ever had guilty feelings about your gambling?

5. Have you ever borrowed money from friends, family members or from work to help finance your gambling?

6. Have you ever gambled until all your money was gone?
APPENDIX C

Mental Health Screening Form III

Guidelines for using the Mental Health Screening Form III:

The MHSF-III was initially designed as a rough screening device for clients seeking admission to substance abuse treatment programs.

Each MHSF-III question is answered either “yes” or “no”. All questions reflect the respondent’s entire life history; therefore all questions begin with the phrase “Have you ever...”

The preferred mode of administration is for staff members to read each item to the respondent and get their “yes” and “no” responses. Then, after completing all 18 questions (question 6 has two parts) the staff member should inquire about any “yes” response by asking “When did this problem first develop?”, “How long did it last?”; “Did the problem develop before, during or after you started using substances?”; and, “What was happening in your life at that time?”. This information can be written below each item in the space provided. There is additional space for staff member comments at the bottom of the form.

The MHSF-III can also be given directly to the client to complete, providing they have sufficient reading skills. If there is any doubt about someone’s reading ability, have the client read the MHSF-III instructions and question number one to the staff member monitoring this process. If the client can not read and/or comprehend the questions, the questions must be read and/or explained to him/her.

Whether the MHSF-III is read to a client or s/he reads the questions and responds on his/her own, the completed MHSF-III should be carefully reviewed by a staff member to determine how best to use the information. It is strongly recommended that a qualified mental health specialist be consulted about any “yes” response to questions 3 through 17. The mental health specialist will determine whether or not a follow-up, face to face interview is needed for a diagnosis and/or treatment recommendation.

The MHSF-III features a “Total Score” line to reflect the total number of “yes” responses. The maximum score on the MHSF-III is 18 (question 6 has two parts). This feature will permit programs to do research and program evaluation on the mental health-chemical dependence interface for their clients.

The first four questions on the MHSF-III are not unique to any particular diagnosis; however, questions 5 through 17 reflect symptoms associated with the following diagnoses/diagnostic categories: Q5, Schizophrenia; Q6, Depressive Disorders; Q7, Post-Traumatic Stress Disorder; Q8, Phobias; Q9, Intermittent Explosive Disorder; Q10, Delusional Disorder; Q11, Sexual and Gender Identity Disorders; Q12, Eating Disorders (Anorexia, Bulimia); Q13, Obsessive-Compulsive Disorder; Q14, Panic Disorder; Q15, Obsessive-Compulsive Disorder; Q16, Pathological Gambling; Q17, Learning Disorder and Mental Retardation.

The relationship between the diagnoses/diagnostic categories and the above cited questions was investigated by having four mental health specialists independently “select the one MHSF-III question that best matched a list of diagnoses/diagnostic categories.” All of the mental health specialists matched the questions and diagnoses/diagnostic categories in the same manner, that is, as we have noted in the preceding paragraph.

A “yes” response to any of questions 5 through 17 does not, by itself, insure that a mental health problem exists at this time. A “yes” response raises only the possibility of a current problem, which is why a consult with a mental health specialist is strongly recommended.
Mental Health Screening Form III

Instructions:

In this program, we help people with all their problems, not just their addictions. This commitment includes helping people with emotional problems. Our staff is ready to help you to deal with any emotional problems you may have, but we can do this only if we are aware of the problems. Any information you provide to us on this form will be kept in strict confidence. It will not be released to any outside person or agency without your permission. If you do not know how to answer these questions, ask the staff member giving you this form for guidance. Please note, each item refers to your entire life history, not just your current situation, this is why each questions begins – “Have you ever…”

1. Have you ever talked to a psychiatrist, therapist, social worker, or counsellor about an emotional problem?  
   YES   NO

2. Have you ever felt you needed help with your emotional problems, or have you had people tell you that you should get help for your emotional problems?  
   YES   NO

3. Have you ever been advised to take medication for anxiety, depression, hearing voices, or for any other emotional problem?  
   YES   NO

4. Have you ever been seen in a psychiatric emergency room or been hospitalized for psychiatric reasons?  
   YES   NO

5. Have you ever heard voices no one else could hear or seen objects or things which others could not see?  
   YES   NO

6. a) Have you ever been depressed for weeks at a time, lost interest or pleasure in most activities, had trouble concentrating and making decisions, or thought about killing yourself?  
   YES   NO

   b) Did you ever attempt to kill yourself?  
   YES   NO

7. Have you ever had nightmares or flashbacks as a result of being involved in some traumatic/terrible event? For example, warfare, gang fights, fire, domestic violence, rape, incest, car accident, being shot or stabbed?  
   YES   NO

8. Have you ever experienced any strong fears? For example, of heights, insects, animals, dirt, attending social events, being in a crowd, being alone, being in places where it may be hard to escape or get help?  
   YES   NO

9. Have you ever given in to an aggressive urge or impulse, on more than one occasion, that resulted in serious harm to others or led to the destruction of property?  
   YES   NO
10. Have you ever felt that people had something against you, without them necessarily saying so, or that someone or some group may be trying to influence your thoughts or behavior? 
   YES   NO

11. Have you ever experienced any emotional problems associated with your sexual interests, your sexual activities, or your choice of sexual partner? 
   YES   NO

12. Was there ever a period in your life when you spent a lot of time thinking and worrying about gaining weight, becoming fat, or controlling your eating? For example, by repeatedly dieting or fasting, engaging in much exercise to compensate for binge eating, taking enemas, or forcing yourself to throw up? 
   YES   NO

13. Have you ever had a period of time when you were so full of energy and your ideas came very rapidly, when you talked nearly non-stop, when you moved quickly from one activity to another, when you needed little sleep, and believed you could do almost anything? 
   YES   NO

14. Have you ever had spells or attacks when you suddenly felt anxious, frightened, uneasy to the extent that you began sweating, your heart began to beat rapidly, you were shaking or trembling, your stomach was upset, you felt dizzy or unsteady, as if you would faint? 
   YES   NO

15. Have you ever had a persistent, lasting thought or impulse to do something over and over that caused you considerable distress and interfered with normal routines, work, or your social relations? Examples would include repeatedly counting things, checking and rechecking on things you had done, washing and rewashing your hands, praying, or maintaining a very rigid schedule of daily activities from which you could not deviate. 
   YES   NO

16. Have you ever lost considerable sums of money through gambling or had problems at work, in school, with your family and friends as a result of your gambling? 
   YES   NO

17. Have you ever been told by teachers, guidance counsellors, or others that you have a special learning problem? 
   YES   NO

________________________________________________________________________

Print Client’s Name: ___________________________ Program to which client will be assigned: ______________

Name of Admissions Counsellor: ______________________ Date: __________________________

Reviewers Comments: _______________________________________________________

________________________________________________________________________

APPENDIX C
BASIS plus

There are two surveys that may be used in on-going screening with clients. Information about the instruments and a review of the questions contained in the surveys is available at the following website.  www.basissurvey.org.

Michigan Alcoholism Screening Test (MAST) and the Drug Abuse Screening Test (DAST)

These are recommended as on-going screening tools. The Health Canada Best Practices on Concurrent Disorders (P. 13) recommends the use of these instruments.  *Permission to copy these instruments into this document will need to be obtained*
## APPENDIX D

### SASKATOON HEALTH REGION
MENTAL HEALTH AND ADDICTIONS SERVICES

### INDIVIDUAL SERVICE PLAN WORKSHEET
(Use additional sheets, as necessary)

<table>
<thead>
<tr>
<th>Date</th>
<th>Name ____________________________</th>
<th>HSN ____________________________</th>
<th>DOB ____________________________</th>
<th>Intake Number ____________________________</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Need Category / Current Situation</th>
<th>Goals (What do you / we want to see happen?)</th>
<th>Strategies / Interventions (What is it that you / we are going to do?)</th>
<th>Timing / Responsibility (Who will do what, when, and for how long / how will we know when we are done?)</th>
<th>Outcomes (What happened? Did the plan work?)</th>
</tr>
</thead>
</table>

### Need for Service Categories for Adult Clients

1. Emotional and Mental Well Being
2. Substance Use and Problem Gambling
3. Danger to Self or Others / Personal Safety
4. Spirituality
5. Stressful Life Events / Trauma
6. Physical Health
7. Medication Management
8. Daily Living Skills
9. Personal Response to Illness / Problems, Substance Use, Problem Gambling
10. Family / Caregiver Concerns
11. Friendship / Social Relationships
12. Recreation / Leisure
13. Work / Education
14. Income
15. Housing
16. Legal / Advocacy Issues
APPENDIX D

Saskatoon Health Region
Mental Health and Addiction Services

Name _____________________
HSN _____________________
DOB _____________________

Service: ________________
DOB day/month/year

Site: ________________
Intake Number ______________

Individual Service Plan (ISP)

Primary Worker / Case Manager: ___________________________

Consent obtained to release ISP information to distribution list: Yes ___
Consent obtained to place ISP information on the S-Drive: Yes ___

Presenting Issues / Problems to be Addressed / Relevant Circumstances:

Priority Needs Identified:

Outcomes to Date:

Outcomes Yet to be Achieved:
Individual Service Plan
(Page 2)

Name ________________
HSN ________________
DOB ________________
day/month/year
Intake Number _________

Primary Community Supports (Formal and Informal):

Maintenance and Relapse Prevention Plan:

Emergency / Crisis Intervention Plan:

ISP Distribution List:

<table>
<thead>
<tr>
<th>Name</th>
<th>Fax/Mailing Address</th>
<th>Date Sent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Completed by: __________________________   Date: ________________
Next Review Due by: ____________________
APPENDIX E

References:

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   Problems in Alcohol/Other Drug Dependent Persons, Alcoholism Treatment Quarterly, Vol. 19
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