



Centre for Addiction and Mental Health  
Centre de toxicomanie et de santé mentale

Concurrent Disorders  
Knowledge Exchange Area:  
Training Strategy Project  
2003-04

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# Enhancing Concurrent Disorders Knowledge in Ontario

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A Report of the Concurrent Disorders Training  
Strategy Work Group

*April 2004*

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## Executive Summary

Concurrent disorders (CD) was identified as a priority area for the Centre for Addiction and Mental Health in 2002. In line with this recognition, the Concurrent Disorders (CD) Knowledge Exchange Plan was developed to improve the application of research-based knowledge on concurrent disorders in assessment, screening, stigma, treatment, family support, system planning and program modelling. Under this plan, a Training Strategy Project was also struck in 2003 to identify CD training issues and make recommendations for an Ontario-wide training system. This document describes the work of this project.

The Training Strategy Work Group comprises six CAMH employees with backgrounds in CD therapy, consultation, and education and publishing. The work group first developed a framework for developing a training and education strategy. Then, members undertook a literature review, analysed an existing CAMH CD training initiative and conducted a survey of key informants. The work group then developed a number of recommendations and strategies to improve CD training in Ontario, both in CAMH and externally.

The framework that guided the process called for defining the workplace context, the audience that needs training, existing competencies and gaps, and goals. This was used as a basis for understanding training needs and developing appropriate strategies, in terms of formal education programs, brief workshops and conferences, or informal knowledge exchange such as online discussion forums.

The literature review revealed the differences between the mental health and substance use systems in terms of training, knowledge and perspectives. The literature suggested that training could break down barriers, but mechanisms were needed to share knowledge, provide access to training and ensure that the information learned was sustainable. Some strategies that were recommended to build competency were: cross training between experts from different agencies; shared training between agencies; ongoing consultation from a multi-disciplinary team of experts; running workshops; using Internet technology; training the trainer; and producing practice guidebooks for consistency in care. It was also recognized that training should be customized to suit audience needs. For training curricula, it was recommended to include attitudes and values training, consumer and family involvement, standards and practice guidelines, and measurable outcomes. Finally, certification was recommended for all levels of professionals.

The case study involved a CD training initiative with the Schizophrenia Program and Concurrent Disorders (CD) Service at CAMH. Through a proposed 50-50 split of trainers from both programs, a key goal was to increase the Schizophrenia Program staff's competency in concurrent disorders and develop their ability to train colleagues in their program themselves. The training was rated highly and increased motivation for some Schizophrenia Program staff to complete further training in CD. Two CD groups were also implemented in the Schizophrenia Program as a result. There were some challenges in achieving the 50-50 split due to training resource deficiencies, so a smaller fraction of Schizophrenia Program staff were involved in training. Also, on two occasions registration targets were not met and training had to be cancelled, possibly because training changed from "mandatory" to "optional, but recommended" status. As a result of this experience, the importance of strong leadership, team-specific training, program-specific needs assessment, requirement for mandatory training, and a multi-modal training design became evident. Different training levels for basic versus specialized capabilities were also recommended. The case study also reinforced the value of standardized content, participant reference materials, evaluation, and the recognition of professional development.

The key informant survey involved interviews with 24 professionals with expertise in CD, both at CAMH and externally. Eight questions based on the framework described earlier

were posed to key informants. Some of the training issues they identified were silos between the two fields, lack of policy framework for CD, and the complexity of care. Suggested training solutions included cross training, experiential education and apprenticeships, understanding the audience, and tackling attitudes and stigma. Key informants expressed a preference for training delivered as formal education, followed by informal learning, and brief workshops or conferences. They felt CAMH should take the lead in CD training, while some also suggested partnerships with other organizations, such as the Canadian Mental Health Association, Ministry of Health and Long-Term Care (MOHLTC), universities and colleges. All key informants were interested in learning from the experiences in other provinces and countries.

Overall, the work group found a consensus in the literature, CAMH case study and key informant survey. With regards to context and audience, it was recognized that CD treatment is currently fragmented and that the second disorder often goes undiagnosed in a person presenting with an addiction or mental health problem. Training was seen as a way of improving assessment or screening among service providers. The work group identified a range of professionals as those who could benefit from CD training, including front-line mental health and addiction staff, family doctors, corrections staff, and others. Other important aspects of training identified were dealing with attitudes, delivering creative approaches with long-term follow through, and recognizing the training. Finally, it was acknowledged that the lack of resources was a recurring issue to implement effective training.

Based on this information, the work group developed 26 recommendations in the areas of leadership, resourcing, content/competencies and delivery. A key recommendation in terms of leadership is that CAMH should work with the MOHLTC to support and endorse training, policy development and system integration. In addition, it was deemed important for CAMH to provide recognition for training through certificates and in performance appraisals, develop a CD assessment "tool kit," and work broadly for recognition of training and inclusion of training in relevant college and university programs.

With regard to resourcing, key recommendations included broadening the pool of faculty, using train-the-trainer strategies where appropriate, funding resources for training, including people in recovery, and budgeting for backfill costs, using cross training or shared training.

The work group tackled the issue of content/competencies by profession, identifying five key categories of professional: CAMH/community mental health and addictions clinicians; clinical professionals (family doctors, ER doctors, nurses, EAP clinicians); allied professionals (corrections, income support, intake workers, shelter workers, etc); managers and administrators; and DHC and MOHLCT staff. Under each category of professional, recommendations were made about level of skill needed (capable vs. specialized), knowledge and attitudes.

The work group recommended adopting a variety of methods for training and education, including cross training, workshops and conferences, e-learning, grand rounds and experiential education. It was also recognized that evaluation and audience needs assessment should occur continually to ensure learning outcomes are met.

The CD Training Strategy Project will continue its work in 2004-2005. The objective for this second phase is to build on the recommendations of the report. An Implementation Committee, consisting of members of the work group, will be set up to monitor the implementation of the recommendations. In addition, the work group will begin to develop partnerships with post-secondary institutions to enhance CD training throughout the province.

## Introduction

*“There is such a demand for CD training. This is a wonderful indication that people are recognizing how prevalent and important it is.”<sup>1</sup> (KI)*

The Training Strategy Project is one of seven projects of the 2003-4 Concurrent Disorders (CD) Knowledge Exchange Plan at the Centre for Addiction and Mental Health (CAMH). The plan aims to improve the application of research-based knowledge on concurrent disorders. The Training Strategy Project Work Group met for the first time in July 2003.

The mandate of the work group was to develop plans to improve the effectiveness and extent of training in concurrent disorders treatment in the province of Ontario.

Our objectives were to identify CD training issues, discuss and propose next steps, build on past and current efforts and make recommendations that will contribute to a comprehensive training strategy for Ontario. Our hope is to increase system capacity to provide service to people with concurrent disorders.

The Training Strategy Work Group in 2003-04 consisted of the following CAMH employees<sup>2</sup>:

- Elizabeth Hendren-Roberge, Education and Publishing Consultant, North Region; Project Lead, CD Training Strategy Project
- Christine Bois, Knowledge Exchange Manager for Concurrent Disorders
- Betty Dondertman, Manager, Publishing and Continuing Education
- Sylvie Guenther, Project Consultant, North Region
- Megan McCormick, Therapist II, Youth Addiction Service and CD Service
- Andrea Tsanos, Service Manager, Concurrent Disorders Service

*“A plan is a great thing but it’s just words on paper unless someone is dedicated to making it happen. CAMH and the training people in particular need to step up to the plate and say ‘we’re going to do this and we’re going to do this right’...” (KI)*

This report describes the work of the CD Training Strategy Work Group in 2003-04, including recommendations to build a CD training strategy.

We begin by defining the term “concurrent disorders” in Ontario and explaining the role of CAMH’s Concurrent Disorders Knowledge Exchange area. Next we present a framework for developing a training and education strategy. To help us formulate our recommendations for training initiatives, we undertook a literature review, analysed an existing CAMH CD training initiative and conducted a survey of key informants. Results are presented here. Finally, we outline our recommendations and strategies for improving CD training within and external to CAMH.

## What are Concurrent Disorders?

The definition of concurrent disorders (CD) approved for use by all CAMH Concurrent Disorders Knowledge Exchange projects is as follows:

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<sup>1</sup> This and other highlighted passages in this report are direct quotations from either the key informants (KI) interviewed by the work group or from the evaluation (E) of the Schizophrenia Concurrent Disorders Training Program.

<sup>2</sup> The committee wishes to thank Anita Dubey for her editing assistance.

"The concurrent disorders population refers to those people who are experiencing any combination of mental health and substance use disorders."

In the U.S., this population is referred to as having a "dual diagnosis" (which in Canada refers to a concurrent mental illness and developmental disorder). Other terms commonly used in the U.S. and other English-speaking countries are "co-occurring" or "comorbid" disorders.

*"People are no longer as dismissive of CD as they were before. Mental health folks thought addiction was scary, and vice versa, and this stigma and ignorance were due to not knowing about it." (KI)*

Since the diagnosis of concurrent disorders encompasses numerous combinations of mental health and addiction issues with a broad spectrum of symptom severities, developing and promoting a common language to describe the range of CD symptoms and their treatment is of key importance. The work group hopes that along with this process, there will be a natural corollary of increasing training opportunities that will enable practitioners from separate disciplines and job descriptions to engage in clear, useful dialogue.

*"We need to recognize that two people with CD are as different from each other as anyone else." (KI)*

## The Concurrent Disorders Knowledge Exchange Area

*"There is no wrong door for service. We don't need the same door for everyone; we do need different doors, but everyone needs to provide service that recognizes and identifies CD." (KI)*

Concurrent disorders (CD) was identified as one of three priorities for CAMH through an extensive strategic planning and consultation process with stakeholders across Ontario in 2002. Within the Communication, Education and Community Health Division (CECH), the term "knowledge exchange" is used to describe the application of research-based knowledge. It emphasizes the reciprocal nature of the process as opposed to more traditional, hierarchical notions of one-way "knowledge transfer."

Other projects in the CD Knowledge Exchange area will also yield important insights to help shape training initiatives in Ontario. These projects include:

### **The CD Family Project**

This project is intended to improve the quality of life for family members of people with concurrent disorders through the provision of a peer support/ psychoeducational group intervention model.

### **The CD System Planning Project**

This project is intended to improve system integration in communities to provide service to people living with CD. Nine System Planning Consultants are involved with CD planning groups across Ontario.

### **The CD Program Models Project**

A survey of 15 CD programs in Ontario and other jurisdictions has been completed as part of this project, and members are developing a report summarizing these programs and their "program ingredients."

### **The CD Screening and Assessment Tools Project**

This project aims to increase the clinical ability to identify those living with concurrent disorders. A provincial advisory committee provides direction and support to screening initiatives.

### **Stigma Project**

This project addresses the barrier of stigma that prevents those with concurrent disorders from accessing services. The group will develop and disseminate an interactive presentation package to address values and attitudes to be used by service providers in various contexts across Ontario.

### **Concurrent Disorders Screener**

This project is intended to assess the use of reliable, brief and easy-to-administer screening tools to indicate whether clients should have more detailed assessments for addiction and/or mental health problems. Two programs are pilot sites for this research.

### **Handbook Project**

CAMH will produce a handbook entitled "Treating Addiction and Mental Health Problems Concurrently," as another resource for clinicians.

The CD Knowledge Exchange Area has a Planning and Implementation Committee consisting of both CAMH staff and external people. This committee provides advice on the projects and their implementation. They have also provided feedback for the training strategy project.

# Framework for developing an education and training strategy

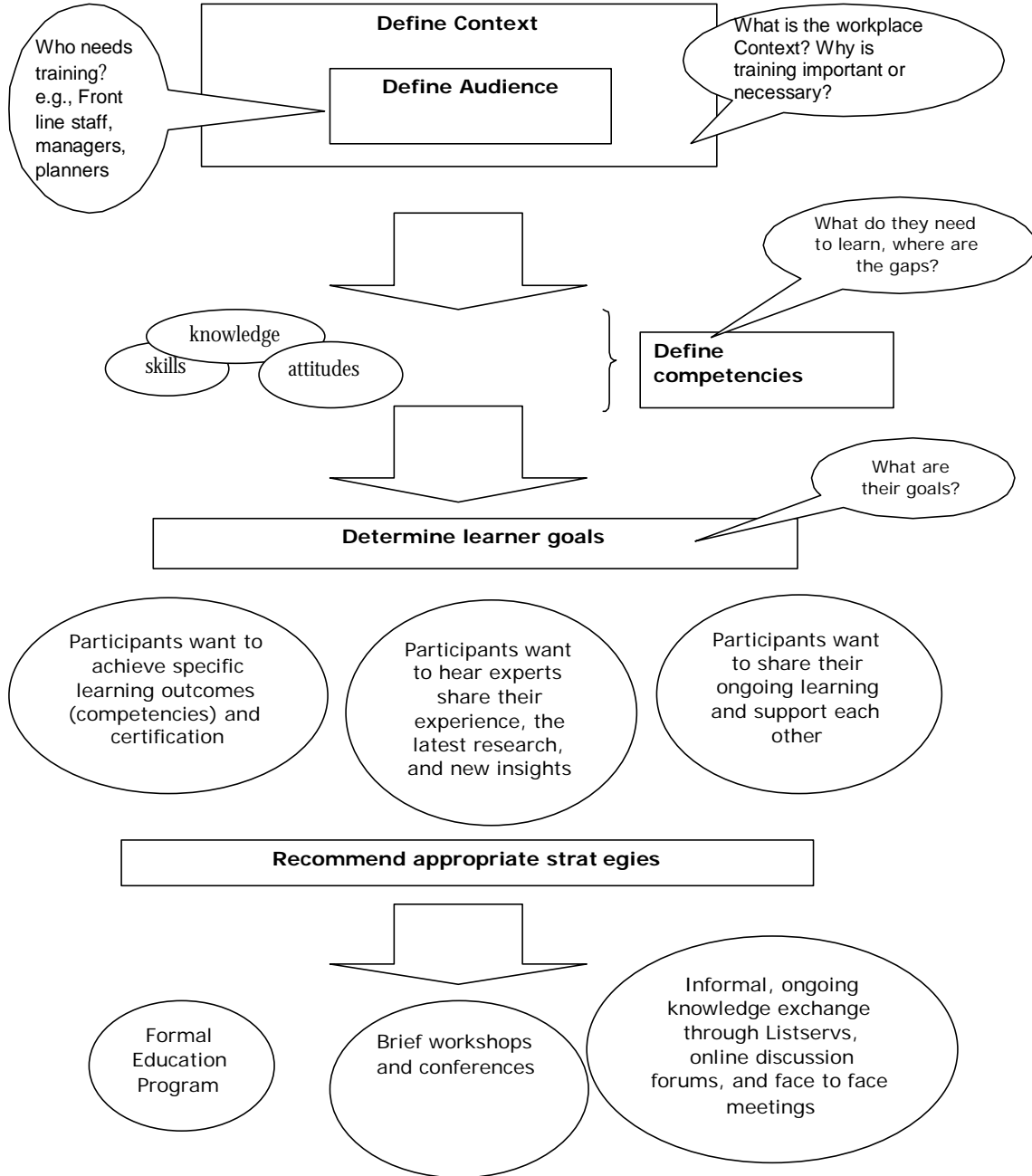


Figure 1. Framework for developing an education and training strategy

Figure 1 shows the key questions that the Training Work Group addressed to determine who needed training and education, what knowledge was needed and how it should be delivered. Each area was addressed through the following activities:

**Defining context and audience:** A substantial body of knowledge already exists that sheds light on these questions. In addition, the literature review and the responses from the key informant survey informed this area.

**Defining competencies and determine learner goals:** These questions were addressed through the literature review, evaluation feedback from the CD capacity-building training and the key informant survey.

**Determining appropriate training delivery strategies:** The key informant survey, CD capacity-building training evaluation, and the literature review informed these questions.

### A note about training vs. education

While the terms 'training' and 'education' are often used interchangeably, they are not the same.

*Training consists in the memorizing of bodies of knowledge and the acquisition of skills (theoretical and practical) without reflective, critical understanding. Intellectual disciplines as well as vocational preparation can consist in nothing more than training. Education, in contrast, is distinguished by the application of critical inquiry to significant issues and the related concepts and theories. In education, learners actively construct their knowledge rather than being passive recipients of a body of beliefs dutifully packaged and conveyed by teachers. (Crittenden, 1992)*

The work group addressed issues for both education and training initiatives.

## Literature Summary

The work group completed an extensive literature review on CD and related training issues, which included perspectives from Australia, the U.S, the U.K., and other Canadian provinces. Education and Training were consistently listed as vital program components to CD programs. The full bibliography is included in the reference list. We have drawn some of our conclusions from these readings.

The CD Best Practices document (Health Canada, 2001) states that professional training; experiential knowledge and perspectives differ between mental health and substance use systems. Some barriers between the two systems are a result of the separate training and development in the two fields. Training can play a role in bringing the systems together (i.e., in coordinating and communicating across the systems).

It is best to customize the training to the unique needs of the clinical staff working in these programs. Knowing more about clinicians' readiness and needs helps trainers to increase clinicians' capacity to screen, assess and treat people with concurrent disorders.

Practitioners need a mechanism to share information and lessons learned. Training and education must be a cornerstone of concurrent disorders program and system development.

Agencies and organizations need resources and funding to gain access to training. They need bottom up leadership and networks in relation to knowledge transfer and/or training. A healthy mix of top-down commitment and bottom-up linkages is suggested (Health Canada, 2001).

A policy framework is integral to provide guidelines and approaches to certification, establishing credentials, and accountability. This allows for consistency.

The literature described a need for a Concurrent Disorders Resource Centre that would provide a central access place where knowledge, information and Best Practices could be shared. This would include all aspects of CD: networking, leadership and building strengths.

The literature consistently outlined ways to ensure that the information learned would be sustainable.

## Competency building

Here are some strategies to consider for competency building suggested by the literature:

- **Cross training:** Experiential learning acquired through cross training, co-location, job shadowing and/or a “staff swap” is beneficial. This type of training occurs when staff from one agency trains service providers from another agency. An example would be an addiction therapist working in a mental health program for a set time period, who then brings his/her new knowledge to the agency of origin. This type of arrangement can also include consultations. Front-line workers can also train each other through presentations, brown bag lunches, site visits, sitting in on a session with their clients at other services, or observing client interventions conducted by other workers. The creation of workgroups and/or networks can assist this process. Staff can also share program-related information in staff meetings, grand rounds, workshops, forums, conferences, newsletters and social activities. If only one staff can attend a training event, that person can share the information with their team.
- **Shared training:** This occurs when a training event is organized by one agency that invites service providers from another agency or agencies. There could be different cost sharing arrangements (e.g., the second service would not be charged a cost, or resources from different agencies could be pooled).
- **Ongoing consultation:** Creating access to technical clinical support ensures that learning and support does not end with the training event. A multi-disciplinary team of experts should be available to consult and provide ongoing supervision to clinical teams for patient and treatment issues. Clinicians learn best through a longitudinal process of acquiring skills, practicing skills, getting feedback and refining skills.
- **Motivation:** People are more motivated to engage in programs that are accredited or certified; this requires formal curricula development and credentialing.
- **Workshops and Conferences:** These can be useful to inform service providers about resources and referral criteria, and to educate staff about screening and assessing for CD, motivating clients to get treatment, and strategies for working with the CD population.
- **Use of technology in training:** For ongoing support, a Canadian-based Web site could complement a CD resource centre. Other Web-based ideas include e-learning, tele-psychiatry, online CD Journal Clubs and a CD Network of Providers and Programs through listservs.
- **Train the trainer:** Use opportunities to increase the pool of trainers available.
- **Guidebooks:** Books that describe clinical and practice guidelines would help to create consistency in service delivery.
- **Tools:** There was an identified need for training and education in clinical assessment (e.g., an assessment tool), as well as the need for a valid CD screening tool.

## Levels of Training

The training should be customized to suit the audience; mental health and addiction service providers have different needs. Two different levels of training are also required. Basic training gives clinicians a working knowledge of CD issues such as assessment, basic interventions and motivational interviewing. Advanced training includes the competencies above, plus specialized knowledge in assessment methods and procedures, treatment programs, consultation to service providers, and conducting clinical research in concurrent disorders.

These same themes were repeated throughout the literature. In addition, consumers and their family members can be powerful trainers.

## Training Curricula

The Co-Occurring Mental and Substance Disorders Panel (Minkoff, 1998) in the U.S. suggests that there is no model curriculum. However, the panel recommends including the following four elements in CD curriculum design:

- 1) Attitudes and values must be a specific focus of training interventions; development of knowledge and skills alone is not sufficient for establishment of appropriate attitudes. Overt and covert biases about all aspects of individuals with co-occurring disorders must be systematically addressed.*
- 2) Consumer and family involvement in the training process is essential to establishing sensitivity to consumer/family perspectives, understanding the importance of empathic detachment, and experiencing the process and promise of recovery.*
- 3) Systems standards, practice guidelines, and relevant literature regarding co-occurring disorders, as defined in this document and elsewhere must be formal parts of the curriculum.*
- 4) Specific dual diagnosis competencies (attitudes, values, knowledge, and skills), as outlined herein, should be identified as specific measurable outcomes of each curriculum module.*

## Certification

The same panel recommends establishing certification for all levels of professionals, case managers and addiction counsellors.

*Certification as a 'dual diagnosis clinical specialist' is a natural incentive for clinicians who successfully complete training in an organized curriculum, and demonstrate attainment of recommended competencies. In addition, dual diagnosis certification creates a standard for demonstrating that staff in programs serving dually diagnosed consumers have attained the necessary level of competency to provide quality care. (Minkoff, 1998)*

## Case Study: CAMH CD Capacity-Building Initiative

The experience of this pilot program provided valuable information and insights to the work group.

### CD Capacity-Building Initiative background

Currently clients must physically attend the Russell Street site to receive concurrent disorders treatment. However, it is preferable to offer CD treatment to clients in their existing programs where they are comfortable and have relationships with staff. As the consolidation of CAMH programs to the Queen Street site is not expected for five to 10 years, interim solutions are needed. CAMH's mission statement reflects a commitment to providing comprehensive, well co-ordinated, accessible care for people with addictions and mental illness.

The Schizophrenia Program was selected as the pilot program for CD capacity-building at CAMH for two reasons: (1) Roughly 50% of people with severe mental illness will meet criteria of a concurrent substance use disorder in their lifetime. Therefore, this program already attracts clients with concurrent disorders. (2) Because schizophrenia is a chronic mental illness, it makes more sense to build CD capacity directly in a program to which clients are expected to have long-term connections.

A needs assessment survey was administered to the entire Schizophrenia Program staff in 2001. The results showed a need for more information about concurrent severe mental illness and substance use disorders, skills training to work with these clients and improved linkages between services.

A pilot training event was then carried out the same year with two clinical programs within the broader Schizophrenia Program. The program has 465 clinical inpatient and outpatient staff. To date, 215 (46%) staff members have received CD training.

The CD Capacity-Building Initiative outcomes include:

- (1) advancing the agenda of integration within CAMH
- (2) offering the opportunity to further professional growth of staff developing basic-level competencies
- (3) distributing the clinical capacity to work with clients with concurrent disorders more broadly
- (4) reducing the burden on limited staff members in the Concurrent Disorders Service.

### Strengths of the CD Capacity-Building Initiative

**Highly Rated Training Evaluations:** The training evaluation results have consistently yielded highly favourable ratings on all aspects of the training.

*"I liked the comprehensive content, knowledgeable presenters, the group participation. I have most enjoyed sharing of experiences, perspectives, approaches and creative thinking." (E)*

*"I really enjoyed this two-day course. It provided me with an insight, which would make me think carefully about my approach to my patients with concurrent disorders. For example, I did not have a positive attitude about harm reduction prior to the course. A very good, insightful course." (E)*

*“What I liked best about the workshop is that I learned or gained new perspectives on CD which would benefit (me) greatly when dealing with clients. Issues (that) one never gave thought to have suddenly become important. I shall readily recommend this workshop to my peers.” (E)*

**Staff dedication:** A motivated training team was assembled without new resource allocation and within existing, busy workloads. These staff members developed the content and course design, taught the material, and met to review evaluations. This initiative would not be possible without their contribution.

**Motivation for further learning:** As a result of the training, six Schizophrenia Program staff became interested in CD and completed the CDS Action Trainee Program. In this program, they attended an eight-session weekly therapy group for clients with concurrent severe mental illness and substance use problems. Schizophrenia Program staff sat in the group as a 3<sup>rd</sup> co-facilitator to make direct clinical interventions, rather than sitting behind a one-way mirror. This experience demystified what is involved in facilitating a concurrent disorders group and gave clinicians hands-on skills and confidence. Staff needed approval from supervisors for the time away from their service.

**Development of novel clinical service:** Trainers who were part of the CD Capacity-Building Team developed and implemented two concurrent disorders groups within the Schizophrenia Program. One was located at Archway, a satellite program, and the other was at the Queen Street site. In one case, the Schizophrenia Program clinician leading the group completed the CDS Action Trainee Program. In the second, a therapist from the CD Service co-facilitated the group for three months to support the clinician. As per this model, after the CDS therapist cycles out of the group, it becomes a training opportunity for another Schizophrenia Program clinician to co-facilitate, and the group is led by Schizophrenia Program staff. Staff from the CD Capacity-Building Team who work in the CD Service act as consultants to Schizophrenia group facilitators.

**Ongoing research evaluation:** An important component has been a study, underway since June 2003, entitled, “Evaluation of a Capacity-Building Staff Training Initiative in Concurrent Severe Mental Illness and Substance Use Disorders.” (O’Grady & Tsanos, in progress). An evaluation tool, the Training and Support Needs Questionnaire (TSNQ), (Maslin et al, 2001) is administered before the CD training and again after completion (see Appendix C). In addition, there is a qualitative component involving a 10-minute audio taped interview with staff who have consented to participate. The first part of the study seeks to evaluate the effectiveness of training staff in the Schizophrenia Program, while the second part seeks to evaluate whether client outcome has been enhanced because of the training. The desired sample size is 196 staff.

## Challenges with the CD Capacity-Building Initiative

**Acquiring Staff/ Faculty Resources-50-50 collaboration:** CD staff members, with their competing demands for training, are not able to commit significant resources to every clinical program at CAMH.

*“Faculty availability... there are eight staff in the CD Service who do training and have responsibilities to train the entire Schizophrenia Program staff, the rest of CAMH and external trainings also.” (KI)*

As such, a resource-matching arrangement was the model contract in CD’s partnership with other clinical programs – in this case, the Schizophrenia Program. The original agreement was for a 50-50 collaboration of staff as training resources between the Concurrent Disorders Service and the Schizophrenia Program. Unfortunately, competing budgetary demands precluded these plans and the resulting resource deficiency presented challenges to the initiative. To illustrate, the CD Program faculty provided 69% of training for each two-day workshop while the Schizophrenia Program staff provided

31%. If the Schizophrenia Program staff had been able to provide its share of 50%, then its staff would become self-sufficient more quickly and been able to manage most of their training. The CD staff could be phased out and move onto another CAMH clinical program that needed CD capacity building while continuing to act as consultants for the Schizophrenia Program.

Another benefit of 50-50 collaboration is that staff would receive training from their peers. It was felt with this model, staff might have more buy-in, trainer credibility would be ensured, and it increase the likelihood that the training would feel customized and relevant, since Schizophrenia Program trainers know their clients and staff better than external trainers.

There is a continued effort to recruit additional staff within the Schizophrenia Program to join the capacity-building team to better match the resource complement, but this has not been an easy task.

**Achieving registration targets:** A registration target of 40-45 staff per training event was set to train the 465 staff efficiently and to justify the faculty resources involved in the training. However, reaching this target registration has been a challenge at times. Initially, the training was slated to be mandatory for all program staff. However, this resulted in some resistance. Some questioned whether the staff were “ready” for this training, while others believed that these staff might be the ones who need the training most to explore their potentially stigmatic attitudes and values. There was resentment that the physicians in the program were absent from these so-called mandatory trainings. Without physician attendance, some felt that patient care could not be modified to incorporate the philosophies of care learned from the CD training.

There were also difficulties in giving staff the time to attend the training due to unbudgeted nursing backfill costs. Schizophrenia Program Management subsequently decided that the training was no longer mandatory, and then staff attitudes about the training diminished and further affected registration. Two sessions were cancelled because only nine participants registered. The vacillation of the training between being “mandatory” and “non-mandatory” status may have confused the motivation to attend. Currently, the training is deemed “optional, but recommended” by the Directors of the Schizophrenia Program, with the idea that if 50% of staff receives the training, this will represent a significant accomplishment.

**Changing Leadership within the Schizophrenia Program:** Since its inception, the CD Capacity-Building Initiative has shared leadership from the Concurrent Disorders Service and the Schizophrenia Program. The Manager of the CD Service served as the lead and a Manager from the Schizophrenia Program as the co-lead. Unfortunately, there have been three Managers in the Schizophrenia Program since 2001. This has presented transition challenges to the lead from the CD Service, and has perhaps created confusion on the part of the Schizophrenia Program staff.

## Recommendations from CD Capacity-Building Initiative

**Leadership:** The leadership for the training is crucial. A simultaneous bottom-up and top-down leadership is ideal. It is important to have the endorsement from Senior Management that CD is a priority, as well as buy-in from the Director and Service Manager/direct clinical supervisor levels. Ideally, there should be collaborative leadership from both the CD Service and the clinical program managers to share leadership responsibilities. Local clinical leadership in the program shows staff that their management is invested in the initiative. Including clinical staff from the two programs in the Capacity-Building Team demonstrates a simultaneous bottom-up shared leadership.

*“It needs to be driven in a kind of pro-active way, or you get inertia happening, and people just drift back to the ways they’ve always looked at the world and practiced.” (KI)*

*“You also need to work from the ground up where there is leadership in organizations from their administrative and clinical leaders, and they’re making clear that their agency is committed to being CD-capable or become specialists in CD treatment. I think what we have to do is get out of the idea that you’re not going to continue to be just addiction only or mental health only.” (KI)*

**Team-specific training:** The recommendation is to train staff from a particular program together, rather than from various clinical programs. The team-as-whole model gives staff with similar clients an opportunity to discuss their work with colleagues over time. A client with concurrent disorders in one program, such as the Schizophrenia Program, will have very different needs than clients in another program such as the Mood & Anxiety Program. Some treatment interventions will apply widely, but many will be unique (Health Canada, 2001) and need to be customized.

*“Training should not be focused on individuals, but rather staff who work together in a team should be trained together as a unit to ensure that a change is made in the team’s approach/philosophy.” (KI)*

*“Train teams/services as units. Encourage staff to own the new way of working with this client group, and integrate it into their every day practice.” (KI)*

**Needs assessments:** A program-specific needs assessment will determine current core competencies, staff readiness to receive CD training and the unique needs of the program. Staff feedback helps to customize training, and this process engages staff in developing a plan for their own program.

*“Perhaps you should first assess who exactly your audience is before you start training them – identify their needs / knowledge base etc. and gear your material accordingly (i.e., follow the adage ‘Start where the client is at’).” (E)*

*“Training depends on the specificity of the people being trained (i.e., the Schizophrenia Program staff have a very Severely Mentally Ill (SMI) focus, training for physicians may also focus on SMI but also increased psychopharmacology, training for general staff may need more general info on mental illness, stages of change, etc).” (KI)*

**Training status; mandatory vs. optional:** Staff motivation to attend training is influenced by how the training is positioned. The experience with the Schizophrenia Program has illustrated the pros and cons to both options. Mandatory status may evoke resistance by staff. Optional status may lessen the perceived importance of training, or the influence in changing the program’s mandate to work with CD clients. If clinical staff are expected to build a CD learning goal into their performance objectives, this supports the mandatory status of the training. In addition, the fact that CAMH’s Functional Plan directs every clinical program to develop basic competencies in CD implies the need for mandatory training.

*‘Mandatory’ training can be a barrier – resistance.” (KI)*

*“Good for both experienced & inexperienced staff; excellent – should be an organizational standard.” (E)*

**Multi-modal training design:** In addition to having a didactic component, it is also important to build in opportunities for practical training, with small group work, skills building, and videos illustrating clinical work. This is important to keep participants engaged and make the training more applicable to clinical practice. Many participants from the Schizophrenia Program cited the value of role-plays and on small group work for discussing case studies. Actual cases from the Schizophrenia Program were solicited before the training to incorporate their clinical challenges into the training. Many participants appreciated having a team of trainers, which provided an array of clinical styles and perspectives that sustained interest over the training period.

*“The broad range of topics and overall workshop helped to increase my awareness and knowledge in this area, and how to approach and treat clients who have mental illness and abuse substances. Also, the different facilitators brought a wide range of experiences with their areas of practice, which made it interesting.” (E)*

**Incremental approach to training:** Clinicians learn best through a longitudinal process of acquiring skills, practicing skills, getting feedback and refining skills (Torres et al., 2001). Following CD training completion, intermediate and advanced training courses should be offered. Additionally, booster sessions or training sessions for new clinical staff should also be available. Finally, after training, the capacity-building team of CD experts should be available to consult and provide ongoing supervision to their clinical teams.

*“People who complete the Intro CD course should then know what is next for them after that.” (KI)*

*“Training should be provided within a context where support is given for implementation of new skills/approach (i.e. through: management structures, supervision, team/individual professional development... time to deliver the new intervention(s), and to read, as well as booster/refresher training.” (KI)*

*“Ongoing knowledge is critical (‘if you don’t use it, you lose it’) – however, with the limited number of trainers, the initial training can’t always be offered, let alone the updates and continuing ed.” (KI)*

**CD capacity-building training team:** A core team of CD staff is required. This team is envisioned to be a cohesive, dynamic, and highly motivated group of individuals. The literature strongly suggests that teams should be multi-disciplinary to help ensure that the training will represent different philosophies of care, such as harm reduction, and not just a medical model. The team’s activities should include education, consultation and supervision to support the units/services within the program being trained. Master’s-level clinicians (e.g. therapist II’s; or advanced practice clinicians) with addictions and mental health knowledge and a flair for training and education would be ideal team members. They could be drawn from disciplines including psychology, social work, nursing or a related health discipline. In addition, including an educational specialist is recommended to help to design the training, provide facilitation and ensure adherence to adult education principles. The core team might attract graduate students and post-doctoral fellows. Staff on the capacity-building team should have this role clearly identified in their performance objectives for the coming year.

**Skills development for trainers:** Potential trainers on the CD capacity-building team should be offered training in adult education principles and training methodologies.

**Train-the-trainer approach:** This approach has been used in the CD Capacity-Building Initiative with the Schizophrenia Program at CAMH, as well as in Peel Region, Sarnia, Muskoka-Parry Sound, and New Mexico. There, the Train-The-Trainer curriculum has

increased access and clinical competency (New Mexico Department of Health, 2002). This is a smart use of resources and broadens the pool of potential trainers.

*“People who have completed the training and show an interest in training need to be encouraged to become trainers and build confidence by (becoming buddies) with existing trainers.” (KI)*

**Involving people in recovery as part of the training team:** We need to include consumers as an integral part of training initiatives because they inspire and motivate professionals, and lend an important perspective. Consumers can advocate for services, participate on planning committees and evaluate services among other roles.

This recommendation has been receiving increasing support, and has been endorsed by CAMH’s Client Empowerment Council and the Concurrent Disorders Knowledge Exchange area. Each year, CAMH organizes several Community Information Forums on CD topics that include consumers in recovery from CD on the panels. Their perspective invariably makes a profound impact on the audience. If a consumer cannot be involved, the next best advice is to incorporate real client videos depicting assessment interviews or therapy sessions. (Informed consent from clients must naturally be obtained).

*“In the future, it might be helpful to invite or incorporate a consumer/survivor person of concurrent disorders to speak in the workshop.” (E)*

*“Maybe... try to attract people with mental illness who are working as peer counsellors or are running recovery-based businesses. Bring people into the training who are themselves managing their own recovery (e.g., addiction workers in recovery). However, note that they have different capacities to manage a two-three day workshop, so you may need to be sensitive to their own capacities. You may need a different format for the workshop with a lot of breaks for these folks.” (KI)*

**Different training levels (Level I, CD Capable & Level II, CD Specialized):** CD Capable clinicians would be able to provide a minimal level of integrated mental health and addiction services for clients. CD Capable mental health clinicians would typically be capable of helping clients who also had substance use disorders of low severity. Similarly, CD Capable addiction clinicians could help clients with mental illnesses of low severity. CD Specialized clinicians are able to provide fully integrated mental health and addiction treatment to individuals with a high severity of both issues. The levels are explained in further detail below.

**LEVEL I, CD Capable:** Staff in all addiction and mental health programs should have knowledge and skill in the following areas regarding concurrent disorders:

- attitudes and values about addiction and mental illness (includes stigma)
- identification (recognition, screening)
- assessment
- treatment planning
- referral
- provision of Level I treatment interventions (e.g. motivational Interviewing, harm reduction, relapse prevention)
- case management and supportive care.

Level I Client Vignette: A client with a single psychiatric disorder and single concurrent substance use disorder.

This client has a diagnosis of schizophrenia and is connected to the Schizophrenia Program at CAMH. He has a psychiatrist and a case manager, and neuroleptic medication is part of his treatment plan. The client has disclosed the use of crack cocaine, which he uses in binges, particularly when his monthly disability cheque arrives. His substance use has had negative consequences on his mental health, and may jeopardize his housing situation, since he knows that substance use is not tolerated in the supportive housing arrangement where he lives. The client recognizes the consequences of ongoing use, but still values the enjoyment and escape he gets from it. He is open to receiving help to explore his concurrent disorders issues, but feels ambivalent about giving up use entirely.

**LEVEL II, CD Specialized:** Staff working in Level II Programs (e.g., a concurrent disorders program, such as the Concurrent Disorders Service) should be skilled in the following areas:

- all Level I competencies noted above, plus:
- specialized assessment methods (e.g., Structured Clinical Interview for DSM-IV (SCID)) and procedures
- specialized therapies and modules (e.g., dialectical behaviour therapy)
- specialized consultation to Level I staff
- clinical training and education in the assessment and treatment of concurrent disorders
- collaborating and conducting clinical research in concurrent disorders.

**Level II Client Vignette:** A client with multiple Axis I and II psychiatric diagnoses who uses multiple substances (i.e., alcohol, cannabis, cocaine, and opiates).

The client's previous psychiatric diagnoses have been inconsistent and even contradictory at times. They have included dysthymia, panic disorder, post-traumatic stress disorder, and borderline personality disorder. However, the latter diagnosis has been a consistent. While this client has had numerous assessments and admissions within mental health, most notably in psychiatric emergency departments, she has not managed to link up to follow-up and treatment. Her repeated efforts to get help have met with rejection and exclusion from various treatment programs due to substance use, or recent self-harm behaviour related to ongoing suicidal ideation. She has had repeated admissions to substance use programs, spanning withdrawal management, outpatient and residential programs. However, addiction counselling has failed to address her concurrent psychiatric issues, and she feels that the complexity of her issues is not adequately understood. She has been told she has "high case management needs, and requires intensive treatment resources," which programs have claimed they are "not able to offer at this time." This has left her feeling like a system misfit and has reinforced her feelings of hopelessness and despair.

*"Identification, assessment, and intervention are... level 1. We're not trying to make everybody a specialist in concurrent disorders, but we're trying to make everyone capable of identifying, assessing and working with people with concurrent disorders. That's pretty ambitious. In addition to that... those people then are entitled to have a reasonable expectation that in doing their work they have access to specialized (level 2) services." (KI)*

**Standardized content:** The training content and curriculum needs to be standardized for consistency. Following *Best Practices: Concurrent Mental Health and Substance Use Disorders* (Health Canada, 2001) and taking an evidence-based approach as much as

possible are crucial. A shared vision, with a consistent language and philosophy, will help to promote a common understanding.

*“Would like to see a consistent way of talking about CD and training.” (KI)*

**Participant training handouts:** In addition to handing out copies of presentations, it is helpful to provide recommended readings, which should include a comprehensive reference list relevant to the program’s specific CD population. Information on referral agencies accepting CD clients, assessment measures and other relevant topics would make the participant package a useful reference resource.

*“The binder is excellent, well-organized, excellent content, follows Best Practices. The references, charts are all extremely helpful.” (E)*

*“I appreciate the tremendous work put into the handouts: a great resource to be shared by colleagues, clients, students and the public.” (E)*

**Pilot:** A pilot CD Training should be conducted with a subset of program staff before rolling it out to the entire program. The pilot will yield important feedback and suggestions on whether the training feels relevant and customized.

**Training evaluation:** Quantitative and qualitative evaluations of the effectiveness of training events are important. This feedback enables trainers to refine and improve further trainings. It would also be useful to evaluate whether client outcomes have been enhanced with staff training, although this is a larger research undertaking that requires additional resources.

*“It’s encouraging to know of all that is happening (or poised to happen) in the area of concurrent disorders – this area seems to have been shunned for some time – I feel that I have been given permission to carry on with my shift in attitude (re: concurrent disorders) and therefore in the direction of my practice.” (E)*

*“Nice to see the change in attitude in the treatment of concurrent disorders – uplifting.” (E)*

**Recognition of professional development:** As noted above, the annual performance review process should include a discussion of concurrent disorders in upcoming performance objectives. Staff members who have completed the training should receive a certificate of completion as a minimum. It would be ideal if the training were accredited for professional development/continuing education training hours.

*“Let staff feel training is beneficial to their own personal development as clinicians (e.g. receive certificate of attendance, diploma, credits etc...).” (KI)*

## Simultaneous CD Capacity-Building efforts

The most common barriers cited to the above recommendations include limited time and money/resources. The following is a list of suggested CD capacity-building efforts that require no money at all and can serve as important adjuncts to CD Capacity-Building training:

- (1) Attend internal CD training/workshops offered (if all staff cannot attend, send one or two staff who can come back and share the info with the team).
- (2) Build a professional CD learning goal into their performance objectives for the coming year.
- (3) Participate in a CD Action Traineeship.

- (4) “Job shadow” a staff who works in the Concurrent Disorders Service.
- (5) Explore cross training with a “staff swap.” An addiction therapist could work in a mental health program for six months, and vice versa. Then bring back the knowledge/skill to the home location.
- (6) Explore options for a secondment to a program that practices integrated CD treatment (e.g., the Concurrent Disorders Service).
- (7) Have a CD-novice clinician co-facilitate a new CD group in the unit/service, along with an experienced clinician from the Concurrent Disorders Service.
- (8) Following CD training, start to apply what has been learned with clients, and discuss this during clinical supervision. There is no need to wait to become an “expert” before working with CD clients.
- (9) Express interest in becoming a concurrent disorders “champion.” This can be someone on the team/unit who is motivated to learn more about concurrent disorders. Ideally, the champion can also serve as a trainer. Champions should have clearly defined responsibilities in their performance objectives and be accountable for advancing concurrent disorders. These champions must also be recognized for their initiative.
- (10) Read more about CD. Encourage staff to share articles with the team/unit; start a monthly “CD Journal Club” in the unit/service.
- (11) Introduce discussions of CD issues in team meetings and case rounds.
- (12) Seek ongoing CD supervision and mentorship for CD clients.
- (13) Seek consultation from CD experts. They are only a phone call away.

## The Key Informant Survey

### Methodology

The CD training strategy project focused on interviews with key informants. The work group identified most key informants by virtue of their existing roles and expertise in concurrent disorders. Others approached us as a result of information distributed at CAMH CD courses and events.

A total of 24 interviews were completed by telephone or in person. Some informants used a standard template and filled in their responses. (see Appendix A).

Our key informants can be categorized as follows:

- Eight were external to CAMH and included case managers, counsellors and a consultant from the Ministry of Health and Long Term Care (MoHLTC). One respondent was French-speaking and was interviewed in French.
- Sixteen were internal to CAMH. They included the perspectives of staff and managers in the following programs or departments: international health; CECH; Research; clinical services; education & publishing; clinical programs. Of this group, 12 were from Toronto, and four were from regional CAMH services.

### Survey questions

Our questions were based on our framework (see Figure 1) and addressed training issues, barriers, competencies, types of education and the relevancy of knowledge sharing with other jurisdictions.

The eight questions were:

- 1) In your opinion, what are the training issues with respect to Concurrent Disorders?
- 2) What are some suggested solutions (to address these issues)?
- 3) From your perspective, what are the barriers (with respect to Concurrent Disorders training)?
- 4) Please rank these types of competencies in CD in order of importance:  
*Knowledge / Skill Development / Attitudes / Values.*
- 5) Please rank the importance of the following types of education for CD:  
*Formal / Informal / Brief workshops & conferences.*
- 6) In your opinion, who should take the lead for providing concurrent disorders training?
- 7) Are you interested in what's happening with respect to concurrent disorders in other jurisdictions (such as the U.S. and Australia)?
- 8) Other comments were invited.

## Survey responses

### 1. CD Training Issues

Why is training important or necessary? Our informants identified a number of issues with respect to CD and training.

- silos between the treatment settings and between the mental health and addictions fields, lack of coordination
- lack of a policy framework for CD
- issues around the complexity of care, e.g., diversity of clients and their needs (no two clients are the same)
- staff attitudes, values, and beliefs
- resources, e.g., staff release time to take training, faculty time, cost of training and travelling for training, particularly in northern Ontario, where distances require air travel
- faculty recruitment issue and shortage of trainers/faculty
- inconsistency of standards of practice, e.g., professional governance
- lack of training in French
- lack of evidence-based practice.

### 2. Solutions for CD Training

Our informants identified various solutions to address issues with respect to CD training.

- break down silos; incorporate cross-training and de-segmentation
- introduce innovative approaches for learner follow-up; incorporate experiential education; explore apprenticeships
- develop a better understanding of the audience and audience segmentation; match the teaching with professional needs; use a stepped model – one size does not fit all
- start with attitudes: training must address stigma
- broaden the pool of faculty; build capacity; train-the-trainer

- acquire more research dollars, funding from the Ministry of Health and Long-Term Care (MOHLTC)
- use technology to reach more people
- work for a better recognition of education, educational standards and certification
- work with the MOHLTC to provide leadership.

### 3. Barriers

The barriers identified by our informants were similar to the issues identified earlier.

- silos and fragmentation; differences between MH and addictions fields; ownership of the client group; lack of common definitions
- lack of management support
- limited resources, time and money; compensation issues; limited availability of trainers
- lack of evidence-based interventions
- staff attitudes, stigma
- mystique around CD
- staff resistance to mandatory training
- immediate relevance not apparent

### 4. Types of competencies

Bloom's taxonomy is widely used in curriculum development and particularly in the development of learning outcomes for adult education. Bloom's taxonomy outlines three major aspects of learning and claims that learning outcomes may result in a change in attitude, knowledge or skills. Key informants were asked to rank the relative importance of these learning outcomes, along with a change in *values* as a fourth learning outcome.

There was very little difference in the ranking of skill developments vs. attitudes vs. knowledge. Each of these outcomes was ranked as important, while values ranked consistently less so.

However, many of our informants did perceive that attitudes and values were the most important type of knowledge to cover. Those that did not identify attitudes as the highest priority believed that staff already had the appropriate attitudes from working with clients for many years and therefore ranked it lower.

### 5. Types of education

*"Certification is very important for front-line workers; they want their training to be recognized, (which is) especially true of people with no prior academic work. Informal education is good for sharing knowledge, but learners need to have their specific needs met." (KI)*

For our purposes, the work group determined that education and training could be categorized into three types: formal education programs (accredited or certified), brief training workshops or conferences, and informal, ongoing knowledge exchange through listservs, online discussion forums and face-to-face meetings.

Our informants expressed a clear preference for formal education, followed by informal methods and brief workshops. Thus the three strategies for learning are ranked as follows:

- 1) Participants want to achieve specific learning outcomes (competencies) and certification (formal education programs).
- 2) Participants want to share their ongoing learning and support each other (informal learning).
- 3) Participants want to hear experts share their clinical experience, the latest research and new insights (brief workshops or conferences).

#### 6. Taking the lead

Eleven out of 16 CAMH key informants as well as several external key informants felt that CAMH should take the lead. Among the reasons cited were, “It’s our mandate,” and “We do leading-edge research.” Many suggested that CD training could best be accomplished through partnerships between divisions and departments such as the CD Knowledge Exchange area, Education & Publishing, the CD Service, and International Health. Others saw this as a joint responsibility between research, clinical programs and education.

Several key informants felt that other organizations should take the lead, perhaps in partnership with CAMH. These could include:

- key players (e.g., Canadian Mental Health Association, Alcohol and Drug Recovery Association of Ontario)
- community-based agencies, to form training coalitions
- external experts
- Ministry of Health and Long-Term Care, District Health Councils
- universities or colleges
- initiatives co-led between the mental health and addiction fields.

#### 7. Other jurisdictions

Our key informants expressed an interest in learning from and sharing knowledge with experts in the U.S., Australia, U.K., other Canadian provinces and New Zealand. They identified the benefits of comparing research, evaluation outcomes and clinical programs. However, someone needs to take on the task of synthesizing research from these other jurisdictions to create a research digest for CD.

#### 8. Other comments

Informants expressed a variety of views. Here is a sample:

*“It’s our canvas and we can go ahead and paint on it.” (KI)*

*“We need to plan for the long term regarding training. People can’t learn it all at once. They need time to change the way they work and the services they offer. The training should be offered as a menu of continuing education courses.” (KI)*

*“In training, we need to recognize all of the parts of best serving our clients – research, clinical treatment and frontline work.” (KI)*

*“One little piece I would add is when you get people to apply for this, who sign up for the workshop, I think it helps a lot in terms of the training if the instructor gets a lot more information about the audience. What I mean by that is more about their experiences with particular concurrent disorders training and a lot more about what they want to learn about. That would be more specific: learning how to assess, learning how to treat, learning how to deal with crisis, learning how to deal with the addiction side... learning how to do the mental health side... you can have some sort of a checklist, information on how many clients did you see, what percentage of their clientele has this problem and so on.” (KI)*

*“Public education around stigma is so important. From community studies we did at CAMH and replicated in the community, we learned that if you talk to consumers, the least level of stigma (although there is considerable stigma) is with mental health. Next is addictions... and the greatest stigma by far is with CD. People with concurrent disorders reported being more stigmatized for their addiction problem than for their mental health problems.” (KI)*

*“We need to be doing whatever policy and advocacy work we can, with the Ministry. (Mental health) and addiction are not speaking to each other to the extent that they should be.” (KI)*

## Summary of Findings

The work group found a consensus across the literature, case study and the survey in terms of context, competencies and training delivery issues. Some of these observations are summarized in this section.

### Context and audience

#### Concurrent disorders treatment and care in Ontario

*“We’re all over the place with CD stuff. It’s fragmented, uncoordinated, and the left hand doesn’t know what the right hand is doing...It’s depleting people’s resources and is confusing our audience.” (KI)*

*“The mental health variance is that our people have real illnesses and people with addictions just do stupid things. They don’t see addiction as illness. On the addiction side we often see mental illness as overwhelming and un-helpable.” (KI)*

The following systems have traditionally had the strongest involvement in treating CD clients:

- addictions system
- mental health system (medical and psychosocial)
- psycho-geriatric services
- medical professionals in other specialties, including emergency departments

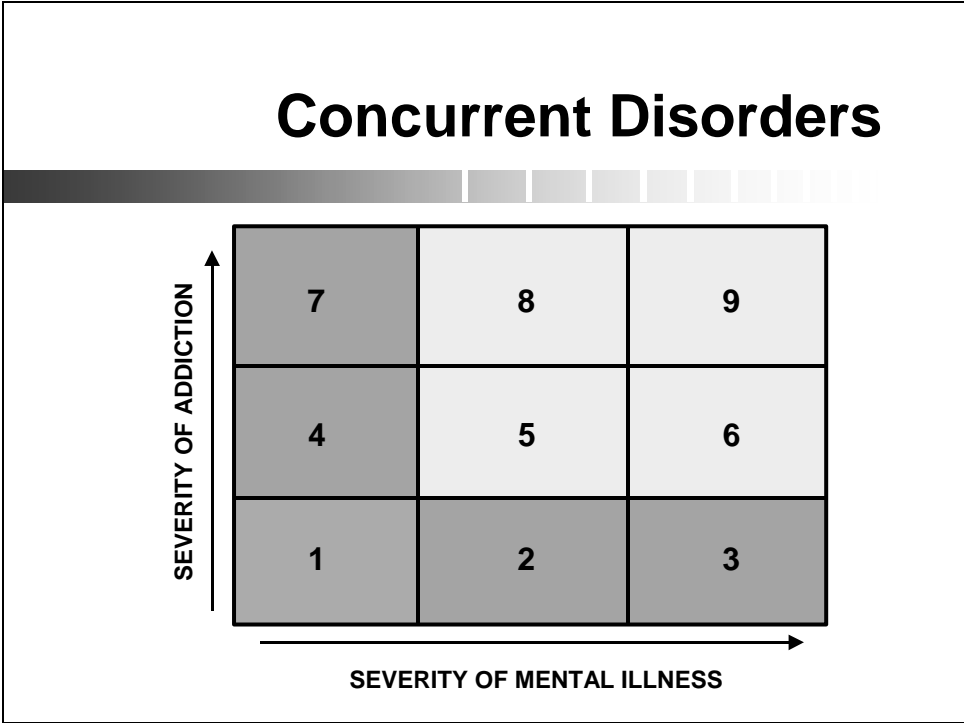
Professional training, ideological perspective and treatment techniques differ between mental health and substance abuse systems. The practical result of this lack of integration is that addiction issues are often undiagnosed for clients receiving treatment for mental illness, and mental illness is often undiagnosed for clients receiving addiction treatment.

Even for correctly diagnosed CD clients, treatment often entails a fragmented approach, involving separate practitioners in separate treatment settings. The development of integrated treatment systems is an important change required in CD service.

*“...If none of the structure, philosophies or policies change, then all of that new knowledge is wasted.” (KI)*

Fifty-six of the 150 agencies in the province report that they will accept clients with CD, but only a few offer treatment programs designed specifically for those with concurrent disorders. Many programs indicate an intention to develop treatment services designed for CD. This intention represents a considerable opportunity. (Centre for Addiction and Mental Health, 2003).

Programs can be defined as either Concurrent Disorder Capable (CD Capable) or Concurrent Disorder Enhanced (CD Enhanced). CD Capable programs provide a minimal level of integrated mental health and addiction services for clients with concurrent disorders. Thus, CD Capable mental health programs would typically be capable of helping clients who also had substance abuse disorders of low severity. Similarly, CD Capable addiction programs would be capable of helping clients who also had low severity mental disorders. CD Enhanced programs are those that provide fully integrated mental health and addiction treatment to individuals with concurrent disorders, including those who have a high degree of severity of both disorders. (Florida Department of Children and Families, n.d.).



**Figure 2. Severity scale for concurrent disorders (Smith, 2000, adapted from NASMHPD/NASADAD, 1998)**

Many concurrent disorders clients fall within the low severity bands as shown in Figure 2. (cells 1, 2, 3, 4 and 7). The most important outcome from training is to prepare service providers to assess and screen for substance use or mental health disorders. As service providers become better at this, then the most experienced clinicians can focus on the severe cases (cells 5, 6, 8 and 9).

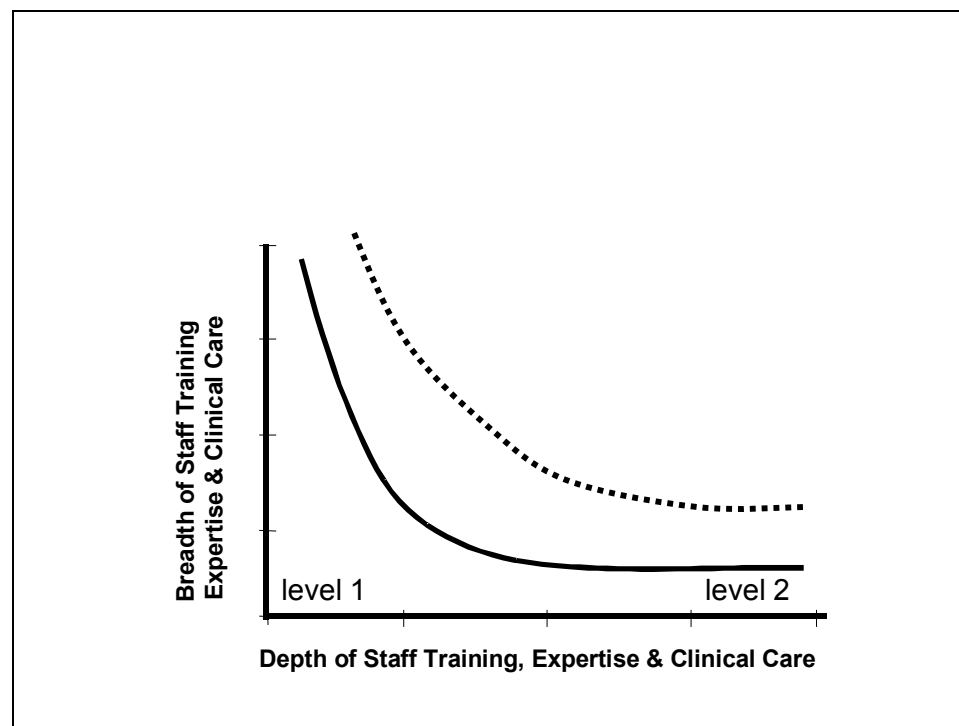
People who work in the systems mentioned above and who could therefore benefit from CD training include:

- front-line professionals in mental health and addictions treatment settings (e.g., CAMH clinical staff, physicians, social workers, psychologists)
- clinical professionals who may encounter people with mental health and substance use disorders (e.g., family doctors, Community Health Centre staff)
- allied professionals who may encounter people with mental health and substance use disorders (e.g. corrections, income support, shelter staff)
- managers and perhaps support staff in the settings above (e.g. CECH provincial services staff, CAMH managers and directors)
- DHC and MoHLTC staff

It is important to distinguish between levels of knowledge, which are referred to as the CD Capable level, or level 1, and the CD Specialized level, or level 2, which were described previously.

These clinicians work with people with more severe problems as represented by cells 5, 6 and 8. They need opportunities to share their knowledge and experience of advanced topics in CD.

The next graphic illustrates these ideas in terms of capacity building.



**Figure 3. Capacity building in addictions and mental health (Smith, 2000)**

The goal is to increase the breadth of training for most practitioners over time as indicated by the dotted line on the right. It is important to realise that CD capacity building will take time.

## Competencies/learning goals

It is clear that attitudinal change must be part of any education program (e.g., issues of stigma for this client population). Our research found general agreement about the need to provide distinct levels of training.

## Training and education delivery

Many creative solutions were mentioned in regard to using a variety of training and education methodologies. Longitudinal training ensures longer-term follow through. There is strong agreement that people want their training to be recognized.

Some issues with the current CAMH education and training programs are:

**Congruency of audience.** The identification of audiences is inconsistent. As well, broad categories are grouped together. This makes it extremely difficult to match learning objectives with participants' entry skills and knowledge levels.

**Congruency among courses.** The topics, treatment approaches, etc. appear to vary by course. For example, depending on the faculty, participants may be exposed to narrative therapy, motivational interviewing or cognitive behavioural therapy. As well, a "balanced approach" needs to be taken when talking about therapeutic approaches.

**Varying theoretical frameworks.** Among the courses, different theoretical frameworks are used to structure courses (e.g., Stages of Change, Dimensional Approach, DSM). These are not applied consistently. For example, peer reviewers have flagged the Dimensional Approach as a way to understand co-occurring disorders. The dimensional approach is a classification model with four dimensions: anxiety, psychosis, depression, and anger. It has been used as a classification system for mental health problems in the CD certificate modules, but is not even mentioned in the Introduction to CD courses.

## Resource issues

The lack of resources is a recurring issue for implementing effective training. Increasing the pool of faculty is a priority as is the need for funding for staff as well as trainers to attend training.

## Recommendations

The work group has developed recommendations around leadership, training content, delivery and resourcing, with a focus on both CAMH-specific and external settings.

### Leadership

Ministry of Health and Long Term Care role

- 1) The CD Knowledge Exchange Area should work with the Ministry of Health and Long Term Care (MOHLTC) to provide leadership to support training, develop policy and support system integration efforts.
- 2) The MOHLTC should endorse CD as a priority for policy development, and to endorse system integration.
- 3) The MOHLTC should encourage more research into CD and lobby for federal grants.

#### CAMH role

- 4) Provide recognition to staff who have participated in training and trained others. A certificate of training completion is one example. (Other examples are in Appendix D.)
- 5) Ensure that a valid CD assessment “tool kit” is developed and available.
- 6) Recognize training in the performance appraisal and development review (PADR), and use PADR to set objectives for trainers and staff taking training.
- 7) Work with colleges and universities to include CD in clinical education programs.
- 8) Work for a better recognition of education, educational standards and certification.
- 9) Fulfill the mandate of training CAMH staff in CD.
- 10) Coordinate and plan among the players: CD KE Area, CD clinical services, Education & Publishing, Research.
- 11) Examine faculty recruitment and compensation issues. Clinicians should contribute to education efforts as part of their job description, and this should be linked to performance appraisal. Policies and the Code of Conduct should support this initiative.
- 12) Identify champions in all CAMH clinical teams, provincial services teams and at the senior management level.
- 13) Identify an access point for external requests for CD training to enhance planning for events and to ensure that there are sufficient trainers available.

#### Resourcing

- 14) Broaden the pool of faculty and ensure that there are French-speaking faculty.
- 15) Use train-the-trainer strategies for appropriate content sections.
- 16) Fund the development of guidebooks and other resources for training.
- 17) Offer adult education and presentation skills training to potential faculty.
- 18) Involve people in recovery as part of the training team.
- 19) Provide backfill to participants and trainers (budget for this).
- 20) Encourage groups to share costs of hosting training events.
- 21) Encourage cross-secondments to assist training.
- 22) Recruit external trainers.

#### Content/competencies

- 23) Adopt best practices around curriculum design and establish learning outcomes based on the following analysis:

	CAMH and community mental health & addiction clinicians	Clinical professionals (family doctors, ER doctors, nurses, EAP clinical staff)	Allied professionals (corrections, income support, shelter workers, intake workers, etc)	Managers, administrators	DHC staff, MOHLTC staff
<b>Skills</b>					
Screening, basic assessment, recognition and referral	√	√	√		
Provision of level I treatment interventions (e.g., motivational interviewing, harm reduction, relapse prevention, stages of change)	√	√			
Case management and supportive care	√	√	√		
Comprehensive diagnostic assessment methods (e.g., SCID) and procedures	√*	√**			
Specialized level II interventions, therapies and modules (e.g., dialectical behaviour therapy)	√	√			
Specialized consultation to level I staff	√				
Providing clinical training and education in the assessment and treatment of concurrent disorders	√				
<b>Knowledge</b>					
Psychosocial insights and awareness of addiction and mental health issues	√	√	√	√	√
Prevalence of CD, understanding of persistence of stigma	√	√	√	√	√
Terminology, standardization of language	√	√	√	√	√
Understanding of policy and system issues	√			√	√
Pharmacology, interaction of drugs	√	√			

\* If in scope of practice (e.g., psychologists, physicians).

	CAMH and community mental health & addiction clinicians	Clinical professionals (family doctors, ER doctors, nurses, EAP clinical staff)	Allied professionals (corrections, income support, shelter workers, intake workers, etc)	Managers, administrators	DHC staff, MOHLTC staff
Harm reduction principles	√	√	√	√	√
Awareness of clinical research in concurrent disorders	√			√	√
<b>Attitudes</b>					
Recognition of one's own attitudes and values about addiction and mental illness, stigmatized beliefs	√	√	√	√	√
Resistance to change	√	√	√	√	√
Empathy	√	√	√	√	√
Comfort level with diverse populations and diverse characteristics of CD clients	√	√	√	√	√

## Delivery

24) Adopt a variety of methodologies for training and education:

- cross training
- workshops and conferences
- technical solutions and e-learning (e.g., online courses, listservs, websites, online community of practice discussions)
- grand rounds
- experiential education, use of role plays, group work
- incremental, or longitudinal approaches; ongoing consultation

25) Continually evaluate training to improve and to gauge whether outcomes are met.

26) Use needs assessments to ensure a better understanding of audience and fitting the audience needs to learning outcomes.

## Next Steps for the CD Training Strategy Work Group

The CD Knowledge Exchange Area Planning and Implementation committee provided feedback for the Training Strategy Project about the importance of addressing training/education for staff and at the university/college level. Consequently, the CD Training Strategy Project will continue its work in 2004-2005 with its second phase objective being to implement and build on the recommendations of this report.

To achieve this, an Implementation Committee will be set up to further define the recommendations and monitor their implementation. This committee will act as a sub-committee of the Training Strategy Project and will report to the Project Lead.

In addition, the work group will develop a strategy to partner with post-secondary institutions to enhance CD training throughout the province. Tasks may include, but are not limited to: developing mechanisms to ensure that CD is included in curricula (including the Northern Ontario Medical School curriculum, currently under development); developing CD knowledge and expertise in institutional faculty; and partnering with these faculty and institutions to offer training opportunities throughout the province. This will contribute to the development of a pool of new staff that can be hired with knowledge of CD.

This objective is consistent with capacity building as described in the Functional program for the CAMH provincial role, Student Education and Training:

*As an academic health sciences centre, the Centre is formally affiliated with numerous universities and colleges worldwide to provide training to students working toward a professional designation. There is a Centre-wide expectation that all programs and services will provide and support training opportunities for these students.*

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Centre  
for Addiction and  
Mental Health  
Centre de  
toxicomanie et  
de santé mentale

CD Training Strategy Project

**-KEY INFORMANT INTERVIEW (DRAFT)-**

Date of interview: \_\_\_\_\_ Time: \_\_\_\_\_  
(dd/mm/yyyy)

**Preamble:**

Hi there. My name is \_\_\_\_\_, and I'm part of a concurrent disorders working group that suggested I give you a call. Is this a good time?

*Our Training Strategies Project is trying to identify CD training issues in order to develop a training strategy which will "improve the capacity of the MH and addiction systems and the ability of service providers in Ontario to meet the needs of people affected by concurrent disorders". As you know, there is a high demand for CD training externally and internally to CAMH, with a limited pool of qualified trainers. As part of this process, we wish to conduct Key Informant Interviews with various stakeholders like yourself for their valuable input and perspective. Your consent to be included as a Key Informant will be very helpful to us in our work.*

Name of Key Informant: \_\_\_\_\_ Position Title: \_\_\_\_\_  
Employer: \_\_\_\_\_

**Affiliation/Perspective of Key Informant:**

- Addictions                       Mental Health  
 Internal to CAMH               External to CAMH
- Discipline:
- Psychiatry
  - Psychology
  - Social Work
  - Nursing
  - Other: \_\_\_\_\_

QUESTION:	RESPONSE:
(1) In your opinion, what are the training issues with respect to Concurrent Disorders?	
(2) From your perspective, what are the barriers?	

<p>(3) What are some suggested solutions you might have?</p>	
<p>(4) Please rank order the following list of CD competencies in concurrent disorders, in order of importance:</p> <p>(Please rank in order of importance):</p> <p>___ Knowledge (e.g. prevalence of concurrent disorders; best practices information)</p> <p>___ Skill development (e.g. using assessment tools; motivational interviewing approach of rolling with resistance)</p> <p>___ Exploring "Attitudes" about addiction &amp; mental illness (e.g. stigmatic views that may exist such as "addicts are weak individuals"; or, "abstinence is the only acceptable goal for someone with concurrent disorders")</p> <p>___ "Values" about addiction and mental illness (e.g. "the family is important")</p>	
<p>(5) How important or useful do you feel the following 3 types of education are:</p> <p>Please rank in order of importance:</p> <p>___ "Formal" education (e.g. competencies &amp; certification )</p> <p>___ "Informal" education (e.g. participants want to share their ongoing learning and support each other, such as with a CD Journal Club or CD Listserve)</p> <p>___ Brief workshops &amp; conferences (i.e., hearing experts share their experience, latest research)</p>	
<p>(6) In your opinion, who should take the lead for providing concurrent disorders training?</p>	
<p>(7) Are you interested in what's happening with respect to concurrent disorders in other jurisdictions (such as the U.S. and Australia)?:</p>	
<p>(8) Other comments:</p>	

*-Thank you for taking the time to participate in this interview. Your feedback has been very helpful.-*



Projet de stratégie de formation sur les troubles concomitants  
- ENTREVUE AVEC L'INFORMATEUR -

Date de l'entrevue : \_\_\_\_\_ Heure : \_\_\_\_\_  
(jj/mm/aaaa)

Le formulaire de consentement a-t-il été rempli ? Oui  Non

Nom de l'informateur-clé : \_\_\_\_\_ Titre de poste : \_\_\_\_\_  
Employeur : \_\_\_\_\_

Affiliation/perspective de l'informateur-clé :

- Toxicomanies  Santé mentale  Troubles concomitants  
 Affiliation interne (CTSM)  Affiliation externe  Autre

Domaine :

- Psychiatrie  
 Psychologie  
 Travail social  
 Soins infirmiers  
 Intervenant des services de toxicomanie /intervenant des services sociaux  
 Autre : \_\_\_\_\_

QUESTION :	RÉPONSE :
(1) Selon vous, quels sont les problèmes de formation à retenir dans le domaine des troubles concomitants ? (Question incitative : vous pouvez vous servir des mots « disponibilité », « accessibilité » ou « pertinence » pour inciter le répondant à faire des commentaires sur les « problèmes »).	
(2) Avez-vous des solutions à proposer ?	
(3) Selon vous, quels sont les obstacles ?	

<p>(4) Classez les compétences suivantes du domaine des troubles concomitants et ajoutez vos commentaires.</p> <p>(Numérotez-les de 1 à 4 selon le degré d'importance que vous leur accordez.)</p> <p>___ <b>Connaissances</b> (p. ex., prévalence des troubles concomitants, ou information sur les meilleures pratiques)</p> <p>___ <b>Acquisition de compétences</b> (p. ex., utilisation d'instruments d'évaluation ; technique d'entrevue motivationnelle consistant à « s'adapter à la résistance de la personne »)</p> <p>___ <b>Exploration des attitudes envers la toxicomanie et la santé mentale</b> (p. ex., préjugés selon lesquels « les toxicomanes sont des personnes faibles » ou « l'abstinence est le seul objectif acceptable pour une personne ayant des troubles concomitants »)</p> <p>___ <b>Les « valeurs » entourant la toxicomanie et la maladie mentale</b> (p. ex., « la famille est importante »)</p>	
<p>(5) À votre avis, lequel des trois types d'éducation suivants est le plus important ou le plus utile ? Ajoutez vos commentaires.</p> <p>(Numérotez-les de 1 à 3 selon le degré d'importance ou d'utilité que vous leur accordez.)</p> <p>___ <b>Éducation « institutionnelle »</b> (p. ex., aptitudes et certification)</p> <p>___ <b>Éducation « informelle »</b> (les participants désirent apprendre ensemble et s'entraider, p. ex., à l'aide d'un club de journal sur les TC ou d'un Listserv TC)</p> <p>___ <b>Conférences et ateliers courts</b> (p. ex., écouter des experts parler de leurs expériences, dernières recherches)</p>	
<p>(6) Selon vous, qui devrait jouer le rôle de chef de file pour fournir des séances de formation sur les troubles concomitants ?</p>	
<p>(7) Êtes-vous intéressé(e) par les développements dans le domaine des troubles concomitants dans d'autres pays (comme les É.-U. ou l'Australie) ?</p>	
<p>(8) Autres commentaires :</p>	

*-Merci d'avoir bien voulu participer à cette entrevue, vos commentaires sont précieux. -*

## Appendix B: CAMH CD Education and Training Activities

- Concurrent Disorders Certificate Program
  - Mood Disorders and Substance Use
  - Anxiety Disorders and Substance Use
  - Anger/Aggression and Substance Use
  - Psychotic Disorders and Substance Use
  - Trauma and Substance Use
- Introduction to Concurrent Disorders
- Advanced Concurrent Disorders
- Troubles concomitants: toxicomanie et sante mentale
- Working with Youth with Mental Health and Substance Use Problems
- Introduction to Concurrent Disorders: Bridging the Gap Between Mental Health and Addiction Services (Online course)
- CAMH CD Service's Capacity-Building Initiative for Schizophrenia Program
- CAMH CD Service Action Trainee program
- Understanding the Needs of People Who Have Addiction and Mental Health Challenges
- Pharmacological Challenges for Clients with Substance Use and Mental Health Problems
- Assessing /Treating Concurrent Disorders
- Addressing Stigma of Mental Health and Substance Use Problems
- Interactions between Psychiatric Medications and Drugs of Abuse
- Borderline Personality Disorders and Substance Use

Appendix C: Maslin questionnaire

N-002

THE TRAINING AND SUPPORT NEEDS QUESTIONNAIRE (TSNQ)

PLEASE ANSWER ALL 7 QUESTIONS

Name: \_\_\_\_\_

\*\* (Please Note: Your name will be kept confidential – only code number in upper right hand corner will be used to identify you).

Professional Designation / Role: \_\_\_\_\_

Service / Team \_\_\_\_\_

- 1. If applicable, how long have you been working with clients who have a severe mental illness and who also use drugs and / or alcohol problematically?

\_\_\_\_\_

- 2. In the past, how have you personally dealt with clients who use alcohol and / or drugs problematically and also have a severe mental illness?

Referred to specialist service \_\_\_\_

Tried to work jointly with other professionals \_\_\_\_

Focused primarily on the mental illness \_\_\_\_

Focused primarily on the drug / alcohol use \_\_\_\_

Other (please describe) \_\_\_\_\_

3. In the past, how has your service or department dealt with clients who use alcohol and / or drugs problematically and also have a severe mental illness?

Referred to specialist service \_\_\_\_

Tried to work jointly with other professionals \_\_\_\_

Focused primarily on the mental illness \_\_\_\_

Focused primarily on the drug / alcohol use \_\_\_\_

Other (please describe) \_\_\_\_\_

4. How do you rate knowledge of the issues of combined severe mental illness and problematic alcohol / drug use?

0 \_\_\_\_\_ 1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_ 4 \_\_\_\_\_ 5

( 0 = no knowledge ; 5 = expert knowledge)

5. How do you rate your competence in dealing with clients who have a severe mental illness and also use drugs / alcohol problematically?

0 \_\_\_\_\_ 1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_ 4 \_\_\_\_\_ 5

( 0 = none ; 5 = expert)

How do you rate the importance of combined problematic drug / alcohol use and severe mental illness?

0 \_\_\_\_\_ 1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_ 4 \_\_\_\_\_ 5

( 0 = irrelevant ; 5 = essential)

6. Please state how strongly you agree or disagree with the following statements by ticking the appropriate box:

	Very Strongly Agree	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Very Strongly Disagree
I am interested in the nature of combined severe mental illness and problematic drug / alcohol use							
In general, one can get satisfaction from working with clients who use drugs / alcohol problematically and also have a severe mental illness							
I feel I have a working knowledge of combined severe mental illness and problematic drug / alcohol use							
I have a clear idea of my responsibilities in working with clients who have a severe mental illness and also use drugs / alcohol problematically?							
If I needed to, I could easily find someone to help me with clients who have severe mental illness and use drugs / alcohol problematically							
I feel it is part of my professional role to work with clients who have severe mental illness and use alcohol / drugs problematically							

7. Do you feel you need additional support to enable you to work with clients who use alcohol and / or drugs problematically and also have a severe mental illness?

YES / NO

What might this support entail?

-Thank you very much for your participation!-

## Appendix D: Staff Recognition Strategies

### Suggestions for Rewards & Recognition For CD Trainers & Champions

Recognition is more than a simple thank you. It is an important responsibility that will be rewarded by committed and enthusiastic trainers. Leadership needs to be creative. Trainers should be recognized and rewarded in various ways. Recognition should be offered regularly; it encourages trainers to remain committed to the initiative.

THINGS THAT WOULD COST MONEY: (the cost depends on the size of team and would have to fit in the program's budget)

- Take the team of CD Trainers out for lunch.
- Provide CD Capacity-Building Team members with a modest gift certificate (e.g. \$25 to Indigo; Starbucks; Famous Players).

THINGS THAT WOULD NOT COST MONEY:

- Have the manager or co-leads send out an e-mail to the entire unit/service/team after a training event acknowledging the person's contributions as a trainer.
- Provide a certificate recognizing their status as a CD trainer/CD champion.
- Create a bulletin board that features pictures and accomplishments of specific trainers/champions
- Send a card to each individual CD trainer signed by the co-leads and manager praising his/her hard work and contribution
- Acknowledge and praise the CD trainer in his/her annual performance appraisal and development review (PADR) for their hard work and contribution. Acknowledge his/her professional commitments and achievements.