Centre intégré de santé et de services sociaux
de la Montérégie-Ouest

Explanatory guide to the clinical process in specialized addiction services

Direction des programmes santé mentale et dépendances (DPSMD)

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The individuals who contributed to producing this document are listed in the “Background” section.

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List of abbreviations and acronyms

AOD	Alcohol and other drugs
ARHSSS	Act respecting health services and social services
ASAM	American Society of Addiction Medicine
CISSS	Centre intégré de santé et de services sociaux
DPSMD	Direction des programmes santé mentale et dépendances
DSMREU	Direction des services multidisciplinaires, de la recherche et de l'enseignement universitaire
GD	Gambling disorder
HRO	Human relations officer
HSSN	Health and social services network
IIP	interdisciplinary intervention plan
IP	Intervention plan
ISP	Individualized service plan
INESSS	Institut national d'excellence en santé et services sociaux
MSSS	Ministère de la Santé et des Services sociaux
OUD	Opioid use disorder
PIU	Problematic Internet use
PRES	Regional specialized assessment program
RPCS	Resource person in clinical supervision
SREPED	Regional professional addiction support service
SUD	Substance use disorder
TP	Treatment plan

Glossary

Assessment	An assessment involves making a clinical judgment about a person's situation based on the information available to the professional, as well as communicating the conclusions of that judgment.
Bibliotherapy	Reading-based therapy to promote healing.
Case worker and physician	A person who, as part of their duties, intervenes with the service user, by planning, coordinating, or providing care and services. This includes the notion of technician and professional: educator, human relations officer (HRO), nurse, auxiliary nurse, nurse clinician, specialized nurse practitioner.
Clinical coach	Refers to an individual who provides professional coaching to other members of their team. They provide support for the application of practice standards (clinical coaching specialist (CCS), representative of the Service régional d'encadrement professionnel en dépendance (SREPED), professional coordinator, and nurse clinician assisting the immediate supervisor (ICASI)).
Clinical judgment	Cognitive process that allows the case worker to take the most appropriate actions, based on known information about the service user, best practices related to the service user's characteristics, and the context (CISSS de la Montérégie-Ouest, 2019).
Consent	Expression of the service user's will regarding an act to be performed by another person. Consent to care and services must be voluntary and informed. • Voluntary consent: Without any form of pressure or discrimination by the professional, the case worker, the family or the entourage. The service user gives their consent with complete confidence. • Informed consent: Having all the appropriate and necessary information, which they understand, and having been informed of the consequences of their consent, the service user consents with full knowledge of the facts (CISSS de la Montérégie-Ouest, 2021).
Disciplinary assessment	Members of the multidisciplinary team who are members of a professional order conduct assessments within their respective fields of practice. Reserved assessments may only be performed by licensed professionals (Office des professions du Québec, 2013).
Evidence	All knowledge derived from scientific, circumstantial and experimental data (Straus *et al.*, 2018).
External partner	A professional working with the service user and their entourage, at an institution or an organization other than those of the CISSS de la Montérégie-Ouest (inter-institution or inter-sector) (community organizations, support groups, etc.).
Interdisciplinary team	A group of professionals with specific training, competencies and experience, who work together to develop a comprehensive and common understanding of a service user, so they can share responsibilities and provide a coordinated intervention. The professionals work together to develop an interdisciplinary intervention plan (Hébert, 1997).
Internal partner	A professional from another program or department of the CISSS de la Montérégie-Ouest (intra-institution).
Intervention plan	The intervention plan is developed jointly with the service user and is used to determine the rehabilitation objectives and to measure progress and achievement of objectives. It is "a clinical activity that allows for a common understanding of the service user's needs and that underpins the intervention, providing clarification on the roles and responsibilities of each

	person; it is also an opportunity to strengthen the rapport with the service user" (CISSS de la Montérégie-Ouest, 2020, p.8). In this document, the term "intervention plan (IP)" refers to all of the following: treatment plan (TP), physician's medical mote (PMN) and therapeutic nursing plan (TNP); interdisciplinary intervention plan (IIP); individualized service plan (ISP).
Multidisciplinary team	A group of several professionals in which each person performs their tasks independently. Each person represents their own discipline, does their own assessments, sets their own objectives, writes their own reports, and creates and tracks their own program. They establish an intervention plan, for which they are responsible (Larivière & Ricard, 1998, in CIUSSS MCQ, 2018).
Case manager	"A member of the multidisciplinary team responsible for overseeing the planning, coordination, continuity, and integration of care and services. Whether or not they combine this role with clinical tasks specific to their field, they support and guide the service user and their entourage through the service continuum" (MSSS, 2017). The case manager is the person who knows the service user best, has followed them for the longest time, or is best positioned to coordinate services between the various professionals.
Rehabilitation	A process of personal development, learning and relearning that allows the person suffering from an opioid use disorder who so desires to gradually regain control over their life and to restore their physical, psychological, and social balance, through means other than addictive behaviours (ACRDQ, 2014). The concept of rehabilitation envisioned by Addiction services includes reducing addictive behaviours combined with abstinence in a context where the addiction is situated on a continuum ranging from transient to chronic (ACRDQ, 2014). The service user's rehabilitation is centered on a personalized alignment between the severity of the service user's problems, their motivation to change, and the treatment required by their condition.
Entourage	Includes people who are important to the service user. These can be family members (parent, sibling, spouse, child) or anyone with a strong connection to the service user (friend, tutor, case worker, etc.)(ACRDQ, 2014).
Specialized addiction assessment	Establishes the severity of the addiction in a person who meets the criteria for a substance use disorder (SUD), gambling disorder (GD), or problematic Internet use (PIU), for the purpose of referring them to specialized addiction services (MSSS, 2018). Done using validated standardized tools by a specialized addiction services professional trained to use them. *The assessments currently used for entourage and PIU cases are in the process of being standardized.*
Specialized services	Adaptation or rehabilitation services for a person living with a condition and/or a problem requiring specialized expertise. Provided in response to a need for which significant progress is expected. Specialized services are a complement to specific services (consultation, transfer of expertise, training) (MSSS, 2017).
Standardized screening tool	A standardized measurement instrument. A rigorously developed tool used to measure a concept (or indicator) in an objective, standardized way. It can be defined as a series of self-reported questions or items used to measure a concept (Streiner *et al.*, 2015).
Summary assessment	Determines the service user's eligibility for specialized addiction programs, through the use of standardized or in-house screening tools (for entourage and PIU cases).
Service user	Anyone who is receiving or who has received care and services from the DPSMD's specialized addiction services (adults and youth, SUD, GD, PIU, entourage).

Foreword

The Centre intégré de santé et de services sociaux (CISSS) de la Montérégie-Ouest employs close to 8,850 individuals, and 560[1] physicians at 120 facilities. The organization provides general services, routine first-line care, and specialized services at hospitals, long-term care centres, and rehabilitation centres. As such, the CISSS de la Montérégie-Ouest has regional jurisdictions for physical rehabilitation, intellectual disability, autism spectrum disorder, and addiction services.

The CISSS de la Montérégie-Ouest's mission, in keeping with that of the Ministère de la Santé et des Services sociaux (MSSS), is to maintain, improve and restore the health and welfare of the Québec population by providing access to a range of integrated, quality health and social services, thus contributing to the social and economic development of Québec.

[1] Total number of physicians with privileges at the institution.

1. Introduction

1.1. Background

The mission of the Direction des programmes Santé mentale et dépendance (DPSMD) is to improve the psychosocial health of the general population and that of vulnerable citizens living with mental health and addiction problems, within a continuum of services based on the hierarchy of care and services (CISSS de la Montérégie-Ouest, 2019a).

With a focus on **recovery** of the person (see Section 3.2) and the full upholding of their civil rights, management ensures the quality, efficacy and efficiency of evidence-based clinical practices. More specifically, the **specialized addiction services sector** of the DPSMD offers services aimed at improving the quality of life of the general population and of vulnerable individuals living with addiction problems, as well as their entourage. This sector has a regional mandate in the Montérégie region for English- and French-speaking service users and on the island of Montreal for the English-speaking population (CISSS de la Montérégie-Ouest, 2019a).

This document stems from a desire to harmonize and consolidate a clinical intervention process and services within the specialized addiction services for the entire territory served. It is based on best practices derived from evidence and theoretical foundations and is underpinned by the values and standards of practice of the CISSS de la Montérégie-Ouest. The clinical process is the basis for the program, guides, and reference documents used by the department.

The clinical process is the set of operations aimed at determining, on a personalized basis, the needs of the service user and their entourage in terms of services and interventions adapted to their situation (CIUSSS Mauricie-Centre-du-Québec, 2018). It helps determine the steps needed to ensure the delivery of quality, safe, and relevant care and services, while respecting service users' rights.

Organization of services

A diagnosis is not an eligibility criterion for specialized addiction services. Eligibility is determined using standardized screening tools for the following problems:

- Substance use disorder (SUD)
- Gambling disorder (GD)
- Problematic Internet use (PIU)

The care and services provided by the specialized addiction services case workers are in line with MSSS orientations outlined in the 2018-2028 interdepartmental action plan on addiction (IAPA). The care and services are grouped within different services in order to meet service users' needs (CISSS de la Montérégie-Ouest, 2019a):

- Regional specialized assessment program (PRES)
- Substance and withdrawal management
- Outpatient and inpatient rehabilitation services
- Opioid substitution therapy (OST)
- Social reintegration service
- Support services for the entourage

Service episode

The clinical process in specialized addiction services is limited to a service episode. This is the period of time during which the service user and their entourage receive services, which are established according to an intervention plan (IP).

A service episode has a beginning and an end (see service episode end criteria in Section 4.7). The simultaneous involvement of other CISSS de la Montérégie-Ouest programs or departments and of external partners from the Montérégie HSSN is sometimes necessary.

1.2. Recipients and purpose of this document

The clinical process is a reference tool that all DPSMD case workers, physicians, and managers of specialized addiction services. They need to consult when a service episode is opened, thereby triggering the need for an IP, regardless of the type (treatment plan (TP), interdisciplinary intervention plan (IIP), individualized service plan (ISP), etc.). See the regulation on the drafting and review of service user intervention plans (REG-10173) for a description of the different types of IPs (CISSS de la Montérégie-Ouest, 2019b).

The purpose of this document is to provide case workers and managers with a **common vision of the clinical intervention process** by informing them of the steps to follow from the beginning to the end of a service episode.

The clinical process provides information on **what is expected** of case workers and is intended to guide and support their clinical practice in order to have a comprehensive vision of the service user's situation, as well as that of their entourage, and to adjust the interventions accordingly..

2. Foundations

2.1. Legal framework

The clinical process used by specialized addiction services was developed in accordance with the laws and regulations that define the service users' rights and that provide a framework for intervention planning and professional practice:

- *Civil Code of Québec* (S.Q. 1991, c.64, s.11, 12, 13, 14, 15, 16, 17, 18);
- *Act respecting health services and social services* (CQLR, c. S-4.2, s. 4, 5, 6, 8, 9, 10, 11, 12, 13, 19.0.1, 39.6, 100, 101, 102, 103, 104, 505);
- *Organization and Management of Institutions Regulation* (c. S-5 r.5, s. 6, 35, 42, 49);
- *Professional Code* (CQLR, c. C-26, s. 37, 37.1, 37.2, 39.4);
- *Youth Protection Act* (CQLR, c. R-34.1, s. 2.4, 8, 32, 39, 39.1);
- *Act respecting the protection of persons whose mental state presents a danger to themselves or to others* (CQLR, c. P-38, s. 8, 9, 14, 15, 16, 17, 18, 19).
- *Act to combat maltreatment of seniors and other persons of full age in vulnerable situations* (CQLR, c. L-6.3, Chapter IV, s. 8., Chapter III, s. 17, 20, 21.)

2.2. Guiding principles

The guiding principles of the clinical process are based on work done by specialized addiction services and on the 2018-2028 interdepartmental action plan for addiction (MSSS, 2018).

Promote access to and continuity of care and services: The specific needs of each service user are taken into consideration in the delivery of specialized addiction services. This principle reduces

barriers to access by providing coordinated and integrated care and services in an equitable manner, regardless of factors such as income, place of residence, education, level of vulnerability, etc. The “no wrong door” principle applies.

This means connecting with individuals who meet the eligibility criteria for specialized addiction services at the right time, in the right way, and in the places where they live (MSSS, 2018). Continuity refers to the involvement of a case manager and an emphasis on interprofessional collaboration with internal and external partners to ensure a smooth transition for the service user. These actions ensure the process meets the service user’s needs efficiently and effectively, and that interventions are results-oriented and have direct impacts (benefits) on the service user and their entourage.

The service user at the centre of discussions and decisions that concern them: The service user is the main partner in any interventions that concern them. “Their active participation, along with that of their entourage, is essential to the organization, planning and delivery of care and services” (MSSS, 2018). Importance must be given to upholding, respecting, and protecting the person’s rights by respecting their personality, way of life, differences, wishes, opinions, aspirations, abilities, potential, and connections with their environment (MSSS, 2017 and 2018b).

The establishment of a care and services partnership between service users, their entourage, and health and social services professionals helps to ensure the experience is in line with the service user’s and the entourage’s expectations and needs, and favours their self-determination. This partnership reinforces the service user’s autonomy and responsibility with regard to their rehabilitation process and their health.

Collaborative practice in the delivery of care and services: Promoting respect and recognizing the contributions of all partners helps to increase the collaboration, teamwork, and trust needed to work from a shared care and service perspective (Thomson, D., 2015). The quality of care and services is positively influenced when a collaborative practice approach is adopted by all internal and external partners, and by the settings that service users are likely to frequent during the process. Collaborative leadership supports the implementation of this guiding principle.

The members of the entourage are important partners in the various steps of the clinical process. They encourage the service user to maintain the process and work toward achieving their goals. When the service user is a member of the entourage, the involvement of those close to them is just as important.

Actions based on knowledge and experience: Basing and updating interventions and the organization of services as closely as possible on evidence-based approaches, interventions and theoretical models, promising or innovative data, and best practices. The quality of professional practice is based on “the importance of experimental innovation, which refers to the knowledge and experience of case workers, users of alcohol and other drugs (AOD), gamblers and Internet users, and their entourage” (MSSS, 2018).

3. Conceptual framework

The fundamental theoretical concepts, conceptual models and approaches recommended by specialized addiction services are closely related. Together, they form the foundations of the intervention.

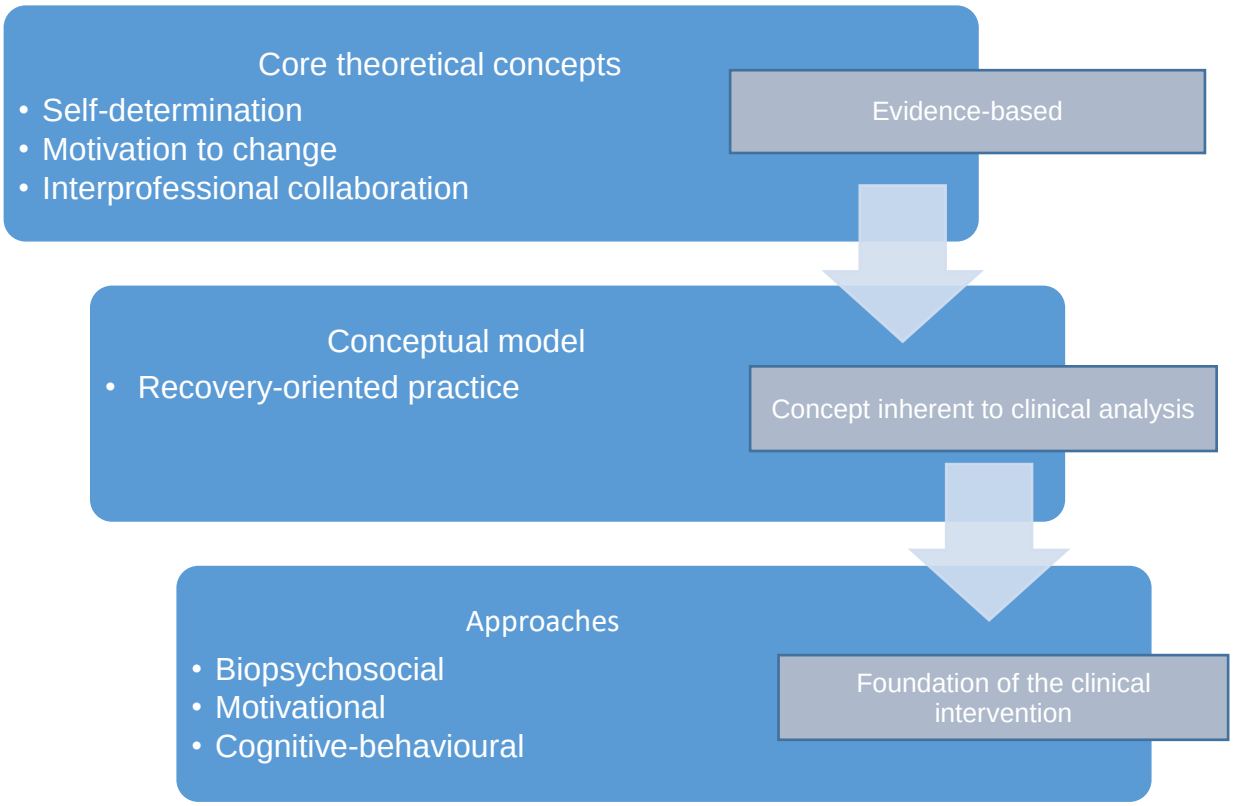

Figure 1 Conceptual framework

3.1. Core theoretical concepts

In addition to the previously mentioned guiding principles, other key concepts have been identified as central to the clinical process of specialized addiction services:

Self-determination

Self-determination is “the act of deciding by oneself and for oneself.” This includes the notion of decision-making autonomy, which is defined as the ability to exercise one’s judgment and make decisions about one’s life, in a fair and informed manner, with or without assistance, while accepting the possible associated risks. It refers to the notion of *empowerment*” (MSSS, 2021, p.83). According to self-determination theory, a context that promotes autonomy and an increased feeling of competence contributes to an increased readiness to change (Tremblay & Simoneau, 2010).

From an intervention perspective, a practice based on self-determination should have the following characteristics (Fong *et al.*, 2019; *Psychotherapy and Counseling – Selfdeterminationtheory.Org*, 2022; Sarrazin *et al.*, 2011):

- A case worker who listens well, empowers the service user, expresses understanding, and works to build a rapport with the service user;
- A non-hierarchical communication style;
- Positive and/or constructive feedback for the service user;
- Full information for the service user about their health, treatment choices and competencies.
- New ways for the service user to meet their needs in terms of relationships, competencies and choices.

Motivation to change

Motivation to change is a person's willingness to change their own beliefs and behaviours (Carleton University, 2015). It is mutable, and the helping relationship can have a significant influence on it. Service users who are reluctant or ambivalent to change benefit from the motivational interviewing approach to prepare them for change or to help them maintain the changes they have already made.

Interprofessional collaboration

The severity of the addiction problem and the co-occurring issues (judicialization, mental health disorders, intellectual disability, physical health problems, etc.) require strong collaboration and teamwork with partners, as well as the use of complementary expertise (MSSS, 2018).

Interprofessional collaboration is defined as: "An optimized dynamic process that is part of a participatory partnership approach to care and services, in which the person, their entourage, and the community are key players on the clinical team" (CISSS de l'Outaouais, 2020).

The involvement of one or more members of the interdisciplinary team and of internal and external partners is required to achieve a common objective focused on the needs, well-being and health of the service users. It is a communication and decision-making process that promotes the accountability and commitment of all parties and that enables the knowledge and competencies of the various stakeholders to synergistically influence the care and services provided (Consortium national de formation en santé, 2017).

There are six core competencies central to effective interprofessional collaboration (Consortium national de formation en santé, 2017):

- Provide care and services centered on the person, their entourage, and the community;
- Ensure clear communication between professionals;
- Clearly define, understand and respect the roles, responsibilities and expertise of the various professionals;
- Implement collaborative leadership;
- Work as a team for the well-being of the service user and their entourage;
- Prevent and resolve conflicts between professionals.

3.2. Conceptual model and clinical approaches

The conceptual model and clinical approach serve as guidelines for implementing interventions, thus supporting the application of each step in the clinical process. They must guide case workers and be reflected in the care and services they provide to service users and their entourage.

The conceptual model influences the case worker's perspective on all aspects of their interventions, whereas the clinical approach guides their interactions with the service user.

The conceptual model chosen by the DPSMD is **recovery-oriented practice** since it applies to anyone who might benefit from specialized addiction services. Interactions with service users during interventions are framed by approaches. The ones chosen by the specialized addiction services are: **the biopsychosocial approach, motivational interviewing, and the cognitive-behavioural approach**.

3.2.1. Recovery-oriented practice

The conceptual model of recovery-oriented practice is based on the person's experience and their journey toward a life they consider satisfying and fulfilling, despite their personal difficulties. This model is based on the adoption of practices that inspire hope (Mental Health Commission of Canada, 2015; MSSS, 2017).

Interventions with the person are based on the core components of recovery and must be guided by the belief that the person has the ability to take action with respect to: (Association québécoise pour la réadaptation psychosociale, 2018; Centre d'études sur la réadaptation, le rétablissement et l'insertion sociale and Centre national d'excellence en santé mentale, 2012; Mental Health Commission of Canada, 2015; MSSS, 2017).

- Regaining control over their life;
- Identifying their own needs and strengths;
- Developing their skills;
- Being accountable for their actions;
- Using available resources to meet their needs.

In the recovery-oriented conceptual model, **community** refers to the importance of providing interventions directly in the person's living environment and encouraging them to use resources found in their own neighbourhood or community.

The following is a non-exhaustive list of ways to adapt the recovery-oriented approach to the service-based rehabilitation process (Association québécoise pour la réadaptation psychosociale, 2018):

1. Case workers develop partnerships with neighbours and communities;
2. The entourage is involved;
3. Case workers play a key role in helping the person engage in activities not related to mental health or addiction;
4. Services extend beyond managing symptoms to promote workplace integration, life goals, hobbies, and interests;
5. Case workers are well informed about support groups and community activities;
6. The procedures in place can be applied to quickly refer service users to other resources;
7. Service users are involved in the assessment, development, and delivery of services.

3.2.2. Biopsychosocial approach

"The biopsychosocial approach is a way to understand the origin of addictions, but also the consequences of them. This comprehensive conceptual model therefore guides the intervention in a structured way, without prescribing a specific therapeutic method. It states that all three spheres (biological, psychological and social) must be taken into account in attempting to understand the emergence of an addiction, but also in developing a treatment plan" (Bertrand *et al.*, 2010, p.3).

"Because of its multidimensional nature, the biopsychosocial approach is considered a comprehensive approach to addictions. It is actualized in intervention practices ranging from pharmacotherapy to cognitive-behavioural, motivational, systemic, etc. psychosocial

approaches. […] Intervention approaches take different forms depending on the issue and the need, the evidence, the expertise of the case workers, and the clinical orientations" (Bertrand *et al.*, 2010, p.3).

According to this approach, the treatment offered to the service user is not aimed solely at reducing the symptoms; it must also be adapted to their biological, psychological, and social needs in order to promote their recovery (Chauvet *et al.*, 2015).

The social aspect of this approach is central to specialized addiction services. Family and/or couples' meetings must be scheduled and systematically offered, and even strongly recommended. A specialized assessment of the entourage is part of the core services, from the outset (ACRDQ, 2011).

3.2.3. Motivational interviewing

Motivational interviewing (MI) is a person-centered intervention approach that aims to increase an individual's motivation to change a specific behaviour through directive communication, by encouraging the person to explore and overcome their ambivalence (R. Miller & Rollnick, 2013). Motivational interviewing is a collaborative, person-centered conversational style used to build motivation and commitment to change, by exploring and overcoming ambivalence, and by exploring the person's reasons for wanting to change, all within an atmosphere of acceptance and compassion (R. Miller & Rollnick, 2013).

The use of motivational interviewing, starting from the assessment meeting onwards, contributes to a significant increase in service user retention and engagement in the rehabilitation process (Desrosiers & Ménard, 2010). This approach plays a large role in helping the service user to achieve their goals, or at least to understand the reasons why they want to change (Institut universitaire sur les dépendances du CIUSSS du Centre-Sud-de-l'Île-de-Montréal, 2016).

Because personalized feedback is another ingredient known to promote awareness and intention to change, it is frequently incorporated into MI (Burke *et al.*, 2003), without necessarily being a component of it (Desrosiers & Ménard, 2010). Moreover, the **transtheoretical model (stages of change)** (Prochaska & DiClemente, 1992) presented in **Appendix A** is often used as a complement to MI.

This approach involves the non-linear use of four processes (Association francophone de diffusion de l'entretien motivationnel, 2022):

- **Engaging in the relationship** means establishing a relationship based on mutual trust and respectful assistance by:
  - Showing empathy and non-judgment;
  - Supporting the service user's free will and autonomy;
  - Lessening the service user's resistance.

- **Focusing** aims to "reach an agreement with the person on the direction the support will take":
  - Listening to the service user's goals in terms of the changes they want to make;
  - Communicating relevant goals that could be worked on;
  - Determining the goals to work on with the service user or agreeing on a common theme for the change.

- **Evoking** is the process by which the case worker helps the service user to verbalize their own arguments and motivations to change by drawing out the change discourse**.**
  - Encouraging the change discourse (advantages of changing/disadvantages of maintaining behaviours);
  - Evoking the service user's personal resources, desires, and motivations to change;
  - Working with the service user to increase their sense of self-efficacy;
  - Evoking the discrepancies between values and addictive behaviours;
  - Adjusting interventions according to the stages of change (Appendix A) and the level of care and services required.

- **Planning** is possible when the service user is committed to the process and willing to work toward change.
  - Evoking the service user's strengths, competencies and experiences that can be used to make the desired changes;
  - Exploring and identifying the means available to the service user to initiate the identified changes;
  - Learning about tools the rehabilitation centre can give the service user to promote their autonomy and free will;
  - Supporting the service user in implementing these tools.

3.2.4. Cognitive-behavioural approach

The cognitive-behavioural approach is a set of interventions based on learning theories (Institut universitaire sur les dépendances, CIUSSS du Centre-Sud-de-l'Île-de-Montréal, 2016). It promotes the use of a set of techniques aimed, among other things, at analyzing thoughts, emotions, consequences, behaviours, etc.

This approach promotes the development of skills to avoid and manage at-risk situations and to increase alternatives to the behaviours the service user wants to change. Monitoring thoughts (cognitive distortions, automatic thoughts) and behaviours is a tool used in this approach.

There are various types of interventions: teaching by the case worker, at-home exercises (self-observation, meditation, breathing, relaxation, visualization, etc.), coaching by the case worker to develop new skills through role playing, modelling, coaching on updating the proposed tools, etc. (Magill & Ray, 2009; Shearer, 2007).

4. Stages of the clinical process

"The clinical process explicitly frames the intervention through a series of measures, sometimes offered as instructions ("the case worker must…," "the case worker's role at this stage is to...") and other times as suggestions ("at this stage, the case worker can..."). It is a general way of proceeding that addresses all the interventions surrounding the development of the service user's IP" (Fournier, 2009, p.14).

The case workers' clinical judgment, knowledge, and experience remain essential to the clinical process.

During a service episode, the simultaneous involvement and collaboration of the programs or departments of the CISSS de la Montérégie-Ouest and other CISSSs or hospitals are sometimes necessary. At any time during the clinical process, a referral to another DPSMD service, to a CISSS de la Montérégie-Ouest internal partner, or to an external partner may be considered, depending on the evolving needs of the service user and their entourage.

Stepped care and services is a model of care and service delivery in which interventions are carried out in a hierarchical manner based on the service user's needs (Chauvet *et al.*, 2015). To help the service user

achieve their goals, the minimum necessary care and services are provided; when the proposed treatment is insufficient, they are increased. Assessment and monitoring of the service user's progress will determine whether the care and services need to be increased or decreased (stepped up or stepped down). The more complex the problems, the more complex the interventions (Chauvet *et al.*, 2015; INESSS, 2019).

Specialized addiction services are organized based on a **hierarchy of care and services (stepped care and services)**. This service organization has been proven effective in a context of specialized addiction services because (Caron & Bellemare, 2019; Institut universitaire sur les dépendances, CIUSSS du Centre-Sud-de-l'Île-de-Montréal, 2016; Sobell & Sobell, 2000):

- the services are adapted and personalized to the service user and their entourage;
- not all service users respond equally to different types of interventions and approaches;
- service users' needs and motivation to change can evolve rapidly;
- the flexibility of the care and services offered promotes treatment compliance;
- service users' characteristics, needs, and requests are taken into account to ensure an optimal level of care and services that is as accommodating as possible.

The hierarchical delivery of services is intended to facilitate the migration of service users between service levels through liaison mechanisms between care and service providers. Three levels of addiction services are recognized and defined by the MSSS: general services, specialized services, and highly specialized services. As such, the hierarchical delivery of services aims to provide the service user with the right service, at the right time, in the right place, with the appropriate expertise. Two-way mechanisms are needed to facilitate the transition between specialized and highly specialized services, and general services and specific services (MSSS, 2007).

The level of care and services required is determined during the initial assessment and during IP elaboration and reviews; it is reassessed regularly throughout the rehabilitation process, based on (Caron & Bellemare, 2019; MSSS, 2020; Sobell & Sobell, 2000):

- frequency of addictive behaviours observed through weekly monitoring;
- severity of the problems;
- persistence of the symptoms;
- degree of impaired functioning;
- complexity of the clinical situation (co-occurring disorder, need for social reintegration, etc.);
- service user's preferred choice of treatment;
- response to the treatment offered;
- history of previous approaches (recurrence, approaches not completed, other services received, level of care, services never offered, etc.);
- service user's reasons for wanting to change;
- service user's availability and availability of other care and services required.

Specialized addiction services case workers determine the intensity of care and services required based on the clinical assessment and the specific needs of each service user, ensuring they are minimally disruptive to their lifestyle while being as effective and efficient as possible (MSSS, 2018). The modulation of care and services could correspond to:

A lower level of care and services, or a decrease (step down) in intensity by potentially:

- offering self-care tools (bibliotherapy, meditation exercises, etc.);
- decreasing or stopping certain services (individual, family, couple's meetings, etc.);
- decreasing or stopping participation in a service;
- recommending a period of reflection before continuing the process;
- stopping the process and referring the service user to another, less intense service, offered by general social services or by an internal or external partner, as needed;

A higher level of care and services, or an increase (step up) in intensity by potentially:

- increasing the frequency of individual, family, or couple's meetings;
- participating in several groups simultaneously;
- referring the service user to internal and external partners for interprofessional collaboration;
- referring the service user to highly specialized services;
- involving new members of the entourage in the process;

Maintenance of the services:

- maintaining the objectives and means established in the IP;
- maintaining the rehabilitation services (e.g., individual, group meetings, etc.);

A **guide for the practical use of stepped care and services** is presented in **Appendix B** and **a continuum of stepped care adapted to the biopsychosocial and MI approaches** is presented in **Appendix C**.

Interventions carried out during the clinical process must be carefully considered and updated based on the stepped care and services approach. The main steps in the clinical process are described in the following figure:

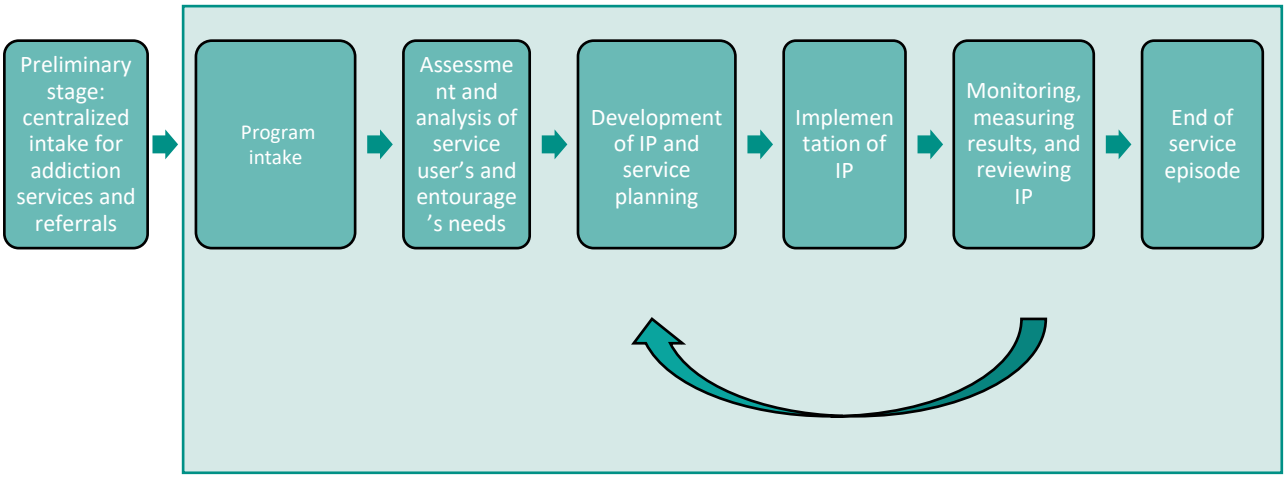

Fig. 2 – *Stages in the clinical process*

4.1. Preliminary stage: centralized intake for addiction services and other referral mechanisms

The service request is analyzed in order to make a decision on the eligibility of the request (Direction des programmes Santé mentale et Dépendance, 2021a). This analysis is done using standardized screening tools, an in-house screening tool (for the entourage), or a specialized addiction assessment (done by the liaison nurses) and **must be completed** for all service requests by one of the following actors:

- the centralized intake desk for specialized addiction services;
- internal and external referring persons (first-line addiction worker, community or school setting, teacher, social worker, physician, etc.);
- the hospital liaison person;
- case workers (for on-site service requests).

When the referring person has not filled out the standardized screening tool, they are asked to fill it out with the service user to confirm eligibility, if they have been trained to use the standardized screening tool.

The case worker who receives the referral or an available case worker must fill out the standardized screening tool if it would take too long for the trained referring person to fill it out with the service user, or if the referring person has not been trained on the standardized screening tool.

While it's best to handle all requests through the centralized intake desk, the concept of "*no wrong door"* is applied, in order to adjust to the needs of service users.

Once eligibility is confirmed, the service user's priority level must be established,[2] and the service user assigned to the required service, based on the problem identified. To do so and to ensure the safety of the service user and the public, the following activities are done by the case workers or by the centralized intake desk:

- Determination of what triggered the service request, and the service user's expectations and needs;
- Results of the standardized screening tools;
- Suicide risk assessment;
- Adult homicide risk assessment and management, if applicable (Outil d'estimation et de gestion du risque d'homicide);
- Referral to required services as needed, with the service user's consent.

The main steps carried out by the centralized intake desk are illustrated in Figure 3.

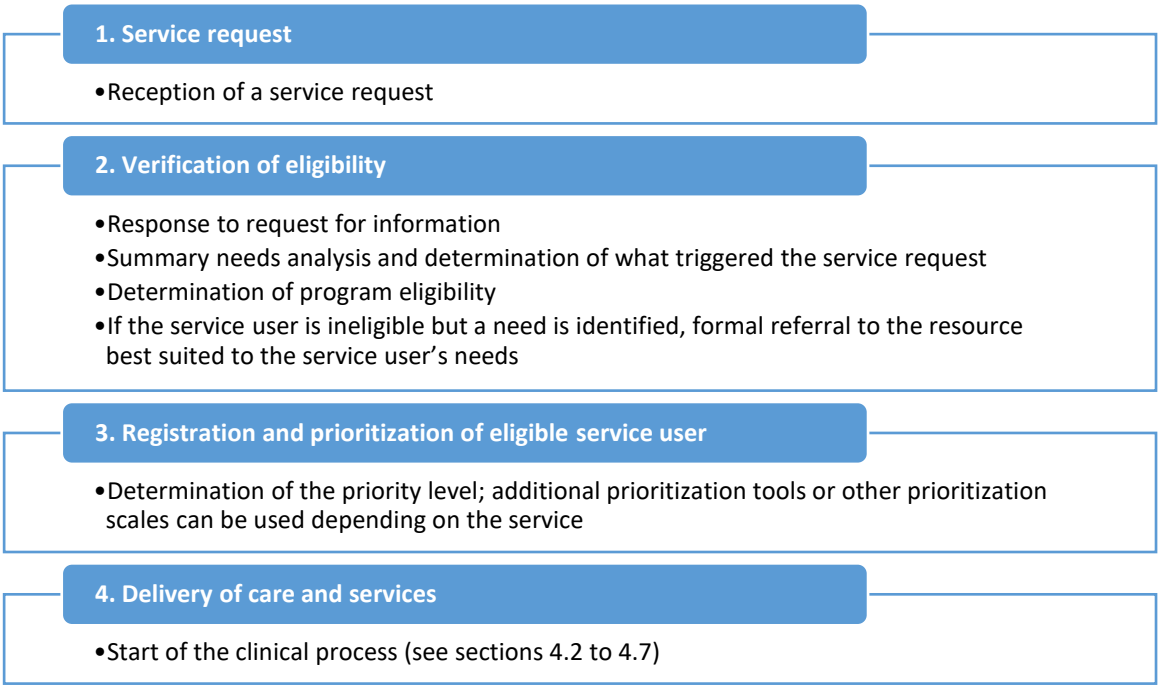

Figure 3 Steps carried out by the centralized intake desk

This preliminary step to the clinical process ends once the service user is assigned to a case worker or registered for an intake activity, or when the care or service episode begins. Note that it is **strongly recommended** to encourage service users to come to their first appointment **accompanied** by a member of their entourage, their referring person or a case worker, in order to support the service user, gain a dynamic and interactional understanding of the service user and their entourage, and promote better compliance with the service (ACRDQ, 2011).

[2] A document is currently being drafted to determine the priorization criteria for the clientele of the external services.

The following steps are presented in the order in which they must take place. The recommended duration of each step is determined by the work organization, the MSSS recommendations, and the clinical judgment of the case workers.

4.2. Program intake

This step aims to present the services to the service user and to validate their understanding of the service request, from a recovery perspective. It is the foundation of the partnership relationship with the service user, and its success will be influenced by the rapport created between the case worker, the service user, and their entourage.

This step is carried out by the case worker conducting the intake meeting or by the case manager. The case manager is assigned based on their job title and the complexity of the issues facing the service user and their entourage, the clinical issues, or the competencies required, when possible. Otherwise, they are assigned from among the available case workers.

Intake is done as a group or individually. At points of service where group intake is offered, individual intake is reserved for service users under the age of 18, for families, and for service users with limitations, psychological difficulties, social issues, or any other factor deemed relevant by the case worker.

4.2.1. Summary analysis of the request

This step is done before the meeting with the service user. It involves reading the information **already in the service user's file** and preparing for the intake.

- Read the file in full, identifying the relevant reports and assessments as well as the overview of past services.
- Identify expectations, needs, and any information that requires clarification;
- Confirm the partners involved with the service user and their entourage;
- Identify the legal aspects involved (court order, involvement of youth protection, etc.).

4.2.2. Intake meeting

Before meeting with the service user and their entourage, ensure a clear understanding of the key elements of their situation, to avoid repetition.

- Check the service user's condition during the meeting: intoxication, disorientation, etc.;
- Proceed with double identification of the service user (PRO-10155);
- Present the service offer;
- Present the service user's rights and responsibilities, give a copy to the service user and their entourage;
- Obtain the service user's consent (CLI-60531) to receive care and services, or the consent of the parents or legal guardian if the service user is under the age of 14 and enter the information in the service user's file. For more information on consent, see the CISSS de la Montérégie-Ouest's consent policy (POL-10251).

The following actions can be taken in subsequent meetings, if all elements cannot be addressed in the first meeting. These actions are carried out according to the case worker's clinical judgment, based on the work organization and how the specialized addictions assessment is completed (self-administered or completed by the case worker).

- Explain the case manager's role, agree with the service user and their entourage on the course of the meetings, the expected duration, the procedure in case of a cancellation, etc.;
- Through motivational interviewing (**engaging in the relationship**), **validate** the needs and expectations of the service user and their entourage, and the reason for and context of the request **previously identified** in the screening tools, the progress notes or in the service request form in the physical or computer file;
- Identify the sources and level of the service user's motivation by referring to the **transtheoretical model (stages of change)**;
- If necessary, have the service user sign the confidential information release form needed to exchange information about the service user with external partners (where applicable);
- The confidential information release form is not required for communications and requests for copies of records within the CISSSMOs. However, it is recommended to inform the service user of the intention to contact an internal partner.

➲ If the service user **refuses the service:** Document the reasons given by the service user and their entourage and explain the possible consequences and the alternatives. Let the service user know they can submit another service request at any time. Enter a summary of the discussion in the service user's electronic record.[3]

➲ The service user and their entourage may be referred by the case manager to another CISSS de la Montérégie-Ouest department, or to any other internal or external partner, depending on their needs. The case manager ensures a smooth transition by relying on collaborative agreements between services, when they exist, or by guiding the service user through the process of obtaining the required service.

➲ The point of service (without identifying a specific case worker) provides support to the service user, if required, during the period between receiving the service request and assigning the case manager. All case workers may be asked to support a service user during this period. However, if the service user has developed a rapport with a specific case worker, preference will be given to that case worker to provide the required support (depending on their availability).

➲ If a service user misses an intake meeting, see the relevant procedure (Direction des programmes Santé mentale et Dépendance, 2018).

4.3. Assessment and analysis of the service user's and their entourage's needs

This step entails carrying out a specialized addiction assessment[4] in order to identify and analyze the biopsychosocial factors involved in the situation of the service user and their entourage. This analysis establishes the basic information that will influence all subsequent steps in the clinical process. There can be no more than 15 business days between the service request and the start of the assessment (with the exception of the entourage) (MSSS, 2022).

4.3.1. Identification and use of relevant assessment tools

The **biopsychosocial** needs assessment is done using specialized, recognized, standardized,[5] and computerized assessment tools. In addition to the specialized

[3] To add progress notes to the electronic records system, see the existing procedures (Direction des programmes santé mentale et dépendance, 2022).
[4] According to the professional orders, each discipline involved must also carry out its own assessment.
[5] The department has authorized the use of in-house tools pending the standardized tools provided by the MSSS for service users with problematic Internet use and their entourage.

assessment, many complementary assessment tools are available to case workers to obtain an accurate portrait of the service user's needs.

These tools and methods are used to determine:

- the presence of other addiction issues;
- the possible presence of co-occurring disorders;
- the need for social reintegration;
- the risk of suicide (for all service users) and/or homicide (for adults);
- the strengths and resources of the service user and their entourage, as well as their environment;
- the service user's stage of motivation in relation to their change objective;
- the level of care and services required.

This ensures that the selected care and services are safe and appropriate for the needs of the service user and their entourage.

➲ If needed, immediate interventions can be made (crisis management, support, etc.).

➲ The assessment must take into account the precariousness of the service user's situation, such as constant monitoring of the vulnerability factors to ensure the safety and well-being of the service user and their entourage.

➲ The assessments must be recorded in the service user's file in accordance with current standards (legislation, policies and procedures, professional orders' record-keeping requirements).

It is important to speak to the service user about the merits of involving their entourage in the rehabilitation process. This recommendation may cause the service user some anxiety; it's important to be sensitive and receptive to their fears, as this will help get the entourage on board with the service user's rehabilitation process as quickly as possible.

4.3.2. Analysis of the data according to level of care and services required

The analysis of the data obtained from the assessments done by each discipline (and the other assessments) forms the basis for a professional opinion. It also helps identify recommendations that can be discussed with the service user to make a joint decision about the care and services they will receive. This analysis considers the level of care and services required and must be guided by the fundamental principles of the recovery model and the biopsychosocial approach. It is about drawing conclusions based on the information obtained during the administration of the assessments, considering all the factors involved (protective factors, risk factors, service user's needs, preferences, etc.).

Personal and environmental factors can have a significant influence on the service user's involvement in their rehabilitation process and its success. It is therefore important to assess the overall situation of the service user and their entourage and the elements that may be included in the intervention plan, such as which members of the entourage to involve in the process, the service user's history (past use of specialized addiction services, past and current use of other services), the risk and protection factors related to the social environment, living environment, socioeconomic situation, etc.

4.3.3. Feedback on assessments

The results of the analyses and assessments are sent to the service user and their entourage, with the service user's consent (when they are present during the meeting). The results are shared during a discussion, in plain language. This is the perfect time to talk to the service user and their entourage to help them make an informed decision. During this step, the case worker takes the approach of commitment to the relationship and focusing **of the MI** presented in Section 3.2.4, and the principles of the recovery model, **by creating hope.**

The service user and their entourage are encouraged to express their opinion about the information presented and to ask for clarification, if necessary. This discussion lets the case workers, the service user, and their entourage:

- develop the partnership relationship;
- hear the opinions of all parties;
- discuss the vision of the problem and the associated factors;
- discuss the risks associated with addictive behaviours;
- reflect the strengths and competencies of the service user and their entourage;
- set priorities;
- discuss the services that will be offered based on the intensity of care and services required;
- discuss the needs, expectations, motivations, interests, and changes they want to prioritize;
- explore their understanding of the situation;
- give recommendations and referrals, and provide guidance by addressing the following:
  - The relevance of making a referral (if the assessment reveals that the level of care and services required is consistent with general social services, for example);
  - The level of urgency of the referral;
  - The best time to make the referral;
  - The terms and conditions (Who does what? Should they go directly to the organization themselves?);
  - Wait times for these services, where applicable;
  - The level of commitment these new services will entail.

➲ At the end of this step, the service user and their entourage must have received all the information needed to make a voluntary and informed decision, and the priority needs must have been identified with the service user, their entourage, and the case workers involved.

➲ The results of this discussion must be recorded in the service user's file.

4.4. Development of the intervention plan (IP)[6] and service planning

An IP must be present as soon as follow-up is initiated with the service user or their entourage. The purpose of an IP is to set objectives according to the S.M.A.R.T. model (see Appendix D) with the service user, their entourage, and the partners involved. This step is based on the priority needs

[6]The IP is mandatory in accordance with the *Act respecting health services and social services* (CQLR c. S-4.2, Sect. 102). For more information, see the Règappendix
lement sur les modalités d'élaboration et de révision des plans d'intervention des usagers (REG-10173) available for consultation and download on the CISSS de la Montérégie-Ouest intranet.

identified in the previous step, with a focus on the service user's competencies, abilities, and resources rather than on their limitations, from a recovery perspective. The IP must be developed based on the **organization of stepped care and services**.

It identifies:

- what the service user and their entourage want to work on with respect to the priority needs;
- the goals to be pursued;
- the means/strategies to be used;
- the frequency of meetings and the anticipated length of time the services will be provided;
- the services required and the resources needed to meet the needs.

This step involves planning how the intervention results will be measured.

4.4.1. Identification of relevant partners

When the service user's authorization is present in the file (for external partners), it is important to contact the internal and external partners to establish potential areas of collaboration, validate information, update services received or in progress, check the dates for ISP, etc.

Interprofessional collaboration

If the service user has various issues requiring services from different departments, it is imperative that the case workers concerned work together (e.g., a service user with an active service episode in the mental health program will have both an addiction IP and a mental health IP, but both case workers will need to be in contact to plan the IIP.

4.4.2. Advance preparation for the IP/IIP/ISP

When the case manager is the only case worker involved with the service user, or when they need to prepare for a consultation meeting, they must familiarize themselves with the main points to be discussed with the partners before the IP meeting takes place, including:

- → Identify and organize important points to list before the meeting;
- → Reflect on the significant elements to evoke;
- → Explore the different collaboration opportunities with internal and external partners, given the priority needs.

Interdisciplinary collaboration is needed when two or more case workers from different disciplines are involved, or when working with an internal or external partner at the CISSS de la Montérégie-Ouest.

After notifying the service user and obtaining their consent to share information, the case manager must contact the appropriate case workers to:

- share the expectations and priorities mentioned by the service user and their entourage;
- share observations and insights from various case workers;
- smoothly coordinate the interventions;
- schedule the IP/IIP/ISP meeting.

To meet the service user's needs, the case worker(s) select(s) the type of plan required (IIP and/or ISP).

Multiple plans may be needed, but each case worker involved in drafting the IIP or ISP (as the case may be) must also develop an IP for their discipline. When another professional drafts the IP, case workers must ensure their interventions are in line with the plan.

4.4.3. Preparing for the IP/IIP/ISP meeting with the service user and their entourage

It is important to prepare the service user and their entourage by asking them who they want to invite and by explaining what will happen at the meeting to develop the IP/IIP/ISP:

- Terminology;
- Meeting objectives;
- Who will attend and what their roles will be (e.g., in relation to their mandate);
- What to expect during the meeting;
- Identification of needs and expectations.

→ During an **interdisciplinary** IIP or ISP meeting, the case manager explains to the service user what will happen at the meeting and addresses any concerns they might have. The main case worker in the file, the service user, and their entourage also identify the priority objectives and their expectations about how the services will be coordinated. Finally, the case worker obtains the service user's consent for the members of the interdisciplinary team to attend the meeting to develop their IIP or ISP.

Each member of the interdisciplinary team or partner present at the ISP meeting ensures that the service user and their entourage understand the services being offered and provided, while identifying the objectives in accordance with their mandate and discipline.

→ During a **multidisciplinary** meeting, the main case worker prepares the service user and their entourage for the IP meeting, using strategies similar to those recommended for an IIP-ISP.

→ Each service user can have an individual IP as well as a family/couple's IP.

4.4.4. Meeting to draft the IP with the service user and their entourage

The purpose of this meeting is to agree, with the service user and their entourage, on the objectives and intervention methods, based on the service user's needs, assessments, values, reality and conditions. The plan must take into account the service user's change objectives, which may have emerged through the process of evoking, planning and focusing that took place during the motivational interviewing.

How feasible the chosen methods are will determine how actively the service user and their entourage are involved in the process and how easily they achieve their objectives. The same attention must also be given to the internal and external partners who will be involved, to determine the feasibility of the objectives based on their availability.

The evidence suggests that a plan's effectiveness largely depends on the service user's commitment to and active participation in identifying the target objectives.

The choice of **intervention objectives** may be guided by the following elements:

- They are safe for the service user;
- They are consistent with the service user's rehabilitation goals;
- They are consistent with the priorities and possible level of involvement of the service user and their entourage;

- They are more likely to be achieved if the service user and their entourage receive specialized addiction services;
- They can be modified during the treatment;
- They are short term;
- They follow the S.M.A.R.T. model (see Appendix D).

→ The IP must reflect **the service user's needs** as identified by the service user themselves, their entourage, and the case worker.

→ It is important to choose terms that will encourage commitment by the service user and their entourage.

→ The IP is drafted on the form currently in effect. The IP must be placed in the service user's file and a copy given to the service user and their entourage.

4.5. Implementation of the IP

Interventions are conducted with the service user, their entourage, and the internal and external partners, when required and according to the agreed-upon terms. The case manager monitors the objectives, the treatment efficacy, and updates to the IIP or ISP throughout the services, even when multiple partners are involved. This involves adjusting services according to the level of care and services required, through continuous monitoring and the least intrusive methods possible that correspond to service users' evolving needs. Each case worker involved implements the plan based on the specific objectives or orientations developed jointly, the intervention methods, and the schedule agreed upon with the service user and their entourage.

Progress notes or follow-up notes entered in the service user's file must reflect the service user's progress toward achieving the objectives and the means identified in the plan. The notes must be produced in a timely manner, in accordance with the institution's record-keeping policies and procedures, to ensure continuity of the intervention.

Depending on the changes seen in the service user and their entourage, ongoing clinical discussions may take place between the case manager and the other case workers or partners to ensure the consistency and relevance of the interventions and the maintenance of a common vision of the situation.

4.6. Monitoring, measuring results, and reviewing the IP

4.6.1. Monitoring

While the IP is active, the case manager must be proactive and continuously vigilant regarding:

- regular monitoring of addictive behaviours and the change objectives of the service user and their entourage;
- changes in the service user's physical, psychological, or social condition and adjustment of services, if required;
- involvement of the service user in the approach;
- the need for a step up or step down in care and services (see Appendices B and C);
- analysis of risk factors to ensure the safety of the service user and the general public;
- analysis of shortfalls between the terms of the IP and the services provided;
- quality of the care and service experience for the service user and their entourage;
- the need for a new assessment based on difficulties identified.

The IP must reflect any changes in the service user's situation and be tailored to their reality throughout the clinical process.

4.6.2. Measurement of results and review of the IP

At this step, it is important to ensure that the IP has been followed, that it has produced the expected results, and that the service user has had a quality experience. The case worker must remain attentive to the service user and their entourage in terms of their satisfaction with the services received and any needs not met. At this step, they must also follow the stepped care and services approach, in order to adjust the intensity of services to the service user's situation.

The review entails the periodic monitoring of the elements in the IP. It is carried out with the service user, their entourage, and the partners, if required, who jointly agree on changes to the objectives and methods in the IP. As stated in the *Règlement sur les modalités d'élaboration et de révision des PI des usagers*, "reviews must be done according to the terms established during development of the IP, when a change occurs in the service user's condition or needs, or according to the standards set out by the service user program or the MSSS" (CISSS de la Montérégie-Ouest, 2019, p.14). The IP must be reviewed within 90 days.

The review is an opportunity to:

- go over the objectives with the service user, adjusting, removing or adding objectives accordingly;
- readjust and modify the plan and services, as needed, based on the changes in the service user's clinical situation;
- step up or step down the care and services;
- verify achievement of the objectives and the expected results;
- measure the impact of the intervention methods;
- share the service user's and entourage's vision of the set objectives, and the intervention strategies for achieving them.

4.7. End of episode, recommendations, orientations

The **service episode** may **end** at any time, once any of the conditions listed below are met:

- Achievement of the plan's objectives;
- At the end of an assessment, there is no identified need or request from the service user or their entourage;
- The service user is transferred to another resource for treatment of the addiction (external partner without a collaboration agreement with the CISSSMO) or to an institution for another reason;
- A new factor emerges that prevents the service user and/or their entourage from participating in and achieving the objectives in the intervention plan (prison, illness);
- Various constraints, including a lack of cooperation from the service user. *Before making this decision, see the procedure on service user absences;
- Inability to reach the service user, failure to follow the rules, expulsion or re-transfer of the service user;
- The service user and their entourage voluntarily and knowingly express their intention to end the services or refuse the services being offered;
- The service user leaves the region or dies.

Once almost all the objectives of the IP have been met, the case manager lets the service user and their entourage know that the interventions are about to come to an end. The service user is an active participant in this step, which involves agreeing on which objectives were met and/or what

to do next. With the service user's agreement, the partners concerned are informed that the service episode has come to an end.

Once the service user and their entourage have completed the process, or the service episode has come to an end, a debriefing meeting is held.

Each time a service episode ends, a note, a summary, or a closure report (depending on the program and as per instructions from the professional orders) must be placed in the service user's file as soon as possible, in accordance with the institution's policies and procedures on record-keeping. The note, summary, or closure report must contain:

- a summary of the interventions carried out;
- the degree of achievement of the objectives;
- the service user's satisfaction with the services received, if that information is available;
- the reason for the closure according to the IP, recommendations for a future approach, or follow-ups required;
- referral of the service user to other services or partners, if required. The report is a way to ensure continuity with interventions in a subsequent care or service episode (where applicable);
- all relevant clinical information.

The end of the service episode is the final step in the clinical process.

When the case worker is acting as the case manager, they must make sure arrangements are in place for the service user's follow-up before ending the service episode. They are also **responsible for ensuring continuity of the service user's services within the network by:**

- telling the service user how to access the services, as needed;
- supporting them and doing everything possible to make sure they receive the required services;
- facilitating readmission to specialized addiction services when a new service request is made (the case worker or the clinical coordinator offers the service user an appointment without referring them to the centralized intake desk and does the required assessments themselves).

5. Implementation

To assist case workers and managers with updating the clinical process, the professional coordinators, the SREPED respondents and clinical activities specialists, and the clinicians designated by management and the DSMREU provide support measures and an implementation plan containing various modalities, such as:

- Training and skills development activities;
- Appropriation activities;
- Clinical support for case workers;
- An assessment of implementation of the clinical process and its effects;

These support measures help to track the implementation of the clinical process, its quality and its follow-up. These support mechanisms ensure the relevance and consistency of the clinical process with the DPSMD's service offers, and with the norms and standards of practice within the CISSS de la Montérégie-Ouest.

5.1. Required competencies

The required competencies related to the clinical process used by specialized addiction services apply to all case workers who work with service users and their entourage in the various addiction programs and services.

Competency profiles specify the knowledge and competencies expected of all case workers in the performance of their duties. They include general and functional competencies related to the job title. For more information about the required competency profiles, see the Cadre de références sur les profils de compétences – employés catégorie 4, the Référentiel de compétences des membres de l'équipe de soin, and the Référentiel de compétences Intranet du CISSS de la Montérégie-Ouest for category 1 employees.

Management in specialized addiction services also expects case workers to have specific competencies related to the clinical process, which are listed in Table 1.

Competencies needed to apply the clinical process used by specialized addiction services
• Be familiar with the content of this document, including the basic concepts, the model (recovery) and the approaches recommended (biopsychosocial, cognitive-behavioural approach, and motivational interviewing), the steps in the clinical process (stepped care and services model), and the associated clinical tools; • Be familiar with the needs and the risk/protection factors of the clientele served by DPSMD's specialized addiction services; • Be familiar with the service offer, the eligibility criteria, and the trajectories of the various internal and external partners for supporting the clientele served; • Be familiar with best practices in risk prevention in terms of worsening behaviours, addictions and health for the clientele served by specialized addiction services; • Be familiar with how to draft and review service user IPs (CISSS de la Montérégie-Ouest, 2020); • Be familiar with the legal obligations related to interventions with this clientele; • Be familiar with the care and services consent process so as to guarantee respect for the principles of the service user's autonomy, integrity and inviolability, by recognizing their right to consent to or refuse the care and services offered to them (CISSS de la Montérégie-Ouest, 2021). • Tailor their interventions based on **recovery-oriented practices** at each step in the clinical addictions process; • Establish the level of care and services required for a service user based on the needs assessment. • Use motivational interviewing techniques throughout the clinical process; • Work in partnership with service users, their entourage, community partners, and other health and social services stakeholders; • Recognize the experiential knowledge of the service user and their entourage; • Build on the strengths and assets of the service user and their network; • Support the service user in exercising their rights and the social roles they want to fulfil (know-how); • Promote healthy lifestyle habits; • Provide suicide screening or intervention services; • Draft intervention objectives using the S.M.A.R.T. model; • Apply the CISSS de la Montérégie-Ouest consent policy to all care and services; • Maintain a rapport (empathy, active listening, expertise, clear advice) while taking into account the profile of the clientele served; • Adapt interventions to the situation and the cultural and religious values of service users and their entourage; • Work with professionals in other disciplines; • Demonstrate interpersonal and communication skills, in order to arrive at joint decisions with the service user and their entourage;

• Be willing to reflect on their practice and actively participate in professional development activities.

Table I: Competencies needed to apply the clinical process

Competency development activities may be carried out in relation to the **competencies needed to apply the clinical process in specialized addiction services**. These activities will be spread out over time, based on the priorities and needs identified in the competency development plan. The content will also be tailored to the case workers, depending on their roles and needs, and the human and financial resources available within the institution. For more information about competency development activities, the case worker should speak to their immediate supervisor.

Depending on the needs identified, the competency development activities may take different forms (clinical videos, learning activities, training, etc.). Regular clinical support meetings with the resource person in clinical supervision (PRCS) are needed to guide case workers through complex cases.

5.2. Roles and responsibilities in the application of the clinical process

Addictions coordinator

- Ensures that the DPSMD's addiction program is supported by a tailored clinical process developed based on current best practices;
- Facilitates the assignment of the necessary resources within the addictions program in order to update the clinical process and the dissemination, implementation, training, and ongoing assessment activities for the identified elements of the clinical process;
- Contributes to the development of the clinical process for the addictions program;
- Contributes to the implementation of dissemination, implementation, training, and ongoing assessment activities.

Service managers

- Take part in promoting the clinical process;
- Disseminate the clinical process and ensure its application in their sector;
- Ensure ongoing dissemination of the DPSMD's clinical process for all new employees (e.g., digital learning environment (DLE) page);
- Provide staff and managers with required and relevant training;
- Ensure that case workers participate in the required training, learning workshops, and other development activities;
- Ensure their service offer and clinical documentation are consistent with the clinical process;
- Monitor the number of IP/IIP/ISPs and the deadlines for drafting and reviewing IPs;
- Consolidate inter-program, inter-department, and inter-CISSS collaboration mechanisms;
- Gauge the satisfaction of service users and clinical teams through the various means at their disposal;
- Commit to reviewing the clinical process for continuous improvement purposes.

People in clinical leadership roles: clinical activities specialists, professional coordinators, SREPED, ICASI respondents.

- Implement and oversee the clinical process within their respective teams;
- Facilitate knowledge transfer and learning activities based on identified needs;
- Facilitate training on the clinical approaches of the clinical process;

- Contribute to applying clinical supervision methods in line with the clinical process;
- Contribute to improving professional practice in line with the clinical process;
- Identify competency development needs with the case workers in line with the clinical process;
- Contribute to developing and applying norms and standards of professional practice;
- Collaborate with the DPSMD to support the development of best practices;
- Promote interprofessional collaboration and the care and services partnership;
- Monitor the quality of the clinical process within their program or department.

Case workers

- Learn the content and apply the steps of the clinical process;
- In accordance with the CISSS de la Montérégie-Ouest's policy on consent to care and services, obtain the service user's voluntary and informed consent before providing care and services and throughout the service episode;
- Identify their training needs with respect to the content of the clinical process and update their training, with the exception of scheduled training sessions.
- Participate in competency development activities offered by the institution;

Case manager

- Ensure a **smooth service trajectory** for the service user and their entourage (facilitate access to the various services in the program, and readmit the service user, as needed);
- Facilitate access to the services offered by internal and external partners (e.g., adult mental health, DPJASP, DSSADG, Aire ouverte, rehab centres, community organizations, schools, youth centres, addiction prevention organizations, etc.)
- Promote interprofessional collaboration and avoid working in silos;
- Act as the main contact person for the service user and their network;
- Coordinate, plan and lead interdisciplinary services (IIP) and coordinate the individualized service plan (ISP), where applicable;
- Monitor the objectives, treatment efficacy, and updates to the IIP or ISP throughout the services;

The case manager's role **ends**:

- When the service episode ends (Section 4.7);
- When another case manager is appointed **by the professional coordinator**, for clinical reasons in the interest of the service user and their entourage (e.g., request for a change by the service user or the case manager).

Peer support workers

- Foster a feeling of hope in service users, as people who have faced and overcome addiction-related issues and adopted recovery strategies;
- Support and empower service users to regain control over their lives and their recovery;
- Provide expertise to keep the team focused on reducing stigmas and encouraging individuals to participate actively in their services (Association québécoise pour la réadaptation psychosociale, 2013, 2021).

Service users, representatives and entourage

- Get involved in the various steps of the clinical process;
- Based on their capacities and expectations, co-draft and review the IP by sharing all the information required for the needs assessment;

- Ask case workers to clarify the information in a language that is appropriate for them or ask for support with care and services;
- Sign the necessary authorization and consent forms;
- Share their experience as part of the continuous improvement of services through the various methods available to them.

6. Conclusion

The dissemination and implementation of the clinical process within the clinical teams in specialized addiction services contribute to the quality of services offered to service users. Consistency and harmonization of the practices covered in this document will ensure an equitable, evidence-based service offer. The review of the addiction services program and the drafting of practice guides anticipated in the coming years will help support practice and promote equity among the services offered to service users.

7. Appendices

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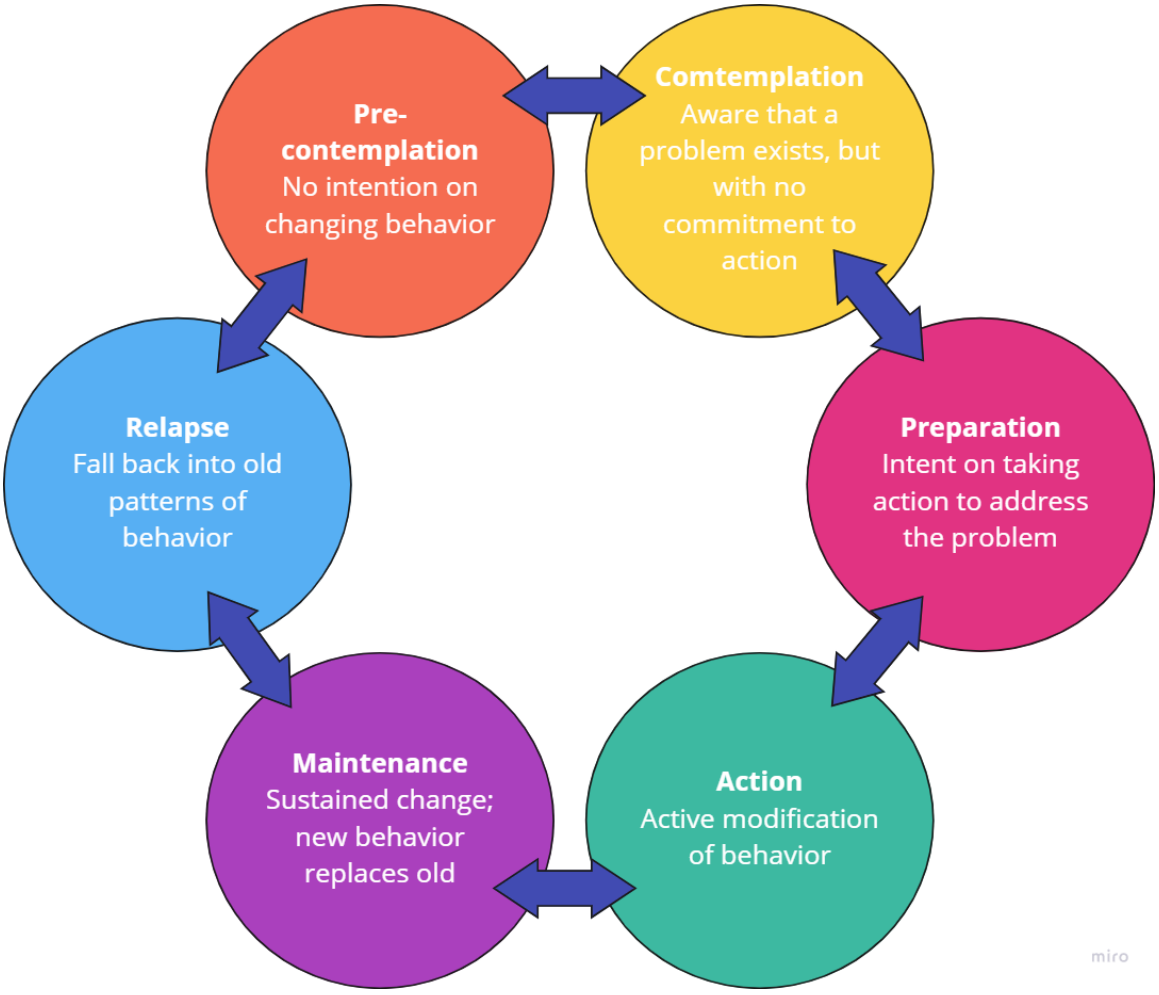
APPENDIX A
Transtheoretical model (stages of change)



1. **Precontemplation**:
   - Does not think they have a problem;
   - Does not want to change their behaviour;
   - Expresses low motivation to change;
   - Does not see the negative impacts in their life (although their entourage does)

2. **Contemplation (ambivalence)**:
   - Characterized by a state of ambivalence
   - Gradually acknowledges the problems, but not ready to commit to a concrete change process

3. **Determination (preparation)**:
   - Acknowledges they have a problem
   - Decides to change their behaviour
   - Thinks of ways they can change and makes plans to do so
   - Is ready to develop an action plan

4. **Action**:
   - Is actively involved, tries different techniques to change their behaviours and environment
   - Makes the decisions needed to achieve the desired changes
   - Gains confidence in their ability to change

5. **Maintenance**:
   - Has made the desired changes and is working on maintaining the status quo
   - Remains aware of potential situations that could cause them to revert to their old behaviours
   - Has strategies in place for dealing with potential risk situations
   - Is motivated to maintain the status quo

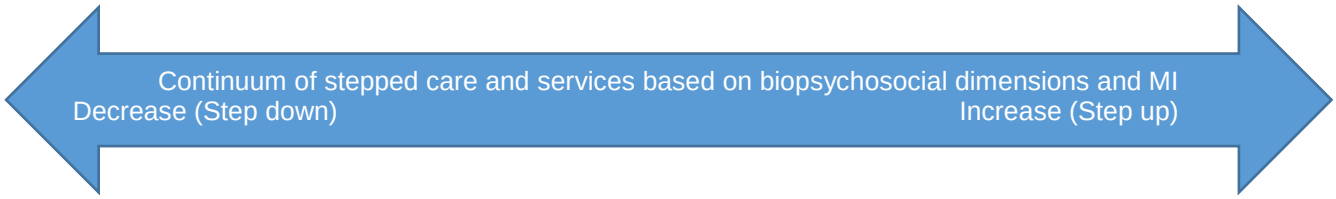
6. **Slip**:
   - Return to addictive behaviours for a short period of time following an episode of abstinence.

   Relapse:
   - Return to addictive behaviours for a long period of time following an episode of abstinence.
   - A relapse can happen and is part of the normal change process. It's not a pathological manifestation, but it can take time for the process to succeed.

APPENDIX B
Practical use of the stepped care and services approach

Practical use of the stepped care and services approach		
	Increase (Step up)	**Decrease (Step down)**
What?	Increase in the intensity of care and services when the initial intensity has not led to an improvement in the service user's condition. Takes the form of an increase in specialized addiction services or the addition of services by internal or external partners.	Decrease in the intensity of care and services when an improvement is noted in the service user's condition.
For whom?	A service user who requires more intense care and services than those initially set out in the IP.	A service user who was receiving more intense care and services and whose condition no longer requires such care and services.
How?	Through a discussion with the case manager. Through monitoring, case discussions, history of previous approaches, and when a discrepancy is noted between the identified and achieved objectives. By exploring the conditions that are helping or hindering use of another level of care. If the case worker and the service user agree on a change in the level of care and services, a three-week trial period is recommended to test the new strategies identified in the IP.	
When?	In line with the intervention plan and in any situation where the service user's safety is **compromised**.	In line with the intervention plan and in any situation where the service user's safety is **assured**.

APPENDIX C
Continuum of stepped care and services adapted to the biopsychosocial approach and MI



Bio	
• Stable health condition • Care or treatment that does not affect involvement in the approach • Service user no longer at risk of withdrawal complications	• Poor health condition • Medical treatment that affects involvement in the approach • Service user at risk of withdrawal complications
Psycho	
• Stable mental health condition • Organizational skills • Autonomous for activities of daily living • Confidence in services • Confidence in ability to maintain the changes • Service user knows their main triggers • Service user has developed psychological coping skills to deal with addictive behaviours, unpleasant emotions, social pressure, difficulties in daily life, etc. • Compliance with medication for mental health problems • Ability to maintain changes in a step-down context • Very few relapses in the past	• Unstable or complex mental health issues, or multiple needs • Challenges with activities of daily living • Unable to hold down a job or stay in school • Frequent interpersonal conflicts • Self-mutilation, aggressive behaviour, marked impulsiveness, suicidal or homicidal ideation, etc. • Distrust of services • At risk of continuing to use or relapsing • Service user has little insight about their main triggers • Service user has developed few psychological coping skills to deal with addictive behaviours, unpleasant emotions, social pressure, difficulties in daily life, etc. • Non-compliance with medication • History of frequent relapses
Social	
• Stable living conditions • No significant financial difficulties • Stability and satisfaction at work or school • No, few, or stable social or legal problems • Present, positive, and supportive entourage • Period of life conducive to change or not	• Poor living conditions, homelessness • Financial problems • Instability or dissatisfaction at work or school • Unstable social or legal problems • Frequent or severe conflicts with family members or entourage • Period of life conducive to change
Motivation to change	
• Moderate-to-high motivation to change; • Stage of change: preparation, action, maintenance, few slips back to previous stages; • Confidence in ability to change • Recognizes the addiction problem and its associated impacts • Active involvement in the approach, achievement of certain objectives in the IP	• Low or highly variable motivation to change • Stage of change: precontemplation, contemplation, preparation, with slips back to previous stages • Low feeling of confidence in ability to change • Low involvement in the approach (absence, little interest, etc.) • Few changes made, objectives of the IP not achieved

APPENDIX D
Criteria for developing S.M.A.R.T. objectives

S.M.A.R.T. objective	
Specific	• Adapted to the characteristics and needs of the service user and their entourage; • Enables the service user and their entourage to improve their condition or level of functioning; • Must be relevant and motivating for the service user and their entourage.
Measurable	• Aim for a level of development or recovery of the service user's/entourage's health or well-being that is observable and measurable; • Specify the success criteria in achieving the objective: duration, target percentage, expected frequency, desired proportion, finished product and characteristics, etc.; • Word the objective so that the progress can be measured following the interventions.
Attainable	• Focus on an objective that can be achieved over the course of the intervention plan; • Formulate the objective positively (focus on improving the situation instead of stopping certain behaviours), in plain language, with an action verb.
Realistic	• Choose an objective that is attainable for the service user and their entourage. • The objective must be realistic given the environment, support network, characteristics, level of functioning; • Have realistic expectations of the service user and their entourage.
Timely	• The timeframe for achieving each objective is limited and specified; • Each objective can be achieved at a different interval within the same plan.

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