Integrating Mental Health Services and Addiction Services

Provided by the Government of Yukon

Louise Michaud, MPA Candidate

School of Public Administration

University of Victoria

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Client: Yukon Department of Health and Social Services
Sherri Wright, Assistant Deputy Minister, Health Services and
Brenda Lee Doyle, Assistant Deputy Minister, Social Services

Supervisor: Dr. Rebecca Warburton
School of Public Administration, University of Victoria

Second Reader: Dr. Thea Vakil
School of Public Administration, University of Victoria

Chair: Dr. Budd Hall
School of Public Administration, University of Victoria
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Executive Summary

Introduction

The Yukon Department of Health and Social Services is the government department mandated to deliver both mental health and addiction services. Currently, these services are delivered by three programs, operating independently of each other. Demand for both mental health and addiction services is trending up and is expected to continue to increase. The department does not expect to receive any significant budget increase in the foreseeable future, so it must find ways to improve service capacity using existing resources. This will require the department to make significant changes in the organization and to the work processes of a system that has been in place for many years. If this problem remains unaddressed, even current service levels will be unsustainable, so this project seeks to answer how, and to what extent, the Yukon Department of Health and Social Services can integrate mental health and addiction services in a manner that is consistent with promising practices in the industry. This paper will also review the potential obstacles to implementing significant change and make recommendations for moving forward.

Methodology and Methods

Borrowing from the concept of appreciative inquiry, this methodology focuses on identifying the positive aspects of a situation and on beginning the process of change management that moves an organization towards a future state that is based on best practices (Hetherington et al., 2009, p.2).

In addition to a literature review, this research consisted of conducting interviews with 18 individuals working for the Department of Health and Social Services. The interview format
was designed to elicit participants’ views on service integration and to ascertain their level of change readiness.

**Key Findings – Literature Review**

The literature review confirmed that co-occurrence of mental health and substance abuse issues is common in Canada and the United States. While there has been skepticism about the validity of integration of services for people with comorbidity relating to mental health and substance abuse, the cautions are generally related to ensuring that two dysfunctional systems aren’t combined to create a bigger issue (Cherry, 2008, p. 410). Service delivery integration, if focused on continuity and quality of care, benefits consumers, service providers, and program administration and funding (Pederson, 2013, p. 753).

The reasons why integration often fails are not typically related to service outcomes, but rather to the logistics of moving to an integrated model. Funding, politics and ideology combined with practical issues (facility location, staff expertise and credentials), pose logistical barriers to service integration (Davidson and White, 2007, p. 110). Different service mandates and disconnected priorities pose additional challenges to linking services (Fuller et al., 2011, p. 4).

The greatest challenge for the public service will be to motivate individual employees to support and implement the change. Developing a collaborative service environment requires an emphasis on organizational leadership and working in partnership (Fuller et al., pp. 4-5). Other key success factors include supervision and peer support, having staff with the right attributes and recognizing the importance of a physical space that is conducive to collaboration (Fuller et al., p. 5).
Lean quality improvement has recently come to the forefront in transforming health services (Steinfeld et al., 2015 p. 505). The complexity involved in providing mental health and addiction services may prove problematic to implementing a Lean quality improvement process (Steinfeld et al., 2015, p. 516). Lean may be more appropriately introduced as a process for improving certain aspects of the service, such as improving access by redesigning the intake process (Steinfeld, 2015, p. 516).

**Key Findings – Interviews**

All participants indicated support for service integration. Probing questions elicited that participants had a vision of what service integration should entail and that they had given consideration to both the potential positive and negative implications that could occur.

The most frequently cited benefit to integration of services was that it would simplify access for clients. Of the 18 participants, 16 identified this as a benefit. The most frequently proposed solution for facilitating client access to multiple services was to move to a common intake tool that would register one client for multiple services, as required. It was proposed that this be accomplished by using a common intake tool and by enabling all intake workers to refer clients to all programs.

Participants identified significant barriers to implementation of a common intake system. These include different software being used to track clients among the different programs, continuing reliance on paper documentation for some programs and the fact that, where electronic records are in use, the systems are not compatible with each other.

Participants identified a certain level of urgency for introducing stability into the service system. It is noteworthy that all respondents identified staff burnout as a risk as things currently stand,
particularly with the impending changes and very little specific information being disseminated to frontline staff.

Options to Consider and Recommendations

Option 1 (not recommended): Continue with the current service model and realize the benefits of removing uncertainty from the system. Staff have indicated that they are part of a mutually supportive team and that there is collaboration taking place among the different service units, albeit informally. This option fails to address issues with staffing levels and does not improve outcomes for clients.

Option 2 (Recommended): Increase service capacity by integrating Mental Health Services, Child and Youth Adolescent Services and Alcohol and Drug Services through service co-location. This option provides the Department of Health and Social Services the opportunity to begin leveraging the benefits of service integration early on, while also providing time for engaging employees and planning for the financial investment required for an integrated service centre.
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1.0 Introduction

1.1 Defining the Problem

The Yukon Department of Health and Social Services is the government department mandated to deliver both mental health and addiction services. Currently, these services are delivered by three programs, operating independently of each other. Though some collaboration has begun, duplicate resources are often required and there is insufficient coordination of service to clients, many of whom access both services through multiple program streams. Currently, these include Mental Health Services, Child and Adolescent Therapeutic Services (CATS) and Alcohol and Drug Services (ADS).

Demand for both mental health and addiction services is trending up, and is expected to continue to increase. The department must increase service capacity through integration of services and effective case management. The focus needs to be on increasing access to services and improving client outcomes in a sustainable manner.

The department does not expect to receive any significant budget increase in the foreseeable future, so it must find ways to improve service capacity using existing resources. This will require the department to make significant changes in the organization and to the work processes of a system that has been in place for many years. While process improvement initiatives can
provide an opportunity to identify and reduce inefficiencies in the existing process, they also represent change and will need to overcome systemic barriers to change of both a technical and cultural nature.

If this problem remains unaddressed, even current service levels will be unsustainable in the medium to long term. Without realizing the benefits of integrating service delivery, either the amount and/or quality of service to each client will be reduced, or other program areas will receive less funding.

1.2 Project Client

The client for this project is the Yukon Department of Health and Social Services, specifically Sherri Wright, Assistant Deputy Minister, Health Services, and Brenda Lee Doyle, Assistant Deputy Minister, Social Services. Ms. Wright is responsible for the overall provision of the department’s health services, which currently includes mental health services, and Ms. Doyle is responsible for Alcohol and Drug Services and for Child and Adolescent Therapeutic Services, which are both delivered under the umbrella of Social Services.

1.3 Research Questions and Project Objectives

The questions that this project seeks to answer is how, and to what extent, the Yukon Department of Health and Social Services can integrate mental health and addiction services in a manner that is consistent with promising practices in the industry. This paper will discuss how integration can increase service capacity, access and efficiency. It will also review the potential obstacles to implementing significant change and make recommendations for moving forward.
Service delivery staff and department policy makers were invited to participate in face-to-face interviews. In all, 18 interviews were conducted over the course of 5 days. The purpose of the interviews was to determine the level to which staff are ready to accept change and to identify ways that department leaders can engage workers in implementation.

The objective of this report is to provide the Department of Health and Social Services with:

- A literature review;
- Analysis of relevant promising practices;
- Stakeholder analysis;
- An implementation strategy; and
- Recommendations.

The remainder of this paper provides additional background on the client; a literature review; a methods section; a discussion of the findings of the stakeholder interviews, and the paper concludes with policy options and recommendations.
2.0 Background

The Department of Health and Social Services provides mental health and addiction services, each with its own service structure, under the umbrella of Health and Social Services. Both branches serve the entire territory, which means delivering services to several remote communities. At the time of writing this project, these areas are reporting to different Assistant Deputy Ministers within the same department.

The three program areas discussed in this paper are: Mental Health Services; Child and Adolescent Therapeutic Services; and Drug and Alcohol Services. While some of the department’s services are delivered through arrangements with nongovernment organizations, these three programs are solely delivered using government employees.

Mental Health Services uses a clinical model to provide “assistance in managing depression, anxiety, schizophrenia, and bipolar disorders” in Whitehorse and throughout Yukon (Yukon Department of Health and Social Services (a), 2015). Acute mental health services are also delivered through hospitals. Mental health services that do not fall within the scope of this program make use of other providers such as community nurses, physicians and through arrangements with nongovernment organizations.

Child & Adolescent Therapeutic Services (CATS) uses a trauma-based clinical counselling model to provide counselling services to children, youth and non-offending family members of children and youth who are dealing with trauma (Yukon Department of Health and Social Services (c), 2016).
The program area responsible for providing Alcohol and Drug Services offers: medical detoxification; Fetal Alcohol Spectrum Disorder prevention; addiction prevention services; addiction treatment services on an outpatient or inpatient basis, as well as treatment specifically targeted at youth; and weekly drop-in recovery group meetings (Yukon Department of Health and Social Services (b), 2015).

Each service is provided from a different physical location within the city of Whitehorse, and each is also responsible for delivering services throughout the Yukon.
3.0 Literature Review

3.1 Introduction

There is a substantial body of literature that considers the benefits and risks of service integration for individuals with both mental health and addiction problems. The majority of literature reviewed to date concurs that, for clients with co-occurring disorders, service integration improves quality of service (Peterson, 2013, p. 752; McGovern et al., 2014, p. 205; Davidson and White, 2007, p. 110).

Peterson (2013) accepts that co-occurring disorders is not recognized as a specific formal diagnosis. Nevertheless, there are attributes that are common to individuals affected by both mental illness and substance abuse (Peterson, 2013, p. 752).

Peterson (2014) tells us that in 2011, there were approximately 45.6 million adults in the United States living with a mental illness and that 17.5% of those people also had a substance use problem. The picture appears more bleak for those individuals whose mental illness is at the more serious end of the spectrum, with 22.6% also having a substance use problem.\(^1\) The estimated prevalence rises to 40% to 70% for people with schizophrenia (Peterson, 2013, p. 752).

In Canada, the report of the Standing Senate Committee on Social Affairs, Science and Technology [SSCSAST] (2006) found that more than half of people who need help with a substance abuse problem also suffer from mental health issues. For those seeking help with a

\(^1\) Pederson, (2013, p. 752) refers to serious mental illness as having symptoms that are to some extent debilitating.
mental health issue, the report found that approximately 15 – 20% have a substance abuse problem (Canadian Centre on Substance Abuse, 2009, p. 2).

### 3.2 Service Delivery

The complexity of delivering services to people with both mental health and substance abuse problems is illustrated by the wide-ranging effects on a number of measures of well-being and health. Individuals with concurrent mental health and substance abuse problems are shown to have higher rates of recidivism, aggressive behavior, suicide, hospitalization, homelessness and HIV, when compared to those with only one diagnosis (Canadian Centre on Substance Abuse, 2009, p. 5). The complexity is further illustrated by the rate at which people with concurrent mental health and substance abuse problems go untreated for either, often both, conditions. Harris and Edlund (2005) studied patterns of service use and found that 46% of people with serious mental illness did not receive treatment, and the number rises to 65% for people with concurrent mental health and substance abuse issues (Harris and Edlund, 2005, p. 954).

### 3.3 Barriers to Integration

Despite the evidence that concurrent mental health and substance abuse problems create added difficulties for sufferers, there remain barriers to service integration. Davidson and White (2007) note that, despite comprehensive research and discussion of barriers, issues such as separate funding streams, politics and ideology combine with practical issues (facility location, staff expertise and credentials), with the result that little has changed over time (Davidson and White, 2007, p. 110). Fuller et al. (2011) cite different service mandates and disconnected priorities as barriers to linking mental health and other healthcare services (Fuller et al., 2011, p.4).
Cherry (2008) highlights the need for policy shifts in both systems to avoid making the mistake of merely integrating two dysfunctional systems (Cherry, 2008, p. 410).

Cultural differences among service providers pose a significant barrier to successful service integration. Differences in education, experience and how service providers come to the career often result in a hierarchical culture in which each group believes that it alone is best suited to providing services to the patient group on whom its services are focused (Fuller et al., 2011, p. 3-4; Peterson, 2013, p. 753; Canadian Centre on Substance Abuse, 2009, p. 226; Gil-Rivas et al., 2005, p. 260). Role clarity and how service providers view their identity within the whole is another important factor (Fuller et al., 2011, p. 3).

3.4 Promising Practices for Integration

Historically, neither the mental health nor addiction service areas have produced particularly stellar results. Cherry (2008) reflects on traditional methods of treating substance abuse issues. He advocates discarding approaches that involve confrontation by staff and other service recipients or expulsion of clients who relapse, as they are counter-productive to positive client outcomes (Cherry, 2008, pp. 420-421). Davidson and White (2007) argue that focusing on treating a pathology, rather than helping clients learn to lead a dignified and functioning life with an ongoing disability, is flawed (Davidson and White, 2007, p. 112). Peterson (2013) also emphasizes the importance of meeting a patient’s individual service needs with a focus on outcomes as a determinant of success when choosing treatment options (Peterson, 2013, p. 754).

Both fields are dealing with tremendous complexity and the literature agrees that the likelihood of successful outcomes increases with service models that are flexible and person-centered. Bringing together the best of both service areas, as well as others, and working to address issues...
and find strengths in the person’s wider circle, including family and community, are crucial to success (Cherry, 2008, pp. 416-417; Davidson and White, 2007, pp. 111-112). Service delivery integration, if focused on continuity and quality of care, benefits consumers, service providers, and program administration and funding (Peterson, 2013, p. 753).

Drake et al. (2004) emphasize that, for service integration to be successful, organizations have to do more than merely put services together. Service customization that is based on the needs of each patient and service provider culture change are key to service integration that will benefit patients.

Durbin et al. (2006) conclude that systems integration, particularly when characterized by strong management arrangements, are positively associated with outcomes relating to service continuity (Durbin et al., 2006, p. 716).

### 3.5 Implementing Change in a Public Service Healthcare System

The greatest challenge with any systemic change within the public service is to motivate individual employees to implement them. Tummers (2011) looks at employee willingness to change in terms of five dimensions of policy alienation, asserting that strategic powerlessness, tactical powerlessness, operational powerlessness, societal meaninglessness and client meaninglessness are perceived by employees and this demotivates them to implement change (Tummers, 2011, pp. 563-566). Evidence of service outcomes is arguably the best way to overcome perceptions that get in the way of moving towards a sustainable collaborative service model.
There is a significant body of literature dedicated to change management and process improvement in the public sector, specifically in the field of public health. Specific to developing a collaborative environment for delivering mental health and other primary healthcare services, Fuller et al. (2011) identify the importance of organizational leadership and partnership formation activities as factors that influence the successful development of collaborative service models (Fuller et al., 2011, pp. 4-5). They also emphasize supervision and peer support, having staff with knowledge and skills in both service areas and the flexibility and confidence to work in collaboration, and the importance of having a physical space that is conducive to collaboration (Fuller et al., 2011, p. 5).

Lean quality improvement has recently been adapted to serve as a transformation process for health services (Steinfeld et al., 2015, p. 505). Much of the success of Lean depends on implementation of standardized processes (Steinfeld et al., 2015, p. 506). Through a Lean quality improvement exercise, a healthcare organization can work through the steps of identifying the service needs and expectations of the client, developing an understanding of the service gaps and developing a standardized client-focused structure to eliminate the gap between client expectation and service outcomes (Steinfeld et al., 2015, p. 508). Lean is dependent on hearing the needs and desires of the client (Steinfeld et al., 2015, p. 510). With an understanding of client expectation in place, an organization must engage service providers in developing tools that they believe will address client needs and establish the physical and management environment to enable and monitor the use of those tools (Steinfeld et al., 2015, p. 512).

The complexity involved in providing mental health and addiction services may require a flexible approach to successfully implementing a Lean quality improvement process (Steinfeld et al., 2015, p. 516). Lean implementation uses extensive training and modeling which, while
effective in manufacturing, must be implemented in a manner that respects the existing skill set that makes up the particular therapeutic service being offered (Steinfeld et al., 2015, p. 517). In addition, organizations providing mental health and addiction services may not be willing, or able, to invest the significant amount of frontline service staff time that it would take to implement Lean in direct service delivery (Steinfeld et al., 2015, p. 517). Where service is based on delivering person-specific service, such as in the case of the therapeutic elements of psychotherapy, Lean may be more easily introduced as a process for improving certain aspects of the service such as accessibility (Steinfeld et al., 2015, p. 516).
4.0 Methodology and Methods

4.1 Methodology

Because the focus of this project is to look at integration of services and to make recommendations regarding effective change management, the methodology chosen for this research borrows from the concepts of appreciative inquiry, which focuses on identifying the positive aspects of a situation and on beginning the process of change management that moves an organization towards a future state that is based on best practices (Hetherington et al., 2009, p.2). Kessler (2013) describes appreciative inquiry as “a method for studying and changing social systems (groups, organizations, communities) that advocates collective inquiry into the best of what is, in order to imagine what could be, followed by collective design of a desired future state that is compelling and thus does not require the use of incentives, coercion or persuasion for planned change to occur” (Kessler, 2013, p.1).

Bush and Kassam (2005) outline the main principles of appreciative inquiry. It must be: based in appreciation; be applicable to the work under discussion; be provocative in order to generate new ideas and ways of thinking; and it must be collaborative (Bush and Kassam, 2005, p. 165).

Kaminski (2012) notes that the main strength of this methodology is its capacity to start the organization on the path of change. It engages the people who will be involved in the change by inviting them to dream about how things can be (Kaminski, 2012).

The research used appreciative inquiry to design interview questions. Participants were asked to identify the positive aspects of their work, rather than emphasizing issues that need to be fixed. This helped to set the context for the remaining questions that asked participants to discuss
service integration and to explore their ideas of what a successful model would look like and how it could be achieved. Appreciative inquiry seeks to engage change participants by focusing on strengths, with the intention of cultivating more of what is going well and maximizing the enthusiasm for change that exists within the organization. The benefit of this methodology is that it involves the people most affected by organizational change in planning for its successful implementation (Kaminski, 2012).

4.2 Methods

The research method chosen for this report was to conduct face-to-face interviews with program staff and policy makers within the Department of Health and Social Services. This research was conducted with the approval of the University of Victoria’s Human Research Ethics Board. The Certificate of Approval is attached as Appendix A.

Individuals were invited to participate through an initial contact from the project client. In order to avoid any potential for coercion, the researcher provided the project client with the content of the e-mail, as they have a power relationship with potential participants. All subsequent communication took place between potential participants and the researcher. The project client agreed to authorize the use of work time for participation in the research. The result was that participants were not inconvenienced by having to use their personal time for the interview. There is a clear power relationship between the project client and research participants at both the frontline service level and at the supervisory level. Participants are employees whose reporting relationships culminate with the project client. In addition, given the size and insular nature of the community in Whitehorse, and throughout Yukon, it must be assumed that participants, the project client, and the researcher will be acquainted with each other.
To safeguard participants, the information they provided in interviews was summarized and amended to protect their identity. Their consent or refusal to participate in the project was also kept confidential. Only the researcher knows which individuals consented to participate and which information came from which participants.

After receiving an initial invitation to participate from the project client, a face-to-face interview was conducted with those invitees who consented. Following the interviews, participants were sent a summary of their conversation and asked to provide or withhold consent for use of the information in the study. All written requests for consent indicated that withdrawing consent was possible at any time, without repercussions, by informing the researcher either verbally or by e-mail. The script for the initial e-mail is attached as Appendix B, the draft script for the face-to-face interviews is attached as Appendix C and the e-mail to request that participants review their summarized conversation is attached as Appendix D.

In order to maintain confidentiality, participants were invited to choose the location for the interview. All participants who provide frontline direct service chose an off-site location, so interviews took place in local coffee shops. Of the three participants in a supervisory role, two of the interviews were conducted in the participant’s office, by their choice. The third also would have preferred to conduct the interview at the place of employment, but accommodated a travel restriction for the researcher, who is visually impaired.

Of the approximately 98 invitations that were distributed to all possible participants, 18 individuals accepted the invitation to participate and interviews were conducted with all participants over the course of 5 days. This means that there was an 18.37% participation rate.
Since the interview questions were structured to invite participants to comment on multiple themes, participants could provide multiple answers to each question.

Pseudonyms were used in the note-taking process and all data was aggregated in the research findings so as to not attribute particular results to particular individuals. Written consent documents will be stored in a locked location at the researcher’s home to safeguard the identity of all participants.

Transcripts of interviews were created by the researcher using a password-protected iPad to create typed notes. This is required as the researcher is visually impaired and hand-written notes are not possible. The transcripts were then sent to the researcher’s personal e-mail and subsequently deleted from the iPad. They are currently stored on the researcher’s personal computer, which is encrypted, and have been deleted from the e-mail account.

All data will be kept on the researcher’s home computer and will be destroyed once the project is complete. The data and consent documents will be destroyed one month after the researcher has completed her Master’s Degree at the University of Victoria.

4.3 Data Analysis

The interview sought to elicit participants’ views on positive aspects of their work and identify areas that could be improved through integration. The interview also consisted of a discussion of the participant’s views on change, particularly who should be involved in creating and implementing the future state that results from the change.

The transcript of each interview was summarized and cleaned up to ensure anonymity and to develop themes for the findings.
A spreadsheet was used to categorize characteristics of the participants’ roles. Only aggregated findings presented as raw data would identify participants due to the small number of subjects, so this was avoided.

A number of themes emerged from the interviews. These were also tracked on a spreadsheet, so as to show the proportion of participants that:

- Are supportive of service integration;
- Identified the need for more staff;
- Identified records management systems as a barrier to collaboration;
- Raised concerns about staff burnout;
- Experienced major change within the past 5 years;
- Cited communication from senior leaders as being vital to the success of change initiatives; and
- Expressed a desire to contribute to the design of the change.

4.4 Project Limitations and Delimitations

The main focus of the project was to assess the level of change readiness within the organization and make recommendations on how the Department of Health and Social Services can leverage service integration to increase service capacity with the ultimate goal of improving client outcomes. The completeness of the information derived from this research was dependent on the willingness of service providers to participate in interviews. Eighteen individuals out of a
possible ninety-eight agreed to participate. While a response rate of 18.37% is significant, it must be acknowledged that participants who self-selected for this research may have been more predisposed to participate in change activities. It is therefore important to exercise caution when using these results to make decisions that impact the entire affected population.

The project does not identify the specific service model that will result, but rather analyzes stakeholder readiness to implement change and recommends a strategy for designing and implementing a model that reflects the research findings.
5.0 Findings

5.1 Introduction

While the findings of the stakeholder interviews are consistent with what is gleaned from literature on integration of services for individuals with concurrent mental health and substance abuse problems, and change management within the public sector, there is a great deal of benefit to be derived from confirming that the issues being faced by the Department of Health and Social Services are consistent with what is being experienced in the sector and that best practices for moving forward can be applied. For participants, the main benefit is that their points of view will inform this report and its recommendations. Their priorities and concerns were candidly expressed to the researcher in a safe environment. The benefit to the Department of Health and Social Services is an increase in the state of knowledge, such that the specific issues, priorities and hopes of affected stakeholders are made available. For this reason, the findings are presented so that an analysis of the participants’ views of the current service model are followed by an analysis of their willingness for change and, finally, a sample of their ideas on what that change might entail.

5.2 Participant representation by program area

The intent of this research was to ascertain the views of a sample of employees engaged in delivering mental health and addiction services for the Department of Health and Social Services. Although no effort was made to ensure representation from all three of the programs that deliver these services, each of the programs was represented by multiple participants. Table 1 shows the distribution of participants by program area. These numbers are fairly representative
of the relative size of each program. The category “other” refers to a participant that bridges at least two program areas. Of the 18 people interviewed, 15 provide direct service while the rest provide supervision. Direct service includes intake and therapeutic counseling (both clinical and non-clinical).

TABLE 1. PARTICIPANTS BY PROGRAM AREA

<table>
<thead>
<tr>
<th>Program Area</th>
<th>Number of Program Staff</th>
<th>Number of Participants</th>
<th>Percentage of Total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol and Drug Services</td>
<td>55</td>
<td>7</td>
<td>12.7</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>30</td>
<td>7</td>
<td>23.3</td>
</tr>
<tr>
<td>Child and Adolescent Therapeutic Services</td>
<td>12</td>
<td>3</td>
<td>25.0</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>1</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>98</td>
<td>18</td>
<td>18.4</td>
</tr>
</tbody>
</table>

5.3 Analysis of current service model

When asked to identify aspects of their work that contribute to achieving their service goals within the current service model, the 18 participants made a total of 71 positive comments in five categories, with the number of respondents commenting in each category varying from 2 (11%) to 18 (100%). All participants cited the support and expertise found within their particular service team and positive aspects of the programs. Table 2 shows that, by far, service teams and the quality of the programs are most often viewed as being responsible for goal achievement in the current service model.
### TABLE 2. FACTORS CONTRIBUTING TO GOAL ACHIEVEMENT BY FREQUENCY

<table>
<thead>
<tr>
<th>Factor</th>
<th>Number of Respondents</th>
<th>Number of Responses</th>
<th>Responses as Percentage of total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team and Programs</td>
<td>18</td>
<td>47</td>
<td>66.2</td>
</tr>
<tr>
<td>Existing collaboration</td>
<td>14</td>
<td>8</td>
<td>11.3</td>
</tr>
<tr>
<td>Service flexibility</td>
<td>6</td>
<td>7</td>
<td>9.9</td>
</tr>
<tr>
<td>Support from management</td>
<td>5</td>
<td>7</td>
<td>9.9</td>
</tr>
<tr>
<td>Physical workspace</td>
<td>2</td>
<td>2</td>
<td>2.8</td>
</tr>
<tr>
<td>Total</td>
<td>18</td>
<td>71</td>
<td>100</td>
</tr>
</tbody>
</table>

Examples of the comments include:

- The Community Program is improving access to services and improving the services themselves;

- I work with an excellent service team;

- Peer consultation on a personal level (e.g. dealing with stress) and a professional level (e.g. accessing each other’s specific expertise) is very good;

- Team consultation is particularly effective when a client is in crisis;

- The ability to cover each other’s caseload when someone is away helps to reduce burnout and stress in general;

- The team has a diverse skill set with a variety of therapy styles. The ability to refer clients to another team member to get the client the service style that will work best for them is good;

- The absence of on-site supervision has caused the team to become very collaborative and supportive of each other. Although more direction would sometimes be helpful; and
• Mental health nurses, in particular, provide much needed additional clinical support.

Six comments specifically identified the value of having a diverse set of therapy styles and skillsets available to respond to client needs and eight comments were made indicating that interagency collaboration is already taking place, albeit informally.

Participants made a total of 90 comments when asked to identify barriers to integration. Table 3 shows that the most commonly expressed concerns related to insufficient staffing and the fear of burnout.

**TABLE 3. BARRIERS TO GOAL ACHIEVEMENT BY FREQUENCY**

<table>
<thead>
<tr>
<th>Barrier</th>
<th>Number of Respondents</th>
<th>Number of Responses</th>
<th>Responses as Percentage of total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inadequate staffing levels and burnout</td>
<td>18</td>
<td>30</td>
<td>33.3</td>
</tr>
<tr>
<td>Current service design</td>
<td>8</td>
<td>10</td>
<td>11.1</td>
</tr>
<tr>
<td>Insufficient management support</td>
<td>7</td>
<td>8</td>
<td>8.9</td>
</tr>
<tr>
<td>Mental Health acceptance criteria</td>
<td>6</td>
<td>6</td>
<td>6.7</td>
</tr>
<tr>
<td>Client consent</td>
<td>6</td>
<td>6</td>
<td>6.7</td>
</tr>
<tr>
<td>Communication</td>
<td>5</td>
<td>5</td>
<td>5.6</td>
</tr>
<tr>
<td>Physical space</td>
<td>4</td>
<td>5</td>
<td>5.6</td>
</tr>
<tr>
<td>Unrelated comments</td>
<td>4</td>
<td>5</td>
<td>5.6</td>
</tr>
<tr>
<td>Insufficient supervision</td>
<td>4</td>
<td>4</td>
<td>4.4</td>
</tr>
<tr>
<td>Service overlap</td>
<td>4</td>
<td>4</td>
<td>4.4</td>
</tr>
<tr>
<td>Scope and complexity of issue in Yukon</td>
<td>2</td>
<td>3</td>
<td>3.3</td>
</tr>
<tr>
<td>Record keeping system</td>
<td>3</td>
<td>3</td>
<td>3.3</td>
</tr>
<tr>
<td>Need for cross-training</td>
<td>1</td>
<td>1</td>
<td>1.1</td>
</tr>
<tr>
<td>Total</td>
<td>18</td>
<td>90</td>
<td>100</td>
</tr>
</tbody>
</table>

**5.4 Analysis of potential for change**
Participants made a total of 65 recommendations for service changes that they felt could be implemented with planning and commitment. Table 4 shows the areas of suggested change with comments about the need for better integration of services occurring most frequently at 18.5 percent.

**TABLE 4. SUGGESTED CHANGES**

<table>
<thead>
<tr>
<th>Change Suggested</th>
<th>Number of Respondents</th>
<th>Number of Responses</th>
<th>Responses as Percentage of total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better integration of services</td>
<td>9</td>
<td>12</td>
<td>18.5</td>
</tr>
<tr>
<td>Training and cross-training opportunities</td>
<td>8</td>
<td>9</td>
<td>13.8</td>
</tr>
<tr>
<td>Increase staff levels</td>
<td>8</td>
<td>8</td>
<td>12.3</td>
</tr>
<tr>
<td>Improve use of web-based technology and social media</td>
<td>5</td>
<td>6</td>
<td>12.3</td>
</tr>
<tr>
<td>Shared records management</td>
<td>5</td>
<td>6</td>
<td>12.3</td>
</tr>
<tr>
<td>Improve quality of supervision</td>
<td>6</td>
<td>6</td>
<td>12.3</td>
</tr>
<tr>
<td>Move to common intake</td>
<td>5</td>
<td>5</td>
<td>7.7</td>
</tr>
<tr>
<td>Broaden mandate of Mental Health Service</td>
<td>4</td>
<td>4</td>
<td>6.2</td>
</tr>
<tr>
<td>Change client consent to facilitate collaboration</td>
<td>4</td>
<td>4</td>
<td>6.2</td>
</tr>
<tr>
<td>Improve flexibility of service model</td>
<td>2</td>
<td>2</td>
<td>3.1</td>
</tr>
<tr>
<td>Improve space</td>
<td>2</td>
<td>2</td>
<td>3.1</td>
</tr>
<tr>
<td>Unrelated</td>
<td>1</td>
<td>1</td>
<td>1.5</td>
</tr>
<tr>
<td>Total</td>
<td>18</td>
<td>65</td>
<td>100</td>
</tr>
</tbody>
</table>

All participants expressed support for an integrated service delivery model. They made 66 comments that demonstrate their understanding of what is being contemplated and their hopes for an integrated system. Table 5 shows that of all these positive comments, 42.4% are unconditionally in support of service integration.
TABLE 5. COMMENT THEMES ON INTEGRATION

<table>
<thead>
<tr>
<th>Comment Themes</th>
<th>Number of Respondents</th>
<th>Number of Responses</th>
<th>Responses as Percentage of total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>In support of service integration</td>
<td>18</td>
<td>28</td>
<td>42.4</td>
</tr>
<tr>
<td>Wants to ensure retention of flexibility and diversity of service capacity</td>
<td>8</td>
<td>14</td>
<td>21.2</td>
</tr>
<tr>
<td>Have questions about process: How does build of new ADS facility relate to co-location? Will future state have safe feedback process?</td>
<td>11</td>
<td>11</td>
<td>16.7</td>
</tr>
<tr>
<td>In support of common intake</td>
<td>5</td>
<td>5</td>
<td>7.6</td>
</tr>
<tr>
<td>In support of co-location</td>
<td>4</td>
<td>4</td>
<td>6.1</td>
</tr>
<tr>
<td>Would prefer an incremental change process</td>
<td>2</td>
<td>2</td>
<td>3.0</td>
</tr>
<tr>
<td>Need more transparency from management and supervisors</td>
<td>2</td>
<td>2</td>
<td>3.0</td>
</tr>
<tr>
<td>Total</td>
<td>18</td>
<td>66</td>
<td>100</td>
</tr>
</tbody>
</table>

Participants made 65 comments relating to change and change management. Table 6 shows that staff want to be involved in the process and that the process will be well planned and executed.

TABLE 6. COMMENT THEMES ON MANAGING CHANGE

<table>
<thead>
<tr>
<th>Views on change</th>
<th>Number of Respondents</th>
<th>Number of Responses</th>
<th>Responses as Percentage of total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff at all levels want to be involved in a meaningful way</td>
<td>18</td>
<td>27</td>
<td>41.5</td>
</tr>
<tr>
<td>Change needs to be clearly understood, especially the desired end state</td>
<td>17</td>
<td>20</td>
<td>30.8</td>
</tr>
<tr>
<td>Staff want to know that change is mindfully considered and evidence-based</td>
<td>11</td>
<td>12</td>
<td>18.5</td>
</tr>
<tr>
<td>Leaders need to champion change</td>
<td>4</td>
<td>4</td>
<td>6.2</td>
</tr>
<tr>
<td>Preference for incremental change</td>
<td>2</td>
<td>2</td>
<td>3.1</td>
</tr>
<tr>
<td>Total</td>
<td>18</td>
<td>65</td>
<td>100</td>
</tr>
</tbody>
</table>


6.0 Discussion and Analysis

This section will consider how the findings of the literature review and the research apply to the questions of how, and to what extent, the Yukon Department of Health and Social Services can integrate mental health and addiction services in a manner that is consistent with promising practices in the industry.

By applying the concepts of appreciative inquiry, the research has identified themes that can serve as organizing principles for understanding the current state and moving through a change process towards a desired future state. This section seeks to explain how the project client can manage the change process to realize the benefits of service integration by leveraging the enthusiasm of a significant proportion of affected employees.

6.1 The Current State: The best and worst of what is happening now

Understanding the current state is essential to identifying the problems to be solved and designing a future state that addresses the right issues.

When asked to identify aspects of their work that contribute to achieving their service goals, participants overwhelmingly identified their service team. On the surface, this would appear to be a strong endorsement of the current state; however, when probed about the value of the team, the comments indicate that mutual support is required to deal with the stress that results from insufficient capacity.

Diversity of skills and specializations were also frequently cited as a positive aspect of the current state. Participants acknowledged the benefit of having colleagues with differing therapy
styles which allow them to refer clients to different colleagues based on client characteristics and needs.

Collaboration among service units was reported as already taking place to the benefit of clients. Nevertheless, this is being done on an informal, ad hoc, basis and is dependent on mutual willingness to consider working outside the defined scope of service. Participants indicated that formal mechanisms for information sharing and working collaboratively are needed.

When asked to identify barriers to achieving their service goals, all participants identified staffing levels as being insufficient to meet the need. The 18 participants made a combined 30 comments mentioning staffing levels contributing to burnout as a concern with the current service model.

Another issue with the current model is the fact that each service unit has an independent and different system of records management. While paperwork was identified as a burden by a small number of participants, the inability to share records due to incompatible methods of record keeping and evolving practices around client consent were frequently cited as barriers to achieving service goals.

Participants indicated that the current service design poses significant access issues for clients. A great deal of frustration exists within the Alcohol and Drug Services team around accessing mental health services for their clients. They perceive the mandate as being too restrictive and would prefer a model where mental health issues are treated concurrently with substance abuse issues. They see the current requirement that substance abuse issues be addressed prior to being accepted by Mental Health Services as unrealistic.
Another issue raised by several staff within the ADS unit is availability of on-site supervision. There is concern that they cannot access the expertise they need in a timeframe that meets their needs.

6.2 A Time for Change

Support for service integration among participants is unambiguous. Participants’ views range from being supportive because they see the need for improving capacity to being dismayed that the question is still being considered, rather than implemented. The time is right for change, and there is a great deal of enthusiasm to be leveraged, but it is important to manage the change in order to capitalize on the opportunity.

Although Lean quality improvement processes have been used to implement transformational change in the healthcare sector, it may be too labour-intensive for this initiative and its focus on standardization of work may not be the best solution for provision of therapeutic services. Lean may be successfully applied to the elements of service integration that deal with access to service. These include, but need not be limited to, intake and referral processes.

When asked what changes they would recommend, participants offered a wide variety of suggestions. They suggested better integration of services, common intake, increasing staff levels, better space, more flexibility to deliver service in different ways, a broader mandate for Mental Health, implementing common records management software, changing how client consent is structured, using technology better, cross-training and improving the quality of supervision. There was far less variety when they were asked to identify what would make change successful. Participants indicated that they want to be involved in a meaningful way and to be confident that the changes are consistent with best practice. They want senior leaders to
champion the change and there is a strong desire for leaders to have and express a clear vision of the future state. Only two individuals expressed a preference for incremental change. The major concern among participants related to transparency and uncertainty.

6.3 Summary

Support for service integration is available among the employees who accepted the invitation to participate in this research. While they value the diversity and autonomy of the current service model, there is recognition that it is not sustainable and is not consistent with promising practices.

They recommend a wide variety of changes, some of which would require little investment and others that may prove cost-prohibitive.

Participants want assurance that financial pressures and efficiency are not the sole motivation for service integration. They want to be involved in designing change that is evidence-based and improves service outcomes.

As the Department of Health and Social Services looks to make changes, senior leadership needs to convey commitment to implementing the change. They need to ensure that middle management (directors and direct supervisors) buy into the change process and communicate appropriately with staff. It is important that the intended future state be clearly communicated.
7.0 Options to Consider and Recommendations

7.1 Options to Consider

7.1.1 Option 1. Status Quo: Current Service Model

Under the current service model, there are clear reporting relationships. While provided in separate streams, the Department of Health and Social Services does have a structure in place that has been providing both mental health and addiction services up to now.

Under the current model, staff have indicated that they are part of a mutually supportive team and that there is collaboration taking place among the different service units, albeit informally.

Should the project client choose to maintain the current service model, and communicate this to staff, it would alleviate a great deal of uncertainty. However, the findings of this research do not support this option.

While the status quo is always an option, the literature and the current research for this report agree that this would not result in the best outcome for staff or for clients. Issues with staffing levels would remain unaddressed and access to services would continue to be disjointed.

Participants have identified significant concerns with service overlap in some cases while in others, service levels are inadequate, if available at all.

For those with concurrent mental health and substance abuse problems, services would continue to be delivered in isolation of each other rather than together, and both the literature and the research findings indicate that this does not result in better service outcomes.
Participants also indicated strong support for service integration. While the integrated model that would best serve clients did not emerge from this research, there is clearly interest from staff in moving to an integrated service model.

### 7.1.2 Option 2. Integrated Service Model

An integrated service model would increase service capacity by integrating Mental Health Services, Child and Youth Adolescent Services and Alcohol and Drug Services through a phased approach that culminates in service co-location.

The research findings in this report indicate staff support for service integration and, to a lesser degree, for co-location. The reservations that participants did express regarding co-location were more logistical than philosophical. Participants from all three programs pointed out that while co-location was a promising practice, they felt that it was unlikely, especially as a new treatment centre is about to open for Alcohol and Drug Services. Other reservations expressed related to ensuring that co-location needs to be carefully planned to allow for protection of vulnerable clients and to accommodate future growth in the demand for service.

This option consists of three phases:

**Phase 1 – Integrating the system:** The first step is to move to a common intake process that allows each program to refer to the others without requiring an additional intake. The information collected at intake is appropriate for any of the programs to begin delivering services with only a minimal amount of additional information gathered. Appendix E provides an overview of the information collected across all three programs. This phase also includes establishing processes for information sharing.
Phase 2 – Designing the new program: This phase consists of multiple projects with the goal of designing the co-located service model. It will consist of setting the desired outcomes, identifying and obtaining resources and approvals, and maintaining the momentum generated by implementing Phase 1.

Phase 3 – Co-location of services: This is the implementation of the service model designed in Phase 2 and would provide the Department of Health and Social Services with the opportunity to begin leveraging the benefits of service integration early on, while also providing time for engaging employees and planning for the financial investment that will be required for an integrated service centre.

The success of this option will be dependent on communicating the motivation for change and the evidence on which decisions will be made. This phased approach could include the following implementation steps, beginning with a facilitated session to engage staff by exploring the dimensions of change and by inviting input into the broad goals of a service transformation plan. Suggested steps for implementing Option 2 are:

1. Conduct a series of facilitated sessions to manage the change process. The purpose of the first session is to launch the service transformation design process to communicate the intent of the change and obtain input into the broad goals of the plan.

2. Strike a project team tasked with overseeing the creation of a detailed plan with a mandate to present the plan to the service community within six months.

3. Develop a communication strategy specifically targeted at program staff to keep them informed about the progress of the work.
4. Implement a common intake process as a measure to immediately improve access to services for clients and to formalize collaborative practices among program areas.

5. Provide comprehensive change management leadership training for management staff at all levels from the Assistant Deputy Ministers through to Clinical Supervisors plus all members of the project team.

7.2 Recommendations

Based on promising practices identified in the literature and on observations made during the research, Option 2 (Integrated Service Model) is recommended for further exploration. The project client may wish to conduct a broader survey of affected staff in order to determine whether the findings from interviews with self-selected participants reflect the views of the entire workforce. This survey will best serve the purpose of either corroborating or refuting the results of this project, if it is conducted in a manner that is mandatory, while protecting the confidentiality of respondents, and allowing for both positive and negative responses.

By choosing Option 2, The Department of Health and Social Services can increase service capacity by integrating Mental Health Services, Child and Youth Adolescent Services and Alcohol and Drug Services through a phased approach that culminates in service co-location. This three-phased option provides the department with the opportunity to begin leveraging the benefits of service integration early on, while also providing time for engaging employees and planning for the financial investment required for an integrated service centre.
References


Canadian Centre on Substance Abuse. (2009). *Substance Abuse in Canada: Concurrent Disorders*. Ottawa, ON: Canadian Centre on Substance Abuse.


Appendix A: HREB Certificate of Approval

Certificate of Approval

<table>
<thead>
<tr>
<th>PRINCIPAL INVESTIGATOR:</th>
<th>Louise Michaud</th>
</tr>
</thead>
<tbody>
<tr>
<td>UVic STATUS:</td>
<td>Master's Student</td>
</tr>
<tr>
<td>UVic DEPARTMENT:</td>
<td>PADM</td>
</tr>
<tr>
<td>SUPERVISOR:</td>
<td>Dr. Rebecca Warburton</td>
</tr>
<tr>
<td>ETHICS PROTOCOL NUMBER</td>
<td>15-457</td>
</tr>
<tr>
<td>APPROVED ON:</td>
<td>26-Jan-16</td>
</tr>
<tr>
<td>APPROVAL EXPIRY DATE:</td>
<td>25-Jan-17</td>
</tr>
<tr>
<td>PROJECT TITLE:</td>
<td>Integrating Mental Health Services and Addiction Services Provided by the Government of Yukon</td>
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<tr>
<td>RESEARCH TEAM MEMBER:</td>
<td>None</td>
</tr>
<tr>
<td>DECLARED PROJECT FUNDING:</td>
<td>None</td>
</tr>
</tbody>
</table>

CONDITIONS OF APPROVAL

This Certificate of Approval is valid for the above term provided there is no change in the protocol.

Modifications
To make any changes to the approved research procedures in your study, please submit a "Request for Modification" form. You must receive ethics approval before proceeding with your modified protocol.

Renewals
Your ethics approval must be current for the period during which you are recruiting participants or collecting data. To renew your protocol, please submit a "Request for Renewal" form before the expiry date on your certificate. You will be sent an emailed reminder prompting you to renew your protocol about six weeks before your expiry date.

Project Closures
When you have completed all data collection activities and will have no further contact with participants, please notify the Human Research Ethics Board by submitting a "Notice of Project Completion" form.

Certification

This certifies that the UVic Human Research Ethics Board has examined this research protocol and concluded that, in all respects, the proposed research meets the appropriate standards of ethics as outlined by the University of Victoria Research Regulations Involving Human Participants.

[Signature]
Dr. Rachael Scarth
Associate Vice-President Research Operations

Certificate Issued On: 26-Jan-16
Appendix B: E-mail to introduce the study to potential participants.

To: (potential participant’s e-mail address)

From: Sherri.wright@gov.yk.ca and Brendalee.Doyle@gov.yk.ca

You are invited to participate in a study entitled Integrating Mental Health Services, Addiction Services and Child and Adolescent Treatment Services Provided by the Government of Yukon, that is being conducted by Louise Michaud.

Louise is a graduate student in the department of Public Administration at the University of Victoria and she is conducting this study on behalf of myself and Brendalee Doyle. You may contact Louise if you have further questions by phone at 867-335-3846 or by e-mail at glouisemichaud@gmail.com.

The purpose of this project is to answer the question of how, and to what extent, the Yukon Department of Health and Social Services can integrate mental health, addiction and child and youth treatment services in a manner that is consistent with promising practices in the industry. The paper will discuss how integration can increase service capacity, access, and efficiency. The paper will also review the potential obstacles to implementing significant change and make recommendations for moving forward.

The Yukon Department of Health and Social Services is the government department mandated to deliver both mental health, addiction services. Currently, these services are delivered independently of each other. Though some collaboration occurs, duplicate resources are often required and there is insufficient coordination of service to clients, many of who will access more than one of these services at a time.

Demand for both services is trending up, and the department does not expect to receive any significant budget increases in the foreseeable future. Enhancing service capacity within existing resources will require the department to make significant changes in the organization and work processes of a system that has been in place for many years. While process improvement initiatives can provide an opportunity to identify and reduce inefficiencies in the existing process, they also represent change and will need to overcome systemic barriers to change of both a technical and cultural nature.
You are being asked to participate in this study because you are an employee who provides mental health or addiction services, or a policy maker in the Department of Health and Social Services. If you do choose to participate, and do so during work hours, you will not be required to make up the time spent doing the interview or travel time if needed.

What is involved

If you consent to voluntarily participate in this research, your participation will include:

If you are an employee or policy maker with the Department of Health and Social Services, you will be asked to participate in a face-to-face interview with the researcher that will last approximately 45 minutes. The interview will take place either at your office, the researcher’s office (which is off-site from the Department of Health and Social Services) or at another location where you feel more comfortable. Subsequently, you will be asked to review a summarized transcript of the interview and provide consent for its use in the study.

Your participation in this research is voluntary. You will find attached a consent form that provides more information on the research and the steps that will be taken to provide you a safe place to participate.

Your participation in this project is extremely valuable as it provides the opportunity to include your priorities and concerns in the recommendations that will inform future direction.

Please contact Louise directly if you would like to participate in this project.

Regards,

Sherri Wright and Brenda Lee Doyle.
Appendix C: Interview Questions

Thank you for agreeing to participate in this study. As mentioned in the e-mail that Sherri sent out, I am doing this study as part of my Master’s degree in Public Administration, and Brendalee Doyle and Sherri Wright are the clients for this research.

The question we are looking to answer is how, and to what extent, the Yukon Department of Health and Social Services can integrate mental health and addiction services in a manner that is consistent with promising practices in the industry. I am producing a paper that will look at how integration can increase service capacity, access, and efficiency. I am also trying to understand the potential obstacles to implementing significant change so that I can make recommendations for moving forward.

The first thing we should talk about is that your participation in this exercise is completely voluntary. You are free to withdraw at any point and that’s going to be completely OK. I, and I alone will know who exactly participated and who said what. So, if you choose to withdraw, there will be no repercussions. On the other hand, by choosing to participate, you have the opportunity to have your concerns and priorities included in the study, and those priorities and concerns will also inform the development of the recommendations.

I will take some notes on this phone, but we are not being recorded. Once we have finished the interview, I am going to summarize the notes and send them to you for review. If you have any concerns, you will still be able to withhold consent to use the information.
Question 1:

Do you consent to continue with the process at this time, and if so, would you please sign the consent form? It is a printed copy of the form sent to you by Sherri. I have also printed a second copy for you to keep.

Thank you. Let’s get started.

I’d like to understand your role in the organization. More importantly, your role in the actual provision of service.

Question 2:

Do you provide:
Direct clinical service,
Direct support service (e.g. clerical or other),
Indirect service such as program design,
Indirect service such as policy making, budget allocating etc.,
Other types of service, and could you elaborate?

Question 3

What are 2 or 3 things that work really well now that contribute to you fulfilling your goals?
Question 4

What are 2 or 3 things that get in the way of you fulfilling your goals right now?

---

Question 5

If you could wave a wand and make 2 or 3 changes to remove the barriers we discussed, what changes would you make?

---

Question 6

Why these changes?

---

Question 7

Do you think that it would be possible to make these changes without a wand? What would need to happen in order to realize these changes?

---

Question 8

Do you think that integrating mental health and addiction services could contribute to making positive changes? Why or why not?

---

Question 9

When considering making changes that would integrate mental health and addiction services, what do you think is the most important that should be kept?

---

What do you think should be left behind?
Question 10
In your opinion, who should make change happen? Who should initiate it, who should design it and who should be involved?

Question 11
Outside the specifics of this program, when you think about making a major change, what are the most important considerations to you. Examples of major changes might be moving, changing jobs, getting married or unmarried, etc.

What are the most important considerations when you are thinking of less significant change? Examples might be repainting a room, reorganizing items in your kitchen or changing your work hours.

Question 12
When you are making changes, how important is it to you to see the end state of the change, and how much detail do you like to have about the end state?

Question 13
What has been the most significant thing that has changed for you in the past 5 years, and was it positive or negative?

Well, this about wraps it up. Moving forward, I will summarize our discussion, and e-mail you.

What e-mail address would you like me to use?
Once you have had a chance to review the information, you will have the opportunity to either give or withhold consent to use it. At this time, do you have any questions or concerns?

OK, on behalf of myself, and of the client, I want to sincerely thank you for participating in this study. If you do have any further questions or concerns later, I am more than happy to talk about them, or you can contact my Academic Supervisor. Her contact information is on the consent form I gave you.
Appendix D: E-mail providing summarized transcript of interviews and requesting consent to use the information

To: (potential participant’s e-mail address)

From: glouisemichaud@gmail.com

Hi Participant:

Thank you for participating in the interview for the study on service integration, that I am conducting as part of my Master’s in Public Administration. Your participation remains a key component of this project as it provides insight into how I can tailor the recommendations to account for the realities experienced by you and your colleagues in service of your clients.

As promised, please see below my notes on your interview. I will be happy to answer any questions you might have. You will note that they are rather vague, but this is to ensure confidentiality. If there is anything that you feel is missing, please feel free to include it in your response.

At this point, I am asking for your consent to include this information in the report. Please review the notes, and if you do consent to its use, please reply to this e-mail, within 7 days, indicating that you have read and consent to the use of the information.

Again, thank you for your participation,
### Appendix E: Comparing Information Collected at Intake Across Programs

<table>
<thead>
<tr>
<th>Information requested on Intake Form</th>
<th>Alcohol and Drug Services</th>
<th>Mental Health Services</th>
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