

Leadership, training, communication and institutional support: keys to service integration for dual diagnosis patients

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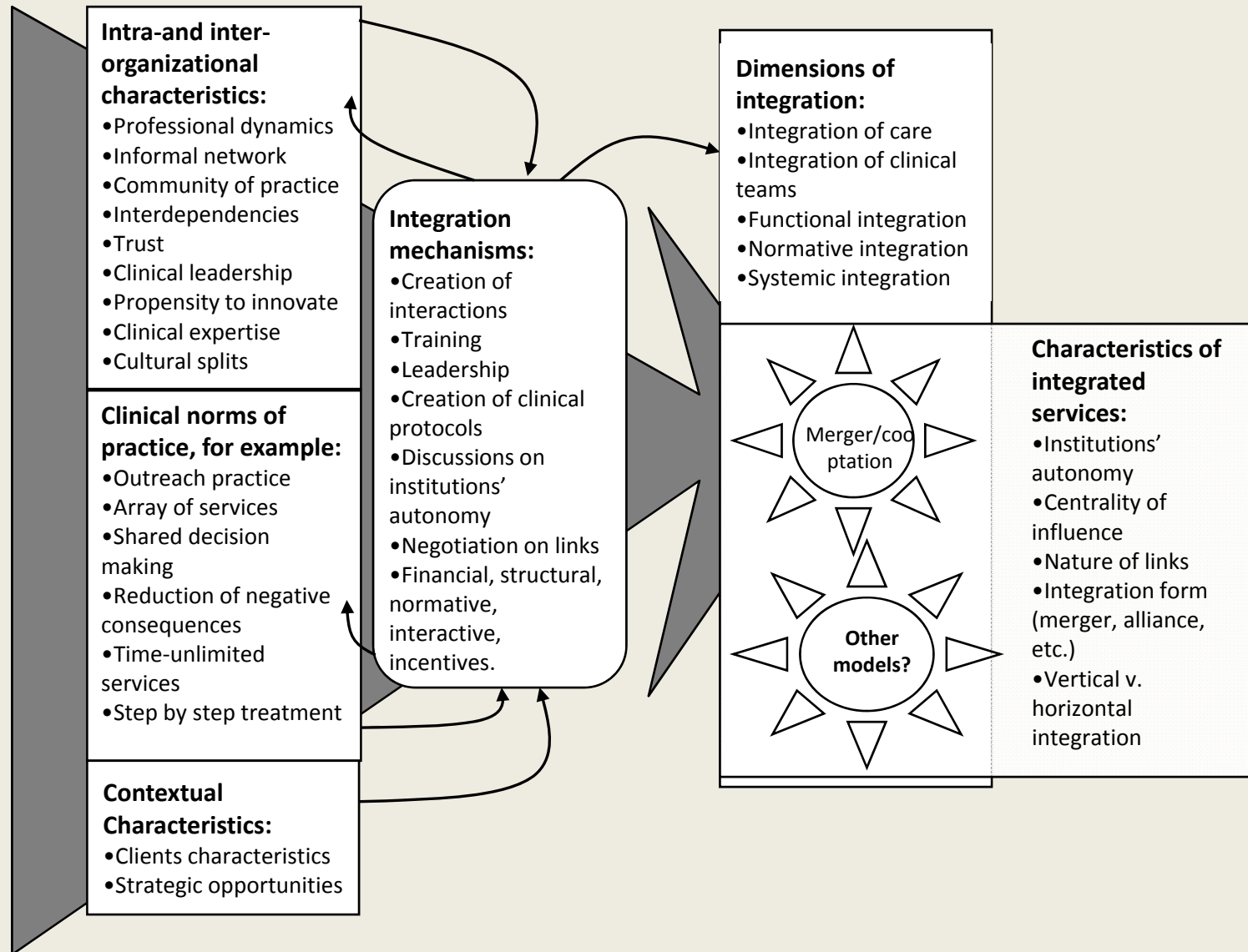
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Conceptual model for health services integration for patients with dual diagnosis



Case 1: Merger

Integration context

Intra- and inter-organizational characteristics

- Two cultures
- Contracts renewed every X periods
- Part-time hiring
- Protocols and procedures of the 2 establishments
- Multiple unions
- Multiple accreditation procedures

- ### Clinical norms of practice
- Integrated approach necessary

- ### Patient characteristics
- A different team supporting each patient
 - Several actors, each with leverage (incarceration, housing, etc.)
 - Different treatment philosophies, approaches, expectations
 - Judiciary process (2nd-line MD has control, community service, probation officer...)

Integration mechanisms

- ### Sharing of expertise
- Occasional training activities
 - Journal Club
 - Administrative meetings every 2 weeks – case discussion
 - Mirror activity, 1/week
 - Team meeting, 1/week
 - Clinical decisions always taken by the team
 - Co-facilitation of group by actors from both rehabilitation and psychiatry
 - Exchanges between professionals for individual follow-up
 - Individual follow-up by 2 professionals
 - Group of patients with personality disorders: patient seen by team, 1/month
 - Group of patients with psychosis: very close team work

- ### Institutional levers
- Versatility required upon hiring
 - In-house creation of administrative tools (accounting for clinical activities)
 - Creation of liaison position

- ### Clinical levers
- Act with flexibility
 - Knowledge of the network
 - Creation of links – Liaison work
 - Identification of contact person
 - Telephone contact with treating professional
 - Meeting with professional / mirror
 - Written report to treating professional

- ### Network actions
- Work with 2nd-line professionals
 - Participation in conferences
 - Invitation to mirror sessions
 - Specific training on request
 - Follow-up patient's file with professional
 - Case discussion
 - Psychiatry consult for rehabilitation sector

Integration status



- ### Normative integration
- Clinical programming for each group
 - Specific therapeutic approach
 - Multidisciplinary and interdependence of the clinical team
 - Common language
 - Common treatment philosophy
 - Treatment protocols based on consensus

- ### Team integration
- Good working relationships
 - Retention of personnel

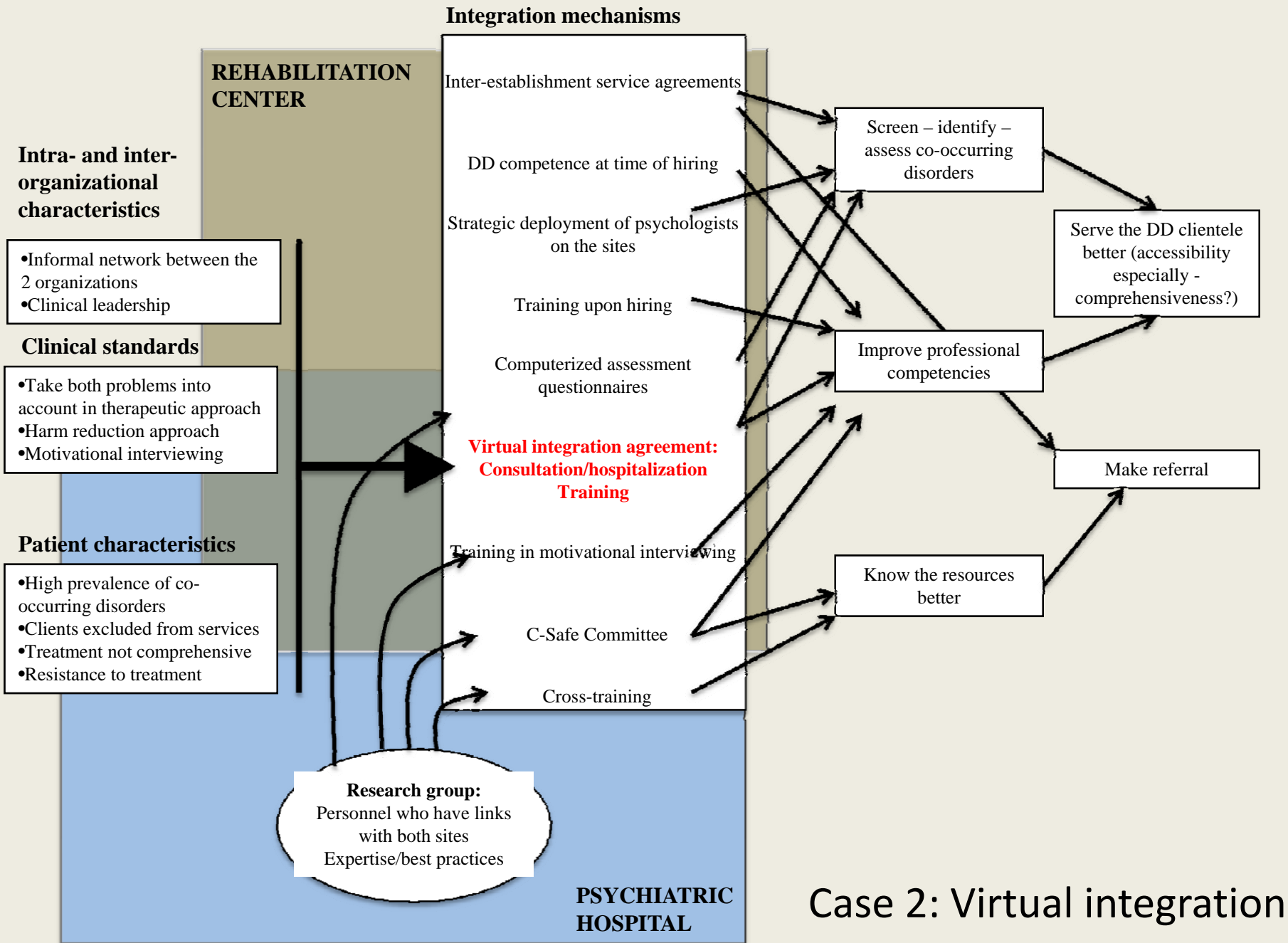
- ### Functional integration
- Duplication of activities
 - Complex management

- ### Care integration
- Evaluation
 - Client retention (motivating waiting lists, ways of working)
 - Regular follow-up (with liaison)
 - Comprehensive clinical management (resource mobilization)
 - Therapeutic continuity
 - Patient returned to 2nd-line services

- ### Integration of levels of care
- Train and equip 2nd-line services
 - Provide accompaniment
 - Demystify psychiatry
 - Improve dialog with 2nd-line services
 - Strengthen 2nd-line services
 - Improve 2nd-line clinical management

Legend:
 : impeding
 : enhancing

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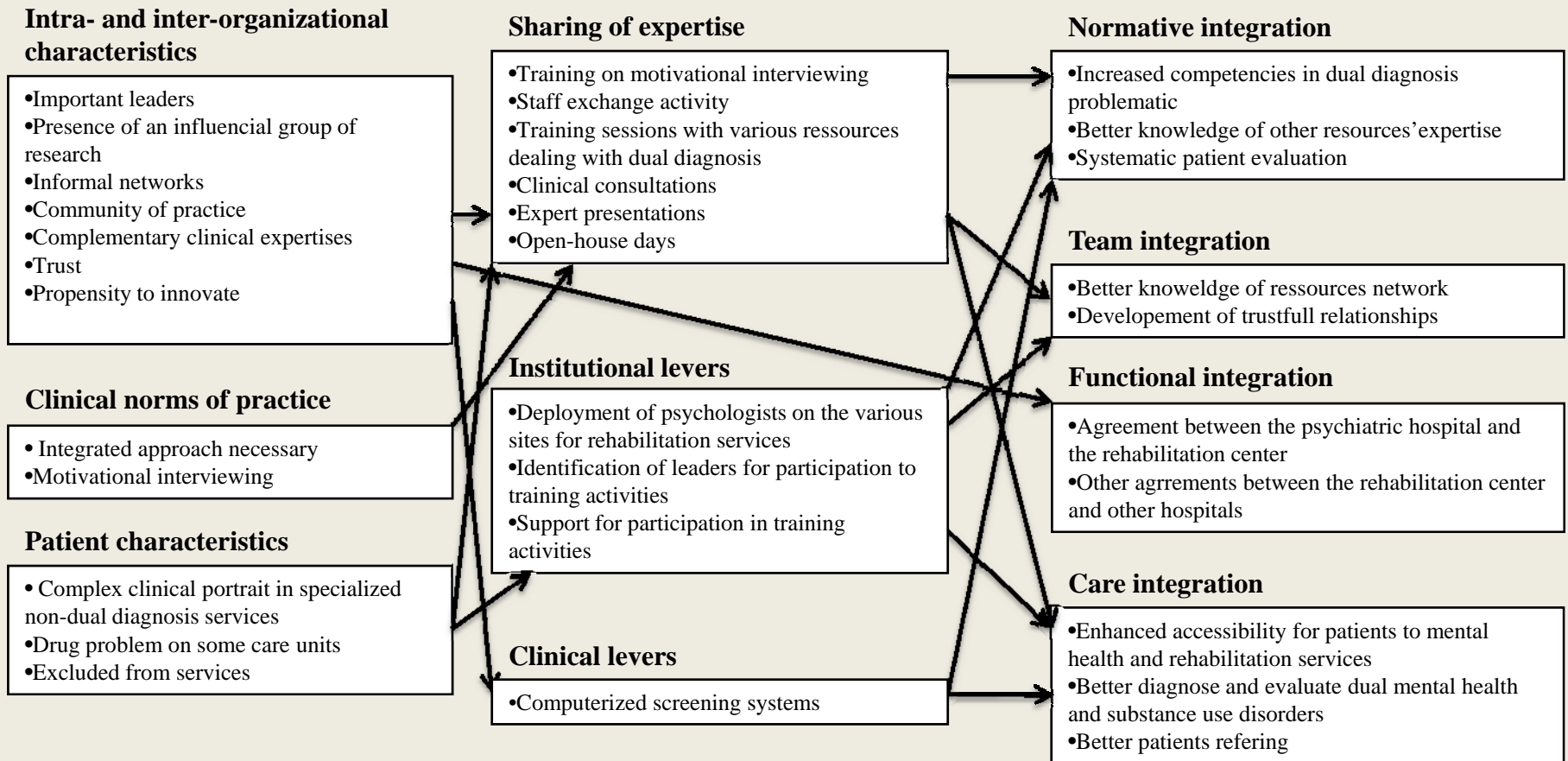


Case 2: Virtual integration

Integration context

Integration mechanisms

Integration status



Legend:

→ : impeding

→ : enhancing

We observed...

- An integration in both cases, with a general level of integration much different.
- The same enhancing factors: clinical leadership, training and communication activities, institutional support.
- The necessity to organize resources in network, even in the cas of the merger.

Whatever the organizational constraints for integrating services for dual diagnosis patients, strong clinical leadership with some institutional support can, through training and communication activities, have a significant impact on patients' quality of care.