COMMUNITY CONNECT

IMPLEMENTATION GUIDE

MARCH 2022

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ACKNOWLEDGEMENTS

This guide was prepared by the Community Connect Pilot Project team of the Provincial System Support Program at the Centre for Addiction and Mental Health (PSSP at CAMH): Matthew Hollingshead and Nicole Nosworthy. It builds on the contributions of past project team members, including: Stephanie Gloyn, Denise Lamanna, Michele Mitchell, David Phillips, and Nitali Tagger.

Our sincere thanks go out to the teams from the Neighbourhood Group, the Glendale House Withdrawal Management Service at St. Joseph's Health Centre (Unity Health), and Women's Own Withdrawal Management Centre for their commitment to improving the wellbeing of women in need of support. Without their willingness to experiment and follow through on the implementation of the Community Connect model, this work would not have been possible.

We warmly acknowledge the members of the Community Connect Steering Committee, who generously provided their time, support, and guidance throughout the project: Gerry Banks, Julia Bloomenfeld, Jon Bushell, Deborah Gardner, Robin Griller, Amber Kellen, Kelly Lawless, Dana Lythgoe, John O'Mara, Linda Picken, Francesca Serwaa, Lorie Steer, Janet Stevenson, and Martha Williams.

We would also like to thank the Centre for Addiction and Mental Health, who provided financial support for this initiative.

Suggested citation:
Provincial System Support Program. (2022) Community Connect Implementation Guide. Toronto, ON: Centre for Addiction and Mental Health.

COMMUNITY CONNECT OVERVIEW

Community Connect is a short-term case management program for women transitioning from Withdrawal Management Services (WMS) to community-based support. The Community Connect Case Manager begins working with women during their WMS stay, drawing on gender- and trauma-informed approaches to help clients identify the support they need to begin or recommit to their individual recovery journeys.

The time immediately following discharge from a WMS presents a critical opportunity for reducing the risk of overdose and ensuring that individuals are connected with the right supports in a timely manner.[2, 6, 14] Staff from community-based organizations often have more flexibility and stronger connections with community partners than their hospital-based counterparts. They can leverage these resources to help clients remain safe and engaged during a time marked by significant vulnerability and potential for positive change.

Community Connect decreases a client's unmet support needs by fostering coordination of care, offering support during service wait periods, and facilitating warm hand-offs to services that meet personal goals. The model's unique foundation of partnership between community- and hospital-based services also offers a framework that centers the value of collaboration and service integration in the pursuit of high-quality client centered care.

The Importance of Being Gender- and Trauma-Informed

Development of Community Connect was guided by the principles of gender- and trauma-informed practice, and a recognition that women who use substances have been consistently underserved by the substance use system. Gender-informed services seek to address how social factors like the expectations of gendered roles or the distribution of resources to services for different genders impact how individuals experience and are able to access appropriate supports.[17] For example, intake and care planning for Community Connect considers issues that tend to have more significance for women, including childcare concerns, involvement with Children's Aid Societies, and the safety of potential housing options.

Including trauma-informed practice principles in Community Connect reflects an appreciation that past experiences of trauma are closely correlated with problematic use of tobacco, alcohol, and other substances.[17] Trauma-informed practices allow service providers to appreciate the context in which a woman who has experienced trauma is living her life while avoiding re-traumatization by supporting safety, choice, and sense of control in the course of their care.[3, 5] The

trauma-informed care principles of trauma awareness; safety and trustworthiness; choice, collaboration, and connection; strengths based and skill building have been embedded throughout the Community Connect service model.[5] This includes prioritizing the hiring of Case Managers who are women, ensuring that communication happens in safe places and through safe means, and that women are provided with as much information and choice as possible about the care they receive.

For more information about gender- and trauma-informed care, please consult these resources:

- New Terrain: Tools to Integrate Trauma and Gender Informed Responses into Substance Use Practice and Policy (Centre of Excellence for Women's Health, 2018)
- Trauma Matters: Guidelines for Trauma-informed Practices in Women's Substance Use Services (The Jean Tweed Centre, 2013)

The Value of Partnership

The importance of partnership to the Community Connect model cannot be overstated. Despite the growing understanding of substance use as a chronic condition, there is a sense that existing systems of treatment and care largely offer short, disconnected sessions of high-intensity treatment.[10, 11] This is often at odds with the reality that recovery is a long-term, personal journey that takes different pathways and sources of support to help improve a person's health, social connections, and wellbeing.[1, 9, 13] Most people will encounter a number of different services and supports over the course of their recovery journeys, and many are left to manage the transitions from one to another on their own.

Withdrawal Management Services offer support for the safe management of withdrawal symptoms and medical complications of individuals with a substance use disorder who are ceasing to use the substance.[2] In Toronto, where Community Connect was created, WMSs are operated by hospitals. They are often framed as the "first-step" in the continuum of recovery and care but evidence suggests that these services require further support because transition from WMS to community has been identified as a time of increased risk.[2] As stated by the Toronto Central Local Health Integration Network in 2015, there is a need to reform WMS for greater coordination of care, integration of services, and infusion evidence-based standards of care to support clients during high-risk transition periods.[14]

Community Connect enhances existing WMS infrastructure by introducing experienced Case Managers who are employed by community-based organizations. Although the Case Manager works primarily from the WMS, they have the flexibility to spend time offsite in ways that may not be possible or appropriate for WMS staff, such as conducting accompaniments, outreach, or engagement activities.

About this Guide

This guide is intended to support community-based substance use and WMS service providers plan for and implement the Community Connect program model. The Service Model section (pg. 12) outlines the essential components of the model and explains what happens during each step of the service. The Practice Standards section (pg. 17) describes observable behaviours for each component that can be used as benchmarks for practice and oversight. The Monitoring and Evaluation section (pg. 30) provides resources to guide the development of an evaluation strategy for implementation of the model.

DEVELOPMENT OF THE COMMUNITY CONNECT MODEL

Community Connect was created to respond to the opportunities identified from the Charting the Path report, which provided an overview of the availability, accessibility, acceptability, and quality of continuing care supports and services for people in recovery in Toronto.[16]

Continuing care describes any kind of support that comes after a period of inpatient, residential, or intensive outpatient substance use treatment to maintain an individual's long-term recovery.[8, 12, 15] It can be offered in many ways, including group counselling, individual therapy, telephone counselling, brief check-ups, self-help meetings, and recreational programming. Continuing care emphasizes the importance of longer-term support for people in recovery and can meet a person's changing needs as they experience periods of relative vulnerability and stability.[18]

Based on consultations with 137 service providers and people with lived experience of accessing substance use recovery supports, the report outlined the following 10 opportunities for action:

- Emphasize social connectedness and relationship building as critical components of continuing care.
- Use data to understand and improve the quality of continuing care.
- Help people make informed choices about their well-being and recovery.
- Ensure that continuing care encourages recovery through the use of clinical, social, and economic supports and services.
- Improve the quality and availability of primary healthcare services for people who use substances.
- Offer continuing care where people in recovery live and spend time.
- Improve discharge planning from clinical substance use services to better support recovery.
- Improve the experience of being on a waitlist.
- Formally include people with lived experience in continuing care.
- Advocate for the view that harm reduction and abstinence-based approaches are complementary rather contradictory.

The entire Charting the Path report, including full details about the findings and opportunities, can be found at improvingsystems.ca/projects/continuing-care-project.

Human Centered Design Methodology

The Community Connect Steering Committee drew heavily on the participatory engagement and co-creation methods of human-centered design to develop the Community Connect service model. Human-centered design collects a variety of tools and approaches that believe solutions to difficult problems are most often found in an empathetic understanding of the people who live with their impacts every day.[4] In its ideal form, human-centered design is inclusive and collaborative, expanding opportunities for a range of people to contribute to design solutions for the problems they face.[7]

The Steering Committee drew on their expertise and lived experience to create a number of plausible, low-resolution prototypes that responded to the opportunities identified in the Charting the Path report. It prioritized those concepts that seemed most likely to generate real-world support and impact, and refined the prototypes into working models. Finally, the Committee selected the Community Connect model and leveraged existing relationships to seek out partners to bring the model to life.

The tools and approaches from the IDEO Field Guide to Human Centered Design proved particularly helpful throughout this process.

Pilot Project Evaluation

A one-year pilot project of Community Connect operated from December 2020 to December 2021. This pilot was a partnership between the Glendale House WMS at Unity Health - St. Joseph's Health Centre, the Women's Own WMS at the University Health Network, the Neighbourhood Group - St. Stephen's Community House, and the Provincial System Support Program at the Centre for Addiction and Mental Health, which provided funding, project coordination, and evaluation support.

Despite disruptions due to the COVID-19 pandemic, results from the pilot project's evaluation showed that Community Connect provided essential guidance and support related to the pursuit of women's recovery goals while they transitioned from the WMSs back to their communities. At a time when important substance use services such as in-residence treatment facilities featured longer than usual waitlists, the Case Manager acted as a steady source of community-based contact and guidance for women while they reconnected with family and navigated referrals for employment, counselling, and virtual support group services.

Guiding Principles

These principles served as the foundation for the development of Community Connect. They describe some of the most important aspirations about the model, and can also be used to guide how Community Connect should be implemented to best support women transitioning from WMSs.

1. Support people to make their own choices.

When people have access to the best available information they are better able to make recovery decisions that line up with their personal circumstances and goals. This includes being transparent about the realistic expectations of harm reduction and abstinence-based programming.

2. Substance use is a chronic condition that impacts all areas of life.

Clinical and medically-based care is important for recovery, but can't address the full range of issues that accompany a long-term health issue. Community Connect strives to support care that encourages lasting relationships, stable housing, and access to employment and income supports.

3. Work with what happened to someone, not what is wrong with someone.

Substance use issues often stem from experiences of past trauma or chronic pain. Addressing these underlying issues means ensuring that support is offered according to the principles of gender- and trauma-informed care.

4. Prioritize human connections.

Trusting relationships are cornerstones of recovery, and Community Connect aims make it easier for individuals to connect with one another, and with people in their broader communities.

5. Meet people where they are.

Support is only effective if people can actually take advantage of it. This means making sure that what Community Connect offers is available at times that are convenient and safe, and in places that are relatively easy to get to.

6. Collect and use high-quality data.

High-quality care needs robust data to ensure that the people actually have their needs met. Community Connect is guided by a strategy of data-informed decision-making that builds on the information that service providers are already using.

7. Focus on times of change.

Times of transition, like the one that comes when a person leaves a withdrawal management service, can be marked by fear, anxiety, and increased risk of overdose. Community Connect aims to set people up for long-term success by encouraging smoother transitions and minimizing the isolation that can accompany sitting on a waitlist.

8. Put people with lived experience in positions of leadership.

Lived experiences of substance use and recovery are important sources of expertise that can enhance the quality of service. Decision-making structures and processes should be flexible enough to welcome and meaningfully include people with a range of experiences.

9. Build on partnerships.

Partnerships between groups and organizations that support people in recovery fuel efforts to improve the Community Connect model by seeking out committed partners and establishing clear expectations for drawing on their unique strengths.

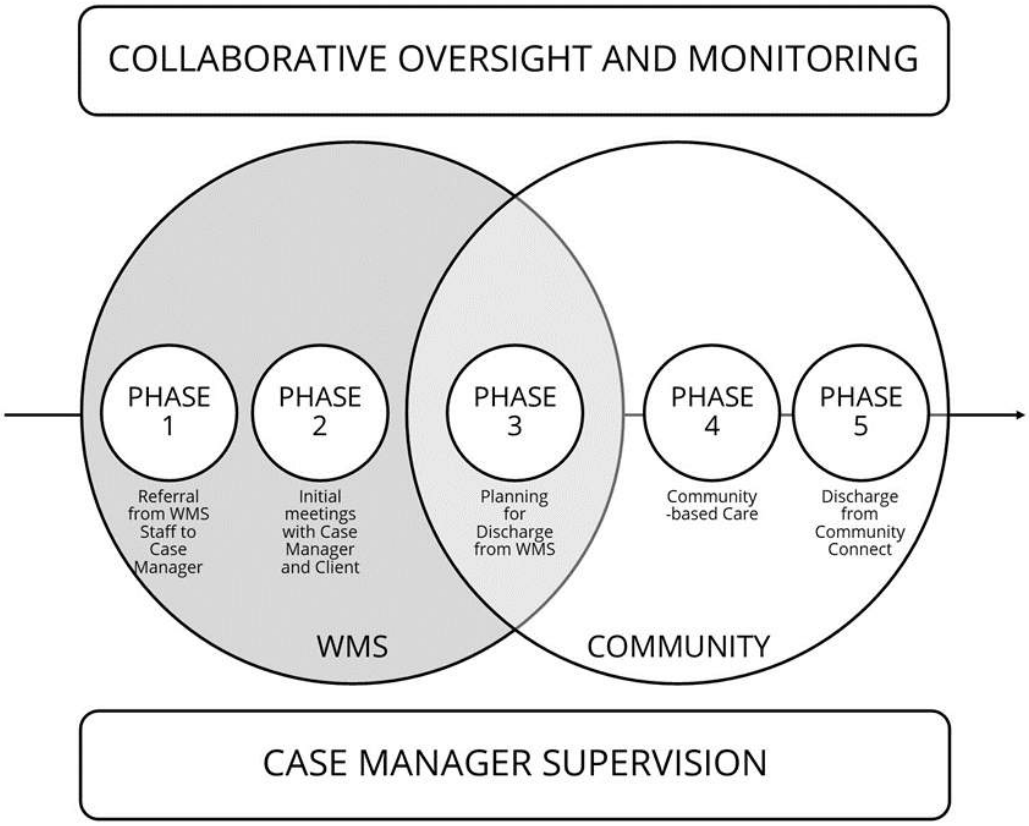
10. Support the people who offer Community Connect.

High-quality care relies on providers who are knowledgeable, skilled, and supported to do their work. Well-supported staff are more likely to bring good attitudes to their work and create spaces that are conducive to the goals of Community Connect.

COMMUNITY CONNECT SERVICE MODEL

The diagram below provides a simplified overview of the Community Connect model. In reality, client service journeys are non-linear, as are journeys of recovery. Phases 1 and 2 take place inside of the host WMS, as WMS Staff identify women who may be a good fit for Community Connect and facilitate an introduction to the Case Manager for intake. Phase 3 sees the Case Manager working with the Client and WMS Staff to prepare for discharge from the WMS and re-entry to the community. Phases 4 and 5 take place in the client's community, as they work with the Case Manager to complete referrals to the supports and services they need to pursue their recovery goals.

Consistency and accountability is maintained throughout the service by regular Case Manager Supervision, which provides an opportunity for the Case Manager and their Supervisor to assess the current caseload and brainstorm solutions to any significant issues related to the work. Collaborative Oversight and Monitoring offers regular opportunities for the Case Manager, Supervisor, and WMS leadership to meet, review key service metrics, and develop strategies for ensuring the continued success of the program.



Service Pathway

The following section describes the general flow of the Community Connect program and does not imply that a common linear path will be followed by each client.

Phase 1: Referral from WMS Staff to Case Manager	
Description	***Suggested Documentation and Information Sharing***

• *WMS Staff determine client eligibility for Community Connect (CC) based on the following criteria. They are:*
  • *a woman;*
  • *experiencing substance use challenges;*
  • *in need of transitional case management support.*
• *WMS Staff describe CC to the client using the CC Promotional Materials.*
• *Client and/or WMS Staff complete basic elements of the CC Intake Package to minimize repetition in the referral process.*
• *WMS Staff and the Case Manager connect to prepare for referral.*
Note: Referrals from WMS may not always result in clients being accepted onto the Case Manager caseload.
	• *CC Eligibility Criteria (opposite)*
	• *CC Promotional Materials (pg. 43)*
	• *CC Intake Form (pg. 40)*

Phase 2: Initial Meetings with Case Manager and Client (at WMS)

Description	*Suggested Documentation and Information Sharing*
• *WMS Staff introduce client to the Case Manager. Represents warm handoff between WMS Staff and Case Manager.* • *Case Manager determines if the client needs a full intake to CC or is in need of one-off support.* • *Case Manager seeks informed consent from the Client for service and information sharing.* • *Client and Case Manager discuss recovery and case management goals.* • *Case Manager creates a Client Record in their data management system.*	• *CC Intake Form (pg. 40)* • *Client Record*

Phase 3: Planning for Discharge from WMS

Description	*Suggested Documentation and Information Sharing*
• *Client and Case Manager establish if existing relationships with service providers, family members, or other sources of support are available.* • *Client and Case Manager develop a referral and support plan to meet the Client's recovery goals.* • *Case Manager aims to meet the Client at least twice prior to discharge from WMS.* • *WMS discharges client.* • *Case Manager updates client record in data management system to reflect changes in the client's goals and circumstances.*	• *Client Record*

Phase 4: Community-based Care

Description	*Suggested Documentation and Information Sharing*
• *Case Manager facilitates reconnection with existing sources of support.* • *Case Manager facilitates warm referrals to identified services, programs, and supports, including through the use of accompaniments, follow-up calls, visits, and supportive counselling as required.* • *Case Manager and Client connect as required to assess if the Client has met their recovery or case management goals. They will also establish if new or different goals have emerged.* • *Case Manager updates client record in data management system to reflect changes in the client's goals and circumstances.*	• *Referral documents for identified supports and services* • *Client Record*

Phase 5: Discharge from Community Connect

Description	*Suggested Documentation and Information Sharing*
• *Case Manager meets regularly with the Supervisor to review caseload and determine when clients are ready to be discharged from the program. Supported by the Caseload Capacity Scale.* • *Case Manager works with client to determine if their recovery and case management goals have been met, or if supports are sufficiently established to continue her recovery after discharge from service.* • *Case Manager discharges client.* • *Case Manager updates client record in data management system to reflect discharge from Community Connect.*	• *Caseload Capacity Scale (pg. 42)* • *Client Record*

PRACTICE STANDARDS

This section outlines the practice standards for each component of Community Connect to guide implementation of the model. Each component is broken down into observable behaviours that outline benchmarks for practice and oversight. The real-world implementation of Community Connect can be compared against these standards to gauge fidelity with the model and highlight areas where strategies for improvement are needed.

- The *Expected Standard* column describes the target behaviours for each component.
- The *Developmental Standard* column describes acceptable practice variations on the path to pursuing the expected standards.
- The *Inconsistent with Model* column describes unacceptable practice and oversight circumstances that should be addressed immediately if encountered.

Phase 1: Referral from WMS Staff to Case Manager			
#	*Expected Standard*	*Developmental Standard*	*Inconsistent with Model*
1	The Case Manager and WMS staff agree upon and **consistently use formal communication methods and provide ad hoc updates** to coordinate shared clients' support needs, appointments, and discharge plans.	The Case Manager and WMS staff agree upon and **consistently provide ad hoc updates** to coordinate shared clients' support needs, appointments, and discharge plans.	The Case Manager and WMS staff **do not consistently communicate** about shared clients' support needs, appointments, or discharge plans.
2	The Case Manager and involved WMS staff **always provide Community Connect service information that is clear and consistent. The first contacts with clients are always warm, welcoming, and collaborative**.	The Case Manager and involved WMS staff **usually provide Community Connect service information that is clear and consistent. The first contacts with clients are usually warm, welcoming, and collaborative**.	The Case Manager and involved WMS staff provide Community Connect service information that is **unclear or inconsistent. The first contacts with clients lack warmth and do not invite collaboration**.

Phase 2: Initial Meetings with Case Manager and Client (at WMS)			
#	*Expected Standard*	*Developmental Standard*	*Inconsistent with Model*
3	The Case Manager **clearly explains** their own role to the client, including the scope and time-limited nature of service, how their work connects and coordinates with WMS services, and the transfer of responsibility for some discharge preparation from the WMS to the Continuing Care Program. **The Case Manager confirms the client's understanding and, if needed, reiterates the information during their working relationship**.	The Case Manager **clearly explains** their own role to the client, including the scope and time-limited nature of service, how their work connects and coordinates with WMS services, and the transfer of responsibility for some discharge preparation from the WMS to the Continuing Care Program. **The Case Manager does not confirm the client's understanding or does not clearly reiterate the information if needed during their working relationship**.	The Case Manager **does not clearly explain** their own role to the client, such as the scope and time-limited nature of service, how their work connects and coordinates with WMS services, and the transfer of responsibility for some discharge preparation from the WMS to the Continuing Care Program.
4	Intake processes **can respond** to the range of possible recovery-related goals (i.e. treatment, housing, family reunification). They are **consistently** based on motivational interviewing and harm reduction approaches.	Intake processes **can respond** to the range of possible recovery-related goals. They are **sometimes** based on motivational interviewing and harm reduction approaches.	Intake processes have **a limited ability to respond** to the range of possible recovery-related goals.
5	**Case Manager, WMS Staff, and clients are aware** of what is involved in the informed consent process – including what is kept in records, the extent and limits of confidentiality, who can access the records, and the procedures for requesting their records.	**Case Manager and clients aware** of what is involved in the informed consent process – including what is kept in records, the extent and limits of confidentiality, who can access the records, and the procedures for requesting their records.	**Clients are not fully aware** of what is involved in the informed consent process – including what is kept in records, the extent and limits of confidentiality, who can access the records, and the procedures for requesting their records.

Phase 2: Initial Meetings with Case Manager and Client (at WMS) (*cont.*)			
#	*Expected Standard*	*Developmental Standard*	*Inconsistent with Model*
6	The Case Manager **always** supports clients to identify their needs and goals, as well as assisting to identify suitable options for services that respond to those needs and goals.	The Case Manager **usually** supports clients to identify their needs and goals, as well as assisting to identify suitable options for services that respond to those needs and goals.	**The Case Manager or the client identifies the client's needs and goals without meaningful input from the other**.
7	The Case Manager **identifies and validates individual clients' stressors and triggers and consistently applies this information in their approach to supporting the client**.	The Case Manager **identifies and validates individual clients' stressors and triggers and sometimes applies this information in their approach to supporting the client**.	The Case Manager **broaches potentially sensitive topics similarly with all clients, rather than considering clients' individual stressors and triggers**.
8	The Case Manager **consistently** works with clients that are pregnant, parenting, and/or involved with child protection organizations to optimize the health of client and child in ways that are consistent with their identified goals.	The Case Manager **sometimes** works with clients that are pregnant, parenting, and/or involved with child protection organizations to optimize the health of client and child in ways that are consistent with their identified goals.	The Case Manager **does not** work with clients that are pregnant, parenting, and/or involved with child protection organizations to optimize the health of client and child in ways that are consistent with their identified goals.
9	The Case Manager **understands** child protection reporting responsibilities and **consistently fulfills these responsibilities in partnership with the client and in a transparent and strengths-based manner**.	The Case Manager **understands** child protection reporting responsibilities and **sometimes fulfills these responsibilities in partnership with the client and in a transparent and strengths-based manner**.	The Case Manager **does not understand** child protection reporting responsibilities and/or **does not fulfill these responsibilities in partnership with the client and in a transparent and strengths-based manner**.

Phase 2: Initial Meetings with Case Manager and Client (at WMS) (*cont.*)			
#	*Expected Standard*	*Developmental Standard*	*Inconsistent with Model*
10	Throughout the process of identifying clients' support needs and goals, the Case Manager emphasizes client choice and control of disclosures.	When starting the process of identifying clients' support needs and goals, the Case Manager emphasizes client choice and control of disclosures.	During the process of identifying clients' support needs and goals, the Case Manager does not emphasize client choice and control of disclosures.
11	The Case Manager gathers relevant basic information about essential aspects of the client's life from every client. This information can be collected over multiple conversations as rapport and trust are built. The Case Manager is mindful of the risk of retraumatization and attentive to the client's stressors and triggers as they learn them. **The Case Manager asks about all of the following**: physical health issues; mental health issues; safety issues; family, caregiving, and childcare responsibilities; parenting issues; child welfare involvement; relationships and supports; pregnancy; sexual orientation; culture and language issues; vocational/workplace/education issues; housing and/or support in their living situation; financial and/or poverty issues; legal involvement; high risk behaviours.	The Case Manager gathers relevant basic information about essential aspects of the client's life from every client. This information can be collected over multiple conversations as rapport and trust are built. The Case Manager is mindful of the risk of retraumatization and attentive to the client's stressors and triggers as they learn them. **The Case Manager asks about some of the following**: physical health issues; mental health issues; safety issues; family, caregiving, and childcare responsibilities; parenting issues; child welfare involvement; relationships and supports; pregnancy; sexual orientation; culture and language issues; vocational/workplace/education issues; housing and/or support in their living situation; financial and/or poverty issues; legal involvement; high risk behaviours.	The Case Manager **only gathers relevant information about clients' substance use**.

Phase 3: Planning for Discharge from WMS			
#	*Expected Standard*	*Developmental Standard*	*Inconsistent with Model*
12	The Case Manager and involved WMS staff **always meet to coordinate discharge planning from the WMS** to ensure that clients are well supported as they prepare to re-enter the community.	The Case Manager and involved WMS staff **exchange information related to discharge from the WMS** as clients prepare to re-enter the community.	The Case Manager and involved WMS staff **do not coordinate discharge planning from the WMS** as clients prepare to re-enter the community.
13	The Case Manager and client **formally discuss where the client will stay** upon discharge from the WMS, including **development of a safety plan**.	The Case Manager and client **discuss housing options upon discharge from the WMS and may discuss related safety issues**.	The Case Manager and client **do not discuss housing options upon discharge from the WMS or related safety issues**.
14	The Case Manager applies their knowledge of communication approaches, technologies, and locations that are more likely to be safe and accessible for women. **The Case Manager fully discusses communication options with clients to identify the best options for individual needs**.	The Case Manager applies their knowledge of communication approaches, technologies, and locations that are more likely to be safe and accessible for women. **The Case Manager discusses some aspects of communication options with clients to identify some communication options**.	The Case Manager applies their knowledge of communication approaches, technologies, and locations that are more likely to be safe and accessible for women. **The Case Manager determines the communication approach without client input**.
15	The Case Manager **sets** healthy boundaries with the client **and ensures the client has an early and clear understanding** of the nature of and rationale for these boundaries.	The Case Manager **sets** healthy boundaries with the client, **but does not ensure the client has an early and clear understanding** of the boundaries or rationale for these boundaries.	The Case Manager **does not set** healthy boundaries with the client.

Phase 3: Planning for Discharge from WMS (*cont.*)			
#	*Expected Standard*	*Developmental Standard*	*Inconsistent with Model*
16	The Case Manager **assesses each client's ability** to communicate confidentially through virtual platforms, explores options to increase confidentiality, and makes plans with the client to work within the constraints.	The Case Manager **assesses most clients' abilities** to communicate confidentially through virtual platforms, explores options to increase confidentiality, and makes plans with the client to work within the constraints.	The Case Manager **does not assess clients' abilities** to communicate confidentially through virtual platforms, explore options to increase confidentiality, or make plans with the client to work within the constraints.
17	The Case Manager facilitates clients' informed decision-making through **thorough education and discussion** of the services available to them, including the benefits and limitations of each.	The Case Manager facilitates clients' informed decision-making through **some education and discussion** of the services available to them, including the benefits and limitations of each.	The Case Manager **creates plans or expects clients to create plans without adequate information** about the services available to them.
18	The Case Manager **maintains a case management plan** for each client **and facilitates meetings** with others in the circle of care.	The Case Manager **maintains non-standardized documentation** for each client **and facilitates meetings** with others in the circle of care.	The Case Manager **does not maintain documentation** for clients or **facilitate meetings** with others in the circle of care.

Phase 4: Community-based Care			
#	*Expected Standard*	*Developmental Standard*	*Inconsistent with Model*
19	The Case Manager **regularly** facilitates connections to specialized services outside of the mental health and addictions sector that support people with trauma (eg. services specifically for people that are women, refugees, Indigenous, queer/trans, etc.)	The Case Manager **sometimes** facilitates connections to specialized services outside of the mental health and addictions sector that support people with trauma (eg. services specifically for people that are women, refugees, Indigenous, queer/trans, etc.)	The Case Manager **does not know about or suggest** connecting with specialized services outside of the mental health and addictions sector that support people with trauma.
20	The Case Manager **consistently** prioritizes facilitation of clients' contact with their children and family (with client and family consent).	The Case Manager **sometimes** prioritizes facilitation of clients' contact with their children and family (with client and family consent).	The Case Manager **does not** prioritize facilitation of clients' contact with their children and family.
21	The Case Manager **consistently and actively facilitates** connection or re-connection to supports using an appropriate level of involvement for clients' individual needs. This may include accompaniment to appointments, post-appointment check-ins, or advocacy on behalf of the client.	The Case Manager **sometimes actively facilitates** connection or re-connection to supports using an appropriate level of involvement for clients' individual needs. This may include accompaniment to appointments, post-appointment check-ins, or advocacy on behalf of the client.	The Case Manager **does not actively facilitate** connection or re-connection to supports.

Phase 4: Community-based Care (*cont.*)			
#	*Expected Standard*	*Developmental Standard*	*Inconsistent with Model*
22	Recognizing the barriers to service connection and transfer, the Case Manager **will make their best reasonable effort** to support clients until a warm handover is achievable. Consideration of ending client support prior to a warm handover is **always managed by the Case Manager and their Supervisor** and will be communicated early and transparently to the client.	Recognizing the barriers to service connection and transfer, the Case Manager **will make their best reasonable effort** to support clients until a warm handover is achievable. Consideration of ending client support prior to a warm handover is **managed by the Case Manager and sometimes their Supervisor** and will be communicated early and transparently to the client.	The Case Manager **does not make their best reasonable effort** to support clients until a warm handover is achievable and does not consult their supervisor.
23	The Case Manager **routinely** works with the client to **revisit their recovery goals, needs, and suitable options for services** using motivational interviewing and harm reduction approaches.	The Case Manager **occasionally** works with the client to **revisit their recovery goals, needs, and suitable options for services, sometimes** using motivational interviewing and harm reduction approaches.	The Case Manager **doesn't work with the client to revisit their recovery goals, needs, and suitable options for services**, or does so without the client's involvement.

Phase 5: Discharge from Community Connect			
#	*Expected Standard*	*Developmental Standard*	*Inconsistent with Model*
24	The Case Manager communicates the time-limited nature of Community Connect throughout their work with **every client** to help prepare the client for the end of their work together. The **communications are always warm, clear, and consistent**.	The Case Manager communicates the time-limited nature of Community Connect throughout their work with **some clients** to help prepare the client for the end of their work together. The **communications are usually warm, clear, and consistent**.	The Case Manager **does not** communicate the time-limited nature of Community Connect to help prepare the client for the end of their work together.
25	The Case Manager and Supervisor **regularly review client progress and initiate discharge planning** when appropriate.	The Case Manager and Supervisor **sometimes review client progress and discuss discharge planning**.	The Case Manager and Supervisor **do not work together to discuss or initiate discharge planning**.
26	The Case Manager **always** holds a meeting with the client and **always includes** her circle of care (including friends/family where applicable) to mark the end of their work together.	The Case Manager **sometimes** holds a meeting with the client and **sometimes includes** her circle of care (including friends/family where applicable) to mark the end of their work together.	The Case Manager **never** holds a meeting with the client and her circle of care (including friends/family where applicable) to mark the end of their work together.

Supervision			
#	*Expected Standard*	*Developmental Standard*	*Inconsistent with Model*
27	The Case Manager and Supervisor have **regularly scheduled supervision sessions**.	The Case Manager and Supervisor have **ad hoc supervision sessions** when considered appropriate.	The Case Manager and Supervisor **do not meet for supervision sessions**.
28	The Case Manager and Supervisor **regularly use the Caseload Capacity Scale** to ensure that the Case Manager is supporting a balanced caseload.	The Case Manager and Supervisor **informally review the size and balance of the Case Managers caseload**.	The Case Manager and Supervisor **do not** review the size or balance of the Case Manager's caseload.
29	**The Case Manager, their supervisor, and WMS staff receive capacity building support at foundational and, for the Case Manager, advanced levels to further their understanding** of women's experiences of trauma and substance use.	**The Case Manager receives capacity building support to further their understanding** of women's experiences of trauma and substance use.	**Involved staff do not receive capacity building support** on women's experiences of trauma and substance use.
30	All staff who work with trauma survivors have structured, strengths -based supervision from someone with expertise in understanding women's experiences of trauma **at least every other week**.	All staff who work with trauma survivors have structured, strengths -based supervision from someone with expertise in understanding women's experiences of trauma **less frequently than every other week**.	Staff who work with trauma survivors **do not consistently** have structured, strengths-based supervision from someone who is trained in understanding women's experiences of trauma.

Collaborative Oversight			
#	*Expected Standard*	*Developmental Standard*	*Inconsistent with Model*
31	Program partners **establish a formal partnership framework (i.e. MoU)** that outlines mutual responsibilities, expectations, and other criteria for offering Community Connect.	Program partners **establish an informal partnership framework** that outlines mutual responsibilities, expectations, and other criteria for offering Community Connect.	Program partners have **no established partnership framework**.
32	Program partners establish a series of **regularly scheduled meetings to review program data, identify opportunities for quality improvement, and refine program functioning**.	Program partners hold **ad hoc meeting to review program data, identify opportunities for quality improvement, and refine program functioning**.	Program partners **do not meet to review program data, identify opportunities for quality improvement, and refine program functioning**.
33	Program partners **establish a monitoring and evaluation framework** (i.e. logic model, evaluation plan) for determining program effectiveness.	Program partners **define measurable indicators and set realistic benchmarks** to monitor and evaluate program effectiveness.	Program partners have **no strategy** for monitoring or evaluating program effectiveness.
34	Staff hiring practices prioritize people with the relevant knowledge, skills, and experience to provide **effective services for women with substance use concerns**.	Staff hiring practices prioritize people with the relevant knowledge, skills, and experience to provide **effective services for women or people with substance use concerns, without addressing the relationship between gender and substance use**.	Staff hiring practices **do not prioritize people with knowledge, skills, and experience relevant to gender or substance use**.

Collaborative Oversight (*cont.*)			
#	*Expected Standard*	*Developmental Standard*	*Inconsistent with Model*
35	The program **collects clients' key demographic information and feedback** to assess whether there is equitable service access and outcomes, with a priority on equity-seeking communities. Those overseeing the program **take actions** to address inequities.	The program **collects clients' key demographic information and feedback** to assess whether there is equitable service access and outcomes, with a priority on equity-seeking communities. Those overseeing the program **take limited actions** to address inequities.	The program **does not collect clients' key demographic information or feedback** to assess whether there is equitable service access and outcomes.

MONITORING AND EVALUATION

The purpose of this section is to guide the development of an evaluation strategy for implementing and maintaining the Community Connect model. The evaluation should at minimum include the following elements:

1. The program Logic Model (see below) illustrates the program's resources, activities and expected outcomes (short and long term).

2. An Evaluation Framework helps plan and keep the evaluation organized. It includes:
   - the primary and secondary evaluation questions (what you want the evaluation to address);
   - the "measures" (specific, observable, and measurable pieces of information that address each evaluation question);
   - data sources (tools used to collect the data);
   - frequency (how often the data is collected); and,
   - analysis (how the data will be analyzed).

3. A Summary of Client Service Data that highlights important demographic and service use information should be produced ahead of every Implementation or Oversight Committee meeting. This summary can help the committee to keep track of program usage and the aggregated demographics of participants to highlight opportunities for program improvement.

Please visit Public Health Ontario for more information on how to develop and conduct program evaluation: https://www.publichealthontario.ca/-/media/documents/A/2015/at-a-glance-10step-evaluation.pdf

Logic Model

The logic model demonstrates what resources and activities are expected to lead to the client, system, and implementation outcomes intended by the Community Connect program.

	Oversight	*Project Management*	*Case Management*	*Evaluation*
Inputs	Relevant management and supervisory level staff from the WMS and community-based organizations Relevant direct service staff from the WMS and community-based organization People with relevant lived and living experience (i.e. former WMS clients)	Implementation Lead(s) Program funding (e.g., materials, equipment, transportation) Honorariums for engaging people with lived or living experience	Full time Case Manager Supervisor In-kind supports (i.e. desk or workspace at the WMS)	Evaluation Lead(s)
Activities	Develop governance documents (i.e. MOUs) Supports project planning and implementation through an Implementation or Oversight Committee Supports implementation decision making Identifies barriers and/or opportunities for external support referral	Coordination of Implementation or Oversight Committee meetings Develops implementation supports, including coaching plans, evidence-informed practices, and policies Revises service pathway to fit needs and circumstances of implementing partners	Establishes and/or maintains connections with external supports Completes intake with client Completes data entry based on intake Identifies women's service needs/goals using motivational interviewing and harm reduction approaches	Overseen by Implementation or Oversight Committee Summarizes client service data Assess women's experiences in Community Connect Ongoing monitoring of Case Manager experience Adhere to data sharing agreements

	Oversight	*Project Management*	*Case Management*	*Evaluation*
Inputs (*cont.*)	Review and approve service pathways	Organizes relevant training opportunities, including for trauma-informed and gender informed practice	Provides transitional support based on client's identified goals Overseen by Agency's Supervisor	Build capacity for data collection and extraction through coaching and training
Outputs	# of Implementation or Oversight Committee meetings Defined roles and responsibilities MOUs	Service pathways and protocols Knowledge translation and communication plan	# of clients participated in Community Connect Supports provided to clients Client service data summary	Client service data summary spreadsheet # Quarterly reports # interviews with clients Continuous monitoring of program implementation Demographic profile of women who access Community Connect
Short-term Outcomes	Increased reach of Community Connect to the intended client base Increased accountability for decision making	Increased support of Case Manager Enhanced communication between partners Mitigation strategies for any barriers to implementation	Proficiency in delivery of trauma- and gender-informed client support and care Meaningful connections/ relationships between Case Manager & external supports	Consistent data collection practices and processes Understanding women's and Case Manager's experiences participating in the pilot

	Oversight	*Project Management*	*Case Management*	*Evaluation*
Short-term Outcomes (*cont.*)	Promotion of trauma- and gender-informed practices when supporting women with substance use	Strengthened relationships among partners	Participation of women in their care planning and delivery Improved understanding of women's journey after discharge from WMS Improved understanding of women's service needs Women feel engaged during their experience with CC	
Long-term Outcomes	Women feel supported in transition(s) between WMS and external supports Coordination of external referrals (e.g., completion of referrals) and navigation of external supports Women's service needs are aligned with service referrals Women's recovery goals are met			

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APPENDICES

Appendix 1: Community Connect Case Manager Sample Job Description

- BA/B.S.W plus 2 years of recent experience in human services, preferably as a case manager or a combined equivalent of education, lived experience and/or significant related training.
- Minimum 2 years' experience working with individuals living with mental health, substance use issues, histories of trauma, and homelessness
- Experience, alignment, and commitment to harm reduction
- Strong familiarity and commitment to women-centred and trauma-informed care
- Commitment to anti-racism and anti-oppressive practices
- Formal training in substance use and mental health is an asset
- Physically able to travel consistently throughout the city on transit
- Recent demonstrated knowledge and skills in assessment, crisis intervention and prevention, conflict resolution, and negotiation skills
- Excellent written and verbal skills in English.
- Proficient with MS Office, and web based data entry for case management and time/labour.
- Familiarity with client data management systems and the training to complete OCAN and/or GAIN is an asset
- Self-directed, organized, and demonstrated supportive team member abilities
- Certification in Conflict Prevention and Intervention or willing to be trained

Appendix 2: Sample Intake Form

	Date of Intake:	Gender and Pronouns:
Legal Name And Preferred Name:	Date of Birth:	Age:
Which of the following currently apply to you? *Client must meet all to be eligible for Community Connect.* ○ Woman ○ Interest in substance use services/supports ○ Unmet health service needs		
Address: Where can we find you?	Telephone number:	
Cultural Background:	Primary language: Preferred language:	
Relationship Status:	Employment Status:	
Legal Involvement:	Education Completed:	
Are you in contact with other agencies?		
What is/are your substance(s) of choice? What are you goals related to substance use?		
How long have you used this/these substance(s)? What is your frequency of use? Have you accessed treatment services in the past/how often? Have you had periods of abstinence? Have you or do you ever share substance use equipment (pipes, needles, etc.)? What has helped you manage your substance use in the past?		

Appendix 2: Sample Intake Form (*cont.*)

<table>
<tr><td colspan="2">Do you use prescription drugs? If so, do you use them as prescribed?

Do you mix the substances you use (including prescription medication)?</td></tr>
<tr><td colspan="2">What would you like support or help with? What do you think would help you? What kind of support interests you?</td></tr>
<tr><td colspan="2">What are some things that you like about yourself? What are some things that you are proud of? What are some of your strengths?</td></tr>
<tr><td>Do you have any children?
# of children:

Do you have any other dependents?
# of other dependents:</td><td>Are you currently pregnant?

Are you receiving prenatal care?

Other supports?</td></tr>
<tr><td colspan="2">Are you currently involved with child protection services?
What sort of support do you need for this?</td></tr>
<tr><td colspan="2">Do you have a primary care physician?

How is your physical health (any short or long-term illnesses)?</td></tr>
<tr><td colspan="2">Do you have a psychiatrist and what do you see them for?

Have you been given an official diagnosis regarding your mental health?

Do you have goals around your mental health?</td></tr>
<tr><td colspan="2">Are you receiving OW/ODSP/other?</td></tr>
<tr><td colspan="2">Please provide an emergency contact:</td></tr>
<tr><td colspan="2">Do you have identification (OHIP/SIN/Birth Certificate)? (obtain photocopies of health care if possible)</td></tr>
</table>

Appendix 3: Caseload Capacity Scale

This scale is intended to provide a quick, consistent method for determining the level of support required from the Community Connect Case Manager by individual Community Connect clients. It is not an assessment of an individual client's complexity of needs or presenting issues and can be used to help balance the Case Manager's caseload.

Level of Support Required	Example of Support Required
Level 1	• Contact with Case Manager occurs almost daily • Difficulties in communicating with client (e.g. unresponsive or lack of access to technology requires in-person follow-up) • Client resists accepting support from Case Manager. • Case Manager follow-up and support required for more than 3 referrals to community support services
Level 2	• Contact with Case Manager occurs weekly (e.g. a quick phone call or text exchange may suffice at times) • Multiple attempts required via phone calls or text messages to communicate with client • Client offers some resistance or ambivalence to support from Case Manager. • Case Manager follow-up and support required for 2 referrals
Level 3	• Contact with Case Manager occurs every two weeks or less • Client responds to phone calls and text messages with predictability • Client accepts support from Case Manager. • Clients are able to manage self-referrals to additional support services, with Case Manager support available as required

Adapted from the TCAT Stabilization Scale.

Appendix 4: Sample Promotional Poster

This poster can be used as inspiration for promotional materials that suit how Community Connect is being offered in your context. Make sure to keep the details are clear and straightforward as possible so that staff and clients can get the essential information as easily as possible.

Appendix 5: Evaluation Data Summary Categories

De-identified sociodemographic and service-related information can be collected and reviewed to better understand the population group being reached and to assess if Community Connect is having the desired effects.

The following suggested data categories can be adapted to suit different contexts and circumstances.

Evaluation Data Summary Categories

Data Element	Reason for Collection
Anonymous Client ID #	Used to anonymously track and organize client data.
Client Age	Determine the age distribution of women participating in the program.
Relationship Status	Provide insight into client backgrounds, social circumstances, and support needs.
Primary Language	Language the client was exposed to from birth provides information about client history and identity.
Preferred Language	Improve understanding around how support materials are meeting the needs to of the population. This is an essential for the delivery of care
Citizenship	Understanding the citizenship of clients will help to improve the kinds of supports the program should be connecting with.
Race	Race/ethnicity data collected as it pertains to the social determinants of health (SDOH)
# of Children	Establish if clients are parents to better appreciate their circumstances and support needs.
# of Other Dependents	Establish if clients are providing care to any individuals to better appreciate their circumstances and support needs.
Primary Care Physician	Connecting with primary care is important for

Appendix 5: Evaluation Data Summary Categories (*cont.*)

Evaluation Data Summary Categories (cont.)	
Data Element	**Reason for Collection**
Pregnant (Y/N)	Inform whether links to specialized substance use programming are required.
Pregnancy	Inform whether links to specialized substance use programming are
Involved with child protection services? (Y/N)	Improve understanding of client group to improve the kinds of supports the program should be connecting with.
Supports needed for child protection services?	Help to guide care planning and coordination of supports.
Area/ Neighbourhood	Area of the city or province in which the client resides.
Housing Type	Type of residence that the client is living in. Field can also be used to clarify the nature of a client's housing situation (e.g. hostel/shelter).
Other Details of Living Arrangement	Indicates who, if anyone, the client is living with.
Presenting Issues	Multiple issues can be identified to provide a better understanding of what services and supports are most valuable.
Actively Engaged/ Connected with Other Community Supports (Y/N)	Determine if clients have any relevant pre-existing support relationships.
Name and contact details for existing community supports	Contact details of pre-existing support relationships to support care planning.
Baseline - Education Level	Improved understanding of the social determinants of health.

Appendix 5: Evaluation Data Summary Categories (*cont.*)

Evaluation Data Summary Categories (cont.)	
Data Element	**Reason for Collection**
Baseline - Employment Status	Client's employment status at the time of program admission. Understanding client's employment status at the time of program admission will help to determine supports needed.
End of Service—Employment Status	Indicates client's current employment at the end of program.
Baseline - Legal Status	Improved understanding of the social determinants of health and contribute to care planning.
Date of Referral to Community Connect	Track and organize program statistics.
Source of Referral to Community Connect	Better understand where referrals to Community Connect are coming from (helpful if there are multiple possible referral sources).
Outbound Referral - Date	Date the client was referred to another organization. Important for calculating wait times.
Outbound Referral - Target Organization Name	Which organization(s) the client is being referred to.
Outbound Referral - Reason for Referral	Reason the client was referred to another organization.
Outbound Referral – Receipt of Referral was Acknowledged by Target Organization	Useful for tracking effectiveness of referrals to different organizations.

Appendix 5: Evaluation Data Summary Categories (*cont.*)

Evaluation Data Summary Categories (cont.)	
Data Element	**Reason for Collection**
Outbound Referral – Client Began Service with Target Organization	Useful for tracking effectiveness of referrals to different organizations.
Caseload Capacity Scale Rating (update as required)	Useful for determining ability of the Case Manager to accept new clients and retain a balanced caseload.
Date of Discharge	Useful for managing caseload capacity.
Date of Discharge from Community Connect	Useful for managing caseload capacity.