TECHNICAL COMPETENCIES

for Canada's Substance Use Workforce v. 3

COLLABORATIVE CARE PLANNING

Canadian Centre on Substance Use and Addiction

Evidence. Engagement. Impact.

Canadian Centre
on Substance Use
and Addiction

All behavioural indicators across proficiency levels are examples only and can be adapted or tailored to meet individual organizational needs and mandates.

For CCSA's competencies, substance use is inclusive of situations where professionals are working with individuals who use or have used substances, are diagnosed with a medically recognized substance use disorder or are experiencing harms as a result of using substances. For more information, please refer to the criteria for substance use disorders in the *Diagnostic and Statistical Manual of Mental Disorders*, 5th edition (DSM-5).

For more information on sex- and gender-based analysis (SGBA+), please visit www.ccsa.ca/sex-and-gender-based-analysis

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COLLABORATIVE CARE PLANNING

Meeting people who use substances where they are at and facilitating their movement within and between service providers. It includes providing information on programs and services to people so they can make informed decisions about the services they receive; maintaining accurate documentation, sharing information appropriately and with consent, and collaborating with other services providers.

*It is recommended that this competency be used in conjunction with the Behavioural Competency, Person-directed Care.

EXAMPLES

1 = Foundational	2 = Developing	3 = Proficient	4 = Advanced
1. Demonstrates the ability to assist colleagues who are in care planning in an administrative or support capacity to ensure care planning is completed collaboratively within and between services 2. Explains the importance of care planning and how it is related to counselling, screening, assessment and treatment planning 3. Explains the process of referral to and from other service providers, including protocols that determine how, when and with whom information and documentation should be shared; explains services and programs to people so they can make informed decisions about the services they receive 4. Explains the benefits of and process for conducting case conferences and teleconferences, and the situations in which each is appropriate 5. Adheres to all legislation, guidelines, procedures and protocols about confidentiality and professional ethics 6. Explains limits of confidentiality in various situations and their implications, as described in applicable legislation and guidelines 7. Consults regularly with others, internally and externally, to facilitate coordinated and collaborative care planning	1. Establishes and maintains collaborative working relationships with people, and with internal and external colleagues 2. Monitors a range of resources to become familiar with current service options available to people and maintains up-to-date records of available services and resources 3. Consults with people to match them with and refer them to the most appropriate available services and supports, using information obtained through dialogue with people and through screening and assessment processes 4. Initiates and participates in case conferences and teleconferences, and promptly conducts all necessary follow-up 5. Uses virtual, telehealth sites and online tools (e.g., video conferencing) to facilitate care planning activities 6. Collaborates with people and their social supports on care planning recommendations and activities 7. Advocates for people when working with related services and supports	1. Establishes and maintains treatment plans as part of a multi-disciplinary team, as appropriate 2. Establishes and maintains therapeutic rapport with people to establish trust and support them in reducing barriers to achieve their well-being goals 3. Conducts on-going assessments and evaluates treatment plans in collaboration with people, adjusting plans, as appropriate 4. Establishes collaborative relationships with a broad range of internal and external services and supports, using these relationships to facilitate referrals 5. Implements changes to service delivery to improve peoples' outcomes (e.g., increased engagement, efficiencies) 6. Collaborates with people to support them to make and follow through on decisions about treatment planning	1. Supervises or coaches others in: a. Undertaking general care planning tasks b. Evaluating complex treatment plans and collaborating with people and other resources to make changes, as required c. Innovating solutions when conventional strategies have been unsuccessful d. Ensuring compliance with care planning protocols and changing protocols, when necessary 2. Reviews counsellors' care planning documentation 3. Approves provision of case-management documentation to people using services and other collaborators, on a case-by-case basis 4. Initiates and facilitates case conferences and teleconferences, as appropriate