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PSYCHIATRY IN MOTION…

A SUBMISSION TO THE ADVISORY PANEL ON HEALTH INNOVATION

December 2014
Canadian Psychiatric Association

Introduction

The Canadian Psychiatric Association (CPA), the national voice of psychiatry, appreciates the opportunity to respond to the call for submission by the Advisory Panel on Health Innovation.

Setting the Context

While *innovation* is an often overused term, the CPA is very pleased to see the federal government show leadership in looking at how proven, applied health innovations can have an impact in providing Canadians with better health, better care and better value – which are the foundation of the Institute for Healthcare Improvement's Triple-Aim approach.

While the CPA shares the view that we need to accelerate the pace at which we need to transform the health system from an organization, finance, delivery and management perspective, an important component is to develop national mechanisms that communicate on-the-ground innovations that are having a cost-effective impact. Currently, this is not in place.

We know there are pockets of excellence that exist across this country, however, we do not have the national mechanisms, strategies and resources to disseminate them across governments and providers, nor do we always have in place the combination of sustainable change management strategies that will ensure their long-term adoption. Clearly, we have work to do, and we look forward to the findings of the Panel.

Innovation in Motion (Question 1 &2)

Given the complementary nature of questions 1 and 2, they will be addressed under this section. The CPA has identified – in a high level manner – 5 innovative models of care that impact on how mental illness is diagnosed and treated. The models do not cover, but cut across different settings (urban versus rural), and focus on different populations (First Nations versus youth), and in different settings (hospital versus community-based care). More detailed information on the models is available on request.

1. ***Maliseet Nations Mental Wellness team Project "Ciw Wolakomiksuwakon" – For Healthy Mind, Body & Spirit – Dr. Nachiketa Sinha***

This innovation represents a new way of working together in First Nations contexts. The Maliseet Nations Mental Wellness Team (MWT) is important in that it is a partnership of multiple sectors across a regional health system with demonstrated potential for scalability. This innovation serves five Maliseet First Nations communities in New Brunswick by providing a culturally appropriate, community based, multi-disciplinary team approach to the delivery of mental health and addictions intervention programs. The core team is composed of a psychiatrist, mental health nurse, elder-cultural advisor and clinical psychologist, with support from a project co-ordinator. The MWT addresses gaps in availability, access, and appropriateness of services for these five communities which are located in the same Regional Health Authority.

Implementation involves: including Aboriginal healing and wellness practices; identifying gaps and barriers; strengthening First Nations partnerships with provincial health-care providers of treatment services in these areas; improving integration and/or access to established provincial and federal programs and services related to mental health and addictions; and, increasing the capacity of staff within these communities to deal with these disorders.

<u>Description of innovation</u>
This innovation involves the delivery of psychiatry services alongside community based teams, in a culturally integrative approach. In addition to oversight from the five Health Directors and a Maliseet MWT Stakeholder Committee, the Maliseet MWT consists of a Project Coordinator, a Core Team, and five named individuals who are the clinical point contact person in each community. The Core Team serves all five Maliseet communities. Two of its specialists (a consulting psychiatrist and a mental health nurse) are contributed by the provincial regional health authority (RHA). This innovation was implemented in New Brunswick, led by

Maliseet Nations, in partnership with New Brunswick Horizon Health Network. Funding support is from the provincial RHA as well as federal funding from Health Canada, First Nations and Inuit Health Branch.

Evaluation

A detailed evaluation of this innovation (see Appendix A) includes documentation of outcomes with respect to six outcomes: collaboration to develop the MWT; improved continuum of culturally safe mental wellness services; collaboration among providers; increased use of promising practices; community ownership and capacity; and knowledge transfer. Specific to patient outcomes and patient satisfaction, the improved continuum of culturally safe mental wellness services in the five Maliseet communities has been documented using a variety of information sources, including administrative data, as described in the 2012 Evaluation Report. This includes that: "Before the project … some First Nations individuals would not access mental health services off reserve for fear that they would not receive culturally safe care. There was also apprehension on the part of service providers to provide services on reserve. The requirement to obtain a physician's referral in order to access a psychiatrist was an additional barrier for First Nations clients, who are now able to self-refer to see the MWT project psychiatrist when they visit communities.

Scalability

The MWT team innovation has been implemented in ten other First Nations and Inuit communities in regions across Canada, demonstrating the scalability of this approach. A key reason for the scalability of this approach would appear to be the community-based, community-driven adaptation of the holistic multidisciplinary mental wellness teams approach to local community strengths and needs. MWT's have flexible service delivery models spanning the whole spectrum of services from prevention to post-treatment follow up.

Economic value

In terms of cost savings, the RHA nurse and the psychiatrist drive to the communities, which is more economical than having the clients drive (funded by Non-Insured Health Benefits) to those clinical services off-reserve. Furthermore, the improved access for a marginalized population helps to reduce inequality of service provision, in a community with greater need than the Canadian population at large.

2. Re-Engineering Mental Health & Addiction: Embedding Clinical Competencies Development in a Lean Management Service Delivery Model (Annapolis Valley Health – Dr. John Campbell)

Annapolis Valley Health has a growing reputation as an innovator in the provision of rural Mental Health and Addiction Services, and as a strong partner in the provision of behavioral health interventions in the management of other chronic diseases. They are the first in Nova Scotia to implement an in-house competency development program called the Choice Partnership Approach (CAPA) for evidence based psychological interventions.

Developed in the UK, CAPA is a mental health service delivery model that combines collaborative and participatory practice with patients. CAPA brings together the active involvement of clients; demand and capacity ideas/Lean thinking; and a new approach to clinical skills and job planning. CAPA improves services to clients by focusing on engagement, therapeutic alliance, choice, strengths, goals and care planning; improving access by ensuring timely appointments that are fully booked (i.e. no waiting lists); and ensuring patients are seen by a clinician with the right skills who routinely use of outcome measures. The 'right skills' are determined by best practices in the field.

Outcomes/Impact

The most obvious and dramatic impact of the introduction of CAPA and evidence-based practice has been quicker access to services by clients and service partners. AVH has been able to reduce wait times for the Child and Youth Mental Health Program from 12 months to 4-6 weeks and for the Adult Mental Health Program from 12 weeks to 5 weeks for first contact. With the implementation of CAPA, AVH has met provincial standards for wait times (90 days for regular appointments) for service 90 percent of the time (see Appendix B) while also seeing a significant increase in referrals. To ensure improved clinical productivity, patient care, and staff job satisfaction, they are establishing 5 evaluation domains: (1) Tracking and Monitoring Indicators; (2) Team Job Plan Summaries; (3) CAPA Fidelity Indicators; (4) Psychological Intervention Fidelity Indicators; and (5) Client experience & Outcomes.

3. First Episode: Psychosis Services (Foothills Hospital, Calgary – Dr. Don Addington)

First Episode: Psychosis Services provide continuous comprehensive care for individuals who have experienced a first episode psychosis from the DSM Schizophrenia Spectrum and other Psychotic Disorders. They comprise several core components including: public and gatekeeper education plus easy access to reduce the duration of untreated psychosis, pharmacotherapy, case management, family education and support, integrated addictions, supported employment and community rehabilitation.

They were originally tested at some academic centres in Canada but there have been no Canadian randomized controlled studies funded. There are studies from other countries. These programs have been implemented in a consistent way in Ontario but implementation elsewhere is patchy.

Evaluation
See the following references in Appendix C: Addington, Addington, and Patten 126-31; Addington et al. 157-67; Addington, Yeo, and Berzins A73; Addington et al. S111; Addington et al. 483-88; Addington, Mckenzie, and Wang 280-82; Addington et al. 452-57; Addington et al.; Addington and Addington 60-67; Addington and Addington 11-13; Addington, Leriger, and Addington 204-07; Addington, Young, and Addington 1119-24; Addington et al. 116-20; Addington and Addington 281-85; Addington and Addington 626-30.

Innovation
See the following references in Appendix C: De et al.; Petersen et al. 602; Craig et al. 1-5; Garety et al. 37-45; Marshall and Rathbone; McCrone et al. 377-82; Nordentoft et al. 167-72.

Scalability
See the following references in Appendix C: Ministry of Health Services 1-105; Ministry of Health and Long-Term Care 1-34.

Economic Evaluation
See the following reference in Appendix C: McCrone et al. 377-82.

4. Transforming Access to Health and Social Services for Transition-Aged Youth in British Columbia (Inner City Youth Program, Providence Health Care- Dr. Stephen Mathias)

This submission recommends the creation of an **inter-ministerial collaboration between five Ministries** heavily invested in the Transition-Aged Youth population: **Health, Children and Family Development, Social Development and Innovation, Justice and Education**. It is proposed that these five ministries form an oversight body for the establishment of an impactful model of care designed to support youth aged 12-24. Elements of the proposal include:

1. The creation of **25 Community Integrated Youth Health and Social Service Centres (CIYHSSs)** in British Columbia over 5 years in a phased process throughout the province of British Columbia. These Centres would host primary care, counselling, mental health, substance use, vocational and educational supports with the opportunity for justice and income assistance services.
2. The creation of a province-wide e-health/telehealth service with **online mental health, substance use and family counselling service** with a focus on serving rural and remote populations while supporting urban centres.
3. The development of a **unifying marketing strategy with strong brand recognition** and opportunity for provincial anti-stigma and awareness campaigns so that positive health may be promoted province-wide.
4. The establishment of a Research and Evaluation Network to focus on the social re-integration of youth into their community.
5. The establishment of a **centralized administration*** to provide the oversight of these youth services.

Expected Outcomes
Based on a conservative estimate of 1100-1500 youth seeking help in each CIYHSS Centre and an additional 25,000 seeking help via the e-health component, it is expected that by year 5 this proposal would support and treat over 50,000 Transition-Aged Youth in British Columbia *per annum* and begin to directly address the

massive impact that untreated mental illness and substance use has on our youth, families and health care system. Additionally, youth health services would be identifiable province-wide with a youth-centric branding campaign designed to raise awareness for early detection and intervention. The integration of a strong evaluation platform with a culture of implementation science, would rapidly place British Columbia at the forefront of youth health and wellness and create a foundation for future British Columbians to readily access health and social services, either via technology or in person.

A copy of the full proposal is available on request.

5. Mental Health Crisis Response Centre (Winnipeg Regional Health Authority – Dr. Murray Enns)

Between 2003 and 2006 the WRHA undertook an extensive review of Mental Health Crisis Response Services to determine how best to respond to needs of mental health clients. The review identified a need for the following: an alternative to the reliance on Emergency Departments in serving the population of mental health clients; a central point of access to a wide range of linked services; better coordination and integration of services; a single assessment and treatment plan; better clinical outcomes for clients; and greater satisfaction among clients, family members, and providers.

This led to the planning of the Crisis Response Centre (CRC) – a service reconfiguration bringing together several crisis response service components under a common management structure with a single access point to linked client services. The CRC Functional Program was completed in February 2006, and opened its doors on June 03, 2013. This aspiring Centre of Excellence in crisis resolution is the first of its kind in Canada and its objectives are to deliver: (1) a primary point of access to assess their needs and arrange crisis services; (2) timely access to mental health professionals for assessment, consultation, and treatment during periods of mental health crisis; (3) best practice, evidence-informed mental health services in an environment that is welcoming and supportive; (4) positive service outcomes upon termination from the CRC service; (5) enhanced linkage, coordination, and integration across services during and after a mental health crisis; and (6) increased satisfaction for clients, families and providers regarding the provision of urgent mental health services during a mental health crisis. The CRC also continually strives to become a centre of excellence in mental health research and innovation to promote learning and growth in quality of care.

There are four service components comprising the CRC: (1) **CRC On-Site Walk-In Service** (accessed in person) – Services offered through the Walk-In component include: screening & triage for mental health and medical concerns, linkage for medical assessment and medical care, integrated mental health assessment (including suicide risk assessment), co-occurring disorders assessment (substance abuse), crisis response interventions (such as crisis intervention, supportive counseling, recovery planning, relapse prevention and others), on-site psychiatrist consultation, linkage to short-term transitional services and longer-term services and supports, and follow-up and/or case closure; (2) **Mobile Crisis Service** (accessed by phone) - is accessible 24/7 by telephone and utilizes all the crisis response actions and interventions listed above (except medical assessment) to address issues of persons in a mental health crisis who are in their own home or community environment; (3) **Brief Treatment Service** (access limited to CRC clinicians and specific referral) – is available by scheduled appointment and provides brief solution focused therapy to assist clients in follow-up to crises. These clients can also utilize the “front door” and registration desk of the CRC On-Site Walk-In Service; and (4) **Psychiatric Urgent Referral Clinic** (access limited to CRC clinicians and internal referral) – is a service available by appointment for clients of CRC and to key community resources. The Clinic provides timely access to psychiatrists for assessment, short-term treatment and medication management; as well as reassessment of known clients, as required. It assists CRC staff in client assessment and in formulating treatment plans. Clients attending this clinic can also utilize the “front door” and registration desk of the CRC On-Site Walk-In Service.

To promote excellence in mental health research the CRC maintains a position of an embedded researcher on its staff. This person is a dedicated information specialist within the CRC working with a multidisciplinary team to address all of the information needs at the CRC. The embedded researcher provides assistance to researchers faced with collection of research information to address issues about its quality, navigation, management and sustained accessibility at the CRC.

Evaluation

A formal three-year evaluation of the CRC was approved by the CRC Project Leadership Group and began in 2013 (Glasgow R, Vogt T, Boles M. Evaluating the public health impact of health promoting interventions: the RE_AIM framework. American Journal of Public Health, Sept. 1999, vol. 89, no.9).

Outcomes

In the first year of operations (June 2013 – June 2014) there have been 5,838 visits to the centre, an average of over 500 visits per month and 16 clients per day. This number continues to grow as the centre becomes more established in the Winnipeg mental health landscape. The average wait time for consultation is 14 minutes. The CRC serves a wide range of adults experiencing psycho social crisis through to symptoms of severe mental illness. As part of the 3 year evaluation being conducted by the WRHA Evaluation Team, feedback on client/family/friend satisfaction was gathered from June 2013 to December 2013.

The feedback forms indicate a high level of satisfaction with services at the CRC (average rating 86%). Feedback was sought in the areas of the CRC being welcoming (average rating 88.4%), helpful (average rating 85.2%), barriers and facilitators. The data suggests that overall the CRC is hitting the mark in creating an environment that feels safe and welcoming, staff that are thoughtful, helpful and keep clients informed, and that clinical care feels kind, professional responsive and non-judgmental. Barriers continue to be stigma: client's own fears, anxiety or pride surrounding mental un-wellness. A second barrier that was frequently noted was being unaware that the service existed. Analysis of the CRC impact on ED mental health visits was undertaken and is continuing.

List of select references are contained in Appendix D.

Experiences & Observations (Question 3)

There are a number of factors that are important to support the adoption of cost-effective on-the-ground innovations:

- Partner-driven buy-in and leadership from providers and decision-makers.
- The identification and implementation of effective change management strategies and resources to ensure long-term success.
- Ongoing/periodic evaluation of structures, processes and outcomes.
- Metrics that focus on the dimensions of quality (e.g., access, appropriateness, provider/patient satisfaction).
- Mechanisms to communicate innovations to other target audiences (i.e., providers, public, patients, decision makers, media), and celebrate success.

The Federal Role (Question 4)

There are a number of ways in which the federal government can support the widespread dissemination of on-the-ground innovations:

- It could align (integrate?) the current composition of C-agencies (e.g., CADTH, CPSI, CFHI) in a way that more effectively reflect the dimensions of quality under one organization (e.g., a National Institute for Quality and Innovation in Health). Such an agency could have the provincial health quality councils as governors with the federal government with a focus on the measurement of quality in health care (i.e., a common set of health system performance indicators) and the dissemination of leading practices in the delivery of health and health care.
- Create a time-limited, issue-specific, strategically-targeted fund (such as a National Health Innovation Fund) with clear terms of reference, deliverables and expected outcomes. This should be developed in close consultation with the provinces and territories, and providers. Such a Fund could lever pockets of excellence that exist across the country when it comes to on-the-ground innovations.
- As a dominant funder of health research in Canada, there needs to be enhanced efforts that connect pillar 2-4 research to changes in health status and health care delivery. The federal government can play a significant role in terms of its leadership role with CIHR vis-à-vis the provinces and territories.

That said, keep in mind that The Strategy for Patient-Oriented Research (SPOR) is a component of the federal government's approach; it should not been seen as a panacea.

- Can work in a more collaborative and strategic relationship with the Council of the Federation's Health Care Innovation Working Group. There is much to be gained here given the policy priorities that have been identified, and the facilitative role the federal government can play, in addition to the number of national health agencies it funds.
- Leveraging change is also a function of enhanced mechanisms that focus on the performance of the health system. Perhaps a dialogue to create a set of common health system indicators should be linked to federal funding for a National Health Innovation Fund?

Where Does Success Lie? (Question 5)

There are a number of strategic opportunities (and their combinations) to improve overall value-for-money in the system:

- Some are linked to the alignment of incentives in the system and how we can get providers working more collaboratively (e.g., shared-care models between family physicians and psychiatrists).
- There are also important points of transition (e.g., hospital and community; primary care and specialty care; acute care and long-term care) that need to be managed more effectively.
- Others are focused around provider leadership in working closely with decision-makers.
- Others are focused on issues related to establishing mechanisms that provide real time feedback on the performance of the health system, writ large.

Appendix C

1. Addington, D., J. Addington, and S. Patten. "Relapse rates in an early psychosis treatment service." Acta Psychiatr.Scand. 115.2 (2007): 126-31;
2. Addington, D., et al. "Performance measures for evaluating services for people with a first episode psychosis." Early Intervention in Psychiatry 1 (2007): 157-67;
3. Addington, D., et al. "A Fidelity Scale for First Episode Psychosis." Schizophr.Bull. 39 S.1 (2013): S111;
4. Addington, D., M. Yeo, and S. Berzins. "EPPubEd, impact of a public education program on population awareness and duration of untreated psychosis." Early Intervention in Psychiatry 2.Supple 1 (2008): A73;
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8. Addington, D. E., et al. "Relationship Between Relapse and Hospitalization in First-Episode Psychosis." Psychiatr.Serv. (2013);
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11. Symptom remission in first episode patients." Schizophr.Res. 106.2-3 (2008): 281-85; Three-year outcome of treatment in an early psychosis program." Can.J.Psychiatry 54.9 (2009): 626-30;
12. Addington, J., E Leriger, and D. Addington. "Symptom outcome 1 year after admission to an early psychosis program." Canadian Journal of Psychiatry 48.3 (2003): 204-07;
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17. Garety, P. A., et al. "Specialised care for early psychosis: symptoms, social functioning and patient satisfaction: randomised controlled trial." British Journal of Psychiatry 188 (2006): 37-45;
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19. McCrone, P., et al. "Cost-effectiveness of an early intervention service for people with psychosis." Br.J.Psychiatry 196.5 (2010): 377-82;
20. Ministry of Health and Long-Term Care. Early Psychosis Intervention Program Standards. 1, 1-34. 2011. Toronto Canada, Ontario Ministry of Health and Long-Term Care;
21. Ministry of Health Services, Province of British Columbia Canada. Standards and Guidelines for Early Psychosis Intervention (EPI) Programs. 1-105. 2010. Electronic Resource, Government of British Columbia;
22. Nordentoft, M., et al. "How successful are first episode programs? A review of the evidence for specialized assertive early intervention." Curr.Opin.Psychiatry 27.3 (2014): 167-72;
23. Petersen, L., et al. "A randomised multicentre trial of integrated versus standard treatment for patients with a first episode of psychotic illness." British Medical Journal 331.7517 (2005): 602;

Appendix D

Emergency Care Task Force, Report to the Honourable David Chomiak, Minister of Health, Province of Manitoba, Winnipeg Regional Health Authority, July 28, 2004.

Best Practice Models

- Recovery Model: Towards Recovery and Well-Being, A Framework for a Mental Health Strategy for Canada, Mental Health Commission of Canada, Nov. 2009

- Medical Model: P Shah, D Mountain, The medical model is dead – long live the medical model, BJP 2007, 191:375-377, DOI 10.1192/bjp.bp.107.037242

- Hospitality - two sources were used: (1) Danny Meyer, Setting the Table, The Transforming Power of Hospitality in Business, Harper Collins Publishers CA 2009 and (2) William B Martin, Providing Quality Service: What Every Hospitality Service Provider Needs to Know, Harper Perennial, 2008

- Trauma Informed Best Practice Guide: Trauma-Informed, The Trauma Toolkit, A resource for service organizations and providers to deliver services that are trauma informed; 2nd Ed, 2013, Klinic Community Health Centre

Evidence based clinical best practice guidelines: the term “best practice guidelines” refers to the growing body of knowledge about services and strategies which have been evaluated and accepted as being effective. There are a number of sources publishing these guidelines including the government, academia and clinical/professional organizations/centers.

Focus groups with clients/family and stakeholders were held to obtain their feedback and responses to crisis response system and reconfiguration. This information was then incorporated into the centre design and program/system delivery