Health PEI

Santé Î.-P.-É.

Health P.E.I.,
Putting out the Welcome Mat:

Improving services for people experiencing concurrent disorders and complex conditions

BobbiJo Flynn, presentation to Canadian Collaborative Mental Health Conference, June 2014

Presenter Disclosure

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No relationship with commercial interests

Objectives for this session

1) Introduce a model for system improvement specific to an integrated mental health and addiction service, for the population of need experiencing, or at risk of, experiencing a concurrent disorder.
2) Share knowledge and experience resulting from the implementation of the Comprehensive, Continuous, Integrated System of Care process to identify the system improvement for people experiencing concurrent disorders.
3) Outline key initiatives planned for and/ or implemented to strengthen collaboration between mental health and addiction service providers.

The P.E.I. Context

- Health PEI was created in 2009 as a strategy to create a sustainable health system through the Health Services Act by separating the Department of H&W (policy) from operations
- The new operational structure governed by a Board of Directors and an Executive Leadership Team
- In 2011, hospital based mental health were merged with community mental health and addictions, creating an integrated continuum of mental health and addictions under one program structure
- Mental Health and Addictions remains the only program area in HPEI with a full continuum of services extending from primary to tertiary care
- In late 2013, MH&A were moved from shared division with Primary Care to a shared division with Acute Care

Who are we?

- MH&A Services: publically funded
  - Represent 1/8 of the HPEI workforce
  - Three recovery homes
  - Services delivered in 22 sites
  - 7 inpatient mental health units
  - 1 inpatient withdrawal management
- Primary, Secondary, and Tertiary care across the Island to all ages

How this came about

- The Mental Health Services Strategy, an internal quality improvement strategy, for Mental Health Services, identified the need to increase capability and capacity for people experiencing concurrent disorders

- Soon after, the ‘Strengthening Addiction Services’ (Drug Treatment Funding Program’) project, also identified this as a priority

- Seeking a method to organize and support improved integrated planning, development of a shared program philosophy, and recognition of the needs of the population served

Population of Need

A small sample of co-occurrence:

- Lifetime prevalence of schizophrenia in the general population is 1% and lifetime prevalence of substance abuse disorders among people with schizophrenia is 47% (2)
- Rates of trauma history are high (25-60%) among people seeking substance abuse treatment (2)
- Risk of schizophrenia is six times higher in users of cannabis, than in non users (1)
- For those with adolescent or childhood ODD, they are twice as likely to develop Substance Use Disorders (SUD) (3)

1.Substance Abuse in Canada: Concurrent Disorders; CCSA (2009)

2.Concurrent Disorders Policy Framework; Concurrent Disorders Ontario Network (2005)

3.Making the Case for Investing in Mental Health in Canada; Mental Health Commission of Canada(2012)

- *"I didn't get help for a long time because with psychiatry they said I had to stop taking drugs before getting any help and substance abuse programs said I had to deal with the mental illness. After an attempted suicide, I was referred to psychiatry for concomitant problems. I started looking for help in 1993 and I only found it in 2005"*

Turning the Key webinar participant, MHCC

Developmental Phase

- Talked with other jurisdictions about their experienced
- Explored a range of methods to achieve our goal
- Most offered little practical/ instrumental support to address change needed across the system
- Several starts and stops
- Trust, Readiness and Acceptance was a challenge at the onset, and continued, from some: fear of unknown, expected changes to be imposed, invalidating current capability and capacity

Comprehensive Continuous Integrated System of Care: What is it?

- It is a process used to achieve the goal of the supporting the development of a system of care that is welcoming, recovery-oriented, integrated, trauma-informed, and culturally competent in order to most effectively meet the needs of individuals and families with multiple co-occurring conditions of all types
- The CCISC model assists to organize services for people and families with co-occurring psychiatric and substance disorders by improving treatment capacity for these individuals within systems
- Improvements are team or site specific and reflect the teams own readiness to change and priorities
- The CCISC uses self survey tools in conversational style, to reflect on areas of strength and improvement
- Results are used to develop work plans, work plans communicated widely, hopefully creating a network where mutual support and shared learning can occur

CCISC Four Basic Characteristics

- **System level change:** designed to be used across level of systems
- **Efficient use of existing resources**: emphasizes strategies to improve services within current service resources
- **Incorporation of best practices**: recognized as a best practice, but also supports incorporation of evidenced and consensus based clinical practices for specific conditions and models
- **Integrated treatment philosophy**: successful treatment interventions are derived from available research and incorporated into an integrated treatment philosophy (and plan) that uses common language that makes sense for both MH&A

CCISC: 12 Steps for Agencies/ Programs developing co-occurring capability

1. Formal Announcement and Commitment
2. Continuous Quality Improvement (CQI) Team
3. Change Agents
4. Goal of Co-Occurring Competency for All Staff
5. Program Self-Assessment
6. Program CQI Action Plan
7. Welcoming and Access
8. Screening
9. Identification and Counting
10. Empathic, Hopeful, Integrated, Strength-Based Assessment
11. Stage-Matched Interventions
12. Integrated Stage-Matched Recovery Planning and Programming

Early Phase

- Small group developed and promoted the concept, began to conceptualize our own vision
- Worked with Zia Partners to help guide our planning and implementation: advice, mentoring
- Started with leadership/ management group
- Used the framework (12 steps) as a roadmap
- Brought together supervisors and self nominated change agents
- Delivered a kick-off event: September 2013

MH&A, Health PEI, Guiding Principles

- Concurrent Disorders are considered to be an expectation for both MH&A Services
- Services and supports will emphasize evidenced based, promising, and emerging practices
- Services will be recovery oriented
- Service will support self management and encourage people to become active and accountable participants in their health
- Services will involve family and support persons, where appropriate and as defined by the individual
- The system will respect and value the contributions of both Mental Health and Addiction Services

The Plan: create community through conversation

- Created a broad network of change agents across the system and sites
- Empower partnerships
- Provided orientation to change agents and managers, and key stakeholders on the model and supporting change
- Included partners in orientation to new model and rationale for this approach
- Provided support to teams to use the self survey approach to support constructive conversation and supporting change at teams level of readiness- continuing to do so
- Disseminated results of survey through a provincial webinar
- Provide ‘technical support’ visits to some teams (further support planned) to develop concrete action plans
- Re-organize QIT membership and terms of reference to provide a steering body and work on system level objectives

Early Results

- Increased ‘welcoming’ activities – physical space, availability of resource information, knowledge translation in program design, increased integrated case planning
- Better understanding of policy and standards changes desired by staff to support improved collaboration and in some cases, integration
- More focus on screening tools and comprehensive assessment
- More focus on matching client readiness with treatment planning, where multiple issues exist
- Orientation to the model and its rationale to 37 change agents plus supervisors and managers agents (about 55)
- Improved team improvement planning

Changes Planned: System Level

- Implement Gain SS province-wide
- Shared access to community electronic record platform between MH & A
- Implement on-site MH & A case conferencing
- Make group work more co-occurring focused
- Implement staff cross-training with the “other sector”
- Seek out common staff training opportunities (i.e. MI)
- Develop Integrated Discharge Plan
- Provide education to staff regarding consent to release/obtain client info policy/forms

Changes Planned or Occurring: Sites

- CMH Outreach Services in Eastern PEI are piloting a blended team given high prevalence of concurrent disorders
- Transition Unit at Addictions (post withdrawal management extended support) planned using concurrent focus
- Increased welcoming activities such as: revamping waiting rooms, more materials available
- Focus on changing language to be more person-centered
- Integration of substance abuse assessment and care planning in inpatient MH West, staged matched
- Shared learning ‘rounds’ between Methadone program and MH Services
- Scheduled case conferences (versus case based)- visiting clinician consult model CMH&A central
- Creation of a standard form for adult and youth services in addictions that uses the integrated treatment and recovery planning

Lessons Learned - Key Insights

- ‘Change Agents’- While people are the leaders of change, often they do not want to see themselves as leaders and some don’t want to take ownership of that change
- Myth busting- When change is feared, messages can become distorted- myth busting must be an ongoing practice
- “Round of Applause” at any stage - teams are at different stages- all stages need to be supported and validated (we knew this but always helpful to stay mindful of this!)
- “Progress Not Perfection”- incremental, do not over-design, be willing to learn and adjust ongoing
- Tap into the knowledge and ideas that exist, support teams to thrive in ways important to them, within a framework
- The importance of creating forums for conversation to build community and collaboration
- Logistical supports are key

Reference:

- Cline, Christine A., Minkoff, Kenneth, 'Developing Welcoming Systems for Individuals with Co-Occurring Disorders: the role of the Comprehensive, Continuous Integrated System of Care'; Journal of Dual Diagnosis, vol 1(1) 2004.

- http://www.ziapartners.com/

Thank you for your interest

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