

Engaging the Vulnerable in the Quality Agenda

Presenter Disclosure

Presenters: Jeffrey Turnbull, Sean Kidd, Paulos Gebreyesus

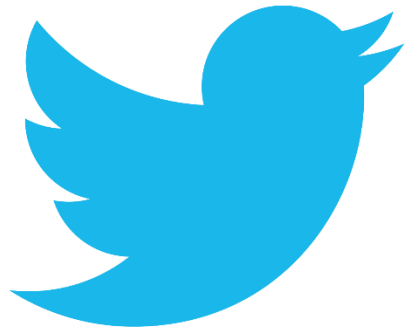
Relationships with commercial interests: None

- Grants/Research support
- Speakers Bureau/Honoraria
- Consulting fees
- Other

Disclosure of Commercial Support

- This session has received no commercial support

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Learning Objectives

1. Explore the guiding principles and strategies used to engage vulnerable populations to inform the design and delivery of their care
2. Learn how others are engaging vulnerable populations and addressing issues of inequity and access to care

Welcome and Speaker Introductions

- Sean Kidd – Centre for Addiction and Mental Health
- Paulos Gebreyesus – Unison Health and Community Services
- Jeffrey Turnbull – Health Quality Ontario

Agenda

1. Introduction

2. Speaker narratives

- Sean Kidd - Advancing inpatient practice through engagement with former clients
- Paulos Gebreyesus - Engaging vulnerable populations in primary health care
- Jeffrey Turnbull – Ottawa Inner City Health: Health for the Homeless

3. Discussion and Question and Answer period

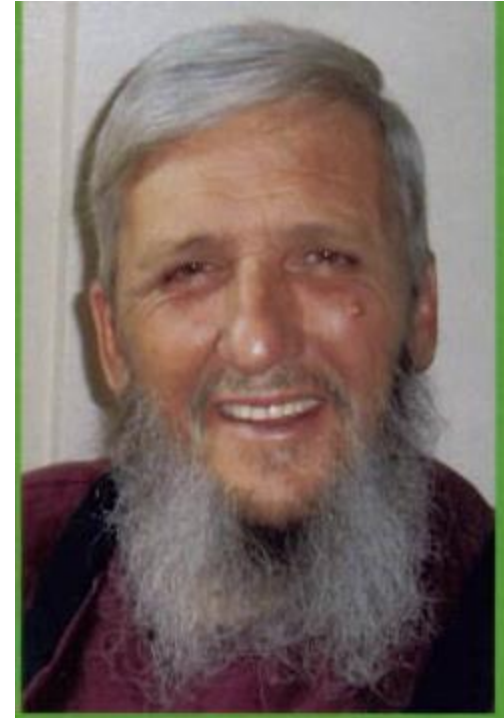
4. Closing remarks

“Our Current System of Health Care is Unsustainable”



Social, Demographic and Political Factors Shaping the Debate

- An aging population
- The prominence of chronic diseases
- Utilization
- Fiscal restraint
- Classic federalism
- Rising social inequity



Implications for Vulnerable Populations



Engaging Vulnerable Populations



Advancing Inpatient Practice through Engagement with Former Clients

Sean Kidd, Ph.D., CPRP

Toronto Centre for Addiction and Mental Health



Acknowledgments

- Leadership Team:
 - Jeremiah Bach, PSW
 - Carrie Clark, MScOT
 - April Collins, MSW
 - Lucy Costa (ED, Empowerment Council)
 - Debora McDonagh, PSW
 - Kwame McKenzie, MD
 - Jane Paterson, MSW
 - Eleu Pontes, PSW
 - David Quarter, PSW
 - Shannon Quinn, PSW
 - Gursharan Virdee, MA
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 - Canadian Foundation for Healthcare Improvement
 - Toronto Centre for Addiction and Mental Health

Background

- Discussion of recovery-oriented care has largely neglected the inpatient context despite:
 - First substantive point of contact with mental health care for most people with severe mental illness
 - Extensively and repeatedly accessed by many with severe mental illness
 - 75% of Canadians with schizophrenia hospitalized
 - 38% readmitted within 1 year
 - Average length of stay is 27 days
 - Sharpest power differentials and most restrictive setting
 - 50% of mental health dollars

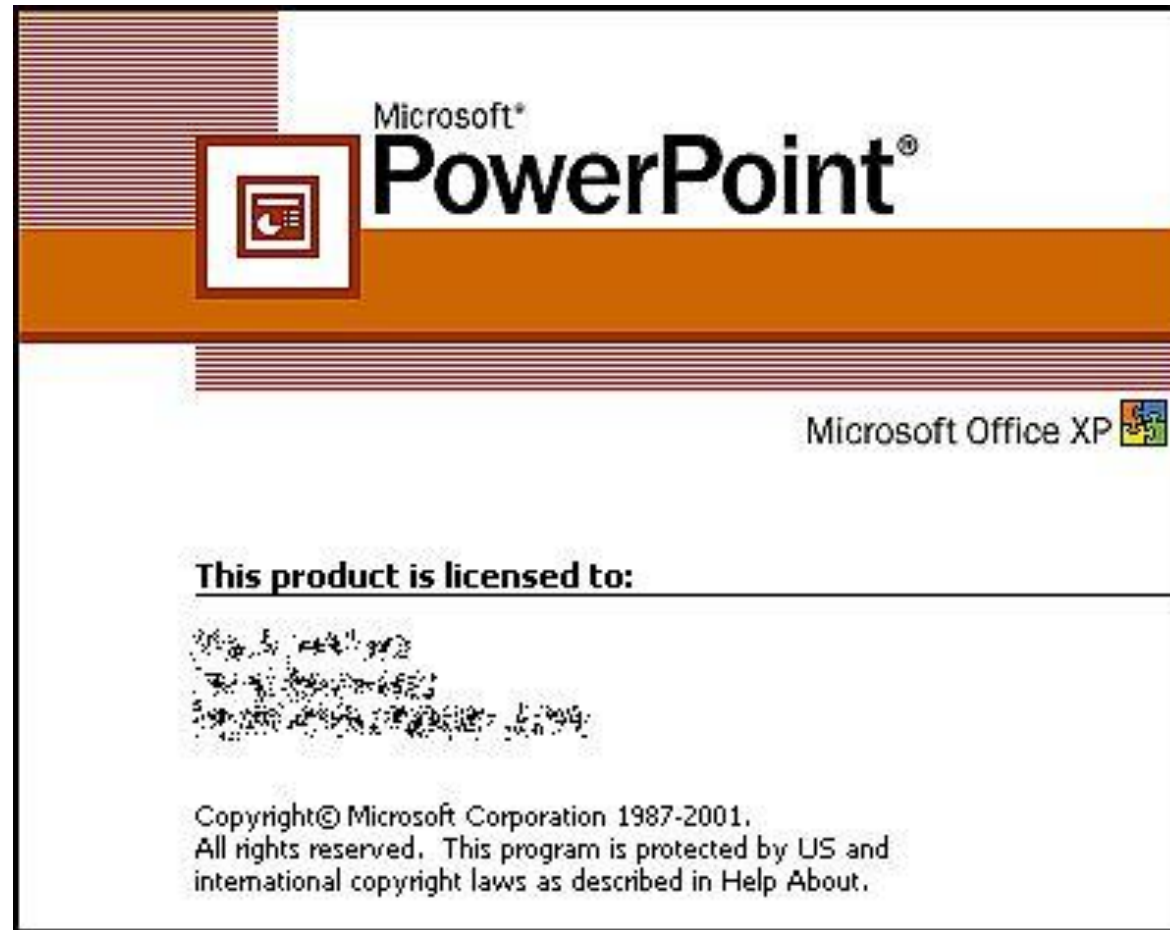
Background

- Inpatient providers
 - Management of risk and clinician-driven decision making
 - Understand the recovery model, but can't see how it applies and are poorly supported
 - Usually only see clients in crisis/at most unwell and acuity (inpatient myopia)

The question:

How can we advance the recovery model
in inpatient psychiatric care contexts?

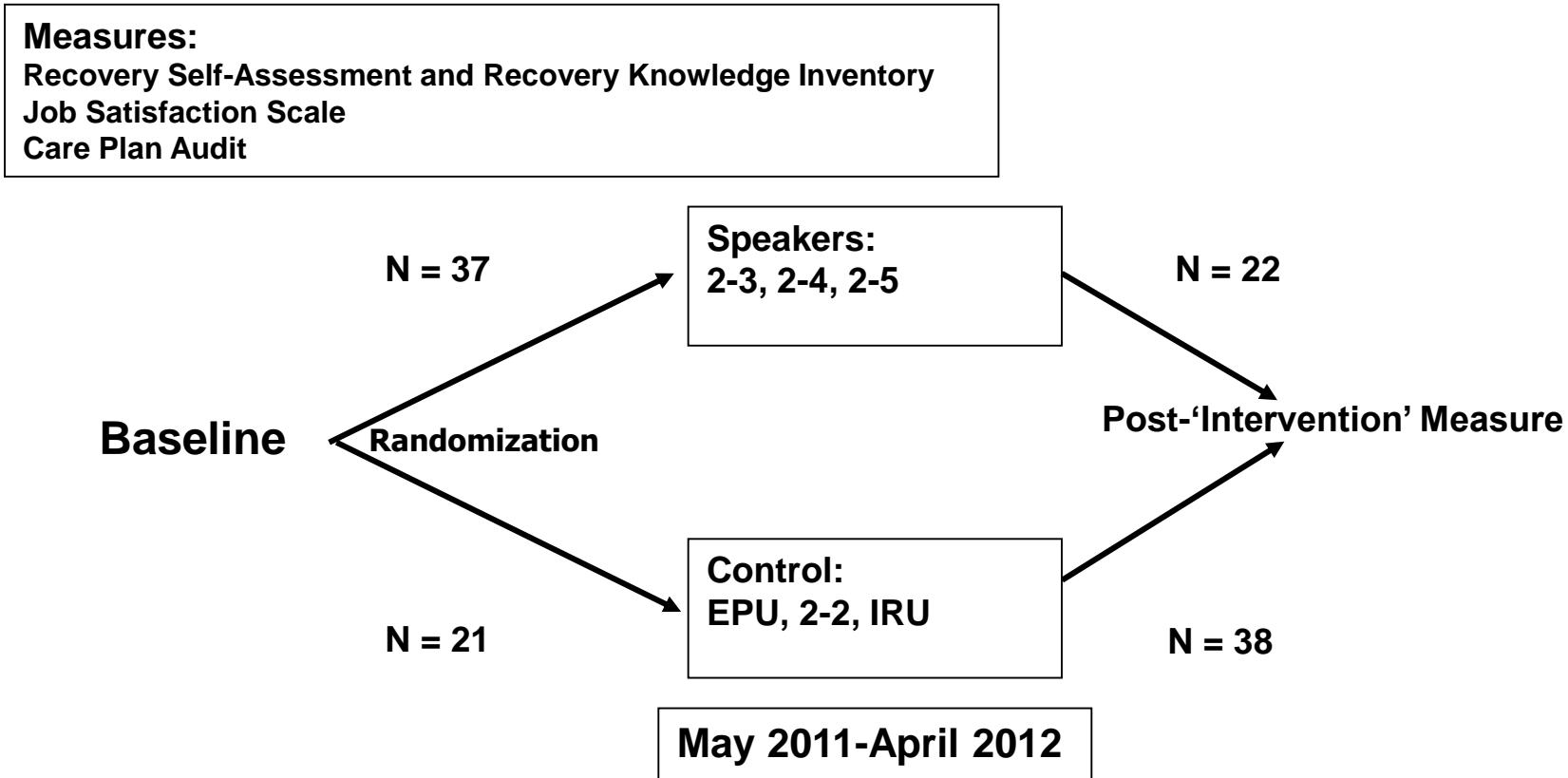
The kiss of death in advancing clinical practice:



The Idea

- Former inpatient clients from CAMH
- Recovery narratives and feedback
- Facilitated discussion

Research Design



“The second thing that was key to my recovery was the influence of my now fiancée, then girlfriend. She had stuck by me through 3 episodes. I found myself on a day pass, and coming back from the beach. I remember sitting there thinking, I could live a life on moments like this, and that I didn't need to see in technicolour or find the proof to time travel, all I needed was love. That is cosmic enough.”

The Quantitative Findings

- Recovery Knowledge Inventory
 - Significant interaction effect
 - Mainly non-linearity of recovery
 - Moderate effect size $d = 0.68$
- Recovery Self-Assessment (RSA) & Job Satisfaction Scale (JSS)
 - Non-significant

The Qualitative Findings – Staff Focus Groups

- **Theme #1: there is hope**
 - Limited views highlighted as was credibility of speakers
 - Saw their role as more meaningful with a boost in pride in work
 - Better relate with clients
 - Improved motivation

The Qualitative Findings – Staff Focus Groups

- **Theme #2: “The more we listen, the more health care improves”**
 - Rare opportunity to reflect on practice
 - Human element and seemingly “insignificant things”
 - Listen and engage: making time
 - Reduced cycles of escalating frustration
 - More active in assessing goals and supporting in areas beyond medication

Implications

- Beyond exposure to skills development and embedding practice
- Evidence for client engagement – within a rigorous framework
- Need to take a harder look at the impacts of these types of approaches
- Knowledge translation and exchange and Workman Arts

Advancing the Recovery Orientation of Hospital Care Through Staff Engagement With Former Clients of Inpatient Units

Sean A. Kidd, Ph.D.

Kwame McKenzie, M.D., M.R.C.Psych.

April Collins, M.S.W.

Carrie Clark, M.Sc.O.T.

Lucy Costa, B.A.

George Mihalakakos, B.A.

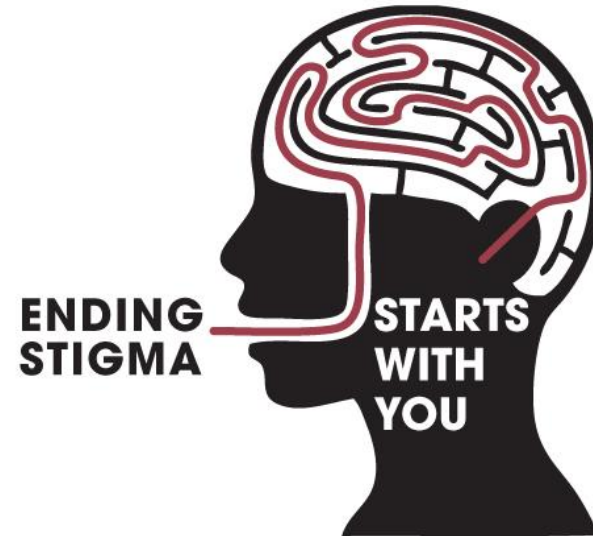
Jane Paterson, M.S.W.

Objectives: This study was undertaken to assess the impact of consumer narratives on the recovery orientation and job satisfaction of service providers on inpatient wards that focus on the treatment of schizophrenia. It was developed to address the paucity of literature and service development tools that address advancing the recovery model of care in inpatient contexts. **Methods:** A mixed-methods design was used. Six inpatient units in a large urban psychiatric facility were paired on the basis of characteristic length of stay, and one unit from each pair was assigned to the intervention. The intervention was a series of talks (N=58) to inpatient staff by 12 former patients; the talks were provided approximately biweekly between May 2011 and May 2012. Self-report measures completed by staff before and after the intervention assessed knowledge and attitudes regarding the recovery model, the delivery of recovery-oriented care at a unit level, and job satisfaction. In addition, focus groups for unit

oriented care, in turn, supports clients as they pursue their own goals by providing care that is individually tailored, respectful of rights, and strengths based and that promotes consumer involvement and hope (3).

Efforts to develop and invest in recovery-based approaches, such as supported employment (4) and Illness Management and Recovery (5), have focused on outpatient services. However, the inpatient setting often represents a critical juncture for people with severe mental illness. For many, it is

Engaging Vulnerable Populations in Primary Health Care



Acknowledgements

Principal Investigators (Community Health Centres)

*Central Toronto CHCs: Joe Bortolussi et al.
South Riverdale CHC: Jason Altenberg et al.
Unison Health & Community Services: Paulos Gebreyesus,
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Consumer-Survivors

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Heather Stuart (Queens University)
Julio Arboleda-Florez (Queens University)
Patrick Corrigan (Illinois Institute of Technology, USA)
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Why are Community Health Centres Important to this work?

- (1) Stigma and discrimination is felt most deeply when accessing health care services
- (2) Community-based component of primary health care in Ontario with particular focus on the social determinants of health
- (3) Work with the most vulnerable populations, specifically certain ethno-cultural groups
- (4) Experience and expertise in community capacity building in low-resourced settings
- (5) Awareness of the problem / willingness to address it
- (6) Opportunities for scaling up

Why is this important to us?

Unison Health and Community Services is a non-profit, charitable, community-governed organization

Vision: Healthy communities

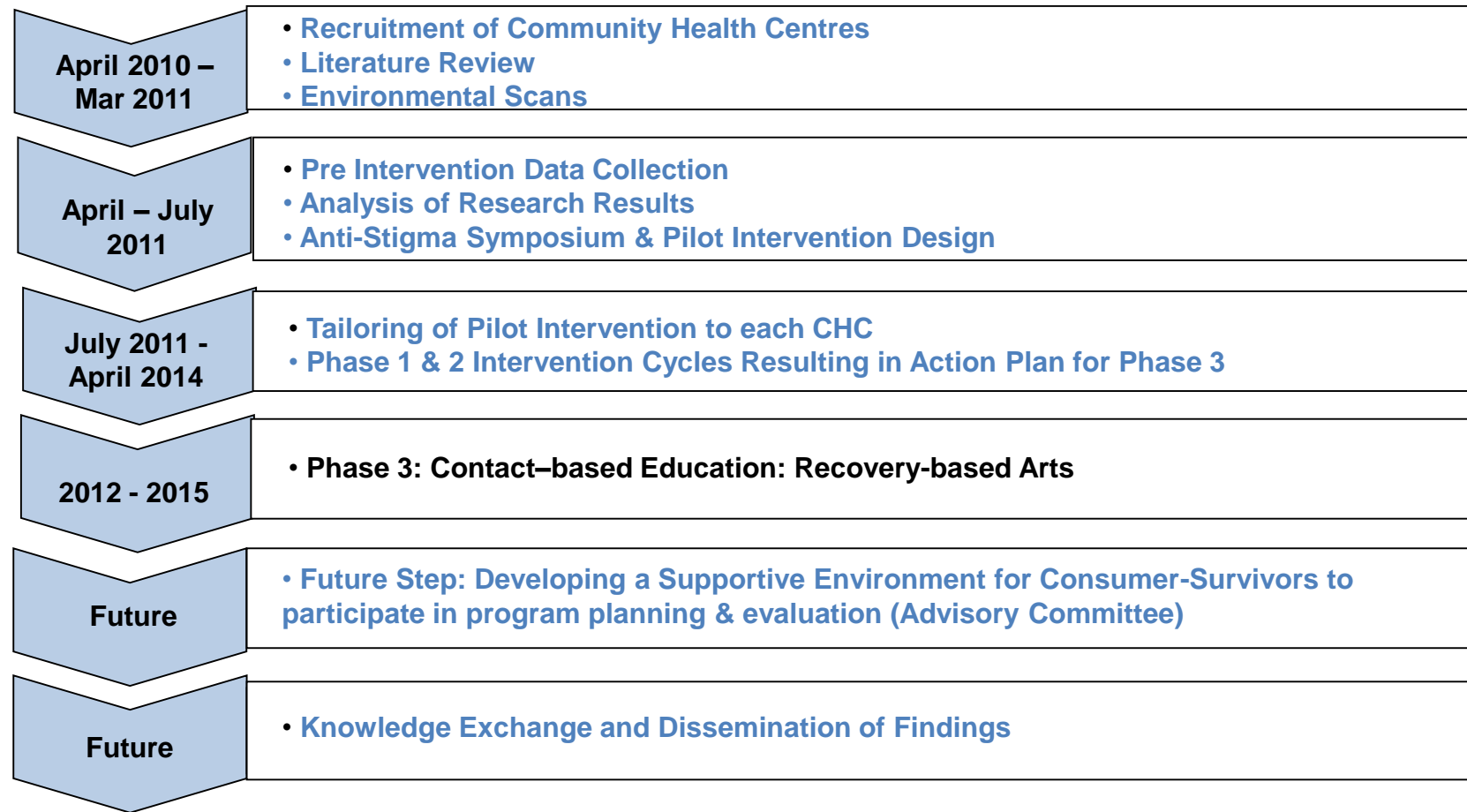
Mission: Working together to deliver accessible and high quality health and community services that are integrated, respond to needs, build on strengths and inspire change

Values: Accountability, Collaboration, Equity

Project Background

- (1) **To examine and better understand** the phenomenon of stigma and discrimination with regard to mental health and substance use issues
- (2) **To identify key elements** to be considered for designing an effective intervention
- (3) **To design a comprehensive anti-stigma/ anti-discrimination intervention** for Community Health Centres (CHC) in Ontario that serve new immigrants, racialized and low socioeconomic status communities
- (4) **To pilot test** the designed intervention
- (5) **To develop a knowledge exchange process** to share the results other CHCs and other community-based agencies in Canada

What did the Initiative Entail?



How will we do this work?

Main Priorities

1. Create an environment that is welcoming and accessible
2. Expand harm reduction services from program level activity to organization-wide commitment
3. Create an advisory team that will inform and lead
4. To reinforce our anti-stigma and anti-discrimination values to our work with consumer-survivors
5. To align our organizational strategic direction with key stake holders in addressing stigma

Key Actions

1. Training and Knowledge Exchange
2. Create an Advisory/Target Team
3. Anti-Stigma campaigns through Organizational Committee
4. Organizational Structure, Services and Processes

What did this require of Unison?

- Opportunity to reflect on our own stigma, commitment
- Consultation and recommendations for the development and content of the workshop
- Expect defensiveness and 'resistance' from managers (relevance) and providers (is this about me?) – Leadership
- Developing and conveying messaging related to workshop participation in order to minimize negative implicit messaging
- Mental Health Task Force - leadership role by volunteering to participate in various workshop activities both prior to and during the workshop. Helped to identify consumer-survivors to lead/facilitate training.
- Management discussions to make the training mandatory or not – decision to close for full day

Contact-Based Education: Recovery Through Empowerment Workshop

Purpose:

To enhance anti-stigma and recovery-oriented competencies of primary health care professionals with regards to individuals living with mental illness and/or substance use issues through an advanced, interactive, recovery-focused training module.

Workshop Content:

- Didactic component: Expert in recovery-oriented practices shared practical examples
- Small group discussions with Consumer/Survivors: Levelling the playing field
- Role play with Consumer/Survivors: Fostering Recovery: Building Humility, Empathy and Understanding
- **Panel discussion with Consumer/Survivors: Best practices in recovery (Photo)**

Evaluation:

- Participant satisfaction;
- Pre-/post-workshop questionnaire scores; and,
- Participants' qualitative written feedback



Findings



Participants: 180 participants (including administrative and clinical staff) attended two workshops held on separate days (April 2 and April 4, 2014)

CHC Location	Questionnaire Type	
	Pre-Workshop	Post-Workshop
Unison (LH)	71%	57%
Unison (KR)	61%	49%

Table 1: Questionnaire Response Rate by CHC Location

Findings

		Paired Differences		t	df	Sig. (2-tailed)
CHC		Mean	Variance			
Unison	Attitudes towards mental illness (Pre)	20.13	62.02	8.523	214	0.000
	Attitudes towards mental illness (Post)	12.96	18.21			

Table 2: Pre- vs. Post-Workshop Questionnaire: Attitudes Sub-Scale



Findings

Strengths	Limitations
Opportunity to work in inter-disciplinary groups	Some participants found the workshop too simplistic and would have appreciated more in-depth coverage of the topics
Opportunity to engage in meaningful discussions with colleagues and share learning/knowledge	Not enough practical tools (especially for clinicians) and skill building activities
Role-play	Too many activities in a short time
Panel discussion	Participants within each CHC workshop had different knowledge levels and skill sets. Consequently, some participants qualified the workshop as 'reinforcing' of their knowledge and would have appreciated a faster learning pace
Expert presenters	Not enough information provided regarding the availability of resources in the community and CAMH
Small group exercises	The workshop was too focused on primary care
Inclusion of consumer/survivors and opportunity to learn from them	Lack of clinicians on the panel
Scenarios used in the small group exercises provided insight into how situations can be managed in practical terms	Groups were too large and it was difficult to hear at times due to the noise level

Table 3: Workshop Strengths and Limitations

Next Steps

- Recovery-Based Arts
 - To utilize the arts through contact-based education in order to confront and reduce stigma among primary health care (PHC) providers and to build capacity in PHC toward an anti-stigma, pro-recovery approach
- Analysis of Internal Policies and Procedures
 - To assess CHC policies and to determine how these policies contribute to or mitigate stigma and discrimination
 - To create recommendations for strengthening CHC policies with the goal of reducing mental health and substance use stigma and discrimination and promote recovery
- Ongoing support for interdisciplinary Mental Health and Substance Use Task Force

Health for the Homeless

Inner City Health Ottawa

Dr. Jeffrey Turnbull

Chief, Clinical Quality at HQO

Medical Director of Ottawa Inner City Health

Homelessness: Mental Health, Addictions and Health

- An environment characterized as alternating between crisis and chaos



The Evolving Nature of Homelessness in Ottawa

7308 individuals



381 Youth

1125 families

1097 women

3296 men

Focus of TED Program

Adult Population

- Used to be 80% males, 20% females, now shift to more women
- Made up of people who “sleep rough”, emergency shelter users, couch surfers
- Also, rooming house tenants, those with stable housing who remain connected to street life (i.e., street involved population)
- Unstably housed



Youth Population

- Highly mobile population
- More “couch surfers” than shelter users
- High rates of substance use and mental health problems
- Many fleeing abuse or, products of the child welfare system



Families

- Poverty is main reason for families to become homeless
- Objective evidence shows that if families are provided with affordable housing, the cycle of homelessness is broken
- Impact on children highly concerning
- Most are single parent families
- Unemployed or underemployed



Women

- Proportionally smaller numbers but, often much harder to serve effectively
- Population splits between those fleeing abuse, those with mental illness and those with substance use issues (many involved in sex trade work), many fit into all three groups
- Many have children, often not in their care



Mentally III

- Depending on the study 15-40% of general homeless population
- 95% in chronically homeless population
- Homelessness may be cause or effect of mental illness
- Current laws are not effective in helping those with greatest need



Impact on Health

- Generally poorer health than other citizens, although self reported health often does not reflect reality (adaptation effect)
- 4x age adjusted mortality rate, typically die 25 years earlier than housed counterparts
- Greater exposure to communicable diseases (i.e., Hepatitis, HIV)
- More likely to suffer complications from simple health problems (fractures, rashes)

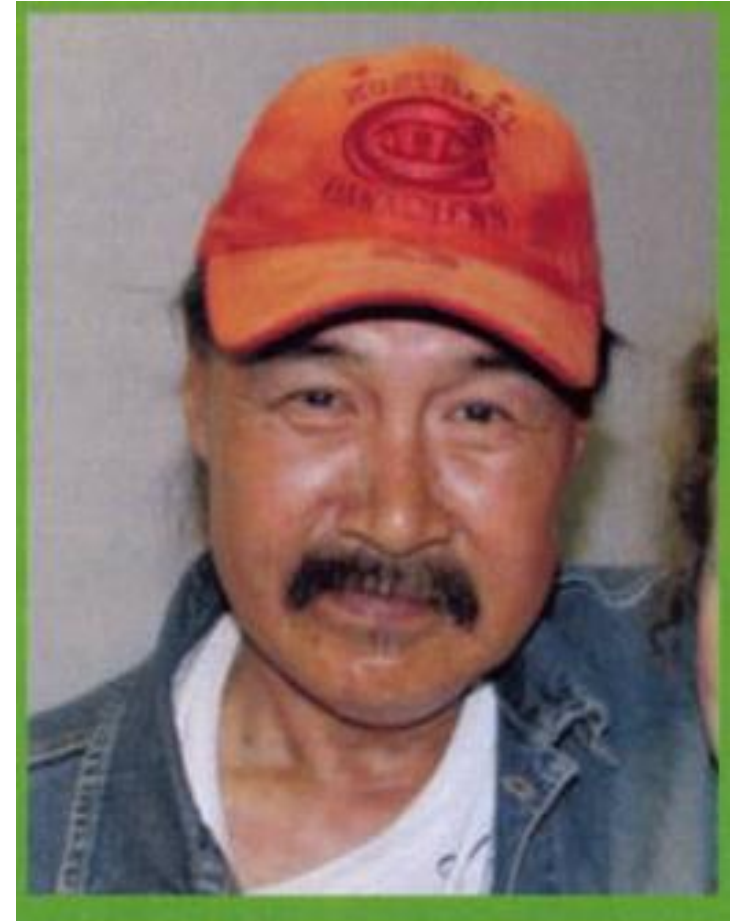
Impact on Health Care Delivery

- Higher burden of disease
- Greater exposure
- Lack of basic resources for self care
- Other circumstances (i.e., mental illness, substance use, need to find shelter) may interfere with efforts to seek care appropriately
- Complex system of entitlements is challenging to both patient and doctor



Challenges to the Physician

- Patient may not admit to being homeless
- Patient may not wish to follow the recommended plan of care
- Patient may be unable to follow the recommended plan of care
- Follow-up challenges
- Everything takes more time than with other patients
- Need to involve other disciplines in care to be effective



Obstacles to Care

- Transportation
- Drug cards
- Stigma
- Medications
- Education
- Health care providers judge negatively
- Concept of health

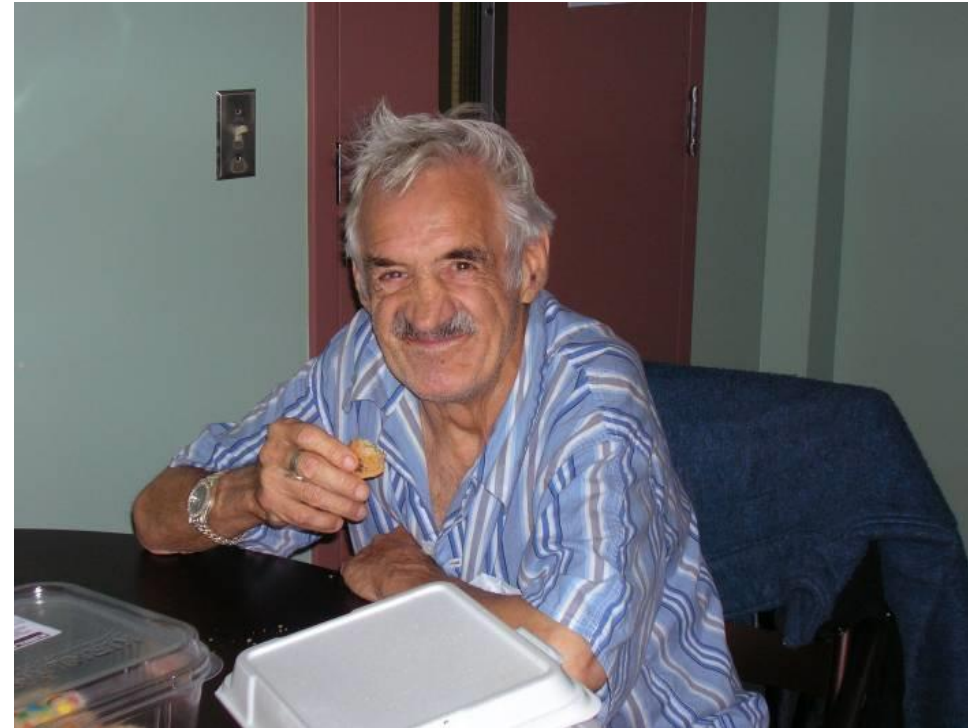


Essential Co-Interventions

- Build trust
- Care on their terms
- Supportive housing (consider other social determinants of health)
- Intensive case management
- Sustained intervention despite failures
- Be flexible and accept risk



Inner City Health: A Health Network for Ottawa's Homeless Community



Ottawa Inner City Health Members

- Ottawa Hospital
- University of Ottawa
- Royal Ottawa Hospital
- Community Care Access Centre
- Community Health Centres
- The Mission
- The Salvation Army
- Options Bytown
- Anglican Social Services
- Cornerstone
- Shepherds of Good Hope
- Canadian Mental Health Association
- Wabano Centre for Aboriginal Health
- Centre for Addiction and Mental Health
- Care for Health and Community Services
- Youth Service Bureau

Summary of Inner City Health Program and Services

- Managed Alcohol Program 16 beds
- TED 46 beds
- Special Care for Women 16 beds
- Special Care for Men 30 beds
- Hospice 14 beds
- Supported Housing
- Oaks 55 units
- Booth House 20 units
- Supportive Housing (SSH) 10 units
- Primary Care Clinic



The TED Team

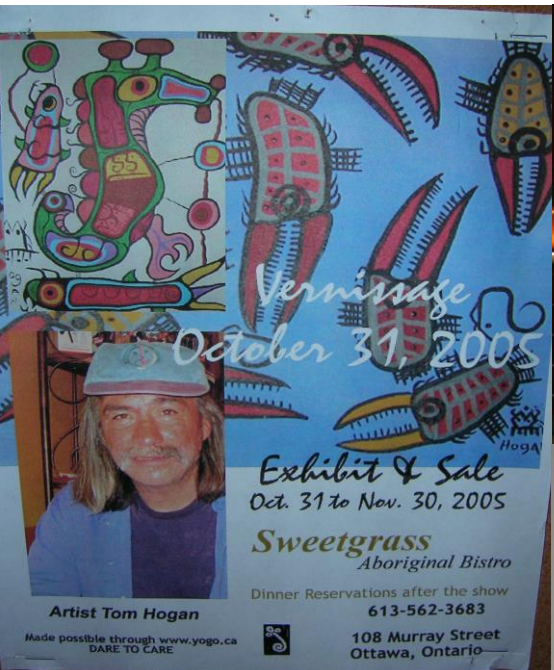
- Peer Outreach Workers
- Front line shelter workers
- Client Care Workers
- Nurse Coordinator
- Physician backup



Supervised Withdrawal
Management Team

- Peer Outreach Workers
- Client Care Workers
- Nurse Coordinator
- Mental Health Nurse
- Intensive Case Manager
- Primary Care Nurse Practitioner
- Physician backup (includes psychiatrist)

Treatment and Care Team



Discussion and Q&A

Closing Remarks

Common themes:

- Meaningful engagement that is done early and in a genuine and strategic way
- Meet people where they are
- Reframe the way we deliver care to accommodate the needs of other populations
- Deliver care on their terms; adjust the way we deliver care to the 5%
 - Not up to them to adjust to the system, it is up to us to adjust the system for them
 - Listen to the patient and design services that are appropriate to their needs
- Need to be risk tolerant