



Consensus Development Conference on IMPROVING MENTAL HEALTH TRANSITIONS

NOVEMBER 4-6 2014

The Westin Hotel, Edmonton, Alberta, Canada

Jury Members

Jury Chair – Alain Lesage
Kathy Aitchison
Rupert Arcand
André Delorme
David Goldbloom
Kaj Korvela
Gloria Laird
Glenda MacQueen
Fay Orr
John J. McSorley
Tom Shand
Michel Simard
Sharon Sutherland
Helen-Maria Vasiliadis

Expert Speakers

Carol Adair
Tim Aubry
Thomas Becker
Dan Cohen
Giovanni de Girolamo
Philippa A. Garety
Linda Gask
Elliot Goldner
Heinz Katschnig
Sarah Lapsley
Eric Latimer
Antonio Lora
Steve Lurie
Orrin Lyseng
Austin Mardon
Oliver Mason
David McDaid
Scott Patten
Thomas Raedler
Luis Salvador-Carulla
Howard Sapers
Jitender Sareen
Hon. Richard D. Schneider
Gerrit van der Leer
Richard Warner

OVERVIEW OF THE CONFERENCE

The Canadian Consensus Development Conference on Improving Mental Health Transitions, is a three-day conference being held in Edmonton, Alberta, from November 4 to 6, 2014. This conference is a juried hearing of evidence and scientific findings. It allows for the engagement and collaboration of experts, policy makers in government and the health system, and stakeholders in addressing key questions around community based care for adults with severe, persistent mental illness.

On the final day of the conference, an expert jury chaired by Dr Alain Lesage, Department of Psychiatry, University of Montreal, will release a Consensus Statement summarising the evidence and making recommendations for policy and practice in Canada and other countries

The Consensus Development Conference model is an exciting format created in the US by the National Institutes of Health (NIH) to increase the dissemination and impact of findings from research. The Institute of Health Economics (IHE) in Alberta adapted this successful model for the Canadian setting and has held six consensus conferences to date: Self-Monitoring in Diabetes; Healthy Mothers-Healthy Babies: How to Prevent Low Birth Weight; Depression in Adults; FASD Across the Lifespan; Legal Issues of FASD; and Surveillance and Screening for AROs (Antimicrobial-Resistant Organisms). Consensus Statements and other documents, along with videotape of the proceedings, can be viewed on the IHE website:

<http://www.ihe.ca/research/knowledge-transfer-initiatives/--consensus-development-conference-program/>

ACCREDITATION



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Attendance at this program entitles certified Canadian College of Health Leaders members (CHE / Fellow) to **7.75 Category II** credits toward their maintenance of certification requirement.



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This event is an Accredited Group Learning Activity (Section 1) as defined by the Maintenance of Certification program of The Royal College of Physicians and Surgeons of Canada, and approved by the University of Calgary Office of Continuing Medical Education and Professional Development. Participants can claim up to a maximum of 13.5 study credits.

SCIENTIFIC CHAIR



Roger C. Bland, CM, MB, ChB, FRCPC, FRCPsych

Roger Bland is Professor Emeritus in the Department of Psychiatry at the University of Alberta and was Chair from 1990 to 2000. He completed medical training at Liverpool University in England followed by internships and then five years in general practice in England and in northern Manitoba before joining the psychiatry residency program at the University of Alberta. His research interests have included psychiatric epidemiology, the long-term outcome of mental disorders, familial distribution of disorders, suicidal behaviors and primary care mental health. He has held a number of administrative positions in mental health with the Government of Alberta, including Assistant Deputy Minister for Mental Health and Medical Director with the Alberta Mental Health Board. Clinically he has worked in rehabilitation psychiatry, general hospital psychiatry, community clinics, primary care psychiatry, crisis services and diversion programs. He has received a number of awards

including: the Michael Smith Award from the Schizophrenia Society of Canada; the Alberta Medical Association Medal for Distinguished Service, the Canadian Academy of Psychiatric Epidemiology and Canadian Psychiatric Associations' Alex Leighton Award in Epidemiology; and the Research Award of the Canadian Association for Suicide Prevention. In 2012 the Governor General appointed him a member of the Order of Canada.

Improving Mental Health Transitions - an overview

The last 50 years have seen the substantial elimination of mental hospitals with care provided in the community and in general hospital settings in most Western countries. While this has also been a period of rapid pharmacological developments, the question remains of whether patients are better served in this system (or non-system) of community care.

To provide some background, we looked at the number of beds available for the mentally ill in Canada over recent times, at reports regarding the growth of homelessness, the increase of the mentally ill in the prison system and the outcome for people with severe persistent mental illness.

We found that Canada has had a massive reduction in the number of psychiatric beds per thousand population with a decrease in the length of stay. There has been considerable expansion of community services, but also a growth in homelessness and incarceration in prisons. Unfortunately there has been no corresponding improvement in outcome for people with schizophrenia, for which the outcome has changed little with modern management. Despite the fact that mental illnesses account for up to 40% of disability in developed countries, in Canada only 5% the health budget is spent on mental health.

We conclude therefore that deinstitutionalization has been a mixed blessing. Most people appreciate the additional freedom of being able to live in the community, but the anticipated improvement in outcomes is not being achieved. The recent evidence shows that the lives of many of those with schizophrenia, even when treated, are bleak, suggests that a review of the way in which we do things is in order. Our home Canadian province of Alberta can serve as a good example: oil-revenue fed comprehensive health-care system, relatively advanced ideas, and inexpensive (for the patient) treatment, and an income support system to ensure, at least, a minimum level of food and housing. Nonetheless, our long term follow up data, drawn from residents of Alberta shows that, once diagnosed, over half of the people with schizophrenia can expect a life characterized by moderate to severe symptoms and disability.

This Consensus Development Conference brings together a substantial number of speakers from a wide variety of countries who have experience of both the problems and potential solutions to the problems being experienced both by those with severe persistent mental illness and the systems that are intended to help them. It is hoped that their collective wisdom of the speakers, the insights of the jury and the audience questions can lead to clear directions about the best path to follow and that this will help guide policymakers, administrators, clinicians and last but not least, consumers and family members in ensuring the best services and programs with the available funding.

JURY CHAIR



Alain Lesage, MD, FRCPC, MPhil, DFAPA

Alain Lesage is currently a professor in the Department of Psychiatry at the University of Montréal. He is a scientist focusing much of his work around mental health and addiction services. He is also the Medical Director of the Mental Health Technology and Interventions Assessment Unit at the Institut universitaire en santé mentale de Montréal, and the Associate Director of the Québec Research Network on suicide, mood disorders and associated disorders. He was formerly the Editor-in-Chief of Santé mentale au Québec, and was the past President of the Canadian Academy of Psychiatric Epidemiology. Dr. Lesage graduated in medicine from the University of Sherbrooke and completed his postdoctoral training at the Institute of Psychiatry and Maudsley Hospital in London, England; and the Istituto di psichiatria in Verona, Italy. He was an invited scholar at the Harvard School of Public Health in 2005 and has recently been invited to join the executive board of the

European Network of Mental Health Service Evaluation (ENMESH). He continues to train the next generation of mental health and addiction researchers in collaboration with Quebec, Canadian and international colleagues. He is an active member on the Mental Health Commission of Canada Advisory Council.

CONFERENCE QUESTIONS

An Overview – Improving Mental Health Transitions

- 1: What is severe and persistent mental illness (SPMI) and its social and economic consequences?
- 2: What is the effectiveness of current interventions for adults with severe, persistent mental illness?
- 3: What is the evidence for the role of other support systems, including primary care in effective interventions?
- 4: What are the effective systems for supporting people with SPMI?
- 5: What information tools are required for high quality system management?
- 6: What further research is needed?

PROGRAM

Day 1: Tuesday, November 4, 2014

- 7:00 a.m. – 8:00 a.m. **Continental Breakfast and Registration**
- 8:00 a.m. – 8:30 a.m. **Opening Remarks: Roger Bland**
Chair, Scientific Committee
- Greetings from: Honourable Stephen Mandel**
Minister of Health
- Greetings from: Councillor Scott McKeen**
City of Edmonton
- Opening Prayer from Elder**
- 8:30 a.m. – 8:45 a.m. **Improving mental health transitions; an overview**
Roger Bland, CM, MB, ChB, FRCPC, FRCPsych
Professor Emeritus, Department of Psychiatry, University of Alberta
- 8:45 a.m. – 9:50 a.m. **Question 1: What is severe and persistent mental illness (SPMI) and its social and economic consequences?**
- What is the magnitude of the problem?**
Scott Patten, MD, FRCPC, PhD
Professor, University of Calgary, AB
- Living with mental illness; a personal perspective.**
Austin Mardon, PhD, CM, LLD(Hon.)
Assistant Adjunct Professor, John Dosssetor Health Ethics Centre
University of Alberta, Edmonton, AB
- Question Time**
- 9:50 a.m. – 10:10 a.m. **Break**
- 10:10 a.m. – 11:40 a.m. **Question 1 (continued)**
- Social impacts of mental illness on individuals and families**
Sara Lapsley, BA, MA
Peer Researcher with the Collaborative Research Team to Study Psychosocial Issues in Bipolar Disorder (CREST.BD)

PROGRAM

What are the connections between mental illness and homelessness?

Tim Aubry, PhD, MA, BA
Chairholder, Faculty of Social Sciences Research Chair in Community Mental Health and Homelessness; Professor, School of Psychology and Senior Researcher, Centre for Research on Educational and Community Services, University of Ottawa, Ontario

Implications of mental illness for corrections

Howard Sapers
Correctional Investigator of Canada, Office of the Correctional Investigator, Ottawa, Ontario

Panel Question Time

11:40 a.m. – 12:40 p.m.

Lunch

12:40 p.m. – 2:40 p.m.

Question 2: What is the effectiveness of current interventions for adults with SPMI?

Outcomes of long term medications

Thomas Raedler, MD
Associate Professor, University of Calgary, Alberta

How effective are psychosocial interventions?

Thomas Becker, Dr. Med
Professor, Medical Director and Chairman, Department of Psychiatry II Ulm University, Germany

How effective are psychological therapies?

Philippa Garety, MA, MPhil, MA(Ed), PhD, FBPsS
Professor of Clinical Psychology, Clinical Director, Psychosis Clinical Academic Group (CAG), South London and Maudsley NHS Foundation Trust, United Kingdom

The role of Assertive Community Treatment

Gerrit van der Leer
Director, Mental Health and Addictions, Ministry of Health Services, British Columbia

Community Crisis care in England and Wales: evidence and implementation

Oliver Mason, DPhil, DClinPsy
Senior Lecturer, University College London
Clinical, Education and Health Psychology, Division of Psychology and Language Sciences, Faculty of Brain Sciences
United Kingdom

PROGRAM

Panel Question Time

2:40 p.m. – 3:00 p.m.

Break

3:00 p.m. – 5:00 p.m.

Question 3: What is the evidence for the role of other support systems, including primary care in effective interventions?

What are the alternatives to hospital care for people with SPMI?

*Richard Warner, MD, DPM
Director, Colorado Recovery; Professor of Psychiatry and Adjunct Professor of Anthropology, University of Colorado, Boulder, Colorado*

Integrating Crisis and ACT teams

*Dan Cohen, MD, PhD
Department Chronic Psychiatry, Mental Health Care Organisation North-Holland North, Heerhugowaard, The Netherlands*

How can family physicians best support people with SPMI in the community?

*Linda Gask, MSc, PhD, FRCPsych, FRCGP
Professor of Primary Care Psychiatry, National Primary Care Research and Development Centre (NPCRDC), University of Manchester, UK*

How have mental health courts, diversion programs, and alternative sentencing been able to assist people with mental illness?

*Hon. Richard Schneider, BSc, MA, PhD, LLB, LLM, CPsych
Justice of Ontario Court of Justice, Chair of Ontario Review Board; Adjunct Professor, University of Toronto, Ontario*

What role do non-government organisations play in effective support systems?

*Orrin Lyseng
Executive Director, Alberta Alliance for Mental Illness and Mental Health (AAMIMH), Edmonton, AB*

Panel Question Time

5:00 p.m.

Closing Remarks

5:00 p.m. – 6:00 p.m.

Reception

PROGRAM

Day 2: Wednesday, November 5, 2014

7:30 a.m. – 8:30 a.m.

Continental Breakfast and Registration

8:30 a.m. – 10:30 a.m.

Question 4: What are the effective systems for supporting people with severe and persistent mental illness?

Long-term mental health care: for whom, how and where?

Giovanni de Girolamo, MD, PhD

IRCCS Unit of Psychiatric Epidemiology and Education, Italy

What is the role of Federal Government in planning and funding mental health strategies?

Steve Lurie, BA, MSW, MM

Executive Director, Canadian Mental Health Association Toronto Branch, Ontario

How important is continuity of care and integration in the provision of effective support?

Carol Adair, MSc, PhD

Associate Professor, Departments of Psychiatry and Community Health Sciences, Faculty of Medicine, University of Calgary, Alberta

What are the effects of supported employment strategies for people with mental illness?

Eric Latimer, PhD

Research Scientist, Douglas Mental Health University Institute and Professor, Department of Psychiatry, McGill University, Quebec

Panel Question Time

10:30 a.m. – 11:00 a.m.

Break

11:00 a.m. – 12:30 p.m.

Question 5: What information tools are required for high quality system management?

Basic support decision tools for mental health system improvement

Luis Salvador-Carulla, MD, PhD

Professor of Disability and Mental Health, The University of Sydney, Australia

PROGRAM

The use of information systems for improving quality of care in severe mental illness

*Antonio Lora, MD
Director, Department of Mental Health, Lecco, Italy
Consultant, Department of Mental Health & Substance Abuse, World Health Organisation (WHO), Geneva*

What are the most effective forms of knowledge transfer to improve quality of care?

*Elliot Goldner, MD, FRC(P), MHSc
Professor, Centre for Applied Research for Mental Health and Addiction (CARMHA), Simon Fraser University, Vancouver, British Columbia*

Question Time

12:30 p.m – 1:30 p.m.

Lunch

1:30 p.m – 2:40 p.m.

Question 5 (continued)

Financial incentives – the role of provider payment mechanisms in relation to the quality of mental health care

*Heinz Katschnig, MD
Professor Emeritus of Psychiatry, Medical University of Vienna, and CEO, IMEHPS. research, Vienna, Austria*

A road map for mental health research

*David McDaid, BSc, MSc, MSc
Senior Research fellow, Health Policy and Health Economics, London School of Economics and Political Science, London, United Kingdom*

Panel Question Time

2:40 p.m. – 3:00 p.m.

Break

3:00 p.m. – 4:00 p.m.

Question 6: What further research is needed?

Introduction and Chair Discussion

*Jitender Sareen, MD, FRCPC
Professor of Psychiatry, Professor of Psychology & Community Health Sciences; Director of Research and Anxiety Services, University of Manitoba*

Panel Discussion

What are the priorities for research and spending in this field?

4:00 p.m.

Closing remarks and summary of day's proceedings

PROGRAM

Day 3: Thursday, November 6, 2014

8:00 a.m. – 9:00 a.m.	Continental Breakfast and Registration
9:00 a.m. – 9:30 a.m.	Reading of the draft Consensus Statement <i>Jury Chair: Alain Lesage, MD, FRCPC, MPhil, DFAPA</i>
9:30 a.m. – 10:30 a.m.	Open discussion
10:30 a.m. – 11:00 a.m.	Break
11:00 a.m. – 11:15 a.m.	Jury Chair Final Comments
11:15 a.m. – 11:30 a.m.	Closing Remarks Closing Prayer from Elder
11:30 a.m.	End of the Conference
11:30 a.m.	News conference/Media availability

THE JURY



Chair – Alain Lesage, MD, FRCPC, MPhil, DFAPA

Alain Lesage is currently a professor in the Department of Psychiatry at the University of Montréal. He is a scientist focusing much of his work around mental health and addiction services. He is also the medical director of the Mental Health Technology and Interventions Assessment Unit at the Institut universitaire en santé mentale de Montréal, and the Associate Director of the Québec Research Network on suicide, mood disorders and associated disorders. He was formerly the Editor-in-Chief of *Santé mentale au Québec*, and was the past President of the Canadian Academy of Psychiatric Epidemiology. Dr. Lesage graduated in medicine from the University of Sherbrooke and completed his postdoctoral training at the Institute of Psychiatry and Maudsley Hospital in London, England; and the Istituto di psichiatria in Verona, Italy. He was an invited scholar at the Harvard School of Public Health in 2005 and has recently been invited to join the executive board of the

European Network of Mental Health Service Evaluation (ENMESH). He continues to train the next generation of mental health and addiction researchers in collaboration with Quebec, Canadian and international colleagues. He is an active member on the Mental Health Commission of Canada Advisory Council.



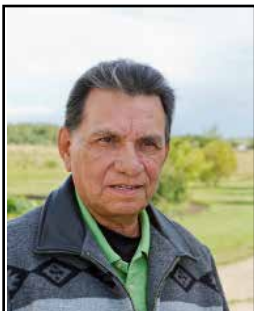
Katherine Aitchison, BA(Hons), BM, BCh, FRCPsych, PhD

Alberta Centennial Addiction and Mental Health Research Chair

Professor, Departments of Psychiatry and Medical Genetics, University of Alberta

Dr. Aitchison serves as an Alberta Centennial Addiction & Mental Health Research Chair. She is Professor of Psychiatry, an Adjunct Professor of Medical Genetics at the University of Alberta, and a Consulting Psychiatrist with the Edmonton Early Psychosis Intervention Clinic. She obtained her BA and BM BCh (MD equivalent) from the University of Oxford, psychiatry specialist training from the Maudsley Hospital, and PhD (Wellcome Trust funded) in pharmacogenetics from King's College London. The latter included a Travelling Fellowship to the National Institutes of Health and the University of Colorado (USA). Her Chair program of work is in Mental Illness and Addictions, with a secondary focus on Suicide Prevention: translational medicine, in order to lead change and support

evidence-based practice, resulting in health care innovations. Her publication areas include human genetics, pharmacogenetics, psychopharmacology, and mental health outcomes. She coauthored a book entitled “First Episode Psychosis” that has been used worldwide and translated into Korean; an updated handbook intended for a wide range of readers including carers is in progress. Dr. Aitchison served on the Faculty of King's College London from 2001-2011, and joined the Faculty of the University of Alberta in September 2011. She co-led a multicentre international pharmacogenetic study (GENDEP), a Workpackage on establishing biological sampling methods for children and adolescents for the STOP grant (<http://www.stop-study.com/>), and serves on Committees including the Canadian Scientific Advisory Committee on Substance Abuse, the Alberta Psychiatric Association Executive Committee, and previously served on the AHE Health Quality Council of Alberta Initiative Steering Committee.



Rupert Arcand

Rupert Arcand is Cree and comes from the Alexander First Nation in Central Alberta. Rupert is a pioneer in the area of Native men's issues and is currently the Executive Director of the Yellowhead Tribal Council Justice Society. He has worked extensively in communities across Canada and the United States, in both Native and Non-native environments. In the last number of years his work has been in the area of restorative justice. Rupert has considerable experience working in the healing field, specializing in areas of Adult Children of Alcoholics, Community Development, Life Skills, and Relationship Building.

THE JURY



Dr. André Delorme, MD, FRCPC

Dr. André Delorme is a psychiatrist and Fellow of the Royal College of Physicians and Surgeons of Canada. He is National Director of Mental Health for the Ministry of Health and Social services of Quebec. He was previously Head of the psychiatry department at the Montreal University Health Center and Medical Director of the Granby Hospital. He still works as a clinician in a PACT team which offers treatment and rehabilitation to schizophrenic and bipolar patients. Dr Delorme produced the Quebec Mental Health Plan of Action in 2005. This plan followed and built on a major overhaul of the public health network by the provincial government introducing a new organization of primary care facilities across the province. It also promotes a model of care shared between family doctors, mental health primary care professionals and secondary care mental health specialists. This new network should have a major impact on mental health promotion and service delivery.



Dr. David Goldbloom, OC, MD, FRCPC

Dr. Goldbloom was born in Montreal and raised in Quebec and Nova Scotia. He completed an honours degree, majoring in Government, at Harvard University and then attended the University of Oxford as a Rhodes Scholar where he obtained an M.A. in Physiological Sciences. He trained in medicine and psychiatry at McGill University and is a Professor of Psychiatry at the University of Toronto. Dr. Goldbloom's activities have been recognized and awarded by his peers and students. He has authored numerous scientific articles and book chapters and has provided talks and lectures to student, professional and public audiences. He maintains an active clinical and teaching role at the Centre for Addiction and Mental Health where he serves as Senior Medical Advisor. He is also Chair of the Mental Health Commission of Canada. In addition to his professional activities, Dr. Goldbloom is immediate past Chair of the Board of Governors of the Stratford Shakespeare Festival of Canada. He is an Officer of the Order of Canada.



Kaj Korvela, BA Art History; BA Fine Arts, BA Education

Kaj Korvela is Executive Director (2003-present) of the Organization for Bipolar Affective Disorder, a consumer driven non-profit that focuses on mood disorders with a particular emphasis on bipolar disorders, as well as a board member/coach and mentor for Opportunity Works, a non profit providing entrepreneurship skills to mental health consumers. He is active in the mental health community including Alberta Health Services (AHS) Strategic Clinical Network, Alberta Alliance for Mental Illness and Mental Health, AHS Patient Engagement Reference Group, Calgary Mental Health Network and the Mental Health Housing Sector. A successful fundraiser through appeal to private and corporate patrons, gaming and other events Kaj is an advocate for the mentally ill through public events and presentations, community consultation and promotion. He also produces educational materials, including the widely recognized and employed "A Guide to Recovery." Research affiliations

and designations include national and international CDRIN, CREST BD - Psychosocial issues in Bipolar Disorders, Certified Peer Specialist, Kaj is also affiliated with Calgary Association of Self Help. As a practicing fine artist, Kaj maintains a studio from his home base in Calgary and is a supporter of Catalyst Contemporary Art, Calgary Philharmonic and local arts groups. He is winner of the 2014 Lt. Governor's True Grit Award.

THE JURY



Gloria Laird

Gloria Laird is a member of the Métis Nation of Alberta and is one of the Elders for the Métis Regional Council, Zone 4. She has one son and two beautiful granddaughters who live at her home part time. She was appointed and served on 3 different Mental Health Boards for the Province of Alberta, advocating for Aboriginal Services within the Mental Health System. At the end of her 6th year and last term, the Board appointed a Wisdom Committee to advocate and guide Aboriginal Mental Health Services and ensure there were opportunities to incorporate Traditional and Spiritual Healing Practices in the Mental Health System. The Wisdom Committee was in existence for about 8 years. Gloria served as Co-Chair on this Committee for the duration of that time, being reappointed by the Committee to continue to Co-Chair. Gloria has also trained in a number of healing modalities, and is a Reiki Master (Reiki means Universal Life force (hands on Healing) Gloria has worked in the Aboriginal Community, Oil Industry, Federal Government and presently for the Provincial Government, Children's Services, and currently works as an Aboriginal Consultant at Yellow head Youth Centre. She has recently been appointed to Alberta Health Services Wisdom Council as one of the Metis Representatives, and is one of the Four Co-Chairs on the Council.



Glenda M. MacQueen, PHD, MD, FRCPC

Professor, Department of Psychiatry, and Vice Dean, Faculty of Medicine, University of Calgary

Glenda M. MacQueen is a Professor in the Department of Psychiatry at the University of Calgary, Alberta, Canada. She is also the Vice Dean of the Faculty of Medicine at the University of Calgary. Dr. MacQueen earned her PhD in Psychology from McMaster University and her MD from McMaster University Medical School, where she also completed her residency in psychiatry. Dr. MacQueen's research focuses on the neurobiology and clinical features of mood disorders. She was a founding member of the Brain Body Institute and is a member of the Hotchkiss Brain Institute and the Mathison Centre for Mental Health Research and Education. Dr. MacQueen is an associate editor of the Canadian Journal of Psychiatry and the Journal of Psychiatry and Neuroscience. Dr. MacQueen was the 2011 recipient of the Douglas Utting award for studies in depression and is the 2014 recipient of the Heinz Lehmann award from the Canadian College of Neuropsychopharmacology.



Fay Orr

Fay Orr was Alberta's fourth Mental Health Patient Advocate from May 2010 until October 2013. In that role Fay was mandated under the Alberta Mental Health Act to investigate complaints and concerns from or relating to mental health patients in Alberta under certificate or community treatment orders. As Advocate, Fay acted as a resource to health care providers on the proper application of the Mental Health Act and provided advocacy perspectives and information to the Minister and the Ministry of Health to assist in the development of policy and legislation. She had articles about Alberta's mental health legislation published in several journals including the Health Law Review and Health Law Canada. During her time as Advocate, Fay helped to establish the Lieutenant Governor's Circle on Mental Health and Addiction. The Circle works to prevent stigma by enhancing awareness and understanding about mental health issues and recognizing significant achievements in mental health and addiction treatment and programming. The Circle administers and hosts the annual Lieutenant Governor's True Awards for Mental Health and Addiction. Fay continues to serve as a director on the LG's Circle. Over the past 21 years, Fay has held several senior positions within the Government of Alberta including: Deputy Minister of Alberta Children and Youth Services; Deputy Minister of Tourism, Parks, Recreation and Culture; Deputy Minister of Community Development; Deputy Minister of Government Services; Managing Director of the Alberta Public Affairs Bureau; and, Communications Director of the Premier's Office. Fay was a journalist before joining the government in 1988. Fay is currently the Vice-Chair of the Board of Directors for the United Way, Alberta Capital Region.

THE JURY



John McSorley, MD, MB, MRCGP

Born in Belfast, Northern Ireland, John McSorley is a child of what was known as “the troubles” which took the lives of over 3000 people in a vicious sectarian civil war that lasted almost 40 years. The trauma of this experience more than anything made him determined at the age of 15 years to leave Ireland and to become a family doctor like his father. He came to Canada, to Coronation, Alberta for 2 years and then moved to Airdrie in 1994. Since then he has served on the board of the Primary Care Network since its inception and was the physician lead in the PCN complex care clinic for several years. He also teaches medical students and international medical students at the University of Calgary. It is no exaggeration to say that he truly loves this work, but if asked to pick a favourite aspect of his work as a family physician it would be working alongside patients who are experiencing overwhelming stress in their lives whether it is from their own or a loved one’s illness.

John’s own experience with clinical depression a few years ago, though awful at the time, has taught him more than any textbook about the devastating effect of mental illness on the individual and their family. He states that he owes a deep debt of gratitude to the AMA Physicians and family support programme for helping him through that challenging time in his life. Medicine, his Catholic faith and his family are the first loves of his life but he also loves to hike, kayak, play soccer, read poetry, modern history and last but definitely not least, spend time with his dog, Seamus.



Tom Shand

Tom Shand has been working in the healthcare field in Alberta and BC for more than 30 years, including the past eight focused on mental health in Alberta. Tom is currently the past chair of the Alberta Alliance on Mental Illness and Mental Health, having served six years as its chair. He is also a founding director, and now past chair of the Lt. Governor’s Circle on Mental Health and Addiction, and was Executive Director of the Alberta Division of the Canadian Mental Health Association for eight years, leaving last April. He is also a core member of the AHS Strategic Clinical Network for Addiction and Mental Health as well as on mental health research projects through CDRIN and CRISM. Tom has played a key role in the development of such significant directions as the introduction of Community Treatment Orders in Alberta and the creation of Creating Connections, the strategic plan for mental health and addiction in Alberta. Tom is a strong advocate for the

need for increased emphasis and support for mental health with increased collaboration between community service providers, various arms of government and the private sector. He believes that the field also requires more research and a stronger voice for those living with mental illness and their families. Given that perhaps only a third of mental health needs are actually clinical in nature, the linkages with such areas as employment, social services, housing, education and justice are vitally important to improving supports and helping to better meet mental health needs. Tom has a background in journalism, fund development and organizational development for NGOs. A graduate of Queen’s University, in human geography and a minor in economics, Tom and his wife Sheila have two adult daughters, one working as a contemporary dancer in Israel and the other in a marketing position in Montreal.

THE JURY



Michel Simard, MA

Michel Simard, a criminologist and theologian, has worked with homeless people for more than 25 years. He is the Executive Director for Centre Le Havre de Trois-Rivières, a front line organisation for homeless men and women. Le Centre le Havre has developed emergency, transitional and long term (permanent housing, work) services. Michel has also contributed to the development of an innovative interorganisational program for chronically homeless people, he is one of the founders of a Quebec homeless network: Réseau solidarité itinérance du Québec, and has been the president of the Quebec Psychosocial Rehabilitation Association. He is a member of the advisory board on the homeless policy and the research committee on homelessness in Quebec for the Quebec Government and contributes to the global development of services for homeless people, including aboriginal people, in Val-D'Or, Québec. He makes a significant contribution to the transformation of services at

Old-Brewery Mission in Montréal, the largest homeless shelter in Quebec. Michel has also participated in many conferences and published many texts related to homelessness.



Sharon G. Sutherland

A longtime Mental Illness/Health Advocate, Sharon is motivated by her son's mental illness and the need to connect with people with similar issues. The Schizophrenia Society of Edmonton provides that connection and important support. Her goals have been to ensure people with mental illness, their families and caregivers have a voice with the policy makers, the development of support programs and resources, changing public perceptions and identifying gaps in the system. "Nothing is simple if you have a mental illness or if you are involved in its treatment."



Helen-Maria Vasiliadis, MSc, PhD

Dr. Vasiliadis has a doctorate degree in Epidemiology and Biostatistics from McGill University and a master's degree in Pharmacology from the Université de Montréal. She also pursued a post-doctorate in Psychiatric Epidemiology at the Harvard School of Public Health. She is currently an Associate Health Professor and a Researcher at the Université de Sherbrooke in the Department of Community Health Sciences at the Faculty of Medicine and Health Sciences and at the Research Centre of the Charles Lemoyne Hospital at Longueuil and is a Junior 2 Research Scholar with the Quebec Health Research Fund (FRQ-S).

Research program: Towards estimating a balanced mental health care system

Prof. Vasiliadis' program of research aims to inform decision makers on estimating a balanced mental health care system in Canada that will provide essential information for planning and budgeting services. This with the ultimate goal to adequately fund services for equitable access to evidence-based mental health services and to support seamless and efficient mental health care for all disorders and mental health client populations. For these objectives, population health and survey data as well as administrative databases are exploited as research monitoring tools that can be used to produce valid and easily available information to adequately fund and plan inpatient and community health services to support evidence-based treatment packages of care. In general terms, the program of research focuses on: (i) estimating the cost of treatment related to the severely mentally ill and those with common mental disorders (depression, anxiety, etc.), which have an important economic and social impact on society; (ii) describe population determinants (predisposing, enabling/impeding, need factors) of service use and (iii) relate health care costs to patient needs, clinical, and quality of life outcomes.

SPEAKERS & ABSTRACTS



Carol Adair, MSc, PhD

Associate Professor, Departments of Psychiatry and of Community Health Sciences, Faculty of Medicine, University of Calgary, Alberta

Dr. Carol Adair has an MSc. in Healthcare Research and a PhD. in Epidemiology (1996) from the University of Calgary. She is a mental health services researcher/psychiatric epidemiologist affiliated with the Depts. of Psychiatry and Community Health Sciences at U of C. Her research interests include measuring outcomes for adults, children and youth with serious mental illnesses such as schizophrenia, eating disorders, disabling mood disorders and addictions with the ultimate aim of promoting their health, wellbeing and quality of life. From 1999-2004, Dr. Adair led a multi-site research program including a large cohort study examining continuity of mental health care in Alberta funded by the Canadian Health Services Research Foundation and 4 other funders. She has

more than 90 published abstracts or presentations, has published more than 85 scientific articles or health policy reports, and is the principal copyright holder for three widely-used research instruments on continuity of care, quality of life and housing quality. Dr. Adair is a co-recipient of the 2008 Canadian Psychiatric Association Award for Outstanding Continuing Education Activity in Psychiatry for a CIHR-funded symposium on Eating Disorders and Obesity. She has also been an active grant reviewer for Canadian research funding and philanthropic organizations such as CIHR, AIHS, Bell Canada as well as for organizations in the US, NZ and the UK. She currently serves as Chair of the Scientific Review Panel for Movember Canada. She has also served in research and evaluation leadership roles including with the former Alberta Mental Health Board and the Mental Health Commission of Canada, and as an expert panelist/committee member on provincial and national mental health surveillance and performance measurement committees, such as for CIHI and PHAC. Since 2007, Dr. Adair has been the national Quantitative Research Lead for the \$110M At Home/Chez Soi multi-site Trial of Housing First for homeless individuals with mental illness.

Abstract: How important is continuity of care and integration in the provision of effective support?

Continuity of care has been touted as important for good outcomes for individuals with SPMI since the 1960s. It has historically, in mental health services, been defined as “a process involving the orderly, uninterrupted movement of patients among the diverse elements of the service delivery system” (Bachrach 1981) but variability in definition persists. Health services integration is even less well defined; just one of many definitions “The extent to which key support functions and activities are coordinated across operating units of the system to realize the greatest value.” (Conrad & Shortell, 1996). While ideas about these abstract health service ‘processes’ and related concepts such as coordination of care remain variable, and stories of ‘fragmentation’ and ‘falling through the cracks’ persist, good progress has been made in the past decade or so on understanding their dimensions and how they can be operationalized in health services. While current evidence for their relationship with patient/client outcomes is not definitive – there is a basic foundation of knowledge to inform practice. In this presentation, what is currently meant by continuity of care (including from both provider and patient/client perspectives), integration and closely related concepts will be explored first. Next, the way that these ideas have been operationalized in mental health services, including examples from programs or interventions at least implicitly designed to improve care continuity for adults with SPMI such as ACT, case management, shared care, housing first and discharge planning will be outlined. Finally highlights from the review literature on the association between continuity and integration on patient/client-level outcomes such as functioning and quality of life and system-level outcomes such as costs will be presented, along with the implications of these findings for policy.

SPEAKERS & ABSTRACTS



Tim Aubry, PhD, MA, BA

Chairholder, Faculty of Social Sciences Research Chair in Community Mental Health and Homelessness; Professor, School of Psychology and Senior Researcher, Centre for Research on Educational and Community Services, University of Ottawa, Ontario

Dr. Tim Aubry is a Full Professor in the School of Psychology and Senior Researcher at the Centre for Research on Educational and Community Services at the University of Ottawa. He is currently holder of the Faculty of Social Sciences Research Chair in Community Mental Health and Homelessness. Over the course of his career, Dr. Aubry has collaborated on research projects with community organizations and government at all levels, contributing to the development of effective social programs and policies. He was a Member of the National Research Team and the Co-Lead of the Moncton site in the multi-site Mental Health and Homelessness Demonstration Project of the Mental

Health Commission of Canada. As well, he is currently the Co-Principal Investigator of the Housing and Health in Transition study, a longitudinal multi-city study investigating the relationship of health status with housing transitions. Dr. Aubry is a Fellow of the Society for Community Research and Action. He received the Award for Contribution to Evaluation in Canada in 2013 from the Canadian Evaluation Society. He has served as the Senior Editor of the Canadian Journal of Community Mental Health (2005-2010). Dr. Aubry teaches graduate courses at the University of Ottawa in community psychology and program evaluation.

Abstract: The Relationship Between Mental Illness and Homelessness: Findings from Prevalence Research and from the At Home / Chez Soi Demonstration Project in Canada

Background: The presence of serious persistent mental illness in the context of poverty and social isolation has been identified in the research literature as a both a risk factor for becoming homeless and a consequence of homelessness. The presentation will briefly review the finding of surveys of the prevalence of serious mental illness among homeless populations in western countries (Fazel et al., 2014). Subsequently, the demographic, clinical, and social characteristics of over 2100 individuals participating in the At Home / Chez Soi (AHCS) Canadian Demonstration Project will be presented. These will be followed by a presentation of the findings emerging from this study in which the effectiveness of Housing First approaches was compared to Treatment as Usual.

Methods: Fazel and his colleagues (2014) conducted a systematic review and meta-regression analysis of studies conducted in 6 European countries and the United States. The AHCS Demonstration Project was a non-blind-parallel group RCT in which the outcomes of 1158 individuals receiving Housing First (HF) were compared to 990 individuals receiving Treatment as Usual (TAU). Individuals in the study were either absolutely homeless or precariously housed (i.e., recent episodes of homelessness) and assessed as having high needs (i.e., lower functioning, diagnosed with more severe mental illness and concurrent disorder or recent hospitalizations for mental illness or recent arrest or incarceration) or moderate needs. Participants were followed for 24 months and data was collected on a wide range of outcomes that included housing status and stability, service utilization, health status, and community adaptation.

Findings: The prevalence of alcohol and drug dependence as well as psychotic illnesses and personality disorders is higher in the homeless population than in the general population. The range of prevalence of these disorders varied greatly across studies and the prevalence of alcohol dependence appears to have increased over recent decades. AHCS participants had experienced a significant history of homelessness, and faced multiple economic, health, and social challenges that contributed to their marginalization. HF was found to be more effective than TAU in assisting individuals to rapidly end homelessness, achieve housing stability, increase their quality of life, and improve their community functioning. Comprehensive costing of services received by the two groups showed HF to be almost cost neutral with HF program costs offset by savings in health, social, and justice services.

Discussion: Prevalence findings from cross country observational studies along with characteristics of AHCS participants will be discussed in the context of the needs of people with serious mental illness who are homeless. Findings on the effectiveness of AHCS will be compared to and interpreted in the context of findings of previous American research on HF.

Conclusions/Policy Recommendations: Program and policy development recommendations will be proposed based on the findings from the reviewed prevalence research and from the AHCS study.

SPEAKERS & ABSTRACTS



Thomas Becker, Dr. Med.

Medical Director & Chairman, Department of Psychiatry II, Ulm University, Germany

Dr. Thomas Becker graduated in 1982, worked on psychiatric reform in Turin, Italy in 1982-1983 (doctoral thesis), subsequently worked in internal medicine and neurology, started his specialist training in psychiatry in 1987, qualified as psychiatrist in 1991, worked as senior medical staff and was appointed lecturer (1994) at the Department of Psychiatry of Wuerzburg University. His research was on neuroradiology findings in patients with psychotic disorders. In 1995, he moved to the Section of Community Psychiatry at the Institute of Psychiatry, King's College London (Humboldt Foundation scholarship) and was involved in mental health services research and European trials. From 1998 to 2002 he worked at the Department of Psychiatry of Leipzig University where he held a Public Health professorial appointment. He was appointed head of the Department of Psychiatry

II of Ulm University (at the Bezirkskrankenhaus Guenzburg) in 2002. His research interest is in mental health services research, social psychiatry and public mental health.

Abstract: How effective are psychosocial interventions?

Background: Psychosocial interventions are essential tools in mental health care. A selection of these interventions is discussed. Some themes covered in a German DGPPN S3 guideline on psychosocial interventions will be presented.

Methods: Literature search and (mostly) systematic reviews were performed (in 2010/2011) for: milieu therapy (MT), peer involvement (PI), case management (CM) and intensive case management (ICM), vocational interventions, residential services, psychoeducation (PE), social skills training (SST), occupational therapy (OT), and sports therapy (ST).

Findings: /Milieu therapy/ MT includes measures that impinge on therapeutic milieu/ atmosphere in joint professional / user groups in the course of treatment. MT provides a context in which treatment interventions can be implemented and treatment aims are reached. There is evidence of its effectiveness in improving mental health outcomes. /Peer involvement/ PI and peer support are supported by promising evidence as innovative interventions in mental health care. /Case management/ Findings on CM are inconsistent. There are difficulties in defining CM. CM strengths include treatment satisfaction and continuity of care. CM was associated with increase in inpatient admissions, inpatient treatment duration declined. Reduction of inpatient treatment days was greater if ICM teams used the assertive community treatment (ACT) approach. Higher fidelity to ACT was associated with reduction in inpatient days. Baseline level of inpatient days in a catchment area influenced the decline in inpatient days. Effects of introducing ICM were related with level of hospitalization prior to ICM. /Vocational interventions/ Studies showed supported employment (SE) to be more effective in achieving job placement. A proportion of SE users fail to find jobs on the general labour market. Other types of work rehabilitation are required, and there is room for pre-vocational training interventions. Effectiveness of pre-vocational training can be improved by financial incentives and psychological interventions. /Residential services/ There is a lack of evidence on residential services for people with severe mental illness. Studies suggest that supported housing arrangements can lead to a reduction in inpatient admissions/ treatment days. Reduction in duration of hospitalization can be achieved by providing long-term residential care. Improved negative symptoms and social networks were reported in dehospitalization studies. Evidence suggests that institutionalization is associated with negative effects. /Psychoeducation/ There is a variability of results on PE. With the exception of the NICE schizophrenia guideline meta-analyses point at positive effects of PE with respect to knowledge acquisition, relapse reduction and inpatient readmissions. /Social skills training/ Social functioning and level of social adaptation of patients can be improved by SST. Effects on other outcome parameters are less homogenous. / Occupational therapy/ Single-arm pre-post studies of OT without control groups were not considered. Systematic reviews could not be found. There is a substantial lack of high-quality studies on OT. /Sports therapy/ ST can reduce positive and negative symptoms, depressive symptoms and anxiety (vs standard treatment). Physical health parameters could be improved. When physical training was compared with yoga rather than standard treatment positive effects of physical training disappeared. Yoga was more effective regarding some outcome parameters. A RCT (in patients with psychosis) showed physical training to be superior to a control condition and to lead to increased hippocampal volume.

Discussion: Psychosocial interventions are strong interventions. The strength of the evidence is varied. Occupational therapy requires effectiveness research. The use of psychosocial interventions rests on experience, evidence and ethics.

Conclusions/Policy Recommendations: Psychosocial interventions are indispensable in building mental health care systems. Vocational interventions and residential services are mandatory. Social skills training and sports therapy are important tools. Peer involvement could help in moving mental health services forward.

SPEAKERS & ABSTRACTS



Dan Cohen, MD, PhD

Department Chronic Psychiatry, Mental Health Care Organisation North-Holland North, Heerhugowaard, The Netherlands

Dr. Dan Cohen studied Medicine in Amsterdam and specialized in Psychiatry in Gent (Belgium) and Leiden (Netherlands). Doctorate on thesis "Diabetes mellitus in schizophrenia and schizoaffective disorder: an iatrogenic or endogenous problem? (Utrecht 2006)

Affiliations:

- Department of Clinical Epidemiology, University Groningen (Netherlands)
- Assertive Community Treatment Heerhugowaard
- Out-patient clinic for metabolic disturbances in patients with SMI

He lectures regularly on the issue of diabetes mellitus and other metabolic disorders in schizophrenia and related diseases. Member of advisory board of Eli Lilly and Bristol-Myers Squibb.

Abstract: Integrating Crisis and ACT teams.

Traditionally, patients were admitted to a psychiatric hospital for treatment. Once outside their own familiar environment, they often needed further treatment for so called (re-)socialization. In contrast, for optimal recovery and patient satisfaction, patients need maximum control over their own life, supplemented with support on demand and or when indicated in those parts of their behaviour, in which they are more or less dysfunctional.

Transition to outpatient-based treatment is a complex undertaking, that requires changes in the whole organization, on all levels and in all segments. In accordance with the law of supply and demand, existing beds tend to be filled with patients with an indication for hospitalization. Most patients suffer from schizophrenia, bipolar disorder, personality disorder, some with comorbid addictive disorders. In short, they are patients with severe mental illness (SMI). Change needs to start with the development of an adequate outpatient supply that replaces inpatient care. Transition will be accompanied by a shift of costs, not by cost reduction.

FACT

- Development and installation of functional assertive community treatment teams (FACT). The Netherlands has currently approximately 200 FACT-teams.
- FACT-teams are a multidisciplinary team that is responsible for all patients with SMI in a catchment. Every team has one psychiatrist, one psychologist, 6-8 care-providers with a nursing background who have a caseload of 19 patients for full-time equivalent, social psychiatric nurses, a dual-diagnosis nurse, an individual placement and support (IPS) worker and a peer-worker.
- Flexible treatment. Treatment is provided according to the needs of the patients as assessed by the care provider. The frequency of contact with the care provider normally varies from one a week to once every month. When indicated, the intensity of care can be upgraded to daily home visits, during working hours and, if needed, in the weekend as well.
- Shared caseload. Every patient is paired to a care provider. However, during holidays of the care provider or when intensification of care is needed, the patient is phoned or visited by different team members.
- Catchment area and size of caseload. The maximum caseload of a team should be fixed at around 200 patients. This allows team members to acquire basic knowledge of all patients in care. The catchment area is determined by the number of the patients: 50.000 inhabitants is feasible in the rural parts of North-Holland, while in the one main city of Alkmaar 3 teams are required for a population of 95.000 inhabitants.
- Assertiveness. Exaggerated, the ideal office of ACT-team is empty because all care providers make home visits. In assertive treatment, the need of the patients for FACT-care is assessed by their care provider, independent of the patients need for psychiatric care.
- Individual responsibility of psychiatric nurses. The core skill of nurses, who constitute the majority of the team, is their individual responsibility. As they are the ones who make the home visit, it is the care provider who must assess severity of the patient at home and whether to consult a colleague, psychologist or psychiatrist, because, when something goes wrong, this nurse is the person who has made the last home visit and (s)he will be asked why no consultation took place.

Recommended reading

Veldhuizen R van. FACT: A Dutch version of ACT. *Community Mental Health J* 2007; 43:421-433.

Bond GR, Drake RE. Should we adopt the Dutch version of ACT?

Commentary on "FACT: a Dutch version of ACT". *Community Ment Health J.* 2007; 43:435-358.

Drukker M et al. A real-life observational study of the effectiveness of FACT in a Dutch mental health region. *BMC Psychiatry* 2008, 8; 93.

SPEAKERS & ABSTRACTS



Giovanni de Girolamo, MD, PhD

IRCCS Unit of Psychiatric Epidemiology and Evaluation, Italy

Dr. Giovanni de Girolamo is the former Scientific Director of the St John of God Clinical Research Centre (IRCCS) in Brescia, Italy. Currently he is the Head of the IRCCS Unit of Psychiatric Epidemiology and Evaluation. He has a Degree in Medicine and a Postgraduate Degree in Psychiatry (University of Naples). He has received Fellowships as short-term Visiting Fellow at the Institute of Psychiatry in London (with Prof. Michael Shepherd), at the Institute of Psychiatric Demography in Aarhus (Denmark, with Prof. Annalise Dupont), and at the Western Psychiatric Institute and Clinic in Pittsburgh, (USA, with Prof. David Kupfer). From 1988 to 1994, he worked at the Division of Mental Health of the World Health Organization in Geneva, under the guidance of Norman Sartorius. From 1998 to 2001 he was the Coordinator of the Italian N.I.H. National Mental Health

Project, which involved more than 100 centres throughout Italy. He has set up and directed several multicentre research projects; this is a selection: (i) the national survey of psychiatric residential facilities (the largest survey ever done in this area), called PROGRES; (ii) the national survey on all acute inpatient facilities, called PROGRES-Acute (equally the largest survey ever done in this area); (iii) the Italian site of the WHO World Mental Health Survey Initiative, led by Ronald Kessler (Harvard University); (iv) the large experimental trial on first-episode psychotic patients, called 'GET-UP', involving 110 Italian Community Mental Health Centres; (v) a trial on the use of intranasal oxytocin for the treatment of schizophrenia; and (vi) the European 8-country project MILESTONE on the transition from child/adolescent to adult mental health services. He has been awarded funding from the European Commission for the organization of an European Conference on 'Youth mental health: from continuity of psychopathology to continuity of care', Venice, December 2014. His research focuses on psychiatric epidemiology and health services research; RCT in psychiatry; drug-utilization studies; quality of life. He is the author of 345 publications, including 40 volumes or monographs edited or authored, 251 journal articles (of which 202 indexed in Pubmed) and 68 book chapters.

Abstract: Residential Facilities: are they promoting recovery or are they 'homes for life'?

Background: The closure of mental hospitals in Europe has seen the parallel growth of a large network of Residential Facilities (RFs) for patients needing medium- or long-term mental health care. Yet there are a number of unsolved controversies about the role and the functions of RFs. Probably the main point of controversy is to clearly define whether they should be conceptualized as intensive treatment programmes, or merely as ordinary homes or living settings for people who participate fully in treatment and psychosocial programmes provided by local mental health services.

Methods: The literature on RFs has been reviewed, and data from the Italian survey on RFs, the PROGRES study, the largest survey done internationally so far in this area, as well as from a prospective study (the PERDOVE study) on 403 residents, have been analyzed to draw some general lessons in this area. Findings In Italy, where all mental hospitals have been phased out, psychiatric patients requiring long-term care are being treated in RFs. The PROGRES project in 2000 found in all Italy 1,370 RFs with 17,138 beds, an average of 12.5 beds each 10,000 population and a rate of 2.98 beds per 10,000 inhabitants. Residential provision varied ten-fold between regions and discharge rates were very low. Most had 24-hour staffing with 1.42 patients per full-time worker. In the second phase of the project 2,962 patients living in the sampled facilities were individually assessed; most were males. A substantial proportion (39.8%) had never worked and very few were currently employed (2.5%); 45% of the sample was totally inactive, not even assisting with domestic activities in the facility. Two-thirds had a diagnosis of schizophrenia. In the PERDOVE study, after 1-year follow-up, only 14% of patients were discharged to independent accommodations. Discussion For many patients with severe mental disorders and marked disabilities, limited or absent social support and increasing age, RFs represent, and will represent, 'Homes for life', as Julian Leff named RFs in the framework of the landmark TAPS project.

Conclusions/Policy Recommendations: There is the need to develop a clear taxonomy of RFs, based on specific operational criteria. This taxonomy should spell out acceptable ranges of available RFs, staffing levels, optimal size, satisfactory environmental features and activities needed to fill residents' weekly time, and in particular weekends, evenings, and so on. Precise patients' inclusion criteria should be developed; all patients that are candidates for residential facility admission should receive careful, multidimensional assessments, highlighting not only clinical characteristics but also impairments in social and vocational roles. Management plans and related organizational frameworks should match residents' typologies and their various needs and requests. Patients' rehabilitation plans should be carefully monitored with appropriate instruments. Avoiding an indistinct case mix (i.e. aged patients mixed up with young, treatment-resistant patients) in RFs is a prerequisite for the development of tailored treatment plans and for transforming RFs into effective rehabilitation settings for those patients with realistic prospects of rehabilitation. This strategy also implies the selection of staff with specific characteristics, and a reasonable staff turnover should be foreseen to prevent burnout.

SPEAKERS & ABSTRACTS



Philippa Garety, MA, MPhil, MA(Ed), PhD, FBPSS

Professor of Clinical Psychology, Clinical Director, Psychosis Clinical Academic Group (CAG), South London and Maudsley NHS Foundation Trust, United Kingdom

Dr. Philippa Garety is Professor of Clinical Psychology at the Institute of Psychiatry, King's College London and a consultant clinical psychologist and joint director of the Psychosis Clinical Academic Group, South London and Maudsley NHS Foundation Trust. She was awarded her first degree in Philosophy and Psychology (Natural Sciences) by Cambridge University. She qualified as a clinical psychologist in 1981 at the Institute of Psychiatry, followed by completing a PhD on cognitive processes in delusions. Since then she has combined research with clinical practice and service development. Her main focus of research has been the investigation of how cognitive and emotional processes, such as particular thinking styles or anxiety, contribute to psychosis, together with therapy development, in particular CBT for psychosis. Her work continues to translate the findings of theoretical and empirical research into improvements in treatments and service provision. With colleagues, she established one of the first comprehensive Early Intervention services for people with psychosis (LEO) in the late 1990s. She is currently involved in leading a national programme of Improving Access to Psychological Therapies for People with Severe Mental Illness (IAPT-SMI), a UK government initiative to increase fair access to evidence-based psychological therapies. Her psychological treatment research comprises randomised controlled trials of newer developments of CBT for psychosis and investigations of psychological processes which predict therapy adherence and outcome. She was awarded the Shapiro lifetime achievement award in 2002 by the Division of Clinical Psychology Society and in 2007 was selected as a Senior Investigator of the National Institute of Health Research.

Abstract: What is the effectiveness of psychological therapies for people with severe and persistent mental illness?

Background: People with Severe and Persistent Mental Illness (SPMI) frequently experience persisting psychotic symptoms and mood disturbances that affect everyday life, causing personal distress, impeding social and vocational functioning and leading to relapse and re-hospitalisation. Although the first line of treatment for SPMI is typically medication, many experience a sub-optimal response. Psychological therapies (Ps) have been developed to address these needs.

Methods: Review of meta-analyses, guidelines, expert commentaries and publications from service user / campaigning groups. Wherever possible, evidence for effectiveness for people specifically with SPMI was considered.

Findings: The PTs identified as having the strongest evidence base as helpful for people with SPMI are 'high intensity cognitive behaviour therapy (CBT) and structured family interventions (FI). FI is effective in reducing relapse and rehospitalisation in people with psychosis and bipolar disorder. However, it is only suitable for those in close contact with and willing to involve family members. This may be a relatively small proportion of people with SPMI. CBT is helpful for people with persistent, distressing, medication-unresponsive psychotic symptoms. There is emerging evidence that it may be effective and safe for people who refuse to take medication. In addition, CBT tailored to specific diagnostic groups and/or target problems can help with emotional problems and self-management in psychosis, bipolar disorder and personality disorders.

There is also evidence supporting other approaches including interpersonal therapy, mentalisation-based therapies and arts therapies for specific diagnostic sub-groups/problems.

Service user/ consumer groups are increasingly demanding fair access to PTs.

Even where policies recommend the provision of PTs, there are many reports of difficulties in implementation and obstacles to fair access.

Discussion: The evidence for PTs for SPMI has been accumulating over the past two decades, and is now strong enough to recommend its routine use. Research into how effective it is for specific sub-groups of people with SPMI remains, however, limited. The barriers to fair access are at national and regional policy, local system, service and individual levels. Implementation therefore requires sustained systematic programmes, and is much enhanced by advocacy and support from service user/ consumer groups.

Conclusions/Policy Recommendations:

1. Medication alone is not the optimal treatment for people with SPMI. Pharmacotherapy should therefore be combined with evidence-based PT for optimal treatment effectiveness.
2. The evidence base is strong for 'high intensity' CBT and FI.
3. Where people refuse pharmacotherapy, emerging evidence suggests that it is acceptable and safe to provide CBT alone.

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4. PTs differ in aims and methods and may address specific targets, such as command hallucinations, persecutory delusions, emotional problems
5. Choice of PT should be offered in partnership with the service user and family to promote service user's recovery and self-management goals, in a wider context of recovery-focussed services.
6. To improve access to PTs, national, regional and local organisational programmes and training developments are required. The involvement of service user and consumer groups is an important component of advocacy, policy development and implementation.
7. Further research is required on the application of PTs with sub-groups of people with SPMI.

SPEAKERS & ABSTRACTS



Linda Gask, MSc, PhD, FRCPsych, FRCGP

Professor of Primary Care Psychiatry, National Primary Care Research and Development Centre (NPCRDC), University of Manchester, UK

Dr. Linda Gask is Emerita Professor of Primary Care Psychiatry at the University of Manchester, where she has worked with the Centre for Primary Care since 1992. She trained in medicine in Edinburgh, and in psychiatry in the North West of England, and worked for many years as a Consultant Psychiatrist, latterly in Salford in Greater Manchester where she helped to found an innovative primary care based mental health service. She retired from clinical practice in 2013. Her research initially focused on the impact of training front line health professionals, particularly General Practitioners, in mental health skills, with a focus on managing depression, medically unexplained symptoms and managing people who are at risk of self-harm. She helped to develop

and evaluate the STORM suicide prevention initiative, which has been disseminated throughout the world. She spent a year as a Harkness Fellow in Health Policy Research and Practice, based at the Centre for Health Studies, Group Health Cooperative in Seattle, with Ed Wagner, where she developed an interest in Chronic Illness Care. Since then she has been involved in four randomized controlled trials of Collaborative Care for mental health problems, including depression both with and without comorbid physical illness. She is now developing an intervention for collaborative care (across the interface between primary and specialist care) for people with severe and enduring mental illness (National Institute for Health Research Programme Grant led by Max Birchwood in Birmingham UK). Linda has published more than 150 peer reviewed academic papers, authored or edited half a dozen textbooks on psychiatry and mental health. She has been an advisor for the World Health Organization, working on ICD-11 Primary Care, and a zonal representative for the World Psychiatric Association. She is an Honorary Fellow of the Royal College of General Practitioners.

Abstract: How can family physicians best support people with SPMI in the community?

Background: For people with SPMI, primary care (PC) will be a key (and sometimes only) contact point for health care. However, despite PC offering a less stigmatized setting for care than mental health services, many people with SPMI avoid PC services or attend less frequently than would be expected. Despite the major risk of physical co-morbidity in SPMI, less routine screening or health checks are provided in PC for people with SPMI, and fewer interventions offered to improve physical health care. Family physicians (FPs) report lack of support, problems across the interface with specialist services, and difficulty arranging follow-up and timely re-referral in relapse with uncertainty about roles and responsibilities. Some FPs view SPMI as beyond their remit.

Methods: Narrative review of existing descriptive literature on how family physicians can support people with SPMI with review of recent systematic reviews of interventions.

Findings: Improving access to primary care: Mental health workers have a key role in linking people with SPMI into primary care. Physical health monitoring in primary care: A number of interventions have been described to improve primary care monitoring of physical health care in SPMI, including use of registers and payment to practitioners (UK) and development of clinical algorithms. There is no current evidence from randomized controlled trials to support current guidance and practice for monitoring the physical health of people with SPMI in primary care. This is based on expert consensus. Interventions by FPs to promote physical health in SPMI: Despite evidence for the effectiveness of specific interventions e.g. for smoking and weight reduction these are underutilized. There is a dearth of evidence on the impact of training FPs to engage people with SPMI in discussion about lifestyle or motivate them to engage in treatment. Integrating primary and specialist care: Integrated models of service delivery have been proposed as a means to prevent service fragmentation and improve co-ordination of care for service users. These vary from direct collaboration (in the USA this has also involved co-locating FPs in mental health services) and agreed guidelines to ways of improving communication and formal contractual arrangements. A combination of approaches seems to be important. More evidence is needed on collaborative care interventions for SPMI. Engaging FPs in working with SPMI: Evidence from small-scale initiatives that FPs and PC can be engaged in working collaboratively with mental health professionals.

Discussion: There is limited high quality evidence on which to base recommendations in this area. However, some conclusions can be drawn with respect to good practice.

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Conclusions/Policy Recommendations:

- Mental health workers have a key role to play in (re-) engaging people with SPMI into primary care.
- Family Physicians have a key role to play in improving physical health care outcomes.
- Integrated care models such as Collaborative Care hold considerable promise. Further research is needed to explore impact on both physical and mental health outcomes, and service utilization.
- Mental health services should be jointly engaged with local FPs in developing local protocols for working at the interface, agreeing roles and responsibilities.

SPEAKERS & ABSTRACTS



Elliot Goldner, MD, FRC(P), MHSc

Professor, Centre for Applied Research for Mental Health and Addiction (CARMHA), Simon Fraser University, Vancouver, British Columbia

Dr. Goldner is a psychiatrist-researcher who received an Honours BSc at the University of Toronto, an MD at the University of Calgary, and completed his Psychiatry residency training and MHSc in Health Care & Epidemiology at the University of British Columbia (UBC). He founded and directed the Eating Disorders Program at Providence Health Care, directed Outpatient Psychiatry at UBC Hospital and founded and directed two research centres – one at UBC and the other at Simon Fraser University. Dr. Goldner founded and directed the Division of Health Policy and Services in the Department of Psychiatry at UBC. He is currently a Professor in the Centre for Applied Research for Mental Health and Addiction (CARMHA) which he founded at Simon Fraser University, and is also

an Affiliate Professor in the Department of Psychiatry at UBC. He is the author of more than 100 scientific publications and is the lead author of a textbook entitled, 'A Concise Introduction to Mental Health in Canada.' Dr. Goldner has also authored the chapter entitled, 'Knowledge Translation' in the textbook 'Health Research Methods: A Canadian Perspective.' Dr. Goldner has received awards from the Canadian Psychiatric Association for his research, teaching and scholarly work and was awarded the Alex Leighton Award in Psychiatric Epidemiology by the Canadian Academy of Psychiatric Epidemiology. Dr. Goldner was formerly the Chair of the Science Advisory Committee for the Mental Health Commission of Canada and he has worked closely with governments at provincial, regional and national levels to research and implement programs to improve mental health services.

Abstract: What are the most effective forms of knowledge translation to improve quality of care?

Knowledge translation (KT) efforts are needed to achieve uptake and implementation of improvements to mental health services and policies. Without such efforts, many interventions fail to achieve their maximum potential or reach those most in need. This review provides an overview of the current state of knowledge translation literature and focuses on the role of KT in facilitating improvement of mental health services and policies, with an emphasis on those that aim to improve outcomes and quality of life of individuals with severe mental disorders.

Methods: Two search procedures were combined to obtain relevant publications for review. The first was a systematic search conducted using Medline, PsychINFO and CINAHL databases to identify review articles published in journals from 2007 to 2012 on KT considered to be relevant to mental health practice. Articles were selected on the basis of eligibility criteria and the authors then added further articles deemed pertinent to the focus of the review. The second search procedure used the Medline database to identify articles published from 2000 to August 2014 that address KT specific to services or policy for individuals with severe mental disorders and for schizophrenia and other psychotic disorders. Publications obtained using both search procedures were analyzed thematically and conclusions were drawn.

Findings: The first search, after removing duplicates, yielded 214 review articles, which were scanned for relevance and, subsequently, 45 articles were added by the authors, identified through hand searches of reference lists or from other sources. A total of 60 papers were retained for full review. Qualitative synthesis identified five main themes: 1) Defining and development of KT science; 2) Effective KT strategies; 3) Factors influencing the effectiveness of KT; 4) KT frameworks and guides; and 5) Relevance of KT to healthcare providers. The second search yielded 218 articles, of which 62 articles were retained for full review. Most articles addressed KT strategies aimed at quality improvement of clinical care (such as incorporation of family psychoeducation into treatment protocols, or adherence to evidence-based clinical guidelines such as PORT) and applied a wide range of KT approaches including: educational sessions; dissemination of clinical guidelines; provision of decision-making tools; the formation of quality improvement collaboratives, and; efforts to improve cooperation and collaboration amongst treatment providers. Most of the 62 articles addressed KT directed toward clinicians and patients, whereas few aimed at policy makers and service leaders. Although a substantial proportion of the implementation trials produced disappointing results with low levels of uptake or poor maintenance of quality improvements, other studies were able to achieve measureable and sustained improvements.

Discussion: Specific strategies have been identified to be effective for each of the following three groups: 1) Clinicians; 2) General Public, and; 3) Policy-makers. However, there remains a paucity of evidence regarding effective KT relevant to policy-makers.

Conclusions/Policy Recommendations: Despite limitations in existing evidence, the concept and practice of KT holds potential value for mental healthcare providers. Understanding of and familiarity with effective approaches to KT holds the potential to enhance providers' treatment approaches and promote the utilization of new knowledge in practice to enhance outcomes.

SPEAKERS & ABSTRACTS



Heinz Katschnig, MD

Professor Emeritus of Psychiatry, Medical University of Vienna, and CEO, IMEHPS. research, Vienna, Austria

Dr. Heinz Katschnig is Professor emeritus of Psychiatry, Medical University of Vienna/Austria. Chairman of the Department of Psychiatry and Psychotherapy and the Division of Social Psychiatry at the Medical University of Vienna (1991-2007), Director Ludwig Boltzmann Institute for Social Psychiatry (1978-2014), CEO of IMEHPS.research (Research Institute for “Improving Mental Health Pathways”; 2013). Involved over several decades in doing research on and planning deinstitutionalisation and setting up community mental health services in Austria, and responsible for a completed multi-year project of closing a large traditional mental hospital near Vienna and replacing it by small psychiatric departments in general hospitals and a range of community mental

health services. WHO-EURO counterpart for Mental Health for the Austrian Government, member of national and international mental health committees. Work package leader in multinational European Commission Funded projects, among others on mental health information systems (MINDFUL), financing systems and pathways of care related to mental and physical disorders (REFINEMENT), psychiatric rehospitalisation (CEPHOS- LINK), and in the Austrian national project on decision support for health policy and planning (DEXHELPP). Participant in the EU 7FP project on a roadmap for mental health research (ROAMER) and representative of the Austrian government in the ongoing European Commission “Joint Action on Mental Health and Wellbeing” in the work packages on “deinstitutionalisation” and “mental health in all policies”. Author and editor of several books, among them on life events and psychiatric disorders and on quality of life in mental disorders (the latter published in two editions and four languages). Author of more than 400 publications on clinical, social psychiatric and public mental health topics.

Abstract: Financial incentives – the role of provider payment mechanisms in relation to the quality of mental health care.

Background: In modern welfare states health care is fragmented in terms of entitlement to care, its funding and organisation. Different sectors – primary/secondary, outpatient/inpatient, acute/chronic, mental/physical - are not well coordinated. In mental health care, different treatment philosophies, e.g. biological vs psychological, complicate the issue. When it comes to the integration of health with social care the situation becomes even more complicated. Policy objectives of deinstitutionalisation and promotion of community mental health care are often not met because financing mechanisms, including raising and pooling of funds, provider payment mechanisms and user contributions, and related incentives and disincentives, are not well aligned to meet the needs of persons with mental disorders.

Methods: The information presented here is mainly based on the findings of two work-packages (financial incentives and pathways of care) in the EU funded project “Research on Financing Systems Effect on the Quality of Mental Health Care - REFINEMENT”, in which eight European countries with different political, health and social care systems took part (Austria, England, Finland, France, Italy, Norway, Romania, Spain). Three approaches were used: (1) reviewing the literature, (2) collecting specific examples of financial incentives and disincentives in partner countries, and (3) developing assessment tools (based on the principal agent model) for describing and analysing financing mechanisms and pathways of care.

Findings: Incentives in provider payment mechanisms focused on separate sectors of care are detrimental to the policy aim of coordinated and integrated care for persons with mental disorders; they may distort intended care pathways and lead to unnecessary duplication of services. A telling example is the DRG system for hospital care with its incentive to increase the number of admissions, problems with the comorbidity with physical disorders and cost-shifting to social care institutions. Specific tariffs in fee for service systems in the outpatient sector may incentivise cream skimming and lead to the neglect of whole patient groups. In view of these problems payment systems which are independent of care settings are being explored, including designing classifications which go beyond diagnosis, regional budgets for integrating in-, day- and outpatient care, and the use of personal budgets from which people with mental disorders can purchase services.

Discussion: Declared policy aims of improving the care of persons with mental disorders are, apart from other reasons such as stigma and discrimination, often not met because financing mechanisms are not integrated and coordinated. In the present mental health care landscape service centred payment mechanisms with specific incentives lead to distorted care pathways and reduced quality of life. Payment systems need to be developed which are independent of the care setting. No “one model fits all countries” approach to the financing of mental health care is possible. A structured approach to analysing the financing system of a specific country (based e.g. on the presented REFINEMENT toolkit) could be a starting point for improvement.

Conclusions/Policy Recommendations: Developing and implementing payment systems that are independent of care settings should be a priority. A structured analysis of the actual funding system for mental health is recommended as a first step.

SPEAKERS & ABSTRACTS



Sara Lapsley, BA, MA

Peer Researcher with the Collaborative Research Team to Study Psychosocial Issues in Bipolar Disorder (CREST.BD)

Sara Lapsley, B.A., is completing her Masters in Counselling Psychology at the University of British Columbia. She is a full-time counsellor and group clinician at the BC Forensic Psychiatric Hospital and an active member of the Collaborative Research Team to Study Psychosocial issues in Bipolar Disorder (CREST.BD). She has done research and published in the areas of recovery, peer support, self-management strategies, and forensic mental health. Sara was diagnosed with bipolar disorder in 2001, and raises awareness about mental health issues through the media, clinician training initiatives, and community events.

Abstract: Social Impact of SPMI on Individuals and Families

Background: According to the World Health Organization, one in four families includes a member dealing with a mental or behavioural disorder. In recent years, institutionalization has been replaced by community living and short term hospitalizations. As a result, families have had an increasing role in providing care to members affected by severe and persistent mental illness (SPMI). A significant burden on the individual and the family unit has been well documented, which includes both objective and subjective indicators of the impact that SPMI has on the family system.

Methods: A survey of peer reviewed literature on family burden was completed. This was supplemented by a review of grey literature which accessed rich sources of information relevant to affected family members. Additionally, the lived experience of the presenter is integrated to illustrate how SPMI can have a devastating impact on the individual and the family unit.

Findings: The literature documents high levels of burden to families impacted by a relative with SMPI. Significant themes emerged related to the direct financial costs of supporting a family member, and indirect costs of lost productivity to family systems impacted by the upheaval. "Stigma by Association" is well documented, and affected families report complex emotional reactions such as grief, resentment, overload, and concerns for the future, resulting in levels of anxiety, depression, and insomnia that are twice as high as in the general population. However, a number of strategies have been identified that can help family members cope with the burden and increase resiliency in face of significant stressors, with particular evidence for the helpfulness of support groups.

Discussion: The various factors contributing to the burden, such as stigma, financial costs, and the effects of stress on the family, must be directly acknowledged and addressed. We also need to consider the intersection of lifespan development and how a mentally ill family member in various life stages such as adolescence, mid-life, and old age may impact the family. Factors such as co-morbid physical conditions, substance abuse, and suicide need to be considered. The literature demonstrates that distress was lower for families who were themselves receiving mental health services. Alleviating the burden and increasing the resiliency of family systems, through of variety of identified mechanisms, can prevent further emotional and financial costs of supporting a family member with SPMI.

Policy Recommendations: Increase mental health care and services directly for individuals and family members; Peer support groups for individuals and families; Provision of educational resources targeted to address the unique challenges that families face; Provision of financial and practical support to individuals and families as needed; Early intervention; Anti-stigma interventions; Further research that draws on the existing expertise of consumers and family members to identify their specific needs and concerns.

References

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SPEAKERS & ABSTRACTS



Eric Latimer, PhD

Researcher, Douglas Institute and Professor, Department of Psychiatry, McGill University, Quebec

Dr. Latimer is Research Scientist at the Douglas Mental Health University Institute and Professor in the Department of Psychiatry at McGill University. He obtained a PhD in Economics from Carnegie Mellon University in 1989 and, before joining the Douglas Institute and McGill University, was Assistant Professor of Health Economics at the Harvard School of Public Health from 1989 to 1996. His research interests focus on community-based supports for people with severe mental illness, including assertive community treatment and supported employment. He has carried out economic evaluations and reviews of the economic evidence for various interventions for people with mental illness, notably supported employment. He has also conducted research on the use of antipsychotic

medications in Québec using large administrative databases. Recently, he was lead investigator for the Montreal site, and lead economist nationally, of the \$110 million Chez Soi / At Home research and demonstration study on homelessness and mental illness. This study tested the Housing First approach using nine concurrent trials in five Canadian cities. Currently he is principal investigator of a CIHR-funded, \$1.2 million study evaluating the strengths model of case management in seven sites across Ontario, Québec and Newfoundland. He has served as consultant to the Québec government as well as research teams in Europe and North America. He is an associate editor of the Canadian journal, *Healthcare Policy*. He teaches economic evaluation in the Department of Epidemiology, Biostatistics and Occupational Health at McGill University.

Abstract: What are the effects of supported employment for people with severe mental illness?

Background: About two-thirds of people with severe mental illness would like to work. A recovery orientation for mental health services emphasizes helping people with mental illness integrate competitive, as opposed to segregated, work settings. Yet, surveys consistently indicate that fewer than 30% of people with mental illness work at all, and even fewer in competitive settings. Over the past 20 years, the Individual Placement and Support (IPS) model of supported employment has emerged as the most effective approach for helping people with severe mental illness integrate the competitive labor market. Developed on the basis of extensive empirical research, it follows 8 principles: (1) competitive work is the goal; (2) any client who expresses a desire to work is eligible to enroll; (3) employment specialists pay close attention to client preferences; (4) employment specialists are integrated with clinical teams; (5) they engage in systematic job development; (6) they offer benefits counseling; (7) job search begins quickly; (8) individualized follow-up is maintained as long as needed.

Methods: A review of the literature on the IPS model was carried out, building on previous literature reviews and including results published until early 2014. The review aimed to address four questions: (1) what are the effects of the IPS model on job acquisition rates and job tenure, compared to other vocational models as a group? (2) do programs that adhere more closely to the IPS model (as measured by a standardized fidelity scale) obtain better vocational outcomes? (3) what are the effects of IPS on any non-vocational outcomes reported in the literature? (4) what are its effects on costs? Findings: (1) Randomized trials conducted in many countries (including one in Montreal) consistently report that IPS is more effective than the alternatives to which it has been compared in raising employment rates. The number of weeks worked in competitive settings is similar across IPS and other programs, among those who do obtain a job; (2) Programs that follow the IPS model more closely achieve higher job acquisition rates; (3) Experimental studies do not, in general, report better non-vocational outcomes in IPS than control groups. If people who work are compared with those who do not work, however, results suggest that working has favorable effects on symptoms, self-esteem and quality of life; (4) studies to date also suggest, analogously, that mental health service costs decrease significantly for people who enter into work thanks to IPS services.

Discussion: IPS is clearly more effective at improving competitive job outcomes than other models against which it has been compared. Indirect evidence suggests that people who enter into work thanks to an IPS program tend to experience improvements in non-vocational outcomes as well as significantly reduced mental health service costs.

Conclusions/Policy Recommendations: A thoroughgoing recovery orientation towards mental health services should lead to a repurposing of existing vocational services, and if needed the development of additional ones, so that all individuals with severe mental illness who desire to work in competitive settings should have access to programs that closely follow the IPS model.

SPEAKERS & ABSTRACTS



Antonio Lora, MD

Director, Department of Mental Health, Lecco General Hospital, Lecco, Italy

Dr. Antonio Lora was born in 1955 in Milan (Italy). He graduated as a Medical Doctor in 1979 at the University of Milan, and specialized in Psychiatry in 1983 at the same University. He worked as a clinician in community mental health services, and is now the Director of the Department of Mental Health in Lecco (close to Milan), managing a network of community mental health facilities (CHMHCs, psychiatric wards in general hospitals, day-care facilities and community residential facilities) in a catchment area of about 300,000 residents. From 1980 onwards, he managed, at the regional level, the mental health information system in the Lombardy Region, and evaluated the regional mental health services. The regional mental health information system is a regional psychiatric case register covering the whole Region, with a population of about 9,000,000. At the

Ministry of Health level, his participation was as an expert to commissions, developing the national mental health information system (including a framework of indicators for mental health services monitoring) and identifying clinical pathways for severe mental disorders and clinical indicators monitoring these pathways. In 2003, he worked for one year in the Department of Mental Health of the World Health Organization in Geneva developing WHO-AIMS, a set of indicators for evaluating the mental health systems of low and middle income countries. Since 2004, he has been a consultant for WHO, collaborating in projects like Mental Health Atlas, which is aimed at assessing mental health systems and, ultimately, monitoring Mental Action Plan 2013-2020 goals. He is past-President of the Italian Society of Psychiatric Epidemiology, and has published more than 120 papers (of which 45 appeared in peer reviewed journals) on mental health services evaluation.

Abstract: The Use Of An Information System For Improving Quality Of Care In Severe Mental Illness

Background: Routine mental health care quality is far from optimal, varying greatly from region to region and provider to provider. A mental health information system represents the main tool to evaluate patients in contact with services and undergoing treatment, but alone it is not sufficient to evaluate care quality. To achieve this, we need to merge the different health databases, and thus move towards a clinically oriented information system, while at the same time we need to identify clinical indicators. Clinical indicators, derived from administrative data and based on evidence, are useful to document care quality, establish benchmarking, and support accountability and quality improvement.

Methods: In the project (carried out in Lombardy, Italy) there was the identification of 41 clinical indicators for schizophrenia, 33 for bipolar disorders and 14 for depression, by experts through Delphi rounds. Each indicator covers both main quality domains (accessibility, continuity of care, appropriateness, safety) and phases of care (first episode, acute care, maintenance and promotion of recovery). These indicators were applied to the Lombardy Region's health databases containing data on mental health activities, hospital admissions, health treatments and pharmaceutical prescriptions. Results from 28,191 patients with schizophrenic disorder (ICD 10 F2 category), cared for during 2009 by the Departments of Mental Health of the Region, are analyzed.

Findings: Community care delivered to patients, such as that involving family members, was more intensive for onset cases than for prevalent ones; in terms of continuity, about six patients out of ten were in continuous care. It is common practice for patients to receive multi-professional interventions, but psychotherapeutic and psycho-educative activities are not widespread, and were delivered preferentially at onset rather than during the maintenance phase. Support for independent living and employment was not frequent, but one sixth of the patients became involved in CHMC social and leisure activities. Following hospitalization, more than half the discharged patients attended psychiatric follow-up at a CMHC by two weeks from discharge, but in the following six months only a quarter of the patients received at least one psychiatric visit per month. Anti-psychotic treatment adherence was much poorer for new cases than for prevalent ones, such as metabolic side-effect monitoring. After the interruption of antipsychotic treatment, half the patients received a follow-up visit to assess clinical status and; only one sixth of patients showing inadequate response to antipsychotic treatment received clozapine. With regard to hospital care, only one patient in ten was compulsorily admitted or restrained; only one admission in ten lasted more than 30 days; two out of ten were readmitted within 28 days of discharge; at the time of discharge the patients were usually given just the one anti-psychotic drug of adequate dosage. Mortality during the period was significant (SMR=2.01).

Discussion: Clinical indicators showed strengths and weaknesses in the Lombardy mental health system. The project's main limitation concerns the sole inclusion of indicators drawn from current information system data.

Conclusions/Policy Recommendations: Clinical indicators generated by merging health databases are a useful tool to routinely evaluate important aspects of the quality of care for patients suffering severe mental illness, placing no burden on mental health professionals.

SPEAKERS & ABSTRACTS



Steve Lurie, BA, MSW, MM

Executive Director, Canadian Mental Health Association Toronto Branch, Ontario

Steve Lurie is currently the Executive Director of the Canadian Mental Health Association Toronto Branch, a post he has held since 1979. Steve has written and lectured extensively on mental health policy issues. He was a principal author of the Graham Report, Building Community Support for People, and conducted the 1992 snapshot of community mental health programs for the Ontario Ministry of Health and the Minimum Data Set Pilot Project (1998), which established a common data set for the reporting of client characteristics and outcomes in community and hospital based mental health services. He served as guest editor of the Canadian Journal of Community Mental Health special issue, Innovation in Community Mental Health: International Perspectives. Since 2004, Steve has had a collaborative relationship with SCARE, a community mental health

and research organization in Chennai, India. In 2007, Steve provided technical assistance to the development of a national mental health plan in Kyrgyzstan, through a project funded by the Soros Foundation. As well Steve and CMHA Toronto have hosted organizations from China, India, US, New Zealand, Australia, the UK and Japan. In 2008, Steve lectured in Japan about community mental health systems, hosted by the Matsubara Psychiatric Hospital. In 2005, he provided technical assistance to the Senate Committee Report Out of the Shadows At Last: Transforming Mental Health and Addiction Services in Canada.

In August 2007, he was appointed to chair the Service Systems Advisory Committee for the newly established Mental Health Commission of Canada. He was recently awarded the Canadian Mental Health Association's CM Hincks award for national leadership in mental health. Steve has a Masters in Management (MM) from the McGill McConnell Voluntary Sector Leadership program (2002) and has a BA (1971) and MSW (1973) from the University of Toronto Faculty of Social Work where he is now an adjunct professor.

Abstract: The Role of the Federal Government in Mental Health

While provinces have a constitutional responsibility for health care, the federal government has cost shared with provinces and territories since Medicare was established. Prior to Medicare, in the 1940's, the federal government provided Dominion mental health grants to the provinces, to help them establish general hospital based services. While the federal government transferred \$41 billion to the provinces between 2004 and 2014 to improve health systems through the Canada Health and Social Transfer, no specific funding was earmarked for mental health. The provinces spent the bulk of their health transfer funding on other areas of health care even though mental illness comprises 13% of disease burden. With the expiry of the CHT, the federal share of health spending will decline from 19% to 11% over the next 10 years. The federal government will have fiscal room to contribute more, while provinces will be constrained according to the Parliamentary Budget Office. The Federal government has funded the Partnership Against Cancer, the Mental Health Commission, and At Home/Chez Soi. Therefore a case can be made for continued funding of mental health services, and the establishment of a Mental Health System Transition Fund to help provinces and territories shift to more community based systems. In addition the federal government has responsibilities to improve services for people in areas of federal jurisdiction: armed forces, RCMP, correctional services, First Nations and Inuit, refugees and immigrants, as well as using the social transfer and Social development funding to improve housing and employment prospects for people living with mental illness.

SPEAKERS & ABSTRACTS



Orrin Lyseng

*Executive Director, Alberta Alliance for Mental Illness and Mental Health (AAMIMH),
Edmonton, AB*

Orrin trained and graduated as a Registered Psychiatric Nurse in 1970 and as a Registered Nurse in 1974. He received his Bachelor of Arts (Special) at the UofA majoring in sociology and psychology (1979). He was employed by the Alberta Government for over 35 years, working as a staff nurse at a Provincial Psychiatric Hospital for 10 years, then as a community mental health nurse for 15 years as a clinician and supervisor of mental health clinics in the suburban communities around Edmonton and finally as a project leader in the corporate offices of Alberta Health for 11 years. He has held various positions such as Acting Manager of Health Promotion and Coordinator of Critical Incident Stress Debriefings for the Edmonton Region, and at the corporate level he worked in a number of capacities such as: Coordinator for mental health initiatives, specifically mental health promotion and Project Leader in Community Development with a focus on building community capacity around mental health and mental health promotion. As Project Leader in Community Development, he lead and facilitated the design and production of a number of published materials drawing attention to mental health concerns within the community. These included: a suicide awareness audiotape (Deanna Don't Do It) - produced to bring awareness to teenage suicide within Aboriginal communities, and several handbooks on depression, bipolar disorder, Alzheimer disease and schizophrenia. These documents were produced to help community members, including caregivers, understand the nature of each mental health concern. He also served as a team member in the production of a videotape (Reach out with Hope) aimed to help individuals identify common signs and symptoms of depression and thoughts of suicide in order to assist those around them. Upon retiring from government in 2000, he became Executive Director for the Schizophrenia Society of Alberta (2000-2005), and during this time, was on the Steering Committee for the first edition of the handbook, Rays of Hope: Learning about Schizophrenia, produced by the Schizophrenia Society of Canada. This resource is now in its 4th Edition. He also was a consultant to the Alberta Mental Health Board in 2007 and 2008 with the role of assessing the extent of collaboration and cooperation between the Regional Health Authorities and the newly formed Primary Health Care Networks to deliver comprehensive mental health services. In 2006 and 2007, he held concurrent Interim Executive Director positions with the Canadian Mental Health Association - Alberta Division and the Society of Alberta Occupational Therapists. He also worked as a Community Mental Health Nurse within the Home Support Team for the Edmonton Mental Health Region of Alberta Health Services from 2006-2009. Since 2008, he has been the Executive Director for the Alberta Alliance on Mental Illness and Mental Health (the Alliance) - a consortium of 14 professional and non-profit organizations that have come together to speak on issues of common concern around addiction, mental illness and mental health. In partnership with the Alberta Disability Forum (a collective of 42 disability organizations), and on behalf of the Alliance, he was co-lead of the recently created document: Valuing and Supporting Alberta's Non-Profit Disability Organizations: Challenges and Solutions. Through his volunteer work he was a founding member and President of the St Albert Stop Abuse in Families Society (1983-1986), which still continues to serve the community.

Abstract: What role do non-government organizations play in effective support systems?

Backgrounds: Non-profit organizations or non-government organizations (NGO) provide a wide range of services and play a valuable and unique role in supporting and maintaining persons with severe and persistent mental illness (SPMI) in the community.

Methods: This view is drawn from ongoing observations and comments by persons living with mental illness and their loved ones, by NGO's and mental health clinicians. It is also demonstrated through ongoing funding by government.

Findings and Discussion: NGOs provide a rich array of services. They work in the areas of supportive housing, supportive work placement and, recreation. They assist, support and encourage their clients to access psychiatric services when they are needed. They offer peer support – which is so critical in helping the person with SPMI to feel understood and not feel alone. They run telephone crisis lines which are frequently used by persons with SPMI because the service is viewed as non-judgemental and is readily accessible. NGOs are a source of support for families who find themselves tired and often frustrated in their efforts to ensure their loved one has access to and continues to use the mental health system. They are uniquely placed to advocate on behalf of the person with SPMI and their families for increased mental health services. In so doing NGOs provide an opportunity for the families and their loved ones to become meaningfully involved in advocacy and education programs that can inform key decision makers and the public about mental illness and its impact.

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Conclusions/Policy Recommendations: Government and large government-funded organizations need to engage the NGOs in discussions and strategic planning for mental health service delivery to persons with SPMI, to reduce any chance of needless duplication and take best advantage of the range of services these organizations provide. Government and other funders need to work with NGOs on stabilizing multi-year funding to better enable the NGOs to do long range planning around their service delivery. NGOs need to have closer communication with other like-minded NGOs to share resources, planning and skill sets to enable more efficient use of their resources. In order to take on a larger role in partnership with government in the planning and supporting of the person with SPMI in the community, NGOs need to consider building their respective organizational capacity through training and skill development.

SPEAKERS & ABSTRACTS



Austin Mardon, PhD, CM, LLD(Hon.)

Assistant Adjunct Professor, John Dossetor Health Ethics Centre, University of Alberta, Edmonton, AB

From an early age Austin Mardon dealt with schizophrenia. His mother became ill with schizophrenia when Austin was just 5 years old. Eventually he also developed the disease, but not before he was able to finish a Bachelor's degree and two Master's degrees. Along the way, he was a member of a NASA Antarctic Meteorite Recovery team and helped discover over 700 meteorites, including some lunar samples. After returning from the South Pole with frozen lungs and nerve damage in his feet from frostbite, Austin hadn't yet completed his PhD program when he descended into the horror of his first psychotic break. Overnight his world changed. His plans for the future took a permanent detour. As he crossed the threshold onto the ward in the psychiatry department, he thought his life was over. Once he was stabilized on his medication, he knew that to stay sane, he had to stay on his medicine, and find something to make his life worth living. Thus began many years of volunteer activity. His commitment to serving others afflicted with this devastating disease continues to this day. He also continued his academic pursuits, and ultimately authored over 50 books, and over 250 peer reviewed abstracts and articles. He has given hundreds of speeches to students, professionals and the general public on living with a mental illness. He has served on a variety of public, private and governmental committees. He has served with The Alberta Disabilities Forum, the Premier's Council on the Status of Persons with Disabilities, and the Provincial Advisory Committee on Mental Health and Addictions. He is an adjunct professor at the University of Alberta's John Dossetor Health Ethics Centre. For his tireless advocacy, he was invested into the Order of Canada in October 2007. He continues to write and advocate for the mentally ill. He believes that his success is due to his optimism, perseverance, the support of his wife and a zealous adherence to taking his medication over the last two decades. He currently lives in Edmonton with his wife, son, and spoiled basset hound.

Abstract

I am afraid to watch the news. It's always something. A man who brings a knife to work and tries to kill his co-workers, a normal college kid who out of the blue kills a bunch of people at a party, or a taxi driver shooting up a lumber mill. Normal people, when they see such things on the TV or in the newspaper will feel bad for the friends and family of those involved. They will feel sad, and perhaps say a prayer. When I see these kinds of things, my first thought is, "please don't let it be someone with schizophrenia." Many times a serious mental illness is involved. Healthy people don't do such bizarre things. I feel as if I have been fighting the stigma of schizophrenia since I was old enough to remember. My mother was diagnosed with schizophrenia when I was 5 years old. I was subjected to scorn and alienation. There was the constant fear of being placed in foster care, or of my parents divorcing, of my father dying from his heart condition because of the stress. The stigma I have lived my whole life with, made me believe when I was first hospitalized with schizophrenia, that my life was over. When I first met my wife, I was afraid to tell her. When I finally did, she said, "That's interesting, so what." I thought maybe she didn't understand what schizophrenia meant. What I didn't know is that she had a long history of working with the mentally ill homeless. She has this natural ability to separate a person from their disease. When I have breakthrough symptoms and think that the TV is talking to me, she very calmly tells me that maybe it is time to turn the TV off. When I first started introducing her to my friends and family, almost everyone asked if she had schizophrenia. She got used to parroting, "no I don't have schizophrenia." The funniest thing is that those who didn't ask, just assumed, and months later were shocked to find out that she didn't have it. If I was deaf or blind, no one would ask my wife if she was likewise afflicted. For those of us with schizophrenia, people just assume that we are so damaged that a normal person wouldn't want to marry us. I even believed that for a long time. It's not easy to be this public. Everywhere I go, people know I have a serious mental illness. It would be so much easier to just blend in or hide. Fear seems to be the largest component of the stigma we face. During almost every speech I give at a school, someone asks if schizophrenia makes you violent. We know that those with schizophrenia are more likely to injure themselves than others, but when one of us becomes violent, it is usually in a dramatic fashion. So how do we fight it? By education, education and more education. As medications and treatments improve, we have to find a way to allow ourselves to reintegrate. It's almost as if we are going to have to learn how to forgive ourselves for being ill. My wife says that all she expects from me is to live as healthy and happy a life as I am capable of. Now, I just have to give myself permission to be content with that.

SPEAKERS & ABSTRACTS



Dr. Oliver Mason, DPhil, DClinPsy.

Senior Lecturer in Clinical Education and Health Psychology, University College London

Oliver Mason is a senior lecturer in clinical psychology at University College London where he has been a faculty member since 2004. He is also Deputy Director of Research and Development for North East London NHS Foundation Trust where he also works as a consultant clinical psychologist. His clinical interests and experience have spanned adult mental health, neuropsychology and community-based crisis resolution. He has been a chief external examiner at several doctoral clinical psychology courses in the UK. Oliver completed his D. Phil. in 1996 at The University of Oxford investigating schizophrenia and schizotypy, and subsequently trained clinically at The University of Wales. His research interests include vulnerability factors for psychosis, as well as its treatment and recovery. He is an author of over 70 chapters and articles across areas of clinical and personality

psychology. He has contributed to a wide range of grant funded studies in the UK National Health Service as a collaborator or local investigator. In this context he will present aspects of the CORE Research Program led by Prof. Sonia Johnson, also at UCL. CORE stands for Crisis resolution team Optimisation and RElapse prevention and is funded by the National Institute for Health Research (UK).

Abstract

Background: The United Kingdom has seen almost universal de-institutionalization from long-stay asylums: However, acute inpatient care is in a state of crisis. I describe the current situation with regards to alternatives to admission in the UK aiming to draw out broader lessons for other contexts.

Methods: Evidence is presented from a range of reviews and empirical studies in respect of both ‘crisis resolution teams’ and ‘crisis houses’ in the UK setting. In particular, I draw on evidence from the CORE Study; a national programme aimed at improving Crisis Resolution Team implementation.

Findings/Discussion: The implementation of CRTs is very variable. When well-resourced and led, CRTs contribute to reduced bed usage, cost savings and improved patient satisfaction. I describe how evidence gathering has led us to a model of best practice and a measure of fidelity against which teams can be judged. The CORE study based at University College London is currently developing a range of implementation resources designed to improve fidelity to this model, and testing these via a randomized controlled trial.

Conclusions/Policy Recommendations: CRTs are a cost-effective alternative to admission that requires well-resourced implementation to achieve their aims. In particular, they require multi-disciplinary professional staff and good working relationships with both inpatient and community teams. When well implemented, CRTs can lead to positive patient satisfaction and staff well-being. Use of fidelity measures and implementation resources are recommended for the cost-effective and successful implementation of CRTs.

SPEAKERS & ABSTRACTS



David McDaid, BSc, MSc, MSc

Senior Research fellow, Health Policy and Health Economics, London School of Economics and Political Science, London, UK

David McDaid is Senior Research Fellow in Health Policy and Health Economics at LSE Health and Social Care and the European Observatory on Health Systems and Policies at the London School of Economics and Political Science. He is involved in a wide range of work on mental health and public health in the UK, Europe and at the global level. He is also co-ordinator of the Mental Health Economics European Network, a member of NICE's Public Health Interventions Advisory Committee, Co-Convenor of the Cochrane Campbell Economic Methods Group and has acted as an advisor to a range of international organisations. He has published over 200 peer reviewed papers and reports, including a report for the UK Department of Health which looked at the economic

case for investing in mental health promotion and mental disorder prevention. He is the editor of two new books – the first on economics and wellbeing and the second, a collaboration between the European Observatory on Health Systems and Policies and the OECD, looks at the economic case for investing in health promotion and disease prevention. He is also a past winner of the European Health Management Association's Baxter Award in 2007 for the best book on health policy – Mental Health Policy and Practice across Europe.

Abstract: A road map for mental health research

This presentation considers how a road map for mental health research can be used to advance future priorities, drawing on recent experience in the development of a road map for mental health research in the European Union. Vital to developing an innovative road map is to provide mechanisms that actively allow for input from a very broad range of stakeholders, ranging from service users through to policy makers and pioneers and innovators from many different industries. Space and time are also needed to future scan and consider how both pure and applied research for mental health may develop over the next 10 to 20 years. The European Roadmap for Mental Health (ROAMER), which is due to complete its work in March 2015, has had a 3 year window in which to make its deliberations. It has used this space to set up a number of different working groups that have not only looked at novel research but also at ways of strengthening research capacity and infrastructure. It has gone beyond consideration of biomedical and psychological research to also look at social and economic research, public health actions and the rapidly developing field of wellbeing research.

This presentation does not seek to go into detail on all of the research priorities that have been agreed upon, but instead highlights several important transversal health economic research challenges that perhaps will not have featured prominently in discussions at this Consensus Development Conference. One key issue is to understand the impacts that different and complex ways of organising and financing mental health services may have on the quality of care and outcomes achieved. This requires a combination of quantitative and qualitative approaches. This has become more feasible with ever growing access to data from longitudinal datasets and improved ways of data linkage within and across health and social welfare systems. Economic incentives can be powerful levers for change, as can for instance be seen in the way Canada has come to the forefront of actions to improve mental health in workplaces, as well as in the way that scholars such as James Heckman and Richard Layard have been able to build the case for early years interventions to improve mental health. A second key issue is to further embed economic analysis prospectively into future research plans rather than being seen too often as an afterthought. One vital area for economic analysis that still receives comparatively little attention, despite its profound impact on people with severe and persistent mental illness, is to better understand the costs of avoidable mental and physical comorbidities. Wellbeing research is currently in vogue, but it remains both complicated and confused with insufficient clarity even on definitions of wellbeing. Nonetheless, another important future research priority might be to consider whether investment in actions to promote better levels of mental wellbeing can in fact also reduce the risk of future mental and physical health problems. Finally achieving all of this requires investment in capacity and infrastructure.

SPEAKERS & ABSTRACTS



Scott Patten, MD, FRCPC, PhD

Professor, University of Calgary, AB

Dr. Scott Patten is a Psychiatrist and Professor at the University of Calgary and a Senior Health Scholar with Alberta Innovates – Health Solutions (formerly the Alberta Heritage Foundation for Medical Research). His research focuses on mood disorder epidemiology both in the general population and in populations with medical comorbidities. This program of research has utilized national survey data, national longitudinal panel data, administrative data, simulation methods as well as prospective and longitudinal studies in Alberta populations. This program of research has produced more than 350 peer reviewed publications. He is the Editor-in-Chief of the Canadian Journal of Psychiatry and was the co-chair of the Scientific Advisory Committee for Canada's National Population Study of Neurological Conditions. Dr. Patten practices psychiatry through the

Peter Lougheed Centre in Calgary and acts as a consultant to the University of Calgary MS Clinic. He teaches epidemiology and supervises MSc and PhD students through the Department of Community Health Sciences at the University of Calgary.

Abstract

Background: Estimating the prevalence of severe and persistent mental illness (SPMI) is a complex task because the concept of SPMI includes several dimensions: severity of symptoms, the severity of impairment, and persistence. The term “SPMI” is sometimes applied to specific diagnoses, usually Schizophrenia and Bipolar Disorder. This suggests that the prevalence of SPMI may be estimated as the combined prevalence of Schizophrenia and Bipolar Disorder. However, this simple approach is problematic because while these illnesses are often severe and persistent, they are not always so. Furthermore, other diagnoses can manifest with severe and persistent symptoms and impairment. An alternative approach is to focus on symptom severity and persistence without restriction to specific diagnoses.

Methods: Three strategies for quantifying the prevalence of SPMI will be described in this presentation. First, available data concerning the prevalence of Schizophrenia and Bipolar disorder will be used to produce a diagnosis-specific prevalence estimate. Second, prevalence data from a major study using methods not dependent on diagnosis will be reported. Finally, the prevalence will be estimated using a hybrid approach that combines information about specific diagnosis and associated severity. Relevant data for the third strategy derives from the 2010 Global Burden of Disease update. Results: According to recent systematic reviews, the point prevalence of Schizophrenia and closely related disorders is approximately 0.7% and that for Bipolar Disorder (I and II combined) is approximately 0.8%. Combining these estimates (strategy 1) leads to an overall SPMI prevalence of approximately 1.5%. A diagnosis-independent definition of “serious” mental illness has been proposed by SAMHS and evaluated in the 2012 US National Survey on Drug Use and Health (NSDUH), providing an implementation of the second strategy. The prevalence of serious mental illness was 4.1% in this survey, representing approximately 20% of those found to have any mental disorder in the survey sample. Application of the third strategy indicates that whereas Schizophrenia and Bipolar Disorders have a low prevalence relative to some other conditions (e.g. Major Depressive Disorder), they are characterized by a larger proportion with severe manifestations of their illness. Conversely, even though Major Depressive Disorder is not typically a severe and persistent disorder, a minority of those afflicted experience a severe and persistent course. Furthermore, due to its high prevalence, the absolute numbers severely afflicted are not trivial.

Discussion: Overall, the third strategy appears to provide the most balanced perspective on the prevalence of SPMI. It is reasonable to regard some illnesses as SPMI because they characteristically produce severe and/or persistent or highly recurrent symptoms, requiring continuous long-term management. On the other hand, a substantial proportion of SPMI in the population is due to unusually severe manifestations of more common disorders.

Conclusions/Policy Recommendations: Overall, a reasonable estimate is that 2-3% of the general population have SPMI at any point in time. Roughly speaking, about one half of the burden of SPMI is due to Schizophrenia or Bipolar Disorder with the remaining half due to various other disorders

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Luis Salvador-Carulla, MD, PhD

Professor of Disability and Mental Health, The University of Sydney, Australia

Dr. Luis Salvador-Carulla is professor of Disability and Mental Health at the Faculty of Health Sciences (University of Sydney, Australia). His field of interest is support decision systems and policy in long-term care, disability and mental health, with a particular focus in the development of integrated atlases of healthcare. He is an honorary member of the World Psychiatry Association and Secretary of the WPA section “Classification, Diagnostic assessment and Nomenclature”. Dr. Salvador-Carulla has intensively participated in the development of international networks in the fields mentioned above, person centred medicine, healthy ageing, and bridging and knowledge transfer between disability, ageing and health. He has been advisor to the Government of Catalonia (Spain), the Spanish Ministry of Health, the European Commission (EC) and the World Health

Organisation (WHO). He coordinated the European Commission (EC) project eDESDE-LTC for the development of an European classification of services for long term care (including persons with disability and ageing population) and he participated as national coordinator in the EC project Refinement to develop a toolkit for the assessment of financing of mental health systems in Europe. He also chaired the WHO working group on the classification of intellectual disabilities at chapter V of the International Classification of Diseases. He received the Leon Eisenberg Award of the Harvard Medical School in 2012 for his contributions in the field of developmental disorders.

Abstract: Basic support decision tools for mental health system improvement: The Integrated Atlases of Mental Health Care

During the last decade Health Atlases have gained increasing attention as support decision tools for guiding health policy, particularly in the context of the evidence-informed model, as they provide a more significant role to context/local information than the traditional evidence-based care approach. However, little is known on the actual impact of Atlases in local resource allocation and implementation. Three major approaches could be identified: 1) population-based top-down atlases using general health care indicators, 2) population-based atlases which incorporate Geographical Information Systems and eventually geocoding of services identified by their names at local level, and 3) Integrated Atlases that may combine multiple health information sources (population, system indicators, traditional listing of services), standard classification of services to allow for territorial comparisons, and different visualization techniques including dynamic spatial analysis. We discuss the policy and practice implications of different service mapping approaches in mental health policy: a) the WHO Atlas series, b) the REMAST atlases in 8 European regions within the Refinement project; and c) the regional Integrated Atlases of Mental Health Care in Spain. We used a standard implementation impact scale to explore the policy impact of several mapping projects of MH Care in Spain carried out by the same service research group. Service mapping was performed in nine regions in Spain, with an additional integrated care approach including health and social care, employment, education, crime and justice and child and adolescent services in 4 regions: Basque Country, Cantabria, Cataluña and Madrid. A high disparity in the impact on policy and practice was observed in these projects mainly related to the extent of cooperation with the regional and national MH planning agencies, the transparency within the organizations and the level of collaboration of the different departments in the regional public care system. Integrated atlases of mental healthcare are key tools for supporting and guiding evidence-informed policy and for understanding the context of care. The design and collaboration with local and regional agencies has a significant impact in the implementation of these visualisation techniques in health policy.

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SPEAKERS & ABSTRACTS



Howard Sapers

Correctional Investigator of Canada, Office of the Correctional Investigator, Ottawa, Ontario

On February 17, 2012, Mr. Howard Sapers was reappointed Correctional Investigator of Canada for a third consecutive term, having first been appointed on February 24th, 2004. A graduate of Simon Fraser University, Mr. Sapers has an extensive background in criminology and corrections gained through a combination of education, employment, community and public service. Prior to his appointment as Correctional Investigator, Mr. Sapers held a variety of criminal justice positions, including: Vice-Chairperson for the Prairie Region, Parole Board Canada; Director of the Crime Prevention Investment Fund at the National Crime Prevention Centre; and Executive Director of the John Howard Society of Alberta. Between 1993 and 2001, Mr. Sapers served two terms as an elected member of the Alberta Legislative Assembly representing Edmonton – Glenora. He

held various Critic portfolios including: Health, Education, Science and Finance. During his second term, Mr. Sapers served as House Leader and Leader of the Official Opposition. An active community volunteer, Mr. Sapers has held a number of positions, including: President of the Canadian Criminal Justice Association; President of the Alberta Criminal Justice Association; and Vice-Chair of the City of Edmonton Safer Cities Advisory Committee. He currently serves as a Chairman of the DND/Canadian Forces Ombudsman Advisory Committee, North American Region Member of the International Ombudsman Institute Board of Directors, and a Member of the Board of the Directors of the Forum of Canadian Ombudsman. Mr. Sapers has received national recognition for his work and service. This recognition includes: the Canada 125 Medal; the Weiler Award for Social Development; the Queen Elizabeth II Golden Jubilee Medal; and the Queen Elizabeth II Diamond Jubilee Medal. In 2010, Mr. Sapers was recognized as a Champion of Mental Health by the Canadian Alliance on Mental Illness and Mental Health and he has received the President's Commendation from the Canadian Psychiatric Association. The Office of the Correctional Investigator serves as an Ombudsman for federally sentenced offenders. As Correctional Investigator, Mr. Sapers continues to pursue priority concerns and challenges in federal corrections such as mental health and corrections, preventing deaths in custody, and the special needs of Aboriginal offenders, aging offenders and federally sentenced women. A much sought after public speaker and media commentator, Mr. Sapers has delivered keynote addresses, guest lectures and chaired academic panels at several prominent conferences and events across Canada and internationally. He has taught courses in Criminology, Correctional Law and Communications in the Correctional Services Program at Grant MacEwan University in Edmonton. Mr. Sapers is an Adjunct Professor in the School of Criminology at Simon Fraser University, and has authored publications including journal articles and textbook chapters on ombudsmanship, human rights and corrections.

Abstract: Implications of mental illness for corrections

Background: An increasing number of federally sentenced offenders present with significant mental health problems at admission and throughout their sentence. The Office of the Correctional Investigator (OCI) has raised numerous concerns with the treatment and management of mentally disordered offenders, including those with severe and persistent mental illness (SPMI).

Methods: As a corporate priority, the Office has published a number of stand-alone reports and investigations looking at access to mental health care in federal penitentiaries, the most recent being *Risky Business: An Investigation of the Treatment and Management of Chronic Self-Injury Among Federally Sentenced Women*.

Findings: In the period between 1997 and 2008, the proportion of offenders with mental health needs identified at intake doubled. At admission, 60% of male offenders and 65% of female offenders require further assessment to determine if they have mental health needs. Currently, 63% of federally sentenced women are prescribed some type of psychotropic medication. The incidence of prison self-injury has more than tripled in the last ten years. An increasing number of use of force interventions involve a situation where a mental health concern has been identified. The five Regional Treatment Centres (psychiatric hospitals) admit only the most acute cases of mental disorder; the regular male institutions lack intermediate health care capacity.

Discussion: Prisons are not hospitals and lack both the therapeutic environment and resources required to address the needs of acutely disordered offenders. The treatment centres struggle with their dual mandate (i.e. prison and hospital, patient and inmate). Some of the treatment facilities are inadequate from a physical infrastructure standpoint. Recruitment and retention of mental health professionals in corrections is a persistent concern. The use of segregation to manage mentally ill individuals is particularly problematic.

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Conclusions/Policy Recommendations:

1. Long-term segregation of acutely mentally ill, self-injurious and suicidal offenders should be abolished.
2. Patient advocates or quality care coordinators should be appointed at each of the five Regional Treatment Centres.
3. The most severely mentally ill male and female inmates should be placed in external treatment facilities.
4. Self-injurious behaviour should be treated and managed as a mental health, not security or behavioral issue.
5. Provide for 24/7 health care coverage at all maximum, medium and multi-level institutions.
6. Increase efforts to recruit and retain more mental health professionals.

SPEAKERS & ABSTRACTS



Jitender Sareen, MD, FRCPC

Professor of Psychiatry, Professor of Psychology and Community Health Sciences; Director of Research and Anxiety Services, University of Manitoba

Dr. Jitender Sareen is a Professor of Psychiatry in the Departments of Psychiatry, Psychology and Community Health Sciences at the University of Manitoba. He currently serves as the Director of Research, and Assistant Head for the Department of Psychiatry. Dr. Sareen is the consulting psychiatrist to the Veterans Affairs Operational Stress Injuries Clinic, and the Winnipeg Jets Hockey Club. Dr. Sareen has published over 225 publications in the field of anxiety disorders, posttraumatic stress disorder, epidemiology, service use, suicide prevention, homelessness, military mental health, and First Nations health. Dr. Sareen has won several National awards for teaching, clinical work and research.

Abstract

Background: The impact of mental illness on society is enormous. Yet, the amount of funding for research in mental health is relatively small compared to other physical illnesses such as cancer, infectious diseases and heart disease. Almost any area of mental disorders and addictions could be studied. Before I state my suggested priorities, I will disclose my bias. I have been doing suicide prevention and traumatic stress research for over ten years.

Key priorities for research:

1. Measurement-based and Evidence-informed care. Many Canadians don't get minimally adequate care for common mental disorders. Most clinicians do not measure outcomes and do not practice within Clinical Practice guidelines. Implementing and evaluating Measurement based and Evidence informed care across our specialty will reduce wasteful resources.
2. Improving access to psychological treatments, and reducing access to inappropriate polypharmacy will save millions of dollars. Psychological treatments are often more powerful than medications, but the access to meds is much easier than psychological treatments.
3. Mental Health Disability Assessment and Treatment Centers. Interprofessional teams that facilitate the recovery from mental illness and help the patient return to work quickly will reduce the disability associated with mental illness.
4. Suicide prevention research that targets the most vulnerable groups (people with co-occurring conditions, previous self harm behavior, transitions between Emergency and hospitalization and outpatient services) will reduce costly admissions, emergency visits and injuries.
5. Biological studies that facilitate the understanding and guidance of rational pharmacotherapy for common mental disorders, such that people are not on polypharmacy inappropriately.

These five approaches, in my opinion, will improve outcomes and reduce the cost of mental illness on our society.

SPEAKERS & ABSTRACTS



Richard Schneider, BSc, MA, PhD, LLB, LLM, CPsych

Adjunct Professor, University of Toronto, Ontario

Dr. Richard Schneider is a Justice of the Ontario Court of Justice (appointed 2000) and Chair of the Ontario Review Board. He was previously a criminal defence lawyer and certified clinical psychologist. Counsel to the Ontario Review Board from 1994 to 2000. Certified by the Law Society of Upper Canada as a specialist in Criminal Litigation. Private practice was generally limited to the representation of mentally disordered accused. Also, Adjunct Professor, Department of Psychiatry, Faculty of Medicine and Faculty of Law, University of Toronto. Named Honorary President of the Canadian Psychological Association in 2002. Also, presently Alternate Chairman of the Nunavut Review Board. A great deal of his time has been spent presiding at the Mental Health Court in Toronto [www.mentalhealthcourt.ca]. Major research interests are competency and criminal

responsibility. Has published extensively in the area of mental disorder and the law. Recent books include: *Mental Disorder and the Law: A primer for legal and mental health professionals* (2006, with H. Bloom); *Mental Health Courts: Decriminalizing the Mentally Ill* (2007, with H. Bloom and M. Heerema); *Annotated Mental Health Statutes* (2007); *The Lunatic and the Lords* (2009); *Law and Mental Disorder: A Comprehensive and Practical Approach* (2013, with H. Bloom) [all published by Irwin Law / www.irwinlaw.com].

Abstract: Mental Health Courts and Alternative Sentencing

Mental Health Courts and 'regular' sentencing courts subscribing to the principals of therapeutic jurisprudence seek to decriminalize the mentally ill. Too often individuals find themselves before the criminal courts as a result of behaviour caused by untreated mental disorder. The focus of these courts is upon getting at and treating the root cause of the criminal behaviour rather than upon punishment. A summary of the procedures employed by these courts and the results obtained from many jurisdictions will be reviewed. It is recommended that the approach described be employed throughout the criminal justice system. At the same time, the long term answer to the problems confronting the criminal courts will no doubt be found with reinvestment in main stream mental health care.

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Gerrit van der Leer

Director, Mental Health and Addictions, Ministry of Health Services, British Columbia

Gerrit van der Leer is the Director of Mental Health and Substance Use services with the Ministry of Health in British Columbia (BC) responsible for policy development, legislation and strategic initiatives, supporting a broad continuum of mental health and substance use services. He holds a Master's degree in Social Work and a Bachelor in Commerce - educated both in Canada and in the Netherlands. Over the past 35 years, he has worked at the senior management and policy development level both in Alberta and British Columbia with an emphasis on policies and services for people with severe and persistent forms of mental illness. Gerrit has been instrumental in the establishment of the Assertive Community Treatment (ACT) program across BC. He has supported the development and implementation of the standards and guidelines for ACT services, including an

ACT evaluation framework and Advanced Practice. (Presently there are 15 ACT teams in BC with additional teams being planned in 2014/15). As part of his role with the Ministry of Health, Gerrit has also supported the development of a number of major provincial mental health initiatives:

- Planning guidelines for Mental Health and Substance Use Services for people with developmental disability and mental illness;
- Family physician treatment guidelines and patient self-management tools for depression, anxiety disorders, early psychosis, eating disorders and substance use disorders;
- Provincial Action plan for people with eating disorders, including the development of clinical practice guidelines, regional action plans and development of enhanced services.
- Standards and guidelines for secure rooms and seclusion practices for mental health units designated under the BC Mental Health Act
- Implementation of the recently announced \$20 million provincial Action Plan that addresses the needs of a specific subset of patients with the most complex forms of Severe Addiction and/or Mental Illness. These patients are more likely to be homeless, have more frequent interactions with police and present a greater risk to themselves and others.

Presently, he is working on provincial guidelines to support the interface between police and local mental health and substance use services in dealing with mental health crisis, including information sharing protocols; a Service Framework for people in contact with the Correctional System in BC supporting continuity of care between community and correctional services; and a Framework for psychosocial rehabilitation with a strong focus on recovery.

In his private life he was a captain of a Voluntary Fire department for over 10 years in Alberta, owns with his wife Leslie an IceCream store in Victoria "IceCream Mountain" and enjoys fly-fishing and travelling.

Abstract: What is the effectiveness of current interventions to improve mental health transitions in terms of the role of Assertive Community Treatment?

Background: Assertive Community Treatment (ACT) is a recovery-oriented mental health service delivery model that provides comprehensive services to individuals living with severe and persistent mental illnesses within the community. ACT services are usually targeted to those individuals who make high use of acute care psychiatric and emergency services. Rather than brokering services, most treatment and rehabilitation services are provided directly by the ACT team. Staff-client ratios are small (approx. 1:10) to ensure adequate individualization of services through shared caseloads. The range of services is comprehensive and flexible and the services are provided in-vivo where problems occur and support is needed rather than in office-based clinical settings. Services are available on a 24-hour basis and the ACT team comprised of 10-12 multi-disciplinary team members (SAMSHA 2001). ACT clients are often admitted to the program after completing treatment in acute psychiatric care or tertiary care facilities or transitioning from homeless shelters. Once admitted, crises are common for ACT clients and crisis assessment and intervention is provided by ACT teams usually in partnership with other crisis intervention services such as mobile crisis response services. ACT teams continue to support clients while receiving short-term treatment in acute care to ensure continuity of care. Within Canada, Ontario and British Columbia are leading the development of the ACT program. Both provinces have developed ACT Standards and participate in a fidelity review process to ensure teams are adhering to the BC Standards and fidelity of the model of care.

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Results: ACT is a rigorously studied mental health practice and the evidence for its effectiveness is well established including mental health transitions (Baronet & Gerber, 1998; Bedell, Cohen, & Sullivan, 2000; Bond, Drake, Mueser, & Latimer, 2001; Gorey et al., 1998; Herdelin & Scott, 1999; Latimer, 1999; Marshall & Lockwood, 1998; Ziguras & Stuart, 2000). ACT is known for its reduction in psychiatric hospitalization, high level of housing stability and improvements in quality of life (Philips et al., 2001; Nelson et al., 2007). Research has shown that ACT services are cost effective for individuals with extensive prior hospital use and frequent involvement with emergency services (Latimer, 1999). The effectiveness of ACT has primarily been demonstrated with people who have a history of psychosis with frequent and extensive use of in-patient psychiatric and emergency services and who do not respond well to less intensive services. Some ACT programs have targeted new clients, such as those with concurrent mental health and substance use disorders, including those frequently involved with the criminal justice system showing promising results, however, the effectiveness and fidelity has not been confirmed for these populations.

Conclusions: The effectiveness of ACT including health transitions and cost effectiveness is well established. Adaptations of ACT in terms of new client populations highlight the need for further research. Up-to-date provincial standards, reliable outcome data and fidelity reviews are essential to ensure ACT programs meet established fidelity requirements.

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Richard Warner, MD, DPM

Professor of Psychiatry and Adjunct Professor of Anthropology, University of Colorado, Boulder, Colorado

Dr. Richard Warner is a British psychiatrist and the director of Colorado Recovery, a program that provides intensive treatment for people with serious mental illness in Boulder, Colorado. He is a Professor of Psychiatry at the University of Colorado. For nearly 30 years, he was the Medical Director of the Mental Health Center of Boulder County where he and his colleagues developed an innovative and internationally recognized system of community psychiatric care. His research has focused on social and economic factors that affect outcome from mental disorder and on effective programs for the psychiatric treatment and rehabilitation for people with serious mental illness. He has conducted cross-national research and lectured widely in Europe and elsewhere. For 15 years, he

helped direct a World Psychiatric Association project combating the stigma of schizophrenia in 20 countries around the world. He is the author of *Recovery from Schizophrenia*, third edition, Brunner-Routledge, 2004; *The Environment of Schizophrenia*, Brunner-Routledge, 2000; *Alternatives to the Hospital for Acute Psychiatric Treatment*, American Psychiatric Press, 1995 and, with Julian Leff, *The Social Inclusion of People with Mental Illness*, Cambridge University Press, 2006.

Abstract

The decline in the use of psychiatric hospital beds, since the 1950s, has provided the opportunity for the creation of a number of alternatives to the hospital for acute treatment. Small, open-door, non-coercive, domestic settings providing similar services to those in a psychiatric hospital unit have been operating in community mental health services for decades in many places around the world including Colorado, British Columbia, Italy and the Netherlands. These alternative settings are in the same tradition as the moral management era York Retreat – small, normalizing facilities that are unlocked and genuinely in the community, allowing the resident to stay in touch with his or her relatives, friends, work and social life. They are more flexible and non-coercive than hospital wards and more likely to be based on peer relationships than on hierarchical power structures and offer opportunities to residents to be involved in the operation of the environment. Since the cost is lower than hospital care, the pace of treatment in the alternative setting need not be as rapid, making it possible to offer a more quiet form of genuine asylum. The recent growth in the use of alternative settings of this type in Britain is a trend that has been stimulated by the closure of psychiatric hospitals and encouraged by the emergence of the recovery model which emphasizes the importance of patient empowerment and interpersonal support. In line with this focus, alternatives to the hospital offer a treatment approach in which coercion and paternalism are reduced and peer support is fostered. They offer a treatment atmosphere with more autonomy for residents and staff. Important benefits include their greater emphasis on human interaction rather than medication, and improved user satisfaction. We should be aware, however, that in the U.S. there is often a drive to increase the size of such residential facilities, lock the doors, and introduce the use of seclusion and restraints – a reflection of the tension between the drive to security and cost-efficiency, on the one hand, and human-scale, personalized care on the other. As in moral management, treating people with respect in normalizing, domestic settings leads them to exercise greater “moral restraint” or self-control over their impulses. When you are in someone’s home, you feel obliged to treat your hosts and their property with consideration, but in an institution, anything goes. This helps us understand why it is possible to care for patients in involuntary treatment in open-door, domestic settings. If the alternative setting is more attractive to the person than a hospital, then he or she will call upon reserves of self-control in order to be allowed stay there rather than in hospital. Cedar House, a 15-bed hospital alternative that has been in operation for over 30 years in the public mental health system of Boulder County, Colorado, has found that the facility can accommodate at least half of the catchment-area patients in need of acute inpatient care at any point in time, including many requiring compulsory treatment. Recently developed British hospital alternatives are similar to Cedar House in that they are small (average capacity 8 beds), provide a fairly extended period of residential care (over a month on average), have staff awake at night and accept compulsory admissions. A substantial proportion of patients are compulsorily admitted and most suffer from psychosis.

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