EPION

EARLY PSYCHOSIS INTERVENTION
ONTARIO NETWORK

After Release of the Ontario Early Psychosis Intervention (EPI) Program Standards:

Results of the 2014 EPI program survey of current practices in relation to the Standards

Final Report

A project of the Standards Implementation Steering Committee

July 2015

camhPSSP
Provincial System
Support Program

The Early Psychosis Intervention Ontario Network (EPION) is a province-wide volunteer network of service providers, persons with lived experience, and families. EPION currently includes over 50 programs and satellite partners across Ontario. The network facilitates collaboration, training, resource sharing, and quality improvement efforts. EPION is funded by the Ministry of Health and Long-Term Care. For more information, visit http://epion.ca/ or http://eenet.ca/the-early-intervention-in-psychosis-for-youth-community-of-interest/.

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Background

In 2011, the Ministry of Health and Long-Term Care (MOHLTC) released the Ontario Early Psychosis Intervention Program Standards to support consistency and quality in the delivery of early psychosis intervention (EPI) throughout the province. The MOHLTC then formed the Standards Implementation Steering Committee (SISC) to support EPI programs in implementing the standards. The SISC conducted two surveys to learn about current programs practices and needs in relation to the standards.

The findings from the first survey can be found at http://eenet.ca/products-tools/implementation-of-early-psychosis-intervention-program-standards-in-ontario-results-from-a-provincial-survey/.

This report focuses on the findings from the second survey.

Key findings

Participation

- All 56 full-service Ontario EPI programs were invited to complete the survey and all responded.

Capacity

- 220 program clinical staff members provide EPI services to almost 4000 clients across the province.
- Programs vary widely in size, from a single service provider working in a rural area to interdisciplinary teams of 15 operating in highly populated urban areas.
- 45% of EPI programs have 2 or fewer clinical full-time equivalent (FTE) staff members and rely on varying arrangements with other programs to deliver EPI services (see section on networks).
- The average caseload is 21 clients per clinical staff, which is higher than the recommended number of 10 to 15.

Training

- Programs are actively using a variety of approaches to train their staff to deliver EPI.
- Still, more training and resources are desired, given the complexity of the model (e.g., multiple components), the continually expanding evidence base, and the challenges associated with staff turnover and multiple program sites.

Monitoring and evaluation

- Monitoring and evaluation had the lowest rates of adherence and programs reported having the greatest number of barriers to implementing them.
- While many programs regularly collect data on client outcomes, they reported lacking time and expertise to use the data to monitor and improve service delivery. Few programs have a designated support person to perform this role or a written evaluation plan.
- At the same time, programs described some creative and effective uses of data, including advocating for more program resources, motivating staff with feedback on client outcomes, and improving the quality of care.

Barrier-free service and health equity

- Programs recognize the importance of improving access and responsiveness of care for all members of the community.
- However use of strategies to implement this aim was inconsistent. Only one-third of programs regularly monitored and reported on their performance.

Networks

- Almost all EPI programs are part of a program network that provides them with support, including access to specialist consultation, training, tools, and other resources. These networks are particularly important for small programs located outside large urban centres.
- Some programs reported difficulty communicating and sharing information across network sites, inconsistent availability of services across the network, and lack of time to participate in network activities.
- Follow-up can help us further understand the range of EPI network arrangements in the province and explore how network benefits can be enhanced

Accountability

- Many programs have implemented or are developing processes to review their compliance with the standards.
- Reporting relationships and communications between LHINs and programs regarding compliance with the standards varies widely across the province.
- The standards provide a foundation for developing more consistent and effective strategies to communicate with the LHINs.

Next Steps

- The 2 surveys conducted by the SISC represent an initial effort to engage the EPI program sector and obtain basic information.
- Next steps include:
    - Exploring the information available in existing data sources for describing EPI program delivery and client experience.
    - Beginning work to develop, in collaboration with stakeholders, a formal structure for monitoring program delivery and outcome, foundational to program improvement.
    - Continuing to build the relationship between EPI and our MOHLTC and LHIN partners, to work together to improve services to meet the needs of young people with early psychosis.

MAIN REPORT

Background

Why early intervention?

Approximately 3% of the population will experience an episode of psychosis in their lifetime[1] and for the majority it will occur between the ages of 14 and 35.[2,3,4] The illness can cause considerable distress to individuals and their families, and disruptions in social relations, education, and work.[5,6] A number of studies have shown that delays in treatment, known as duration of untreated psychosis (DUP), may result in poorer outcomes.[7]

Early Psychosis Intervention (EPI) is a model of care that provides holistic, comprehensive care to individuals as early as possible in the psychosis disease trajectory. Studies have shown that clients of EPI services are less likely to relapse or be admitted to hospital and have fewer symptoms than clients of standard care. They are also more satisfied, more likely to stay in treatment, and more likely to receive psychosocial interventions (e.g., psycho-education, employment support, addictions treatment).[8,9]

The EPI model of delivery was started in Australia in the early 1990s by Dr. Patrick McGorry.[10] Since then, EPI has been implemented internationally and endorsed in numerous national policies/strategies.[11,12] A consensus statement on early intervention and recovery for young people with early psychosis was released in 2005 by the World Health Organization and International Early Psychosis Association.[13]

Core components of the EPI model

EPI is targeted to persons aged 14 to 35, who often do not fit neatly into existing adult and child service areas.[14] In addition to dealing with the symptoms of psychosis, these individuals are struggling to manage their personal development, relationships, school, and work. They may be struggling with the idea of having a mental illness and the question of whether a return to their usual level of functioning is possible. Many are still living with their families.

EPI tries to address the unique needs of adolescent and young adult clients through:

- outreach to raise community awareness and increase early access to support;
- youth engagement in youth-friendly, low-stigma settings;
- management of symptom using low-dose antipsychotic medications;
- social interventions to help individuals maintain or re-establish their roles in the community;
- inclusion of family, with the client’s agreement.

A stand-alone, multi-disciplinary, specialist team with staff trained in EPI and small caseloads is the recommended approach, but not always feasible to implement, especially in areas with smaller, more dispersed populations. Alternative approaches have emerged to fit to the local context. For example, some rural areas use a hub and spoke model, where EPI staff are embedded in community mental health teams (spokes or satellites) with access to leadership and specialist skills from a central hub.[15,16] Ongoing evaluation is needed to monitor the effectiveness of different delivery approaches.[17]

The history of EPI programs in Ontario

The first mention of EPI programs in Ontario occurred in a 1999 policy framework report called *Making it Happen: Implementation Plan for Mental Health Reform*.[18] By 2004, five EPI programs had been implemented in urban hospitals. In December 2004, the Ministry of Health and Long-Term Care (MOHLTC) released the *Program Policy Framework for Early Intervention in Psychosis*[19] and announced new funding for EPI services.

In the subsequent three years, over 30 programs were implemented, based mainly on advice from established EPI programs.[20,21] The extent to which services were consistent across the province, aligned with the core components of the EPI model, and reflected best practice was unknown.

To address this challenge, MOHLTC released the *Ontario Early Psychosis Intervention Program Standards* in 2011.[22]

Ontario's EPI Program Standards

The EPI Program Standards establish clear expectations for EPI programs so that Ontarians across the province can receive comprehensive, high-quality, evidence-informed treatment and support regardless of where they are treated. The standards are based on international guidelines, tailored to the Ontario context.

The standards outline 13 domains of expected practice. The first six pertain to working with clients and their families, and include:

1. facilitating access and early identification;
2. comprehensive assessment;
3. treatment;
4. psychosocial support;
5. family education and support;
6. graduation from the program.

The second half outlines strategies and practices to support a high-quality delivery of care, and compliance with provincial regulations for health care organizations. They include:

7. professional training and education
8. research, program evaluation and data collection
9. client record keeping and management
10. health legislation obligations and complaint resolution procedures
11. barrier-free services
12. program networks
13. accountability to funders

Early Psychosis Intervention Ontario Network

The growth of EPI in the province has been supported and advanced by a volunteer network called the Early Psychosis Intervention Ontario Network (EPION). EPION started as a small, informal coalition of committed individuals in 1999. Membership grew as the number of EPI programs in Ontario increased, with over 50 EPI programs now represented in the Network, along consumers, family members, decision makers, and researchers.

EPION facilitates collaboration between EPI programs, holds provincial conferences and think tanks to address specific issues, maintains a website, and supports educational opportunities. EPION was awarded annualized funding by MOHLTC in 2011.

Supporting standards implementation

The release of the EPI Program Standards reflected the government's commitment to including EPI programs in the Ontario system of care. However, evidence shows that simply circulating documents is insufficient for successful practice change.[23] Active support is required to implement and sustain evidence-based practices.

In 2012, MOHLTC established a Standards Implementation Steering Committee (SISC), with representation from:

- EPION, which was ready and positioned to work with MOHLTC and funded EPI programs to support implementation of the standards;
- The Local Health Integration Networks (LHINs), which play an integral role in funding EPI programs in their communities;
- Persons with lived experience;
- Family members;
- MOHLTC ;
- The Centre for Addiction and Mental Health (CAMH).

CAMH committed to assisting SISC with planning, monitoring, evaluation and other activities to support the implementation process.

Recently, SISC has become a standing working group of EPION. MOHLTC no longer chairs this group but continues to be actively involved. To date, the SISC has focused on learning about current practices and support needs of EPI programs in relation to the standards. Future work will focus on building capacity for monitoring and evaluation. Collaboration between partners is foundational to all activities.

Assessing the Current State of EPI Programs

In 2012, the SISC surveyed EPI programs on their current implementation of the standards, and on areas where more support was needed. The survey focused on standards 1 to 6, related to the delivery of clinical services to clients and families.
Results showed variation in standards implementation across programs. Strategies to improve compliance with the standards were suggested, including:

- use of structured protocols to clarify and monitor the delivery of various components of the model;
- centralized development and sharing of resources (such as educational materials);
- collaboration on tasks such as community education and the development of a referral network.

EPION disseminated the results to EPI programs, LHINs, and academic audiences through a final report[24] and various other channels. EPION held a series of think tanks to explore ways to address some of the challenges identified in the survey.

In 2014, a second survey was administered to obtain feedback on Standards 7-13 and the results are presented in this report. The assessed standards are intended to help programs:

- deliver consistent, high-quality care (#7,#8);
- meet the Ontario vision of accessible care (#11);
- work with other EPI service providers to deliver the full EPI model (#12);
- comply with government accountability expectations (#9, #10, #13).

Standards assessed in survey:

7. professional training and education;
8. research, program evaluation, and data collection;
9. client records;
10. health legislation and complaint resolution procedures;
11. barrier-free services;
12. program networks;
13. accountability.

Survey development

Survey development occurred during the fall and winter of 2013/14. SISC members reviewed and refined the draft questions to increase clarity and relevance to the Ontario system. The revised survey was sent to three EPI program managers for additional feedback on the clarity, relevance, and feasibility to complete.

Four of the standards (training, evaluation, barrier-free, networks) were surveyed in detail, with feedback sought on the following questions:

1. Extent to which implementation of the standard was supporting high quality care;
2. Strategies to implement the standard;

3. Availability of administrative supports to implement the standard;
4. Good practice example;
5. Challenge example.

Fewer questions were asked about the other three standards (client records; health legislation; accountability) where practices are more prescribed. A short section was added on leadership support, which has emerged as one of the most important drivers of successful implementation.[25]

Data collection

Data were collected from February to April 2014. An EPI program list was developed based on participation in the first survey and the EPION membership list. Regional leads ensured the distribution list was accurate and complete. Consistent with the first survey, programs that provided care exclusively to the clients' families were excluded (three programs). Also excluded were educational or step down programs that did not intend to deliver the full model.

The final sample included 56 EPI program sites (referred to as "programs" in the rest of this report). A survey invitation was sent to a contact person at each program, usually a manager or clinical lead, with instructions that one person familiar with the program take the lead on completing the survey, consulting with other team members as needed. Email and telephone follow-up was conducted to encourage completion of the survey.

Standard 12 outlines expectations for program participation in a network – an arrangement with other EPI programs to enhance the delivery of the model. Most program sites work closely with selected other sites to deliver service but do not necessarily refer to this relationship as a 'network'. To clarify their reference point for answering survey questions on networks, we informed each program in advance of which network it belonged to (based on the first survey and selected feedback). Programs were asked to contact the SISC survey team if they disagreed with the indicated network. For a full description of the different networks see the results section of this report.

Quality checking and analysis

Responses were reviewed for inconsistencies, missing data and outliers. Particular focus was given to the accuracy of program capacity data such as caseload and staff size. Where quality issues were flagged, follow-up was conducted with respondents to verify or correct data.

The survey included both closed-ended and open-ended questions. Program capacity data were reported as means and ranges (e.g., for client caseloads and staff size). Program delivery data, such as rates of use of a practice or of need for more support, were reported as percentages of programs indicating "yes", "regularly", or "a fair amount or great deal", depending on the response options.

Results were reported for the whole sample and then separately for large programs (more than two clinical full-time equivalent staff or FTEs) and small programs (up to two FTEs). Smaller programs provide service in more rural areas and the survey afforded an opportunity to investigate where they might require additional support. Given the small total sample size, differences in percentages between large and small programs needed to be very large to reflect real practice differences. We commented when differences exceeded 15%, or if a trend was evident.

Open-ended questions were analyzed using an iterative process where, per question, responses were first listed, retaining the language of the respondent, then grouped according to theme, and finally summarized.

Limitations

As with all self-report surveys, the results reflected the perceptions of the respondent. Although some programs completed the survey with input from a range of staff members, other surveys were completed unilaterally by managers or directors. The views of those in management positions may not always align with the views of frontline staff.

Survey Results

All 56 EPI invited programs completed the survey, resulting in a 100% response rate. Out of 56 programs, 31 (55%) were considered large and 25 (45%) were considered small.

OVERALL RESULTS

Provincial capacity

Table 1 describes the context and capacity of the programs.

Overall, there were 218.6 clinical FTEs working in the 56 programs (excludes managers and administrative personnel), and 3980 currently registered clients. This represented 1.6 clinical FTEs per 100,000 population and 30 clients being served per 100,000 population. The majority of clinical staff were EPI funded but about 3% were funded by another source.

In England and Wales, recent benchmarking data indicated that early intervention teams are serving 58 clients per 100,000 population.[26] While our result is lower, not all persons in Ontario with first episode psychosis receive their health care from EPI programs. A better understanding of the Ontario system is needed to understand current capacity in relation to population need.

While average staff size was 3.9 clinical FTEs per program, they ranged from 0.4 to 15 FTEs. Forty-five percent of programs had 2 or fewer clinical FTEs, 25% had 2.1 to five; 18% had 5.1 to seven, and 12% had greater than seven clinical FTEs.

Large programs (more than 2 clinical FTEs) generally had a larger catchment population and were located in urban or mixed urban/rural settings. Small programs were mostly located in mixed or rural settings. As will be discussed later in this report, most programs were part of a network and small programs reported obtaining considerable support for program delivery from their network.

Average caseload size was 21 clients per clinical staff, ranging from two to 58. Caseload size was similar across large and small programs but above the 10-15 client caseload recommended in the literature.[27,28,29] Higher caseloads can limit available time for client care and other program activities, such as community education and outreach, and family work.[30]

The majority of programs (89%), both large and small, had a psychiatrist who worked regularly with their program, but few (11%) had a general practitioner (GP) who worked regularly with their program. Physician support is discussed in greater depth in the training section of the report.

Table 1: EPI Program capacity by program size

Program features	**Total** (n=56)	**Large** (n=31)	**Small** (n=25)
Area context*			
Catchment area population size (% programs)			
>500,000	21	39	0
200,000-500,000	23	39	4
100,000-200,000	21	16	28
20,000-100,000	29	7	56
<20,000	5	0	12
Rurality (% programs)			
Urban	32	55	4
Mixed	57	45	72
Rural	9	0	20
Staff Support			
Clinical FTEs** (provincial total)	218.6	190.1	28.5
Clinical FTEs per program (mean, range)	3.9 (0.4-15)	6.1 (2.8-15)	1.1 (0.4-2)
Has psychiatrist who works regularly with program (% programs)	89	90	88
Has GP who works regularly with program (% programs)	11	7	16
Client capacity			
Currently registered clients (provincial total)	3980	3313	667
Mean currently registered clients per program (range)	71 (2-408)	107 (22-408)	27 (2-82)
Mean caseload per clinical FTE staff per program (range)	21 (2-58)	18 (6-41)	23 (2-58)

*Due to rounding error and use of ‘other’ response option, percentages may not add up to 100

**Includes all clinical FTEs working in EPI programs, whether or not they are paid out of the EPI budget

EPI program capacity by LHIN

Table 2 reports EPI program capacity by LHIN, based on LHIN funding source. Data show considerable variation in funded EPI program staff and currently registered clients. Actual EPI program capacity within a LHIN may be different than reported in table 2 as programs may be serving clients (and have service sites) in another LHIN (see table 3). Also, a small number of programs that receive EPI funding (such as family or step down programs) were not included in the survey.

More work is needed to understand capacity to provide EPI across LHINs and how needs are being met within LHINs and across the province.

Table 2: EPI program capacity by LHIN (based on LHIN funding source)

LHIN	# Programs			# Current clients	# Clinical FTEs*	Clinical FTEs per 100,000 pop	Area population	Area size (km^2)
	All	Large	Small					
Ontario	56	31	25	3980	218.6	1.6	13,678,700	1,076,395
1. Erie St. Clair	3	3	0	155	15.0	2.3	640,000	7,234
2. South West	5	1	4	558	17.6	1.8	962,539	21,639
3. Waterloo Wellington	4	2	2	240	9.9	1.3	775,000	4,800
4. Hamilton Niagara Haldimand Brant	6	4	2	418	25.5	1.8	1,400,000	6,600
5. Central West**	0	0	0	0	0	0	840,000	2,590
6. Mississauga Halton	2	2	0	166	12.2	1.0	1,200,000	900
7. Toronto Central	7	6	0	677	32	2.7	1,200,000	192
8. Central	3	3	0	323	24.8	1.3	1,800,000	2,730
9. Central East	7	3	4	612	22.6	1.6	1,400,000	16,673
10. South East	3	1	2	175	8.0	1.7	482,000	17,887
11. Champlain	4	1	3	202	16.8	1.4	1,176,600	17,631
12. North Simcoe Muskoka	1	1	0	89	14	3.1	453,710	9,010
13. North East	10	2	8	200	16	2.8	565,000	400,000
14. North West	1	1	0	85	8.5	3.7	231,000	458,010

*includes all clinical FTEs working in EPI programs, whether or not they are paid out of the EPI budget

** This table does not represent actual EPI capacity per LHIN – e.g., CWLHIN receives services from EPI programs in adjoining LHINs (see table 3) and includes one funded EPI program that did not meet survey inclusion criteria.

EPI program capacity by network

The Ontario EPI Program Standards propose that programs join networks to deliver the full model. Of the 56 programs, 53 indicated they belong to a network and three indicated they work alone. Table 3 shows the location and capacity of each network. A later section describes the different network arrangements and the ways in which network members support each other. The strategies used by the stand-alone programs to deliver the full model are not addressed in the survey but also need to be explored.

Table 3: Provincial EPI program networks

Network name	LHIN by funding source	LHIN by physical location	Total sites (#)	Large sites (#)	Small sites (#)	Total clients*	Total clinical FTEs**
Tri- County Network	1	1	3	3	0	155	8.5
PEPP	2	2	5	1	4	558	17.6
1st Step	3	3	4	2	2	240	9.9
Cleghorn	4	4	5	3	2	360	22.6
The Phoenix Program	4, 6	4,6	3	3	0	166	12.2
Toronto EIP Network	7,8,9	6,7,8,9	11	11	0	1180	61.9
Lynx	9	9	5	1	4	359	10.0
Heads Up!	10	10	3	1	2	175	8.0
On Track Champlain District	11	11	4	1	3	202	16.8
Northeast Regional Program	13	12,13	10	2	8	200	15.5
Stand-alone Programs							
Whitby	9	9	1	1	0	131	6.6
Barrie	12	12	1	1	0	89	14
Thunder Bay	14	14	1	1	0	165	8.5

*currently registered in the network programs

** working in network programs, whether or not they are paid out of the EPI budget

Global ratings

Table 4 shows global ratings for implementation of each standard.

Among the four standards that more directly support service quality, ratings were highest for training and barrier-free service (77% and 84%, respectively) and lowest for evaluation (50%) where programs reported the most challenges. Differences between large and small programs were minimal.

For the networks standard, 68% of programs reported that participation in a network improved the quality of care they provided “a fair amount” or “a great deal”. Almost all (94%) small programs reported benefit. Networks are a strategy to help smaller programs deliver the full EPI model and basket of services, and results suggest that this aim is being met. However, some large programs also reported benefit (46%). Follow-up work can explore in detail how networks function and how both large and small programs can use network support.

For the accountability-related standards, almost all programs (large and small) reported meeting requirements “a fair amount” or “a great deal” in relation to accuracy of client records, complying with *Personal Health Information Protection Act* (PHIPA) and complaints resolution process (97%). Since EPI programs are embedded in larger agencies, implementation of these standards may be tied somewhat to host agency practices.

Fewer programs reported having a process in place for reviewing compliance with EPI standards (34%), and few were regularly reporting to the LHIN on their experiences implementing the standards (29%). Exploring how to share and discuss EPI program implementation with the LHINs has been flagged as a need for the next phase of work of SISC and EPION.

These findings are discussed in more detail in the following sections.

Table 4: Overall ratings of standards implementation

	% programs reporting ‘a fair amount’ or ‘great deal’		
Standard Elements	**Overall** (n=56)	**Large** (n=31)	**Small** (n=25)
Service quality	**Implementation improved quality care**		
Training	77	74	80
Evaluation	50	45	56
Barrier-free service	84	84	84
Network support	68	46	92
Accountability	**Implementation met requirements**		
Client records	95	94	96
PHIPA	100	100	100
Complaints resolution process*	97	97	96
Reviewing compliance with standards**	34	27	44
Reporting to LHINs on standards compliance***	29	23	37

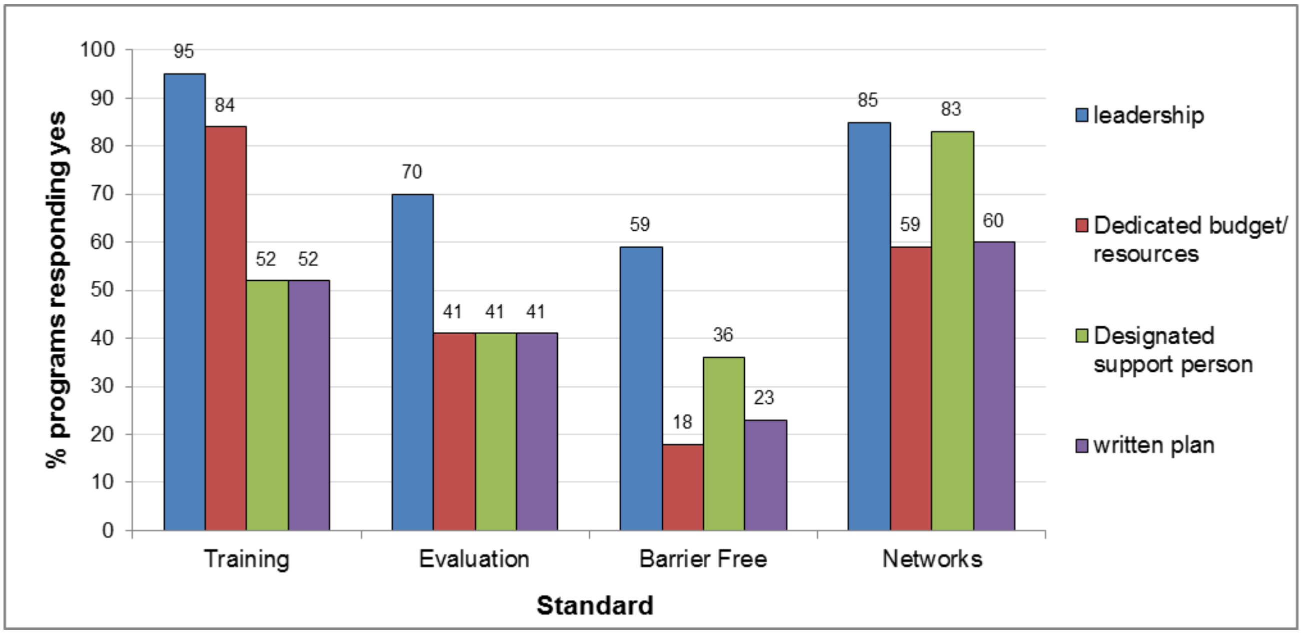
* % reporting ‘yes’
** % reporting ‘yes’; ‘unsure’ responses were excluded from analysis, n=53
*** % reporting ‘regularly; ‘don’t know’ responses were excluded from analysis, n=41

Administrative supports for implementation

Availability of administrative supports can contribute to more successful and sustained implementation of program practices.[31]

As indicated in *Figure 1,* availability was variable. Programs were least likely to have written plans in place and most likely to have leadership support. Barrier-free service was the least well supported standard, although a portion of respondents were unsure of available supports. Training received the highest level of support. These results are discussed in more detail in the following sections.

Figure 1: Availability of administrative supports (n=56)



Notes:
Results are based on 56 programs, except for the network standard as 3 programs were not part of networks.
Results indicate % of programs reporting ‘yes’ versus ‘no’ or ’unsure’. For barrier-free care and network standards, 11% to 23% of programs were unsure.

STANDARD 7: STAFF TRAINING AND EDUCATION

Standard 7 indicates that effective EPI requires skilled professionals on the EPI team and in other health and social services that play a role in early identification and/or ongoing support in the young person’s recovery. Also, because EPI is a relatively young field of practice, new knowledge is being developed that must be integrated into practice.

The survey asked about activities to support EPI training and education, with a few additional questions on psychiatrists working regularly with the program.

Key findings

- Overall, most programs (both large and small) reported that their training and education activities are preparing program staff to provide high quality EPI services (table 5).
- Most programs are actively using a range of education and training activities, and many offered examples of innovative training approaches.
- However, there is a consistent desire for more training across a number of areas, and some respondents noted a need for training for specific staff groups (such as peer workers and family workers) and for psychiatrists working regularly with their programs.
- EPION events are valued and programs would welcome more full-team opportunities.
- More use of communities of practice and journal clubs could help programs stay informed about new information and research.
- Challenges to doing more training include a lack of resources (time/funds) and having to train staff working out of multiple sites.

Table 5: Overall ratings for training/education activity

To what extent do you feel that…	**% programs rating ‘a fair amount’ or ‘a great deal’**		
	All (n=56)	**Large** (n=31)	**Small** (n=25)
Current training/education prepares program staff to provide high quality EPI services	77	74	80
More support for training/education could improve delivery of EPI	41	42	40
Current training/education prepares psychiatrists working regularly with your program to understand/work within EPI approach	46*	52*	40*

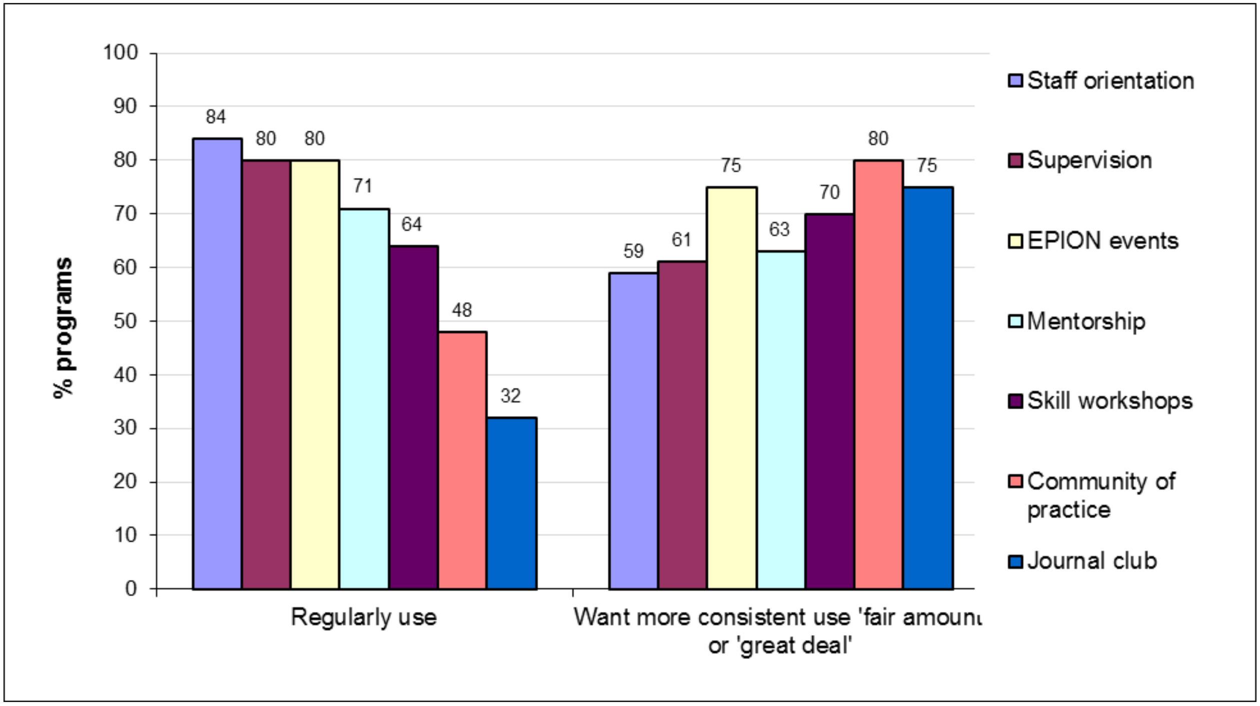
* High % of programs responding ‘not applicable’ (13%-16%)

Implementation strategies

The survey asked about use of selected training and education strategies, based on recommended practices from the international EPI literature[32,33,34,35,36] (*Figure 2*).

While programs reported regular use of a number of practices (new staff orientation, clinical supervision, EPION events, and mentorship), about two-thirds still reported wanting more training to effectively meet staff needs. Regular use of communities of practice and journal clubs is lower (48% and 32% of programs, respectively) and many programs wanted more use of these strategies.

Figure 2: Program use of different training strategies (n=56)



Programs suggested other strategies for training, including:

- province-wide new staff orientation day to review psychiatric interviewing/assessment, psychopharmacology, psychosocial treatment, family treatment;
- opportunity to shadow different programs throughout the province.

Small programs were similar to large programs in their use of most training strategies (not reported in the figure). As will be noted later, many small programs reported receiving training support from their networks. Use of OTN (Ontario Telemedicine Network) for regularly planned education events was suggested.

Areas where more training is needed

Programs were asked to rate the extent to which they would like more training/education for non-medical staff in a number of areas (table 6). Across all the areas, at least one-third of programs said they would like more training. Rates were highest for psychotherapies (examples included cognitive behaviour therapy, motivational interviewing, dialectical behaviour therapy, therapeutic interventions for post-traumatic stress disorder, trauma-informed approach), vocational/educational support, and addictions treatments. More small programs indicated a desire for additional training across every area.

Respondents noted that, while training is provided in most areas, *ongoing* training is needed to keep updated with skills and new practices. Also noted was the importance of having a formalized (rather than ad hoc) training process in place.

Beyond the areas listed in table 6, respondents identified other training topics of interest. Among these were metabolic monitoring and health awareness education, PHIPA training and privacy and consent (especially when working with service providers at different agencies), managing high-risk and vulnerable clients, and appropriate use of social media with clients (such as email, texting, online counseling, Skype).

> *"I think that we have adequate training in almost all of these areas but I think we can all benefit from ongoing training to stay on top of new research and to stay fresh and motivated in what we are doing." (Survey respondent)*
>
> *"There is always room for improvement and there is always updated information available." (Survey respondent)*

Supporting members' need for training is one of the aims of EPION and a web-based training event on psychotherapies (planned before the survey) was held in June 2014.

Given the complexity of the EPI model and multiple areas of training need, future work could target training to support the implementation of protocols for specific model components, and include processes to obtain systematic feedback about the effectiveness of training.

Table 6: Extent to which more training is needed for non-medical staff

Content area	**% programs reporting 'a fair amount' or 'a great deal'**		
	All (n=56)	**Large** (n=31)	**Small** (n=25)
Background			
Understanding the EPI standards	45	36	56
Understanding psychosis	34	23	48
Understanding the EPI model	39	32	48
Early detection and access			
Public education	57	52	64
Early detection and referral	47	39	56
Assessment and treatment			
Comprehensive assessment	45	39	52
Medication management	41	26	60
Physical health monitoring	52	42	64
Psychosocial support			
Psychotherapies	63	61	64
Vocational/educational support	61	58	64
Substance use support	61	55	68
Family support			
Family education and support	54	45	64
Core practices			
Proactive outreach	48	36	64
Recovery oriented approach	38	19	60
Intensive case management	36	19	56
Inter-disciplinary teamwork	34	19	52
Consent to treatment and privacy	32	23	44

Training for specific groups

Programs were asked to identify staff whose training needs were not being well met. Commonly mentioned were peer support staff, where current training is limited and can be challenging because worker backgrounds are so variable. Also mentioned by a few programs were family support workers and nurses.

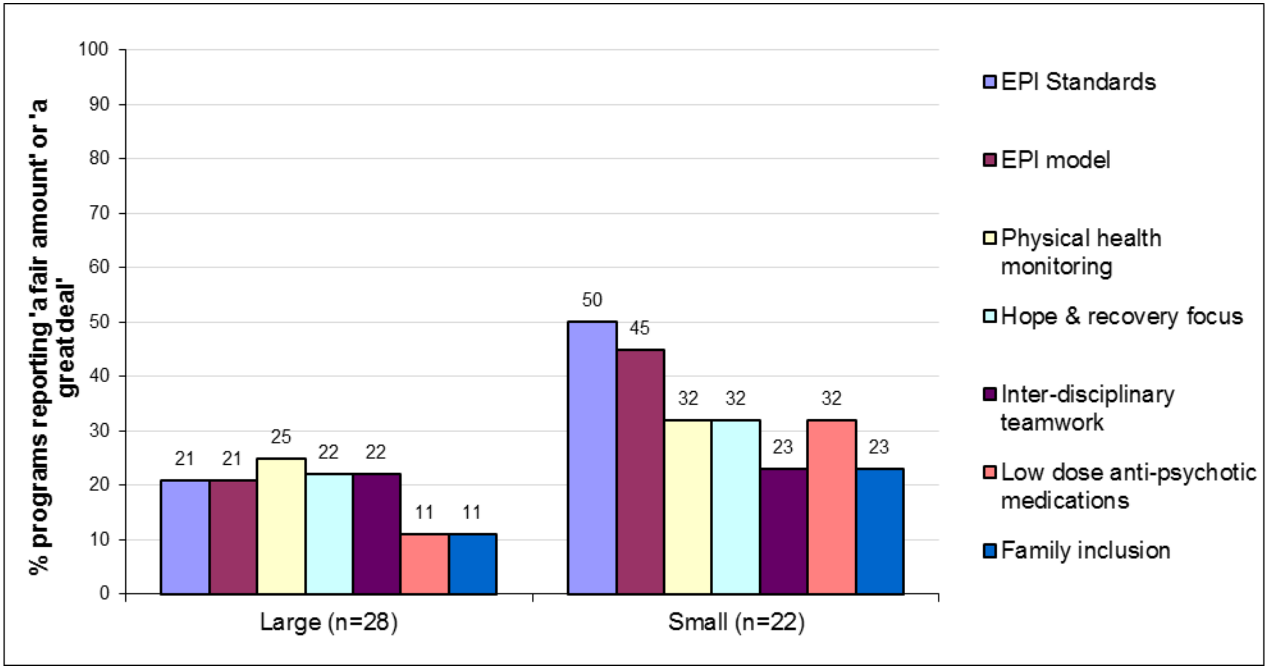
Having better-informed staff in the health and social services that may come in contact with EPI clients was also noted - such as crisis programs, emergency departments, Ontario works, probation, police, general practitioners, and school mental health nurses.

Training for physicians

Most programs reported having psychiatrists who work regularly with their program (89%), very few reported having regular GPs (11%), and 11% reported having neither a regular psychiatrist nor family physician.

While many programs did not report a need for more psychiatrist training, a small portion did, particularly regarding the EPI standards and model. More small than large programs indicated a need for additional psychiatrist training (figure 3).

Figure 3: Extent to which more training is needed for psychiatrists in core content areas



Implementation support and challenges

While most programs reported having a dedicated budget for training, a number said they lacked the funds and time they needed to provide education and training to the desired level. This was particularly the case for programs with multiple service sites. Also, only half of programs reported having a designated support person or a written plan, and one-third have no process in place to regularly review and evaluate their training approach (table 7).

Table 7: Availability of administrative supports to implement education & training

Type of support in place	**% programs reporting 'yes'**		
	All (n=56)	**Large** (n=31)	**Small** (n=25)
Leadership support	95	97	92
Written program policies/ procedures	88	87	88
Dedicated budget/ resources	84	84	84
Regular review/feedback/evaluation	66	65	68
Designated support person	52	45	60
Written plan	52	61	40

Good practice examples

Programs offered a number of creative suggestions to implement education and training. Among these were:

- Develop written education plans with front-line staff and managers to maximize buy-in;
- Select specific staff to specialize in an area and assume a train-the-trainer approach;
- Engage other clinical programs (such as addictions) in the development of best practices;
- Create orientation/resource materials for new staff, updated as an ongoing resource;
- Hold weekly team meeting to review challenges and successes;
- Involve interdisciplinary teams in orientation of new staff;
- Develop a program to train peer support workers informed by national accreditation and certification.

A number of programs also mentioned networks and EPION as valuable training resources.

STANDARD 8: RESEARCH, PROGRAM EVALUATION AND DATA COLLECTION

Standard 8 outlines monitoring and evaluation activities to support delivery of high quality, relatively consistent care across the province and improve outcomes for clients and their families. Regular monitoring can also help identify effective practices for EPI delivery.

Specific components of care to monitor and evaluate include:

- appropriateness of program admissions, treatment plans, and referrals/links to other services;
- client outcomes related to hospitalization, return to school, gainful employment;
- client and family satisfaction.

This standard asserts the longer-term expectation that the MOHLTC, LHINS, and programs will work together to establish performance goals and measures.

Key findings

- Overall, this was the standard where programs reported the lowest rates of use and the most challenges (table 8).
- Many programs are collecting data but they need more time and expertise to use the data to monitor and improve service delivery. Over half of programs need a fair amount or a great deal more evaluation support.
- Data collection challenges included: insufficient time and resources; incompatible IT systems, and ensuring data quality, given multiple staff entering data and stuff turnover. Few programs have a designated support person or written evaluation plan.
- Most programs collect Ontario Common Assessment of Need (OCAN) data but only about half use these data regularly for client care planning and very few use these data for program planning. Programs were receptive to receiving support for more effective use of OCAN data (perhaps through a community of practice).
- Creative and effective uses of data were described, including: advocating successfully for more program resources; motivating staff by providing feedback on client outcomes; and using data to inform program changes to improve quality of care.
- Small programs were less likely to want more evaluation support. In some cases small programs receive evaluation support from their network, and it is possible that they perceive the larger programs in their network as having the primary responsibility for implementing this function.

Table 8: Overall ratings for data collection and evaluation activities

To what extent do you feel that…	**% programs rating ‘a fair amount’ or ‘a great deal’**		
	All (n=56)	**Large** (n=31)	**Small** (n=25)
Data collection and evaluation activities are used to monitor and improve current practice	50	45	56
More evaluation support would improve your ability to deliver EPI	54	65	40

Collection and use of data

Data collection varied depending on the outcome domain but, as indicated in table 9, the proportion of programs regularly collecting data was generally higher than the proportion regularly using data for program improvement. Specifically:

- client outcome data related to school and work participation, and hospital admissions, were regularly collected by most programs (84-86%) and used by about two-thirds for monitoring (59-66%);
- satisfaction data were collected regularly by about half of programs and used for monitoring by slightly fewer.

In relation to client access and referral, many programs were monitoring access (such as referral sources and wait times), but fewer were assessing whether admissions were appropriate, and very few were monitoring whether clients were being linked to follow-up care after discharge. This last item reflects a system continuity of care issue and is difficult for an individual program to monitor.

Among examples of other data they are collecting, most programs mentioned metabolic monitoring, medication monitoring, substance use (such as the Global Appraisal of Individual Needs Short Screener-GAIN-SS), and occupational assessments (such as the Canadian Occupational Performance Measure-COPM).

Rates of collection and use of data were generally similar for large and small programs (not reported in table 8). One difference was in post-discharge monitoring. More small programs report monitoring access to follow-up care, possibly due to greater awareness of local program options.

Table 9: Collection and use of data to monitor components of care (n=56)

Quality of care domain	**Collect data 'regularly' (%)**	**Monitor quality of care 'a fair amount' or 'a great deal' (%)**
Symptoms and functioning		
Client work, education status	86	66
Client hospital use	84	59
Client symptom assessment*	48	NA
Satisfaction		
Client satisfaction with program	61	54
Family satisfaction with program	55	46
Access and referral		
Client access to program (referral source; wait time)	NA	75
Appropriateness of admissions	NA	50
Access to other services while in program	NA	38
Client access to follow-up care after discharge	NA	25

***** using standardized scales (e.g., Positive and Negative Syndrome Scale, Scale for the Assessment of Positive Symptoms / Scale for the Assessment of Negative Symptoms)
Note: NA=not asked

Strategies for program planning and advocacy

Table 10 reports use of data for planning, advocacy, and improvement (table 10). Regular use for these purposes was relatively low regardless of program size.

- About 40-45% of programs are using data to monitor whether they are meeting program targets or standards implementation, and 30% are regularly using data for improvement projects.
- Few programs regularly participate in or conduct research, although more participate occasionally.
- There were no consistent patterns in differences between large and small programs.

Table 10: Program use of data for planning, advocacy and improvement

Data uses	**% programs rating 'regularly'**		
	All (n=56)	**Large** (n=31)	**Small** (n=25)
Review in relation to program targets	45	52	36
Review in relation to standards*	39	36	44
Report achievements	36	42	28
Conduct improvement projects	30	29	32
Conduct education & advocacy	29	23	36
Conduct /participate in research**	9	13	4

* % of programs reporting 'a fair amount'/ 'a great deal'
**34% of programs conduct/participate in research occasionally.

Collection and use of OCAN data

The OCAN is a standardized client assessment that has been implemented in Ontario community mental health organizations. It is intended to support planning both at the client and program level, and also has a potential role for sector/system-wide planning.

Across the province, 84% of EPI programs, both large and small, are collecting OCAN data but about half use it regularly for client care planning and only 18% for program planning (table 11). Few programs report that OCAN data are useful 'a fair amount' or 'a great deal' for these two purposes.

Strategies that programs are using to improve OCAN data collection include:

- training support;
- resolving IT issues;
- integrating OCAN assessments into treatment protocols;
- replacing (not adding to) other paperwork.

> *"Accessibility of [OCAN] would help. Once we have Wi-Fi access, we hope to use iPads to input and more easily share the data with clients/care providers. Clients as well could input the Self-Assessment component on the iPad. Currently, staff do not always have offices/interview spaces with personal computers to have the OCAN open as they complete assessments." (Survey respondent)*
>
> *"We have tried using the goals it comes out with in conjunction with Goal Attainment Scaling to see clients improving on these over time. Some clinicians find this works well." (Survey respondent)*

Some programs noted that obtaining client consent to upload OCAN data to the Integrated Assessment Record,[a] was challenging, especially when the client was unwell.

Suggestions to enhance OCAN data use included:

- developing strategies to simplify data collection and to make it clinically relevant;
- receiving feedback from LHIN/ MOHLTC so programs can see how OCAN data are being used;
- making OCAN shorter and more specific to EPI;
- sharing/comparing data across programs.

Many programs would like more support for using the OCAN. The Community Care Information Management (CCIM) Program[b] is the provincial program responsible for OCAN implementation and is one potential source of support. Another is the organization hosting the EPI program. A community of practice could engage a number of programs and build on existing program strengths.

Table 11: Collection and use of OCAN (n=56)

OCAN activity	How often (% regularly)	How useful (% 'a fair amount' or 'a great deal')
Collect OCAN data	84	Not asked
Use OCAN data for client care planning	52	23
Use OCAN data for program planning	18	11

Implementation supports and challenges

Many programs (70%) reported having leadership and written policies in place to support monitoring and evaluation activities. Fewer (40%) reported having a dedicated budget, designated support person, or written implementation plan in place (table 12). Rates are generally higher for small programs, but given the small sample size, follow-up is needed to understand whether these rates reflect real differences in program practices.

Challenges to implementing this standard include:

- having time/resources to collect data, train staff, and analyze and report data;
- clinician resistance/disinterest;
- challenges in demonstrating importance of evaluation;
- lack of expertise;
- ensuring data quality (multiple clinicians entering data/stuff turnover);
- IT challenges (including incompatible and costly software).

It was suggested that having booster sessions and mentoring for new staff and for those who need additional support could ensure data entry is more consistent. Programs also noted a need for strong

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[a] A secure web-based viewer where an authorized clinician can view a consenting client's mental health assessment information from multiple systems.

[b] Community Care Information Management (CCIM). For more information see https://www.ccim.on.ca/default.aspx

leadership to encourage a culture of evaluation within the program. Data are not often used in program planning/decision making.

Table 12: Availability of administrative supports to implement monitoring and evaluation

Type of support	**% programs reporting 'yes'**		
	All (n=56)	**Large** (n=31)	**Small** (n=25)
Leadership support	70	61	80
Written program policies/ procedures	70	65	76
Dedicated budget/resources	41	36	48
Regular review/feedback/evaluation	n/a	n/a	n/a
Designated support person	41	32	52
Written plan	41	39	44

Good practice examples

Programs provided examples of how data have been used successfully to advocate for more resources, provide feedback to staff, improve efficiency, and adapt services to improve quality of care.

Uses of evaluation data

- *"In the past 2-3 years we have received 1.5 nursing positions, due to data showing a higher rate of utilization of the service." (Survey respondent)*
- *"We have looked at wait times and the referral process and have made changes to make sure clients who need to be prioritized are, and that wait times stay within the mandated timeframe." (Survey respondent)*
- *"We have shown trends in wait times, hospitalizations, and symptom scores (to name a few examples). These types of presentations appear to motivate staff." (Survey respondent)*
- *"Admission data has led to changes in referral process." (Survey respondent)*
- *"Client and family satisfaction data have contributed to changes in admission process." (Survey respondent)*
- *"Through chart audits and feedback, we were able to highlight documentation issues related to first contact with clients who were not engaging with us (i.e. attempts to contact [clients] were not always documented if a chart had not been opened and we changed this process). We were also able to create a system for documenting attempts/contact with clients regarding blood work requisitions in order to follow up if they do not follow through on completing blood work." (Survey respondent)*

STANDARD 9: CLIENT RECORDS

Standard 9 indicates the need for programs to maintain complete, accurate and up to date client records. It also describes program responsibilities in relation to the *Personal Health Information Protection Act* (PHIPA).

Key findings

- Overall, programs reported very high rates of adherence to this standard (table 13).
- Most programs reported having an electronic client record system, but a number reported limitations related to the technology.
- Programs reported high compliance with PHIPA but some also reported challenges related to an inability to share information with family members or other providers.

Table 13: Overall ratings for client records implementation

To what extent is your program able to…	**% programs reporting 'a fair amount'/ 'a great deal'**		
	All (n=56)	**Large** (n=31)	**Small** (n=25)
Maintain complete, accurate, up-to-date records for each client	95	94	96
Comply with the PHIPA	100	100	100

Strategies for maintaining complete and accurate records

We asked programs about strategies used to support accurate record keeping. Most programs (71%) reported using standardized templates, 64% used training, and half used audit and feedback. Results were similar for large and small programs (table 14).

When asked about other supports that would be helpful, the most common response was improved electronic record infrastructure. Though the majority of programs (86%) reported having an electronic client record system, 16% of large and 12% of small programs did not. Many of those with electronic record systems described ongoing technical challenges, including dealing with multiple separate systems. Another suggestion was for simplified documentation requirements and streamlined paperwork (to avoid redundancy).

> *"Technology is a problem. I am working with two privacy walls which may explain my difficulties. I am told that there are four different servers that I am using and depending on the server, I may be able to print or not, or attach documents or not.... Another thing is that my computer shuts down regularly to ask for the username and password to be re-submitted. I appreciate that this is because of privacy concerns, but it leads to frustration."(Survey respondent)*

Table 14: Availability of administrative supports to maintain complete and accurate records

Support mechanisms	**% of programs reporting 'regularly'**		
	All (n=56)	**Large** (n=31)	**Small** (n=25)
Standardized templates and tools	71	77	64
Training	64	65	64
Audit and feedback	50	48	52

Strategies to support compliance with PHIPA

Table 15 shows the administrative supports (policies and resources) available to promote compliance with PHIPA. Most programs had written policies in place and a dedicated support person. About two thirds received training on PHIPA, although a number of programs indicated a desire for additional and ongoing training. Less than half of programs had regular audit and feedback or dedicated resources, both areas where additional support was requested.

Table 15: Availability of administrative supports to implement compliance with PHIPA

Types of support	**% programs reporting 'regularly'**		
	All (n=56)	**Large** (n=31)	**Small** (n=25)
Written program policies/procedures	91	94	88
Designated support person	91	94	88
Training	66	71	60
Audit and feedback	48	48	48
Dedicated budget/resources	36*	42*	28*

*High % of programs responded "Don't know" (13%-20%)

Implementation challenges

Related to PHIPA and privacy legislation, some programs reported having challenges sharing information with groups that are important to the clients' care. The biggest challenge was sharing information with family members (27% of programs). Many programs emphasized the distress that parents experience when a client will not provide consent for their involvement. This is also a serious barrier to families supporting the client. Twenty percent of programs reported difficulty sharing information within the circle of care due to challenges such as confusion over who is included in the circle of care and when consent is or is not required. A small number of programs (9%) also reported difficulty sharing information with other members of their network, sometimes due to the absence of a clear Memorandum of Understanding (MOU).

Other common challenges with maintaining and sharing client records included:

- lack of time and resources;
- lack of electronic records system;
- inability to share a single record system across multiple sites.

"Our nurse is required to use multiple systems at multiple sites. This is challenging because she must learn the systems and they all work differently. She has varying levels of access to the different systems and still must carry information on paper." (Survey respondent)

Some programs also commented on concerns around confidentiality, such as:

- electronic transmissions of information (such as fax and email) have the potential of being sent incorrectly;
- physical space is not conducive to confidentiality (for example, if staff have shared office spaces).

Good practice examples

Programs offered a number of helpful strategies to maintain accurate and confidential client records. These included:

- having remote server access so that staff can update records while in community;
- use of tablets/laptops/smart phones so documentation can be done remotely;
- having a privacy manager who can provide advice on grey situations.

STANDARD 10: HEALTH LEGISLATION AND COMPLAINTS RESOLUTION PROCEDURES

Standard 10 requires programs to comply with Ontario legislation regarding health records and consent to treatment, and to put in place a client- and family-friendly complaints resolution procedure. The survey focused on the complaints resolution component of the standard.

Key findings

- Almost all programs (96%) have a formal policy in place for receiving complaints and for addressing and resolving complaints (not reported in a table).
- Rates are similar for large and small programs.

Strategies for informing staff and clients of complaints mechanism

New staff orientation was used by the majority of programs to explain the complaints procedures to staff (used regularly by 80% of programs) (table 16). Other strategies, such as online resources and training, were used by fewer programs.

Pertaining to clients and families, 55% of programs regularly provided information on how to make complaints during intake, 50% included the information in client materials, and 50% did so in the program's website. Large programs reported having a routine process in place more often than small programs.

Table 16: Strategies to inform staff, clients, and families of complaints mechanism

Strategies	**% programs reporting regular use**		
	All (n=56)	**Large** (n=31)	**Small** (n=25)
Strategies for staff			
Orientation for new staff	80	87	72
Online resources	54	61	44
Online training program	23	16	32
Strategies for clients and families			
Standard part of client intake	55	65	44
Included in materials given to clients	50	61	36
Available through program website	55	65	44

Implementation challenges

Challenges reported by programs include:

- the time required to manage complaints;
- no changes are made based on complaints;
- clients and families are reluctant to complain.

> *"Clients are unlikely to complain about me or the doctor since we are the only early intervention resources in the area."*
> *(Survey respondent)*

Good practice examples

Programs reported some additional strategies they have found helpful to implement a complaints mechanism. They include:

- dedicated complaints personnel who are not program staff so clients are comfortable expressing complaints without concern over their care;
- a patient advisory board;
- use of a term other than "complaints", which has negative connotations. Preferred alternatives include "feedback" or "concerns" process.

STANDARD 11: BARRIER FREE SERVICE

Standard 11 indicates the need for programs to reflect the diversity of the communities they serve and provide services in a manner that is responsive to the diverse backgrounds of clients. The survey asked questions about practices to support access to care in relation to culture and ethnicity, but also other potential personal and social barriers, such as income level, ability, sexual orientation, gender identity, religion, and language.[37,38,39,40,41,42] MOHLTC has identified equity (reduction of avoidable health disparities) as a key component of quality care.[43]

This standard also indicates the need for service delivery in youth friendly settings.

Key findings

- Overall, most programs reported that their clients reflected the diversity of the community and that they were able to provide care that is responsive to this diversity (table 17).
- However, regular use of strategies to support fair access and responsive care (table 18) was variable. Only one-third of programs regularly monitor and report on program performance related to health equity aims.
- Programs identified First Nations communities and individuals with developmental disabilities as groups for whom they need more direction and support related to offering service.
- A number of programs offered creative strategies for promoting barrier-free service that could be more widely shared.
- While there was some variation between small and large programs in implementing this standard, there were no consistent differences. Both showed areas of strength and challenge.

Table 17: Overall ratings for offering barrier-free service

To what extent do you feel that…	**% programs rating ' a fair amount' / 'a great deal'**		
	All (n=56)	**Large** (n=31)	**Small** (n=25)
your program clients reflect the diversity of the community you serve	84	84	84
your program is able to meet the treatment needs of diverse clients	84	84	84
More support to engage and meet needs of diverse clients would improve EPI delivery	38	38	39

Strategies to support barrier-free service

The survey asked programs to indicate which, of a range of strategies generally identified in health equity guidelines and policy (see sources cited on previous page), are used to increase access and responsiveness to diverse client groups (table 18).

While most programs accepted direct referrals from community organizations and individuals and did not require physician referrals, two-thirds or fewer reported regular use of the other strategies. Particularly low use was reported for reviewing area planning documents to understand community diversity, and for regular monitoring and reporting of performance. More formalized systems of incorporating health equity into practice are needed. A small number of programs reported that health equity was not a concern, which may be a barrier to implementing these strategies.

> *"We probably don't raise the issue of equity on a regular basis so we may miss when we have difficulties incorporating a health equity approach." (Survey respondent)*

While results were generally similar for large and small programs, small programs reported more regular use of some strategies to support access (providing relevant information to local communities and meeting with community leaders) while large programs reported more regular use of some strategies to support responsive care (access to interpreters, creating opportunities for staff to review equity issues).

Table 18: Program use of strategies to support barrier-free care

Strategies to support program access	**% programs rating 'regularly'**		
	All (n=56)	**Large** (n=31)	**Small** (n=25)
Accept referrals directly from community organizations, clients, and families (not require physician referral)	89	84	96
Provide accessible, relevant information (about psychosis, about the program) to area communities (e.g., consider language and culture)	46	36	60
Use targeted strategies to encourage access for vulnerable communities	32	29	36
Meet with leaders from diverse communities/groups	30	16	48
Review socio-demographic data/planning reports about local area communities	25	19	32
Strategies to support responsive care	**All** (n=56)	**Large** (n=31)	**Small** (n=25)
Provide access to professional language interpreters for clients and families	63	77	44
Have forum for discussing issues of equity and access (e.g., case conferences, team meetings, performance reviews)	63	74	48
Provide staff training in human rights, including the duty to accommodate and prohibited grounds of discrimination	57	61	52
Recruit staff who reflect the diversity of the local community	50	48	52
Provide program signs and written materials relevant to the diversity of the local community	45	39	52
Monitor and report on program performance related to health	36	32	40

equity (e.g., to Board, to LHINs etc.)			
Provide access to professional cultural interpreters for clients and families	32	39	24
Provide staff training in culturally appropriate service delivery	29	29	28
Strategies to support responsive care	**All** (n=56)	**Large** (n=31)	**Small** (n=25)
Use of Ontario Health Equity Impact Assessment (HEIA) or other tool to systematically assess impacts of program practices on the community	7	10	4

Service provision for specific populations

Since health equity is concerned with program access for groups who are often excluded, the survey asked programs to indicate, from a list of often excluded groups (based on the Health Equity Impact Assessment[44]), where they needed 'a fair amount' or 'a great deal' more support to promote inclusion (table 19).

Almost 40% of programs wanted more support in their work with aboriginal groups, and a number of qualitative responses specifically mentioned the need to build better relationships with First Nations communities. Also, 21-23% of programs desired more support to serve individuals who are deaf/hard of hearing, visually impaired, or who speak neither English nor French.

> *"Support and better connections with aboriginal and ethnic communities would be especially helpful to provide information about our program and for us to better learn the needs of these groups relative to our services." (Survey respondent)*

Differences between large and small programs were variable and generally small. One exception was low income groups, where more small programs indicated a need for more support to promote inclusion.

Table 19: Additional support needed to promote the inclusion of specific populations

Population	**% programs rating ' a fair amount'/ 'a great deal'**		
	All (n=56)	**Large** (n=31)	**Small** (n=25)
Aboriginal peoples (e.g., First Nations, Inuit, Métis, etc.)	38	36	40
Deaf or hard of hearing	23	26	20
Visually impaired	21	19	24
Linguistic communities (i.e., primary language not French or English)	21	23	20
Intellectual/developmental disability	16	10	24
LGBTQ	14	10	20
Ethno/racial communities	14	16	12
Low income	14	6	24
Religious/faith communities	11	10	12
Physical disability	11	7	16
Francophone	8.9	10	8

Programs were asked about admission policies for persons with various conditions, another indicator of who is able to gain program access (table 20).

Almost all programs 'usually' or 'always' accepted persons with substance use problems, justice involvement, and affective psychosis. Fewer accepted persons with brain injury, neurological disorders, and developmental disabilities. Programs described a number of specific barriers to providing care for clients with developmental disabilities. These included:

- the complexity of the clients' needs;
- feeling that supports and activities were required that were outside the program's scope;
- needing better training;
- needing to engage with disability-specific services and providers.

Also noted was a lack of clarity in program guidelines and policies on whether to accept persons with developmental disabilities (some do and some do not).

One-third of programs serve individuals outside of the target age group (14-35 years) specified by the standards.

Differences between large and small programs were generally small.

Table 20: Programs that accept clients with the following conditions

Condition	% programs rating 'usually' or 'always'		
	All (n=56)	**Large** (n=31)	**Small** (n=25)
Substance use problems	95	100	88
Forensic history/involvement	84	84	84
Affective psychosis	75	74	76
Developmental/ intellectual disability diagnosis	45	48	40
Neurological disorder	45	48	40
Brain injury	29	29	28
Ages other than 14-35	32	26	40

Service provision in youth-friendly space

About one-quarter of programs said they operate in a youth-friendly space (table 21). They described using strategies including:

- having waiting rooms with couches, books, Wi-Fi, computers, TV and games;
- hanging client art on the walls;
- having a waiting room television with information about the program, services, and cannabis/substances;
- creating games and tools for cognitive remediation; and
- having a metabolic monitoring room to promote physical wellness.

About one-third of programs said they do not operate in a youth-friendly space and the rate was higher (44%) for small programs. Features that were described as **not** being youth friendly included:

- having a shared waiting room with other mental health services;
- having limited evening services available;
- requiring swipe card access to wait area;
- being in a hospital location or feeling like an office building.

Respondents emphasized the importance of having a location that was not highly visible and not clearly identified as a mental health setting.

This is a program feature where small programs reported having more difficulty.

Table 21: Presence of youth-friendly space (% programs)

Youth friendly space	**All** (n=56)	**Large** (n=31)	**Small** (n=25)
Yes	27	32	20
Somewhat	41	45	36
No	32	22	44

Implementation supports and challenges

Reported access to administrative supports to implement this standard was lower than for the other standards: 36% have a designated support person such as a health equity officer, 23% have a written implementation plan, and 18% have a dedicated budget (table 22). However, a portion of respondents (14-25%) did not know what supports were available to them. Given the high percentage 'not sure', differences between large and small programs could not be examined.

In narrative comments, programs provided more detail about challenges to implementation. Among these were:

- limited resources for conducting community outreach and for implementing and reviewing a health equity plan;
- a need for more staff training;
- difficulty recruiting staff that were reflective of the community;
- an inaccessible physical space.

> *"To access our office one needs to open heavy doors and then go down a long hall which is not always easy for clients in wheelchairs or with mobility issues." (Survey respondent)*

Table 22: Availability of administrative supports to implement barrier-free service (n=56)

Type of support	Yes (%)	No (%)	Not sure (%)
Leadership support (e.g., from host agency, network)	59	25	16
Written program policy	47	36	18
Designated support person/s (e.g., health equity office)	36	50	14
Written plan to implement health equity approach	23	54	23
Regular review/ evaluation/ feedback on health equity goals	21	54	25
Dedicated budget/resources	18	66	16

Good practice examples

Programs offered a number of creative approaches to implement barrier-free service. Among these were:

- Program policy
    - Embed anti-oppression practice into all program areas - staff team, management and board;
    - Make equity of access a standing agenda item at meetings;
- Outreach
    - Develop community partnerships (including community groups, agencies and schools);
    - Review data from local Social Planning Resource Council and New Canadian Centre to learn about growing local communities to target outreach efforts;
- Service delivery
    - Send staff for training on the Health Equity Impact Assessment tool;
    - Access host agency list of staff fluent in other languages for interpretation;
- Reporting/evaluation
    - Collaborate with local agencies to develop statistical reports about under-serviced populations;
    - Implement plan-do-study-act cycle to improve services;
    - Report health equity data to the MOHLTC/LHIN.

"We are part of the network for an inclusive community in [omitted]. This networking group allows us to make good connections with community partners who will then refer." (Survey respondent)

"[We] have a good working relationship with the local high school. They represent a major referral source to the EIP program" (Survey respondent)

STANDARD 12: PROGRAM NETWORKS

EPI is a complex model requiring a range of skills and expertise to deliver. A dedicated program staffed by an inter-disciplinary team is ideally positioned to deliver the full model. However, since only a small percentage of the population is affected by early psychosis, there may be insufficient demand to justify large dedicated models in areas with smaller populations.[45,46] This is a particular issue in Ontario, given its large sparsely populated geography.[47]

The Ontario EPI Program Standards recommend program networks as a strategy to deliver the full model. No specific network arrangement is recommended. Rather, it is suggested that an arrangement be adopted that works for the specific setting and programs.

Network arrangements can encompass the following:

- multiple dedicated programs;
- one central program with satellite sites;
- multiple small programs embedded in local agencies;
- traveling teams with local supports to serve a large geographic area;
- a combination of the above models.

The survey provided an opportunity to learn more about program network arrangements, supports provided, and areas where network support could improve.

Ontario EPI program networks

Based on the results of the first survey and feedback from programs, we learned that the majority of Ontario EPI programs were part of some type of network. However, many do not use this terminology. Therefore, to avoid confusion, we informed each program of the network we believed they belonged to in the survey invitation. We encouraged programs that needed clarification or disagreed with our determination to contact us.

Fifty-three out of 56 provincial EPI programs (95%), including all small programs, belong to a network. Table 23 lists the 10 networks in the province and their network arrangement descriptions, as offered by the programs.

There were three programs that agreed that they were not part of a network and did not answer the questions in this section. It is important to note that networks are one way that programs can obtain support to deliver the full EPI model. Programs can also receive support from other sources, such as their host organization, other community partners, and EPION. For example, the Thunder Bay EPI program uses specialist outreach with local partners to provide services to the more remote communities in its vast catchment area. Follow-up can further explore the array of approaches used for EPI service delivery in Ontario and how networked and stand-alone programs are building capacity to deliver the different components of the model.

Table 23: Ontario EPI Networks

Network name	# of sites	LHIN	Arrangement
Tri- County Network	3	1	Formed in March 2013. It includes three separate programs. Share a common manager, who has access to individual program tools and protocols. Regular communication is strongly encouraged among similar disciplines, and yearly conferencing is a goal of programs.
Prevention and Early Intervention Program for Psychosis (PEPP)	5	2	Includes a hub in London which provides support to four partner sites. The central site provides training, resources, consultation, and some client services (e.g., cognitive testing, groups, family workshop) to the partner sites.
1st Step - Early Psychosis Intervention Program	4	3	One program with central hub and three smaller satellite offices. Most staff will travel to support other clinics, and some services (e.g., family support) are offered centrally
Cleghorn Early Psychosis Intervention Program	5	4	Based at St. Joseph's Healthcare Hamilton with four other EPI providers across the Hamilton Niagara Haldimand Brant LHIN that can access neuropsychological assessments through Cleghorn.
The Phoenix Program	3	4,6	Includes five partners (three clinical sites supported by Schizophrenia Society of Ontario and Halton Alcohol, Drug and Prevention Treatment). The three clinical sites include a hub which provides support to two smaller sites (e.g., through an occupational therapist and a coordinator).
Toronto Early Intervention Psychosis Network (TEIPN)	11	7,8,9	Includes 16 programs, 11 of which were clinical programs that met criteria for inclusion in the survey. Programs are dedicated, stand-alone models, and the network primarily offers an opportunity to share knowledge and resources rather than direct services.
Lynx Early Psychosis Intervention Program	5	9	One program delivered through seven partner agencies in five sites providing services in four counties. A clinical program manager in Peterborough supports the network and provides clinical supervision to all staff. Some resources are provided centrally or shared across sites (e.g., public education and outreach, groups, family support, nursing).
Heads Up! Southeastern Ontario District Early Intervention in Psychosis Program	3	10	Single program located at Hotel Dieu Hospital in Kingston. This program is composed of a central site in Kingston and two satellite sites. Each satellite site has a full-time case manager and a psychiatrist travels to all sites to see clients. Some allied health services in the central hub travel to the satellite sites based on client need.
On Track/En Avance - Champlain District First Episode Psychosis Program	4	11	Includes a central community-based site affiliated with The Ottawa Hospital and three satellite offices in Pembroke, Cornwall, and Hawksbury. Referrals are through central intake in Ottawa or through each site.
Northeast Regional Early Intervention in Psychosis Program	10	13	A non-clinical regional program provides support to 10 different clinical program sites embedded in hospitals or community agencies, grouped into six districts. Training and other supports are provided centrally by regional program to local sites.

Note: Network arrangements are supported by different funding models (e.g., distributed to network members through paymaster, members are part of a single program, each member directly funded by a LHIN). The funding model can affect accountability but was not explored in this survey.

Key findings

- 53 out of 56 programs belong to a network.
- Many programs report that participation in a network improves their capacity to deliver the model (table 24), especially the small programs.
- Small programs reported receiving much more support from the network across all areas than large programs.
- Among network members, the most common supports received were staff training, standardized tools/resources, and specialist consultation/supervision. Fewer programs regularly received direct service support.
- Some programs reported challenges to network participation, including: lack of clarity on network processes (e.g., sharing resources, making decisions, roles, and activities); sharing information for client care and service planning; uneven service availability across network.

Table 24: Overall rating for network participation and support

To what extent do you feel that…	**% programs rating 'a fair amount' / 'a great deal'**		
	All (n=53)	**Large** (n=28)	**Small** (n=25)
Participation in your network improves your ability to deliver the full basket of EPI services?	68	46	92
Participation in your network improves the quality of care that you provide to your clients?	68	46	92
More network support would improve your ability to deliver EPI	26	36	16

Supports received from the network

The survey asked programs to indicate the types of support they received from their network, and any areas where they would like more (table 25). Responses varied, with over half of programs regularly receiving support for staff training, standardized tools/resources, and access to specialist consultation and supervision. About one-third received assistance for direct service to clients or families, and one-quarter received support for incorporating a health equity approach. As would be expected, across all areas, more small programs than large programs reported receiving support (e.g. regular access to specialist consultation was reported by 25% of large programs and 80% of small programs).

Across every area, however, programs reported wanting *more* support (ranging from 28 to 64% of programs). Large programs were more likely to want additional support from their network for training, standardized tools, leadership, and evaluation. Small programs were more likely to want additional network support for training, direct family support, and communicating with the LHIN.

We do not know the details of how networks function but these responses raise the question of whether there is potential for networks to do more to support their members, and what other sources of support are available to draw on and help program networks deliver the full model. Programs also spoke of the value of EPION and of their host agency as important sources of support.

Table 25: Supports received from the network

Support	**Regularly receive (%)**			**Would like more (%)**		
	All (n=53)	**Large** (n=28)	**Small** (n=25)	**All** (n=53)	**Large** (n=28)	**Small** (n=25)
Standardized tools and resources (e.g., clinical protocols, education materials)	57	32	84	53*	57*	48*
Consultation and/or supervision	51	25	80	42	43*	40
Staff training and education	47	25	72	64	68	60
Leadership (e.g., for advocacy, program development, problem solving, system issues)	45	36	56	51	57	44
Data collection and/or evaluation	40	25	56	49	57*	40
Direct client services	34	25	44	28	21	36
Direct family services/supports	32	25	40	47	39	56
Communicating with the LHIN	32*	25*	40*	51	43	60
Incorporating a health equity approach into service delivery	26*	18*	36*	51*	50*	52*

* Some items had high rates of programs responding ‘don’t know’ or ‘not sure’ (11%-18%)

Implementation supports and challenges

Programs were asked about their use of strategies to support network functioning (table 26). Most often used were regular communication, leadership support, and a designated support person. In comparison with the other standards, networks were substantially more likely to have a designated support person. Less commonly available were: a clear decision-making process, a management committee, and a written policy. Not all respondents were able to answer this question, possibly because they were not directly involved in their network support work.

Table 26: Strategies to support network implementation (n=53)

Strategy	Yes (%)	No (%)	Not sure (%)
Strategy for regular communication among members (e.g., meetings, newsletters)	89	6	6
Leadership support (e.g., from host agency or program)	85	4	11
Designated support person (e.g., network coordinator)	83	6	11
Formal agreement among network members outlining roles and responsibilities in the network	64	15	21
Regular review/evaluation and feedback	64	21	15
Written plan outlining network function, role, and activities	60	23	17
Dedicated budget/resources	59	26	15
Clear process for sharing resources among members	59	23	19
Clear decision-making process	55	26	19
Management committee	51	25	25
Written policy	45	28	26

Common challenges included:

- difficulties with communication and information sharing due to technology, privacy issues, terminology, protocols;
- uneven availability of services across sites within network;
- time.

While most programs said they participate in a cohesive, supportive network, a few programs indicated that their network was less well connected.

“Our central site is much larger than the two district sites. It is difficult to provide an equal service to the districts as they don't have the numbers in staff or the diversity in types of clinicians.” (Survey respondent)

“Communication and physical distance sometimes present as challenges. Databases are unique to each agency, therefore information sharing and access is difficult at times.” (Survey respondent)

“It is difficult to find time and space to get together due to geography and caseloads. Our network contains at least seven separate and autonomous organizations with different operating procedures and different priorities.” (Survey respondent)

Good practice examples

Strategies to facilitate network function include:

- regular network meetings;
- formal network structure (e.g., network steering or advisory committee, signed MOUs, shared manager across programs);

Examples of network service roles include:

- client access to programming across sites (e.g., clients from one community attend a group in another community);
- centralized client intake and referral;
- shared responsibility for client continuity of care (e.g., if clients move within the catchment area or are admitted to hospital).

“We meet once per week for clinical interdisciplinary rounds and we link with the different sites in the network via OTN - that way we can all support each other through difficult cases and make team decisions.” (Survey respondent)

“Our wait list for the program has reduced substantially now that we have partners who can provide timely service to clients who are out of town.” (Survey respondent)

“I feel very supported by my colleagues in the network.” (Survey respondent)

STANDARD 13: ACCOUNTABILITY

Standard 13 outlines expectations for accountability to the LHIN. In addition to providing regular reports, programs are also encouraged to report challenges implementing the EPI standards.

The survey asked whether programs had a systematic process in place for documenting compliance with the standards, and if they reported to the LHIN on their implementation experiences.

Key findings

- About a third of programs have a systematic process in place for reviewing compliance with the standards and documenting problems. Another 39% report that this process is under development, indicating an increasing recognition of the importance of implementation monitoring.
- 21% of programs indicated that they or their network regularly report to the LHIN on compliance with the standards. Over one-quarter was unsure of whether/how they report to their LHIN, possibly because reporting is done through their network lead or host agency.
- Important next steps include learning more about LHIN information needs and developing relevant reporting processes for the programs, based on the standards.

Programs offered mixed responses when asked about reporting to their LHIN. Some described extremely positive relationships, including regular meetings and reporting.

> *"Channels of communication are excellent. Regular and frequent meetings are scheduled." (Survey respondent)*
>
> *"Great relationships have formed, and remain essential in the process of growth/development." (Survey respondent).*

Other programs described challenges in communicating with the LHIN due to agency hierarchies and reporting structures.

> *"It is difficult to get direct access to the LHIN to do this. The mental health director has the most contact with the LHIN and information flows through her. We would welcome the opportunity to meet with the LHIN directly." (Survey respondent).*

While this standard sets out an expectation for regular communication with the LHINs, this practice is developmental for many programs. The standards provide a foundation for the EPI sector to develop indicators and processes for improvement and accountability reporting. The surveys represent an initial effort to engage the sector and obtain basic information, and the OCAN may be an opportunity to build on.

Important next steps are learning more about LHIN needs and developing relevant reporting processes, based on the standards. EPION can support this effort through its ongoing sector engagement and collaboration with the LHINs. EPION and the SISC have already started a process of LHIN engagement to understand what information would be useful and feasible to provide.

LEADERSHIP

Although leadership is not explicitly addressed in the standards, leadership commitment is critical for successful implementation.[48,49,50] Therefore, the survey asked programs about leadership support in implementing the EPI standards.

Overall, programs reported a high level of leadership support for protecting EPI resources and staff, acting as program champions, and supporting efforts to meet the standards (table 27). Large programs were slightly more positive than small programs.

Table 27: Leadership support provided to programs

Type of support	**% programs reporting 'a fair amount'/ 'a great deal'**		
	All (n=56)	**Large** (n=31)	**Small** (n=25)
Protect/ensure EPI program resources	88	94	80
Protect staff in their EPI roles	86	90	80
Act as champion for EPI	86	94	76
Support for meeting the EPI standards	80	87	72

Overall, the most common source of leadership support was the program's host agency (73%). Networks were a frequent source of support for small programs (80%) while EPION was a frequent source of support for large programs (71%).

The LHINs were less likely to be rated as a source of support. This may be due to the fact that, as reported in the previous section, LHINs often communicate with the host agency or network rather than individual programs. Improving program communication with the LHINs is a priority for EPION and the SISC going forward.

One challenge noted by some programs was the contradiction between agency policies and the EPI standards. Thirteen percent of respondents reported that program delivery is compromised a fair amount or a great deal by differences between the priorities of their host agency and the requirements of the standards; but almost half reported that this was not an issue for their programs.

A few programs also noted concerns that managers are receiving broader portfolios, limiting their ability to advocate for EPI.

"We used to have a full-time manager who fought for us and protected our resources. He worked very hard to set up a more youth friendly environment for our clients. Unfortunately, we lost him because of politics. We now have a manager divided among three programs. Everyone does their best." (Survey respondent)

"As the coordinator of the program I work hard to meet those goals. Although previously I was dedicated 100% to working with [my program], I now have two other programs in my portfolio. I am not able to dedicate as much time to [my program] as I should. I worry that this is eroding my ability to be a dedicated advocate." (Survey respondent)

Some programs also identified challenges related to the EPI Program Standards.

> *"Given what appears to be the case across the province, it seems that the standards could be revised to include a core (non-negotiable) set of standards and then a section on value-added. There is a disconnect between what is expected to be delivered, what is actually delivered, and what the available resources are to deliver. I see this leadership coming from the MOHLTC and EPION." (Survey respondent)*
>
> *"The standards are helpful in guiding practice, but in some cases are creating barriers…More direction re: how to manage these challenges would be welcomed. Program capacity, the ethics of waiting lists etc. are great challenges." (Survey respondent)*

Programs across the province gave examples where leaders have helped to support standards implementation. Some examples include:

- secured, dedicated resources and time to focus on the standards;
- organized EPION think tanks which brought providers together to work on challenging standards;
- advocating for a space that is youth friendly;
- support for attendance at network and EPION meetings/trainings;
- covering transportation costs when this is a barrier to service.

> *"Leadership at the program level has focused much attention on particular standards…we have streamlined our intake process, reduced wait times, and developed tools which will identify clients sooner…We also work with our satellite sites to provide improved access to clients in rural communities. Leadership has also guided the development of a clinical pathway to address standards #2 through #6, to create a comprehensive treatment plan." (Survey respondent)*

Next Steps

The Ontario EPI Program Standards lay out expectations for EPI delivery in Ontario and provide a core foundation for quality improvement and accountability activities.

The MOHLTC recognized the challenges that implementation poses and created the Standards Implementation Steering Committee. The SISC has a number of objectives, including assessing the current state of EPI program practice with respect to the standards, and identifying gaps and common themes related implementation.

The surveys represent an initial effort to engage the EPI program sector and obtain basic information. A first survey of provincial programs sought feedback on implementation of the first six standards, and results were shared with the LHINs and academic audiences, as well as with the programs themselves. The results helped to generate a number of stakeholder think tanks organized by EPION, looking at community education and outreach, metabolic monitoring, psychological interventions, family work, and knowledge exchange. Similarly, the results of the second survey will be shared with programs to promote reflection about current practice and areas for quality improvement.

Developing strategies for ongoing feedback on implementation and outcomes is an important aim of future work, foundational to program improvement.

EPION and the SISC have already started a process of LHIN engagement, to understand what information would be useful and feasible to provide, especially in the context of the Ontario Comprehensive Strategy for Mental Health and Addictions.

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