Health Innovation Portal:
Archive of Innovative Practices

Theme: **Health Promotion and Disease Prevention (Vol. 1)**

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Selected Search Output Table (December 16, 2013)

SEARCH TERMS:	**N/A**	**LOCATION:**	**All**
HEALTH THEME:	**Health Promotion and Disease Prevention**	**FRAMEWORK CATEGORY:**	**All**
HEALTH SECTOR:	**All**	**SEARCH RESULTS:**	**28 results out of 124**

1. Saskatoon Primary Health Bus

Implementation Year: Tuesday, December 9, 2008 - 15:45	**Location: Saskatchewan**	**Practice Website: http://www.saskatoonhealthregion.ca/your_health/ps_primary_health_health_bus.htm**

SNAPSHOT:

This innovative practice improves access to care in low-income neighbourhoods. The practice was launched in Saskatoon, Saskatchewan, and involves nurse practitioners and paramedics.

CONTACT INFORMATION:

Sheila Achilles, Director Primary Health and Chronic Disease Management Primary Health St. Paul's Hospital 1702-20th Street West Saskatoon, SK S7M 0Z9 Telephone: (306) 655-5806

2. Integration of Primary Health Care Nurse Practitioners (PHC NPs)

Implementation Year: Wednesday, December 9, 1998 - 15:00	**Location: Ontario**	**Practice Website:**

SNAPSHOT:

This innovative practice improves accessibility and quality of primary care through the use of nurse practitioners The practice has been implemented in Ontario in more than 300 primary care settings and involves provincial government funding of nurse practitioner (NP) education and clinical positions in family health teams, community health centres, nurse practitioner–led clinics, and other primary care practices and organizations.

CONTACT INFORMATION:

Ministry of Health and Long-Term Care Email: nursingsecretariat.moh@ontario.ca)

3. System-Wide Case Management

Implementation Year: Wednesday, November 26, 2008 - 14:15	**Location: Alberta**	**Practice Website: http://www.albertahealthservices.ca/services.asp?pid=service&rid=7573**

SNAPSHOT:

This innovative practice improves the coordination of care for persons managing chronic illness. The system-wide case management model was first launched in the Calgary region in Alberta in January 2008 as an 18-month pilot project. At that time, seven case managers were hired; within a year, over 200 clients were enrolled in the program. While the model has changed from its original scope and patient population targets, system-wide case management is still in practice in community care settings in the Calgary Region.

CONTACT INFORMATION:

Name: Barbra LeMarquand-Unich Title: Executive Director (Interim) Organization: Integrated Seniors and Continuing Care (Calgary Zone) Email address: barbra.lemarquand-unich@albertahealthservices.ca Telephone number: 403-943-0252 Information last updated on: August 8, 2013

4. Nurse and Dietitian Health Teams to Prevent Diabetic Complications

Implementation Year: Friday, November 26, 2004 - 14:00	**Location: Alberta**	**Practice Website: http://www.albertahealthservices.ca/services.asp?pid=service&rid=1001687**

SNAPSHOT:

This innovative practice improves the quality of diabetes management through the use of interprofessional health care teams delivering interventions to persons aged 17 years or older with diabetes and hypertension or albuminuria. The initial pilot round was launched in five communities in northern Alberta in 2004. The program has since been expanded to a total of eight communities (two urban and six rural), serving over 3,000 patients.

CONTACT INFORMATION:

Name: Carolyn Good Title: Office Coordinator Organization: Diabetic Nephropathy Prevention Clinics, Alberta Health Services Email address: carolyn.good@albertahealthservices.ca Telephone number: 780-407-1443 Information last updated on: July 26, 2013

5. Mental Health Liaison

Implementation Year: Friday, November 26, 2004 - 14:00	**Location: Alberta**	**Practice Website: http://www.albertahealthservices.ca/services.asp?pid=saf&rid=1017161**

SNAPSHOT:

This innovative practice improves the level of coordination and accessibility of mental health care services in a rural setting in Alberta by providing a direct link among physicians, nurses, and patients. In 2004, the mental health liaison was added as a new position to the Access and Early Intervention Program of Mental Health Services in the community of Rocky Mountain House, Alberta. There are now 27 mental health liaison positions throughout the central region of the province.

CONTACT INFORMATION:

Name: Gloria Bruggencate Title: Instructor Organization: Mental Health Services Email address: gbruggencate@dthr.ab.ca Telephone number: 403-783-7907

6. Healthy Buddies: A Peer-Led Health Promotion Program for the Prevention of Obesity and Eating Disorders in Elementary School Children

Implementation Year: Tuesday, November 5, 2002 - 14:45	**Location: British Columbia**	**Practice Website: http://www.healthybuddies.ca/**

SNAPSHOT:

This innovative practice educates children about nutrition, physical activity, and healthy growth and development. This health promotion program uses a peer-led model in which older children are educated so that they can teach their younger peers. The program was piloted in British Columbia in 2002–2004 and then expanded in 2006–2008.

CONTACT INFORMATION:

Name: Jean-Pierre Chanoine Title: Endocrinology and Diabetes Unit Healthy Buddies Program Organization: BC Children's Hospital Email address: jchanoine@cw.bc.ca or info@healthybuddies.ca Telephone number: 604-875-2345 ext 5120

7. Drop the Pop

Implementation Year: Friday, November 5, 2004 - 14:30	**Location: Northwest Territories, Nunavut, Yukon**	**Practice Website: www.dropthepopnwt.ca**

SNAPSHOT:

This innovative practice addresses the issue of childhood obesity and other nutrition-related health issues as part of a jurisdictional health promotion strategy. The practice was launched in 2004 in Nunavut, starting with 14 schools and involved a government lead, community partners, and administrators/teachers leading individual school efforts.

CONTACT INFORMATION:

Name: Title: Population Health Division, Health Promotion Organization: Government of Northwest Territories, Department of Health and Social Services Email address: healthpromotion@gov.nt.ca Telephone number: Information last updated on: July 29, 2013

8. Positive Parenting Program (Triple P) in Manitoba

Implementation Year: Friday, October 7, 2005 - 15:00	**Location: Manitoba**	**Practice Website:**

SNAPSHOT:

This innovative practice addresses behavioural and emotional problems in children and youth by educating and supporting their parents. It was launched in Manitoba in 2005 and began by training approximately 1,200 practitioners over an initial three-year period.

CONTACT INFORMATION:

Name: Dr. Steven Feldgaier, C. Psych Title: Director, Parenting Initiatives Organization: Healthy Child Manitoba Office, Government of Manitoba Email address: Steven.Feldgaier@gov.mb.ca Telephone number: 1-888-848-0140 or 204-945-3084

9. InSite: Vancouver's Medically Supervised Injection Facility

Implementation Year: Tuesday, October 7, 2003 - 13:45	**Location: British Columbia**	**Practice Website: http://supervisedinjection.vch.ca/**

SNAPSHOT:

This innovative practice addresses problems associated with illegal drug use, such as transmission of blood-borne diseases, fatal drug overdoses, and community safety. The practice was launched in Vancouver, British Columbia, in one clinic and involved a team of nurses, counsellors, mental health workers, and peer support workers.

CONTACT INFORMATION:

Name: Monika Stein Title: Manager, Harm Reduction Program Organization: Vancouver Coastal Health Email address: monika.stein@vch.ca Telephone number: n/a

10. Heart Healthy Kids (H2K)

Implementation Year: Saturday, October 7, 2006 - 13:15	**Location: Nova Scotia**	**Practice Website: http://maritimeheartcenter.ca/h2k-program**

SNAPSHOT:

This innovative practice addresses the impact of sedentary behaviour and physical inactivity on the health of children and youth. This practice was launched as a school-based program in Nova Scotia in 2006. It involved one paid staff member, many adult volunteer supervisors, and student peer mentors.

CONTACT INFORMATION:

Name: Becky Spencer Title: Programs Manager Organization: Maritime Heart Centre Email address: becky@maritimeheartcenter.ca Telephone number: (902) 446-3669

11. Social Work through Hip Hop (BluePrint For Life): Promoting physical and mental health in youth

Implementation Year: Saturday, October 7, 2006 - 11:15	**Location: National**	**Practice Website: www.blueprintforlife.ca**

SNAPSHOT:

This innovative practice addresses the issue of compromised physical and mental health in youth, especially those living in Canada's North and inner cities. This practice was first launched in Nunavut in 2006 and involves hip hop artists and facilitators with social work training, as well as community members to support the

event and follow-up activities.

CONTACT INFORMATION:

Name: Stephen Leafloor Title: CEO Organization: BluePrintForLife Email address: Steve@BluePrintForLife.ca Telephone number: 613 592 2220

12. British Columbia FRIENDS for Life Program: Preventing Childhood Anxiety

Implementation Year: Tuesday, February 3, 2004 - 11:15	Location: British Columbia	Practice Website: http://www.mcf.gov.bc.ca/mental_health/friends.htm

SNAPSHOT:

This innovative practice addresses the issue of helping children and youth cope with stress and develop emotional resilience by teaching cognitive and emotional skills in a simple, well-structured format. The school-based program was piloted in British Columbia in 2003 and launched provincially in 2004, becoming available to all public and independent schools in the province.

CONTACT INFORMATION:

Name: Kelly Angelius Title: Manager, BC FRIENDS For Life Program, Child and Youth Mental Health Services Organization: British Columbia Ministry of Children and Family Development Email address: mcf.cymhfriends@gov.bc.ca Telephone number: n/a Information last updated on: July 17, 2013

13. Positive Parenting Program (Triple P) International

Implementation Year: Wednesday, January 30, 1980 - 00:45	Location: International	Practice Website: www.triplep.net

SNAPSHOT:

This innovative practice addresses the issue of behavioural and emotional problems in children and youth by educating and supporting their parents. This practice was launched in Australia over an extended period, in community and primary care settings, using trained health professionals and others as “Triple P practitioners.”

CONTACT INFORMATION:

Name: Debbie Easton Title: Local contact - Canada Organization: Triple P International Email address: Debbie@triplep.net Telephone number: 905 392 6976 Information last updated on: July 4, 2013

14. Psychosocial/Psychoeducational Intervention for Persons with Recurrent Suicide Attempts (PISA): A Group Therapeutic Approach to Decreasing Suicidal Behaviour in Ontario

Implementation Year: Wednesday, January 20, 1999 - 02:00	Location: Ontario	Practice Website: N/a

SNAPSHOT:

This innovative practice addresses decreasing suicidal behaviour among people who have attempted suicide at least twice. The practice was launched at a teaching hospital in Toronto, Ontario, in 1999. It is run by two professionally licensed facilitators trained in the intervention and a peer facilitator who has graduated from the program.

CONTACT INFORMATION:

Name: Yvonne Bergmans Title: Suicide Intervention Consultant Organization: St. Michael’s Hospital – University of Toronto Email Address: Bergmansy@smh.ca Telephone Number: 416-864-6060 ext. 4078 Information Last Updated On: June, 2013

15. Partners for Life Program/ Solidaires pour la vie

Implementation Year: Wednesday, February 3, 1999 - 01:00	Location: Quebec	Practice Website: www.fondationdesmaladiesmentales.org

SNAPSHOT:

This innovative practice aims to address the issue of undiagnosed depression in youth, which could lead to suicide.This program was launched across the province of Québec in 1998. Teams of trained “animators” provide education sessions and follow-up in high schools across the province.

CONTACT INFORMATION:

Name: Catherine Burrows Title: Director, Youth Programs Organization: Foundation des Maladies Mentales / Mental Illness Foundation Email address: cburrows@fondationdesmaladiesmentales.org Telephone number: 514-529-5354 Information last updated on: July 2, 2013

16. The Reitman Centre CARERS Program: Equipping carers with practical skills and emotional support to provide better care for individuals with dementia

Implementation Year: Sunday, February 3, 2008 - 00:00	Location: Ontario	Practice Website: http://www.mountsinai.on.ca/care/reitman

SNAPSHOT:

This innovative practice addresses the need to equip professional and community carers with practical and emotional coping skills to enable them to effectively provide care to individuals with dementia. The program launched in an academic teaching hospital training centre in Ontario in 2008 with a focus on community-based carers, but is now expanding to provide workplace-based training to carers engaged in the workforce (working carers).

CONTACT INFORMATION:

Name: Dr. Joel Sadavoy Title: Head of Geriatric Psychiatry, the Reitman Centre for Alzheimer's Support and Training; Head of Community Psychiatry Services Organization: Mount Sinai Hospital Email address: Jsadavoy@mtsinai.on.ca Telephone number: 416-586-5262 Information last updated on: August 8, 2013

17. Mental Health First Aid Canada

Implementation Year: Friday, February 3, 2006 - 00:15	Location: National	Practice Website: www.mentalhealthfirstaid.ca

SNAPSHOT:

This innovative practice addresses the need for better mental health literacy within the general population, which facilitates early recognition of mental disorders and actions for prevention and intervention.

CONTACT INFORMATION:

Name: Meaghon Reid Title: Director, Mental Health First Aid Canada Organization: Mental Health Commission of Canada Email address: mhfa@mentalhealthcommission.ca Telephone number:613-683-3738 Information last updated on: June 25, 2013

18. Post-Traumatic Stress Disorder Service Dog Program

Implementation Year: Sunday, February 3, 2002 - 00:15	Location: Manitoba	Practice Website: http://msar.ca/?page_id=213

SNAPSHOT:

This innovative practice addresses providing support for Canadian Forces members (retired or active) suffering with post-traumatic stress disorder (PTSD). The practice was launched in Winnipeg, Manitoba, and involves a lead service-dog trainer and several volunteer trainers.

CONTACT INFORMATION:

Name: George Leonard Title: MSAR Master K-9 Trainer Organization: MSAR Search and Rescue Email address: GL@msar.ca

19. Pan-Canadian Joint Consortium for School Health (JCSH) Healthy School Planner

Implementation Year:	Location: National	Practice Website: http://eng.jcsh-cces.ca

Tuesday, February 3, 2009 - 00:15		

SNAPSHOT:

This innovative practice addresses the need for healthy school environments to help students succeed academically and to make healthy choices. The updated Healthy School Planner has been used by over 400 schools across Canada.

CONTACT INFORMATION:

Name: Ms. Katherine Kelly Title: Executive Director Organization: Pan-Canada Joint Consortium for School Health (JCSH) Secretariat Email address: kakelly@gov.pe.ca Telephone number: 902-888-8029 Information last updated on: July 2, 2013

20. Bounce Back: Reclaim Your Health

Implementation Year: Sunday, February 3, 2008 - 00:30	**Location: British Columbia**	**Practice Website: www.bouncebackbc.ca**

SNAPSHOT:

This innovative practice addresses the issue of mild to moderate depression in primary care patients by using self-help materials and telephone health coaching. It was launched in British Columbia in 2008.

CONTACT INFORMATION:

Name: Title: Organization: Canadian Mental Health Association, British Columbia Division Email address: bounceback@cmha.bc.ca Telephone number: 604-688-3234 Information last updated on: July 4, 2013

21. Mental Health Works

Implementation Year: Saturday, February 3, 2001 - 02:45	**Location: National**	**Practice Website: http://www.mentalhealthworks.ca/about**

SNAPSHOT:

This innovative practice addresses the issue of mental health in the workplace. The practice was launched in Ontario and has now been implemented in multiple organizations by trainers who educate employers.

CONTACT INFORMATION:

Name: Kathy Jurgens Title: National Program Manager Organization: Mental Health Works Canadian Mental Health Association, Ontario Division Email address: kjurgens@ontario.cmha.ca Telephone number: 416-977-5580 ext. 4120 Information last updated on: June 4, 2013

22. Targeted Newborn Screening for Treatable Genetic Disorders in the Old Order Amish Population of Southwestern Ontario

Implementation Year: Sunday, February 2, 2003 - 00:45	**Location: Ontario**	**Practice Website: http://www.biochemgenetics.ca/plainpeople/**

SNAPSHOT:

This innovative practice screens and identifies presymptomatic newborn infants at risk for genetic disorders.

CONTACT INFORMATION:

Name: Dr. Victoria Mok Siu Title: Medical Director, Medical Genetics Program of Southwestern Ontario Organization: London Health Sciences Centre and Schulich School of Medicine and Dentistry, University of Western Ontario Email address: vmsiu@uwo.ca Telephone number: 519-685-8140 Information last updated on: March 27, 2013

23. Neonatal Transition Team: Specialized Nursing Team for Vulnerable Infants

Implementation Year: Wednesday, February 3, 1999 - 01:00	Location: Alberta	Practice Website:

SNAPSHOT:

This innovative practice aims to facilitate the transition of vulnerable (premature or very low birth weight) newborns from acute care to the home environment and community supports.

CONTACT INFORMATION:

Name: Tammy Sherrow Title: Assistant Professor Organization: Mount Royal University Email address: tsherrow@mtroyal.ca Telephone number: 403-813-1924

24. ColonCancerCheck

Implementation Year: Sunday, February 3, 2008 - 00:45	Location: Ontario	Practice Website: http://www.health.gov.on.ca/en/public/programs/coloncancercheck/

SNAPSHOT:

This innovative practice is a population based colorectal screening program. Launched in Ontario in spring 2008, it aims to increase capacity of primary care providers (PCPs) to facilitate the screening tests.

CONTACT INFORMATION:

Name: Jill Tinmouth Title: Scientific Lead Organization: ColonCancerCheck Program, Cancer Care Ontario Email address: jill.tinmouth@sunnybrook.ca Telephone number: 416-480-6100, ext. 5910

25. Primary Outreach Services in British Columbia

Implementation Year: Saturday, February 3, 2007 - 01:00	Location: British Columbia	Practice Website: http://www.vch.ca/home/

SNAPSHOT:

This innovative practice addresses supported housing and emergency shelter residents' overall health by delivering clinical services on-site, improve residents' access to health services, create a strong partnership model in delivering health services, and reduce non-urgent hospital emergency department visits. Implemented in the Vancouver Coastal Health Authority since 2007, the program targets individuals who are chronically homeless, live chaotic lifestyles, and have multiple chronic health conditions, including mental health conditions and addiction.

CONTACT INFORMATION:

Name: Anne McNabb Organization: Vancouver Coastal Health Authority Email address: anne.mcnabb@vch.ca Telephone number: 604-730-7605 x 7605

26. Red Deer Primary Care Network—Chronic Disease Management Program

Implementation Year: Tuesday, February 3, 2009 - 00:30	Location: Alberta	Practice Website: http://www.reddeerpcn.com/OurPrograms/OurPrograms/Default.aspx

SNAPSHOT:

This innovative practice addresses that 30% of the population with chronic disease account for 60% of direct health care costs in Alberta. In response, the Red Deer Primary Care Network (RDPCN) developed and implemented an integrated chronic disease management strategy to improve health outcomes and reduce costs. RDPCN used a health promotion philosophy to design an integrated approach to preventing and managing chronic disease. Adapting the expanded chronic care model, chronic disease management programs are integrated with community-based health promotion strategies.

CONTACT INFORMATION:

Name: Lorna Milkovich Title: Executive Director Organization: Red Deer Primary Care Network Email address: Lorna.Milkovich@rdpcn.com

27. Integrating Supported Post-secondary Education with Supported Employment Program for People with Mental Illness

Implementation Year: Tuesday, February 3, 2009 - 00:00	**Location: Ontario, International**	**Practice Website:**

SNAPSHOT:

This innovative practice aims to facilitate successful college education and employment for students with mental health issues via supported education and supported employment. Launched as pilot studies in Israel and Canada, the program demonstrates that integrating supported education with supported employment may benefit people with mental illness to succeed in skilled occupations.

CONTACT INFORMATION:

Name: Dr. Abraham Rudnick Title: Associate Professor, Medical Director of the Mental Health and Addiction Services (MHAS) Organization: University of BC; Department of Psychiatry Email address: Abraham.rudnick@viha.ca Telephone number: 1-250-370-8396

28. Hamilton Family Health Team—Mental Health Program

Implementation Year: Friday, February 3, 2006 - 02:45	**Location: Ontario**	**Practice Website: http://www.hamiltonfht.ca/i-am-a-patient/mental-health**

SNAPSHOT:

This innovative practice was initially established in recognition that primary care physicians play a central role in delivering mental health care, often with minimal support from mental health services. Since 1994, the Hamilton Family Health Team (formerly Hamilton Health Service Organization) Mental Health Program (HFHT-MHP) has successfully integrated mental health counsellors and psychiatrists into the offices of 150 family physicians in 81 practices across the City of Hamilton.

CONTACT INFORMATION:

Name: Dr. Nick Kates Title: Acting Chair, Dept. of Psychiatry and Behavioural Neurosciences Organization: McMaster University Email address: nkates@mcmaster.ca Telephone number: 905-536-0966

Saskatoon Primary Health Bus

LOCATION:	Saskatchewan	**HEALTH THEME:**	Aboriginal Health
HEALTH SECTOR:	Primary Health Care	**FRAMEWORK CATEGORY:**	

Snapshot: This innovative practice improves access to care in low-income neighbourhoods. The practice was launched in Saskatoon, Saskatchewan, and involves nurse practitioners and paramedics.

Practice Description:

A 2006 study examining health disparities by neighbourhood in Saskatoon showed that low-income neighbourhoods have a higher than average use of health care, higher burdens of illness (including mental disorders, diabetes, chronic obstructive pulmonary disease, coronary artery disease, chlamydia, gonorrhea, hepatitis C), higher rates of teen births, and greater likelihood of low birth weights. Primary health care managers in Saskatoon Health Region recognized that residents of these neighbourhoods (primarily First Nations people, Métis, immigrants, and refugees) could not access primary care easily. To address this concern, they converted a recreational vehicle to serve as a mobile clinic with a fully equipped examination room. The Health Bus, which is staffed by nurse practitioners and paramedics, operates daily to provide primary care services to patients at various locations that are convenient to the residents. Services include blood pressure and blood sugar checks, diagnosis and treatment of common illness and injuries, testing for sexually transmitted infections, provision of free condoms, pregnancy testing, suturing and suture removal, wound care, management of chronic conditions, disease prevention, health education, advocacy, and referral. A community advisory committee helps guide Health Bus operations.

Impact:

The Saskatoon Health Region has tracked program utilization and demographic information of users. During the 2011/12 calendar year, 2,777 patients visited the bus (Saskatoon Health Region, 2012). The majority of visits were for integumentary or ENT conditions. The service was most heavily used by women and by people in the 0–9 and 20–59 age groups.

This innovative practice has been implemented since 2008 and does not have a completed evaluation at this time. While the practice has not been formally evaluated, personal testimonials, observations, and early results suggest that the practice can lead to improved performance metrics and has the potential to produce positive outcomes on health. Early evidence suggests mobile clinics improve screening for chronic conditions (diabetes and hypertension) and coordination of care (Conference Board of Canada, 2012).

An assessment of the costs and savings of this practice has not been completed at this time.

Applicability/Transferability

The success of the program is dependent on commitment to unique interprofessional primary health care teams; investment of resources for primary health care services to a small number of people; and engagement of community members in discussions of the scope of services and location of the bus.

The Health Bus has not been adapted from another jurisdiction. Three mobile primary care clinics designed to serve patients in rural and northern Manitoba communities who do not have a family physician are scheduled for implementation in 2013.

Contact Information:

Sheila Achilles, Director Primary Health and Chronic Disease Management

Primary Health

St. Paul's Hospital

1702-20th Street West

Saskatoon, SK S7M 0Z9

Telephone: (306) 655-5806

Content has been adapted from the following sources and relevant links:

This practice description is based on materials provided by Brian Hutchison and Monica Aggarwal on behalf of the Canadian Working Group for Primary Healthcare Improvement.

Publications

Canadian Health Services Research Foundation. (2010). Saskatoon Health Bus. In *Casebook of primary healthcare innovations: Picking up the pace.* Ottawa, ON: Canadian Health Services Research Foundation. Retrieved from http://www.cfhi-fcass.ca/Libraries/Picking_up_the_pace_files/CasebookOfPrimaryHealthcareInnovations.sflb.ashx

Conference Board of Canada. (October 2012). *Improving primary health care through collaboration: Briefing 1—Current knowledge about interprofessional teams in Canada.* Retrieved from http://www.wrha.mb.ca/professionals/collaborativecare/files/CBCBriefing12012.pdf

Saskatoon Health Region. (2012). *Primary Health Bus report (2011–2012): Events of Distinction 2011–2012.*

External Source: http://www.saskatoonhealthregion.ca/your_health/ps_primary_health_health_bus.htm

Integration of Primary Health Care Nurse Practitioners (PHC NPs)

LOCATION:	Ontario	**HEALTH THEME:**	Access and Wait Times
HEALTH SECTOR:	Primary Health Care	**FRAMEWORK CATEGORY:**	Promising

Snapshot: This innovative practice improves accessibility and quality of primary care through the use of nurse practitioners The practice has been implemented in Ontario in more than 300 primary care settings and involves provincial government funding of nurse practitioner (NP) education and clinical positions in family health teams, community health centres, nurse practitioner–led clinics, and other primary care practices and organizations.

Practice Description:

NPs are “registered nurses with additional educational preparation and experience who possess and demonstrate the competencies to autonomously diagnose, order and interpret diagnostic tests, prescribe pharmaceuticals and perform specific procedures within their legislated scope of practice”(CNA, 2009).

Education

The Ontario Primary Health Care Nurse Practitioner Education Program, established in 1995, is a standardized educational program delivered cooperatively by a nine-university consortium. The program uses multiple delivery modalities, including distance education, and is offered in both English and French. Baccalaureate-trained RNs studying full time can complete the seven core graduate-level courses that comprise the NP certificate program in one year. A combined Masters of Nursing/NP Certificate program has been available since 2008, and in most of the participating universities the combined program is now the only option available. The annual number of spaces in the PHC NP education program for full- and part-time students is currently 200.

Regulation

Ontario legislation providing for the registration of PHC NPs was proclaimed in 1998. Initially, NPs were allowed to order only a specified set of medications and diagnostic tests. Restrictions on NPs prescribing (except for controlled substances) and ordering laboratory tests were eliminated in 2011.

NP Practice

The nature and scope of NP practice varies across primary care settings. Some NPs provide care to a general primary care population while others focus on a specific population or health condition. Their work may involve varying combinations of acute illness care, chronic disease management, illness prevention, and health promotion. Some NPs have their own patient panel, but most share responsibility for a patient population with one or more family physicians.

Impact:

Ontario was home to the first randomized controlled trial (RCT) of NPs, which was carried out in a Burlington family practice setting by Spitzer et al. (1974). Since then, many RCTs have been conducted internationally, mainly in the US, the UK, and the Netherlands. Systematic reviews of these RCTs have consistently concluded that NPs deliver safe, effective care (Horrocks, Anderson, and Salisbury, 2002; Newhouse et al., 2011).

A study by Russell et al. (2009) of chronic disease management in Ontario primary care practices concluded that “Across the whole sample and independent of model, high-quality chronic disease management was associated with the presence of a nurse-practitioner.” Ducharme, Alder, Pelletier, Murray, and Tepper (2009) evaluated the addition of PHC NPs and physician assistants to community hospital emergency departments in Ontario. In emergency departments that had NPs and/or physician assistants, the wait times, lengths of stay, and proportion of patients who left without being seen were significantly reduced.

While the integration of PHC NPs has not been fully evaluated, personal testimonials, observations, and early results suggest that the practice can lead to improved performance metrics and has the potential to produce positive outcomes on health.

An assessment of the costs and savings of this practice has not been completed at this time.

Applicability/Transferability

All provinces and territories have legislation in place for the NP role, although implementation has been most widespread in Ontario. The practice informant did not indicate whether the provinces and territories have worked collaboratively in defining the role of the NP.

The success of this specific program is dependent on:

• educating patients, providers, and insurance companies about the role and responsibilities of nurse practitioners and NPLCs;

• establishing effective governance structures, administration, and organizational development (e.g., interprofessional team functioning, information technology);

• engaging nursing stakeholders;

• providing appropriate NP compensation;

• optimizing roles within the team; and

• aligning financial incentives to ensure specialists are not disadvantaged by referrals from NPs.

Contact Information:

Ministry of Health and Long-Term Care

Email: nursingsecretariat.moh@ontario.ca)

Content has been adapted from the following sources and relevant links:

This practice description is based on materials provided by Brian Hutchison and Monica Aggarwal on behalf of the Canadian Working Group for Primary Healthcare Improvement.

Personal Communication

Skelly, J. (August 19, 2013). [Assistant Dean, Nursing Graduate Program, School of Nursing, McMaster University].

Publications

Canadian Nurses Association. (2008). *Position statement: The nurse practitioner.* Retrieved from http://www2.cna-aiic.ca/CNA/documents/pdf/publications/PS_Nurse_Practiti...

College of Nurses of Ontario. (2013). *Membership totals at a glance.* Retrieved from http://www.cno.org/what-is-cno/nursing-demographics/membership-totals-at-a-glance/

Conference Board of Canada. (2012). *Improving primary health care through collaboration: Briefing 1—Current knowledge about interprofessional teams in Canada*. Retrieved from http://www.wrha.mb.ca/professionals/collaborativecare/files/CBCBriefing12012.pdf

DiCenso, A., Bourgeault, I., Abelson, J., Martin-Misener, R., Kaasalainen, S., Carter, N., … Kilpatrick, K. (2010). Utilization of nurse practitioners to increase patient access to primary healthcare in Canada—Thinking outside the box. *Canadian Journal of Nursing Leadership, 23* (Special Issue), 239–259. Retrieved from https://www.longwoods.com/content/22281/print

Ducharme, J., Alder, R.J., Pelletier, C., Murray, D., & Tepper, J. (2009). The impact on patient flow after the integration of nurse practitioners and physician assistants in 6 Ontario emergency departments. *Canadian Journal of Emergency Medicine, 11*(5), 455–461. Retrieved from http://www.aimhealthgroup.com/pressreleases/companynews_jd.pdf

Horrocks, S., Anderson, E., & Salisbury, C. (2002). Systematic review of whether nurse practitioners working in primary care

can provide equivalent care to doctors. *British Medical Journal, 324*, 819–823. Retrieved from http://www.bmj.com/content/324/7341/819

Mian, O., Lacarte, S., & Koren, I. (2012). *2012 nurse practitioner workforce tracking study*. Centre for Rural and Northern Health Research. Retrieved from

http://www.cranhr.ca/pdf/CRaNHR_2012_NP_TS_survey_report_November_2012.pdf

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System-Wide Case Management

LOCATION:	Alberta	**HEALTH THEME:**	Access and Wait Times
HEALTH SECTOR:	Home and Community Care	**FRAMEWORK CATEGORY:**	Emerging

SNAPSHOT: This innovative practice improves the coordination of care for persons managing chronic illness. The system-wide case management model was first launched in the Calgary region in Alberta in January 2008 as an 18-month pilot project. At that time, seven case managers were hired; within a year, over 200 clients were enrolled in the program. While the model has changed from its original scope and patient population targets, system-wide case management is still in practice in community care settings in the Calgary Region.

PRACTICE DESCRIPTION:

In its initial stages as a pilot program, the system-wide case management was designed to serve four patient population groups: multiple sclerosis (MS), amyotrophic lateral sclerosis (ALS), mental health related to brain injury, and dementia. Two roles were designed to deliver the services of the system-wide case management program. The first was the case manager, who was responsible for overseeing patients' navigation throughout their care pathway. Core components of the case managers' work included patient intake, assessment, care planning, evaluation, reassessment, discharge, and transition. Case managers were considered as experts in available treatment and program options, bridging services for particularly complicated cases, and improving communication through the development of a report system between patient, care project managers, and providers. The second role was the project manager, who was responsible for overseeing the work of the case manager. The two roles worked together to enable broader care management models that include advocacy, building relationships, education, connecting resources, and working directly with other health care team members. Specific roles were dependent on the setting context, resources, and needs of patients/clients.

Once the project surpassed its pilot phase, the costs of running these services were absorbed into the general operations budget of Alberta Health Services. However, the program underwent significant changes from 2009 to 2012 due to broader provincial restructuring efforts. The project manager role was discontinued towards the end of 2008. In addition, the program currently exists for dementia management only, as this was the patient population group that was identified as benefiting the most from these services relative to human resources input.

IMPACT:

To assess the qualitative impact of this pilot project, nearly 100 interviews were conducted with clients, informal caregivers, families, health care professionals, system-wide case managers, and working group members at the midpoint and endpoint of the pilot phase in February 2009. Among respondents, there was consensus around improved access to and integration of services for patients and their families. Acute care data were also collected, but due to sample size and lack of comparison group no quantitative analysis was possible with the given data set. (The terms of continuity of the initiative had to balance out the positive impact assessments with resource allocation projections.)

APPLICABILITY/TRANSFERABILITY:

The system-wide case manager position is similar to other positions, such as patient navigators or care coordinators, in Canada. However, this initiative is distinctively based on its specific population targets and its evaluation framework. The evaluation framework was informed by the Calgary Health Region's Framework for Case Management, Case Management for Continuing Care Clients, the System-wide Case Management Project Charter, and McMaster University's Case Management Workshop Workbook.

Key factors identified as contributing to the success of this program include collaborative partnerships, clinical practice support, staffing, service provision, target populations, goals, outcomes, and appropriate caseloads. As the program continues, program managers have emphasized the need for greater standardization of the guidelines for client intake and assessment; care planning, evaluation, reassessment; and discharge planning particularly. A province-wide evaluation of case management is due to come out in March 2014.

CONTACT INFORMATION:

Name: Barbra LeMarquand-Unich

Title: Executive Director (Interim)

Organization: Integrated Seniors and Continuing Care (Calgary Zone)

Email address: barbra.lemarquand-unich@albertahealthservices.ca

Telephone number: 403-943-0252

Information last updated on: August 8, 2013

Content has been adapted from the following sources and relevant links:

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Personal Communications:

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External Source: http://www.albertahealthservices.ca/services.asp?pid=service&rid=7573

Nurse and Dietitian Health Teams to Prevent Diabetic Complications

LOCATION:	Alberta	**HEALTH THEME:**	Health Human Resources
HEALTH SECTOR:	Primary Health Care	**FRAMEWORK CATEGORY:**	Promising

SNAPSHOT: This innovative practice improves the quality of diabetes management through the use of interprofessional health care teams delivering interventions to persons aged 17 years or older with diabetes and hypertension or albuminuria. The initial pilot round was launched in five communities in northern Alberta in 2004. The program has since been expanded to a total of eight communities (two urban and six rural), serving over 3,000 patients.

PRACTICE DESCRIPTION:

To address the generally increasing burden of diabetes and chronic kidney disease, interprofessional teams were established to include a registered nurse and a registered dietitian in clinics staffed by an endocrinologist, nephrologist, advanced practitioner/project manager, pharmacist, and clerk. The roles of the nurse and dietitian involved promoting the development and use of evidence-based protocols and guidelines, helping to control risk factors through lifestyle coaching, conducting regular follow-ups, and adjusting multifactorial interventions based on individual development.

The clinics were advertised to health care providers to initiate the referral process. New patient intakes involved a standardized assessment conducted by the nurse and dietitian (two hours in duration), subsequent visits lasted one hour, and reports from each visit were sent to the referring physician. The education program for nurses and dietitians associated with introduction of this care model involved an initial five-day residential training program, followed by monthly one-day training sessions, bi-weekly telehealth sessions, and ongoing, on-site mentoring by the program's advanced nurse practitioner.

Initially, the pilot project was funded by the provincial government, with a start-up budget of $800,000 per annum. Funding now falls under the Northern Alberta Renal Program, with the local health authority as the acting employer.

IMPACT:

During the initial data collection period between 2004 and 2005, there were 570 referrals received, 99% of which were eligible and came predominantly from family physicians (as compared to specialists). A longer assessment period continued into 2007, in which 235 patients were followed up for one year of receiving services. Clinically significant improvements were reported for patients across indicators for blood pressure, glycemia, lipid levels, and albuminuria. However, patients who did not adhere to lifestyle changes such as smoking cessation had consistently worse clinical outcomes. Successes were attributed to the role of the interprofessional team and the follow-up visits to reinforce advice from physicians to operationalize lifestyle changes. Follow-up visits were calculated to cost $130 each, but no formal cost-effectiveness evaluation was done.

APPLICABILITY/TRANSFERABILITY:

This innovative practice is considered to be transferrable as demonstrated by its expansion to other northern Alberta communities following the initial pilot period. Although one of the initial clinics in Red Deer closed, there are now eight communities hosting these interprofessional clinics, which are monitoring over 1,800 patients in total. Active clinics include:

• Edmonton, Northeast Community Health Centre (est. January 2004);

• Vermilion (est. January 2004);

• Hinton (est. January 2004);

• Wetaskiwin (est. January 2004);

• Edmonton, Grey Nuns Hospital (est. October 2005);

• Edson (est. January 2007);

• Grande Prairie (est. February 2007); and

• Fort McMurray (est. June 2008).

Challenges in the background context that were noted included persistent underuse of proven therapies, undersupply of physicians in rural settings, and fee-for-service payment schemes that are not aligned with ongoing, chronic disease management. Specific to the introductions of new programs, careful communication was required to establish trust around the transcendence of traditional roles practised by the registered nurses and manage perceptions of overlapping services with pre-existing programs. Key factors contributing to this program's success were the partnership with local health authorities and the positive reception from participating communities.

CONTACT INFORMATION:

Name: Carolyn Good

Title: Office Coordinator

Organization: Diabetic Nephropathy Prevention Clinics, Alberta Health Services

Email address: carolyn.good@albertahealthservices.ca

Telephone number: 780-407-1443

Information last updated on: July 26, 2013

Content has been adapted from the following sources and relevant links:

Publications:

Senior, P.A., MacNair, L., & Jindal, K. (2008). Delivery of multifactorial interventions by nurse and dietitian teams in a community setting to prevent diabetic complications: A quality improvement report. *American Journal of Kidney Diseases*, *51*(3), 425–434. Retrieved from http://www.ajkd.org/article/S0272-6386%2807%2901586-7/abstract

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Personal Communications:

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McKenzie, J. (July 25, 2013). [Project Manager, Alberta Health Services].

External Source: http://www.albertahealthservices.ca/services.asp?pid=service&rid=1001687

Mental Health Liaison

LOCATION:	**Alberta**	**HEALTH THEME:**	**Aboriginal Health**
HEALTH SECTOR:	**Home and Community Care**	**FRAMEWORK CATEGORY:**	**Promising**

SNAPSHOT: This innovative practice improves the level of coordination and accessibility of mental health care services in a rural setting in Alberta by providing a direct link among physicians, nurses, and patients. In 2004, the mental health liaison was added as a new position to the Access and Early Intervention Program of Mental Health Services in the community of Rocky Mountain House, Alberta. There are now 27 mental health liaison positions throughout the central region of the province.

PRACTICE DESCRIPTION:

Key gaps in health care services identified in Rocky Mountain House and neighbouring Aboriginal communities in Alberta included poor coordination and continuity of mental health services; inadequate quality, accessibility, and awareness of available resources; and low numbers of well-trained mental health professionals. Consequently, the development of a mental health liaison stemmed from the need to improve these service gaps to better meet the needs of the population. This was supported by political will at regional levels and in alignment with the Provincial Mental Health Plan. The position was designed for a nonpsychiatric, rural health care setting and involved a broader scope of practice to include any of the following tasks: direct and indirect client intervention, mental health assessment and consultation, risk assessment, crisis intervention, supportive counselling, brief therapy follow-up, advocacy, staff mentoring, education, psychological first aid, research, mental health prevention and promotion, and more. Actual scope of practice for a given mental health liaison practising in a given community is determined by population needs, mental health managers, and site leaders. Ongoing funding for the continuation of this position has been secured through various arrangements of annualizing innovation grants from the province, reorganizing institutionally managed budgets, and adjusting scopes of practice for vacated positions.

IMPACT:

The introduction of this new position in Rocky Mountain House was first evaluated in 2005 by a questionnaire survey of 116 physicians, hospital staff, and community mental health workers. With a 50% response rate, there was unanimous support that the mental health liaison was serving community needs that were previously unmet. Improvements were noted with respect to the appropriateness of mental health care delivered; support for clients, staff, and physicians; continuity of care through follow-up services; and consistency in the coordination of care. While narrative results were consistently positive, reflecting the general acceptance of this position in this community, it is important to note that the results from the Rocky Mountain House setting are highly personality dependent, and thus the data have limited generalizability.

APPLICABILITY/TRANSFERABILITY:

The initial introduction of the mental health liaison position in Alberta was strongly influenced by similar role development undertaken in rural settings in Australia. Although not formally documented, the mental health liaison role in Rocky Mountain House was expanded to seven additional positions in the first year of introduction, and is now practiced by a total of 27 health providers (predominantly nurses) in the Central Region of Alberta. Communities hosting mental health liaison positions are:

• 1 full-time position: Consort, Castor, Coronation; Drayton Valley; Hanna; Hardisty; Innisfail; Killiam; Lamont; Olds; Ponoka; Rocky Mountain House; Stettler; Sundre; Tofield; Vegreville; Vermilion; and Wainwright, Provost

• 1 part-time position: Sylvan Lake

• 2 full-time positions: Camrose, Lacombe, Westaskiwin

• 2 part-time positions: Red Deer, Three Hills

The initial mental health liaison position in Rocky Mountain House is also linked to the integration of mental health liaisons for the Canadian National Committee for Police (http://www.pmhl.ca/Index.html), and is responsible for a similar role (mental health consultant) that is still in place in the community of Drumheller. Other similar mental health liaison positions have been

developed independently across Canada, indicating the level of relevance and transferability of this innovative practice.

Based on the 2005 evaluation, important areas to address for the further expansion of the mental health liaison position include:

• support to prevent burnout, given that the responsibilities overlap with those of physicians, nurses, and staff, and that the incumbents try to provide increasingly accessible services, often outside of regular hours;

• divergence between patient expectations and the professional cultures of physicians, nurses, and staff; and

• determining appropriate remuneration.

CONTACT INFORMATION:

Name: Gloria Bruggencate

Title: Instructor

Organization: Mental Health Services

Email address: gbruggencate@dthr.ab.ca

Telephone number: 403-783-7907

Content has been adapted from the following sources and relevant links: Information last updated on: July 31, 2013

Publications:

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Healthy Buddies: A Peer-Led Health Promotion Program for the Prevention of Obesity and Eating Disorders in Elementary School Children

LOCATION:	British Columbia	**HEALTH THEME:**	Health Promotion and Disease Prevention
HEALTH SECTOR:	Home and Community Care	**FRAMEWORK CATEGORY:**	Promising

SNAPSHOT: This innovative practice educates children about nutrition, physical activity, and healthy growth and development. This health promotion program uses a peer-led model in which older children are educated so that they can teach their younger peers. The program was piloted in British Columbia in 2002–2004 and then expanded in 2006–2008.

PRACTICE DESCRIPTION:

Healthy Buddies is a unique, child-centred health promotion program targeting attitudes and behaviours related to physical activity, healthy eating and beverage consumption, healthy growth and development, and healthy body image.

The *Healthy Buddies* program provides an opportunity to shape the health culture of children and adolescents when they are at school. The classroom setting is used to teach kids about nutrition, physical activity, and healthy development. The social culture in schools contributes to the development of children's attitudes and habits, which influence health and lifestyle beliefs and behaviours as they mature. The Healthy Buddies program also provides the basis for a collaborative relationship among health care, health promotion, and education interests to reduce the incidence of preventable health problems.

Healthy Buddies is a peer-led program designed for use with elementary school students from kindergarten to grade 7. Older "buddies" (in grades 4 through 7) first receive a healthy-living lesson from their teachers. They then act as peer-teachers to deliver that lesson to their younger buddies (kindergarten through grade 3). Teachers do not conduct separate lessons with the younger buddies. Healthy Buddies is implemented in the entire school with all paired classes progressing through the 21 (weekly) healthy-living lessons concurrently, bringing awareness about health promotion into the school environment. The program is an innovative way to promote and improve health for both younger and older elementary students, based on the principle that students can learn from one another in a peer-led education model.

Healthy Buddies is an initiative of BC Children's Hospital, with funding support from the Provincial Health Services Authority.

IMPACT:

The *Healthy Buddies* program was formally evaluated in a randomized, controlled, prospective pilot study, with results published in *Paediatrics*. The pilot study compared the effect of the program (two to three hours per week for 21 weeks) in two Canadian elementary schools; one school implemented the program (intervention: n = 232 children) and one did not (control: n = 151). Outcomes in students from both schools were compared. All students were evaluated at the beginning and end of the intervention, which lasted 10 months over the school year.

Evaluations included measurements of height, weight, blood pressure, and heart rate. Questionnaires assessed students' healthy-living knowledge, frequency of foods consumption, active/non-active behavioural frequency, body satisfaction, and disordered eating symptoms. Compared with control students, intervention students showed an increase in healthy-living knowledge, behaviour, and attitude scores and a smaller increase in systolic blood pressure. BMI and weight increased less in the intervention students in grades 4 through 7, and height increased more in the intervention students in kindergarten through grade 3. Additionally, the student-led program providing an opportunity for older peer-teachers to be positive role models.

Regarding cost, schools implementing the program typically order one or two Fitness Loop Bins ($665.00/bin) and one Classroom Bin ($690.00/bin) for each pair of buddy teachers. All materials and lesson plans for program delivery are included in these package bins can be reused from year to year.

APPLICABILITY/TRANSFERABILITY:

The *Healthy Buddies* program was developed in BC and first piloted in one school district region (Sunshine Coast) from 2002 to 2004. Additional funding was secured to implement the Healthy Buddies program in 46 elementary schools across BC between 2006 and 2008. Follow-up program and process evaluation of this implementation was published in the *Canadian Journal of Diabetes* in 2012.

Extensive program materials and resources (including teacher plans, fitness and nutrition guides, student workbooks, and promotional materials) have been developed and are available on a cost recovery basis to assist in implementing the program. *Healthy Buddies* also exists in two additional versions: First Nations and Inuit. The program has been modified to reflect the respective cultures and habits of these communities. The effectiveness of the First Nations experience has been reported in the *Journal of School Health*.

To date, the program has been implemented in Alberta and Manitoba. The results of the Manitoba experience will be published in *JAMA Pediatrics* (2013). The program is also being adapted in India.

Suggestions for implementation: The program is most applicable for elementary schools with grades K–7. The pilot found that pairing classrooms for the duration of the program can increase fidelity and provide support. Having all students and teachers involved for the duration of the school year helps create a healthy-living environment within the school.

CONTACT INFORMATION:

Name: Jean-Pierre Chanoine

Title: Endocrinology and Diabetes Unit Healthy Buddies Program

Organization: BC Children's Hospital

Email address: jchanoine@cw.bc.ca or info@healthybuddies.ca

Telephone number: 604-875-2345 ext 5120

Information last updated on: July 17, 2013

Content has been adapted from the following sources and relevant links:

Personal Communications:

Chanoine, J.P. (review and feedback, July 2013). [BC Children's Hospital].

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Institut canadien pour la sécurité des patients. *Canadian Disclosure Guidelines: Being open with patients and families*, novembre 2011. Extrait de : www.patientsafetyinstitute.ca/english/toolsresources/disclosure/pages/default.aspx.

Autres :

Chidwick, P. Présentation de résumé dans le cadre du Symposium national sur les soins de santé intégrés du Conseil canadien de la santé (2012).

External Source: http://www.healthybuddies.ca/

Drop the Pop

LOCATION:	Northwest Territories, Nunavut, Yukon	**HEALTH THEME:**	Aboriginal Health
HEALTH SECTOR:		**FRAMEWORK CATEGORY:**	

SNAPSHOT: This innovative practice addresses the issue of childhood obesity and other nutrition-related health issues as part of a jurisdictional health promotion strategy. The practice was launched in 2004 in Nunavut, starting with 14 schools and involved a government lead, community partners, and administrators/teachers leading individual school efforts.

PRACTICE DESCRIPTION:

Concern has grown over time about over the high rate of pop consumption and the increasing rates of obesity, diabetes, and dental cavities in children and adolescents in Canada's north. This innovative practice has been implemented in various jurisdictions as part of a larger strategy to prevent childhood obesity and chronic disease later in life. "Drop the Pop (DTP)" is an annual health promotion campaign designed to increase students' awareness of how sugary drinks affect their health, and to encourage students and their families to drink/eat healthier beverages and foods and make healthy lifestyle choices. It was first implemented in Nunavut, targeting students in kindergarten to grade 12. The original Nunavut approach included (1) schools, classrooms, and students competing for prizes by not drinking pop for one school week, and (2) teachers and students learning about the health impacts over time of drinking pop regularly. The first year involved 14 schools and the number of participating schools grew year over year.

A pan-territorial implementation of DTP began in 2011; the campaign runs between January and March of each year. The campaign theme is adapted in each territory according to differences in funding, personnel, and community-based partnerships. Funding supports provincial promotional activities, school incentives and awards, and school/classroom projects. Sources of funding can include government, non-governmental organizations, and philanthropic organizations. Partners may contribute in-kind resources, such as store coupons for a free fresh fruit or milk. Other resources include the time of territorial (government) leads, school coordinators, community partners, and administrators/teachers leading school efforts. To receive government funding, schools complete an application. Past projects have included, for example, school activities regarding healthy eating and active living, family and community events, school/student challenge projects, health fairs, and nutrition education.

The Childhood Obesity Foundation has proposed that the success of the DTP program is due to its flexible and evolutionary approach. It responds to needs that are identified at the school level and reflects the innovations and ideas of teachers, schools, and communities.

IMPACT:

A 2011 evaluation studied the implementation and short-term outcomes of the 2010/2011 pan-territorial "Drop the Pop" campaign, using survey information.

- Schools (77%) indicated their students brought healthier beverages and foods to school during the campaign period.
- Students reported drinking/eating healthy beverages/foods at school and home duringthecampaignmonth.
- Many parents replied that their children asked them to buy healthy foods or drinks for them to eat at home during that time.
- Students (71%) could identify three foods of which they should eat more, and 86% could identify three foods of which they should eat less.

Personal testimonials and observations suggest that this practice has the potential for positive long-term outcomes on health. An assessment of the costs and savings of this practice has not been completed at this time.

APPLICABILITY/TRANSFERABILITY:

This practice was developed in Nunavut by nutrition and dental health specialists in 2003 and the campaign was launched in 2004. "Drop the Pop" was adopted by the Yukon and Northwest Territories in 2005/2006 and subsequently by other Canadian

jurisdictions. In 2007, the Cree Board of Health and Social Services of James Bay adapted Nunavut's *Drop the Pop Teacher's Guide* for its campaign. The Kidney Foundation of Manitoba invited First Nations schools, parents, and communities to participate in a one-week DTP Challenge. In 2011, Nunavut and Yukon daycares became eligible to apply for funding and to participate in the "Drop the Pop" Challenge

Lessons learned that would affect applicability/transferability of the practice include:

- Local partnerships with retailers have contributed to the program's success.
- Small cash incentives are useful motivators.
- Prize draws are offered to schools to encourage all participants to submit their project and/or financial and evaluation reports.
- It is useful to tie the DTP Challenge to annual jurisdictional initiatives such as nutrition month or dental health month.
- The campaign has been aligned with the Sip Smart! Initiative in some parts of Nunavik in Quebec.

CONTACT INFORMATION:

Name:

Title: Population Health Division, Health Promotion

Organization: Government of Northwest Territories, Department of Health and Social Services

Email address: healthpromotion@gov.nt.ca

Telephone number: Information last updated on: July 29, 2013

Content has been adapted from the following sources and relevant links:

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External Source: www.dropthepopnwt.ca

Positive Parenting Program (Triple P) in Manitoba

LOCATION:	Manitoba	**HEALTH THEME:**	Health Promotion and Disease Prevention
HEALTH SECTOR:	Public Health	**FRAMEWORK CATEGORY:**	Promising

SNAPSHOT: This innovative practice addresses behavioural and emotional problems in children and youth by educating and supporting their parents. It was launched in Manitoba in 2005 and began by training approximately 1,200 practitioners over an initial three-year period.

PRACTICE DESCRIPTION:

The Positive Parenting Program (Triple P) is a parenting and family support system to prevent and treat behavioural and emotional problems in children and teenagers. It supports parents to enhance their parenting knowledge, skills, and confidence, which should lead to reduced behavioural problems in children and teens. Triple P in Manitoba is based on the Triple P system developed by Australian Professor Matt Sanders and is a system of five levels of interventions: from public awareness activities (level 1, Universal Triple P), to brief parent skills counselling and support via primary care (level 3), to intensive family interventions (level 5). Education and counselling can be group-based, one-on-one, or self-directed. Family workers, social workers, psychologists, doctors, nurses, school counsellors, teachers, early learning and child care instructors, and clergy are among the many different service providers who can be trained and accredited as Triple P Practitioners.

In 2005, the Manitoba government committed $1.4 million to implement the Triple P under its Healthy Child Manitoba (HCM) Strategy. There was an initial focus on families with children under age 12, especially those under age six. The short-term goals were to up-skill the workforce and to increase families' access to parenting supports and information. The longer-term goals are to (1) reduce rates of children's social and behavioural difficulties, (2) reduce percentage of children entering school "not ready," and (3) build healthy families and communities.

From 2005 to 2008, Triple P practitioner training and accreditation was conducted for 1,200 practitioners across the province, including those in First Nations communities. Since then, another approximately 1,000 practitioners have been trained and accredited across sectors. Support was also provided for the integration of Triple P into health, education, and social service organizations. In 2008, the Universal Triple P (level 1) was implemented, to inform the public about Triple P and the range of resources across the province. In 2011, Universal Triple P activities were expanded to influence the public's attitudes about parenting and provide parenting tips.

The practice is innovative because it targets parents and families to effect change in the behaviours of children and youth. It is a flexible system that allows information and professional support to be tailored to individual families.

IMPACT:

The Manitoba Triple P does not have a completed outcome evaluation at this time. Personal testimonials, observations, a developmental evaluation, and international research suggest this practice has the potential to realize positive impacts on health. The evidence base for Triple P consists of over 250 published papers, including reports of 140 outcome studies, 68 randomized control trials, and 51 effectiveness and service-oriented evaluations. Research findings include a reduction of problem behaviour in children, improvement of parents' well-being and parenting skills, slowed rates of child abuse, and decreased hospitalizations from child abuse injuries. Research analysis has made the theoretical case for cost recovery with a population-based implementation of the Triple P. An assessment of the costs and savings has not yet been completed in Manitoba.

APPLICABILITY/TRANSFERABILITY:

Triple P has been adopted in 25 countries and in Canadian jurisdictions, such as Ontario and Alberta. Lessons learned from Manitoba's 2010 developmental evaluation include the finding that most of the trained practitioners had incorporated Triple P principles, ideas, and strategies into their existing work. Many of those trained were using the Triple P in a stand-alone fashion while others were using it in a more seamless, integrated manner. The study also found high workplace support for the program's use. Barriers to implementation included parents' literacy levels and language abilities. Ongoing monitoring has

identified gaps in service and challenges for certain groups:

- A Parent Line was established to extend the reach of program information, especially for families in remote areas.
- Stepping Stones Triple P was implemented to support parents of children with disabilities.
- Teen Triple P is in the planning stages, after an equity-focused health impact assessment was undertaken to identify potential inequities.
- Manitoba was the first province to offer Triple P training for practitioners and resources for families in French.
- Triple P for incarcerated parents is the result of a partnership through Healthy Child Manitoba and Manitoba Justice.
- Ongoing discussions with First Nations communities continue, to make Triple P as relevant as possible to meet their needs.

PRACTICE WEBSITE: www.manitobatriplep.ca

CONTACT INFORMATION:

Name: Dr. Steven Feldgaier, C. Psych

Title: Director, Parenting Initiatives

Organization: Healthy Child Manitoba Office, Government of Manitoba

Email address: Steven.Feldgaier@gov.mb.ca

Telephone number: 1-888-848-0140 or 204-945-3084

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Content has been adapted from the following sources and relevant links:

Personal Communication:

Cohen, B., Feldgaier, S., & Serwonka, K. (interview, July 17, 2013; review August 2, 2013). [Feldgaier & Serwonka: Government of Manitoba; Cohen: University of Manitoba].

Publications

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Feldgaier, S., Volk, J., Beaucage, J., Unger, D., Campbell, L., Fulham, R., … Penfold, M. (2011, March). *Disseminating the Triple P—Positive Parenting Program in Manitoba: Lessons learned from a province-wide implementation*. [Presentation to the XLIII Banff International Conference on Behavioural Science].

InSite: Vancouver's Medically Supervised Injection Facility

LOCATION:	**British Columbia**	**HEALTH THEME:**	**Health Promotion and Disease Prevention**
HEALTH SECTOR:	**Primary Health Care**	**FRAMEWORK CATEGORY:**	**Leading**

SNAPSHOT: This innovative practice addresses problems associated with illegal drug use, such as transmission of blood-borne diseases, fatal drug overdoses, and community safety. The practice was launched in Vancouver, British Columbia, in one clinic and involved a team of nurses, counsellors, mental health workers, and peer support workers.

PRACTICE DESCRIPTION:

Vancouver is home to about 12,000 intravenous (IV) drug users, with more than one third living in the Downtown Eastside (DTES). Injection of illegal drugs is associated with significant health and social consequences for users, their families, and their communities. The consequences include injection-related infections, overdose, blood-borne disease transmission, and exposure to discarded needles, violence, property crime, and the sex trade. In the DTES, three in 10 IV drug users are HIV positive, nine in 10 have hepatitis C, and the overall mortality rate is 14 times that of other BC residents.

InSite, North America's first supervised injection facility (SIF), provides 12 booths where clients inject preobtained illegal drugs under the supervision of nurses and other health care staff. InSite supplies users with clean injection equipment that is safely discarded after use. Nurses provide health care services such as wound care and immunizations, and intervene immediately if an overdose occurs. InSite also has addictions counsellors, mental health workers, and peer staff who connect clients to community resources such as housing, addictions treatment, and other support services. InSite was designed to make health care services accessible to IV drug users. If clients choose to access withdrawal management services, the second floor of the facility houses the detox program called OnSite.

Clients can inject illegal drugs at InSite due to a constitutional exemption from Canada's drug possession laws. InSite operated under this exemption from 2003 to 2008, at which point the federal government declined to renew the exemption. InSite supporters launched a constitutional challenge under section 7 of the Charter of Rights and Freedoms alleging that the refusal violated the life, liberty, and security rights of InSite clients. The Supreme Court of Canada ruled in 2011 to uphold the facility's exemption, allowing InSite to stay open indefinitely. InSite is funded by the BC Ministry of Health through Vancouver Coastal Health, which operates the facility in conjunction with the Portland Hotel Society (PHS) Community Services. Stakeholders who perceive InSite's harm reduction approach as innovative include the Canadian Medical Association, the Canadian Nurses Association, Vancouver City Council, Vancouver Coastal Health (the public health authority), and VANDU (Vancouver Area Network of Drug Users).

IMPACT:

The exemption InSite received in 2003 was granted on the condition that the program undergo rigorous scientific evaluation. The first several years of evaluation resulted in more than 30 studies published in peer-reviewed scientific journals. The evaluation focused on four areas: overdoses, health, the appropriate use of health and social services, and the costs associated with injection drug use.

Evaluation of InSite is ongoing and results so far have indicated a range of benefits, including reduced public injecting, fewer publicly discarded syringes, lower levels of HIV risk behaviours (such as syringe sharing), and increased uptake of addiction treatment. A retrospective population-based study published in *The Lancet* found that fatal overdoses within 500 metres of InSite decreased by 35% after the facility opened compared to a decrease of 9% in the rest of Vancouver. In addition, studies investigating potential harms, such as whether the facility encourages IV drug use by making drug injection easier and more comfortable, have not been supported by evidence.

The costs and savings of the facility were evaluated and the results published in the journal *Addiction.* This study found InSite substantially reduced the incidence of HIV infection among DTES IV drug users. The associated savings in averted HIV-related medical costs are more than sufficient to offset InSite's operating costs. InSite's operational budget was $2,969,440 in

2010/2011.

APPLICABILITY/TRANSFERABILITY:

Safe injection facilities in Switzerland and Germany served as models for InSite. Today, more than 90 SIFs operate in over 60 cities worldwide, including the Netherlands, Spain, Norway, Luxembourg, and Denmark. Australia implemented a pilot SIF in 2001 that became a permanent health service in 2010 following a number of evaluations. International peer-reviewed evidence indicates that SIFs are an effective way of reducing some of the harms of IV drug use, including overdoses, public littering of injecting equipment, infection rates of transmissible diseases, and health care costs.

InSite is currently the only SIF in Canada, although there have been attempts to open similar facilities in Ottawa, Toronto, Victoria, and Montreal. In June 2013, the federal government tabled Bill C65, the Respect for Communities Act. This proposed bill outlines the requirements that any new or existing health service provider must meet to be exempted from drug possession laws in order to provide supervised injection services. The requirements set out in the proposed bill pose significant challenges to the transference of this practice within Canada.

PRACTICE WEBSITE:http://supervisedinjection.vch.ca/

CONTACT INFORMATION:

Name: Monika Stein

Title: Manager, Harm Reduction Programs

Organization: Vancouver Coastal Health

Email address: monika.stein@vch.ca

Telephone number: n/a

Information last updated on: August, 2013

Content has been adapted from the following sources and relevant links:

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Pinkerton, S.D. (2010). Is Vancouver Canada's supervised injection facility cost-saving? *Addiction,* 105(8), 1429–1436.

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Vancouver Coastal Health. (2009). *From the ground up: Vancouver's supervised injection site's role in accessing treatment and care*. Retrieved from supervisedinjection.vch.ca/media/insite_groundup.pdf

External Source: http://supervisedinjection.vch.ca/

Heart Healthy Kids (H2K)

LOCATION:	Nova Scotia	**HEALTH THEME:**	Chronic Disease Management
HEALTH SECTOR:	Public Health	**FRAMEWORK CATEGORY:**	Emerging

SNAPSHOT: This innovative practice addresses the impact of sedentary behaviour and physical inactivity on the health of children and youth. This practice was launched as a school-based program in Nova Scotia in 2006. It involved one paid staff member, many adult volunteer supervisors, and student peer mentors.

PRACTICE DESCRIPTION:

The Heart Healthy Kids (H2K) program was launched in Halifax, Nova Scotia, in 2006. It is a school-based program, targeting children in grades 4, 5, and 6 in the Halifax region. The program involves one paid staff member and many adult volunteer supervisors; each school site has a community champion and three to five additional volunteers. The program has the following components:

- **A team-based physical activity challenge**. Participants log their daily physical activity, which is converted into kilometres in a virtual journey across Canada. The challenge is to be the team travelling the longest distance over the school year.
- **H2K Club** (also known as H2K lunches). These are weekly or biweekly lunchtime events that include **peer mentoring** and team building opportunities. Peer mentors are selected and trained at an in-school workshop to be team leaders in the physical activity challenge. H2K Clubs include a team meeting while the participants eat lunch, where peer mentors take attendance, discuss goals, and facilitate discussion about new activities or nutritional foods participants have tried. After the team meeting, participants engage in a series of active games, which are supervised by adult volunteers but facilitated by the peer mentors.
- **Monthly H2K assemblies**. Maritime Heart Centre staff or program volunteers visit each school to hold an assembly with H2K participants to keep them motivated. Progress is recognized and goals are reviewed. Sometimes there are guest speakers or group activity challenges.
- **Semi-annual education sessions.** These share information on heart anatomy and physiology, nutrition, smoking prevention, and risk factor modification. The content conforms to the Nova Scotia Department of Education's Curriculum Outcomes. Volunteer health professionals or students deliver these sessions.

This program is considered to be innovative for its peer mentoring component; it reduces the need for extensive involvement of adult volunteers, fosters student leadership, and allows children to relate positively to each other and to physical activity. The program started as a research project, with funding from the Nova Scotia Health Research Foundation. The Maritime Heart Centre and the Division of Cardiac Surgery provide in-kind support for one full-time program manager. In the 2012/13 school year, seven schools participated in H2K, involving nine Community Champions, 50 H2K Club volunteers, and more than 700 students, including 117 peer mentors. H2K participants logged physical activity of nearly 200 million steps, or 135,000 kilometres.

IMPACT:

This program is being run at a relatively low cost due to its heavy use of volunteers. There are many student and parent testimonials that speak to the positive reception of this program. As well, there has been a multi-year research study to support the program's development. A 2009/2010 pilot study in one school showed that the H2K program, with student peer mentoring, resulted in a 17% increase in physical activity levels. Thereafter, a larger study conducted in 2010/2011 involved a control group and a larger sample size of nearly 800 students in 10 schools. Five control schools received the standard H2K program, involving the physical activity challenge and education sessions. The same program, with the addition of peer mentoring, was run in five intervention schools to determine the difference associated with peer mentoring. In all control and intervention schools, the following outcomes were measured: physical activity (through daily pedometer use and website tracking), education (through pre- and post-session testing), height, weight, waist circumference, and cardiovascular fitness (determined using the

PACER shuttle run test to calculate maximal oxygen consumption). The results showed that while there were improvements in heart health knowledge in both groups, only the intervention schools showed statistically significant increases in their activity (of more than 1,000 steps per day on average) and maximum volume of oxygen uptake, suggesting that peer mentoring is associated with improvement in daily activity levels and cardiovascular fitness. Further, a qualitative sub-study indicated that the experience of peer mentoring was perceived positively. Participants believed peer mentoring to be enjoyable and felt that it affected participants' activity levels because peer mentors acted as helpers and supporters, organizers and administrators, and expanders of social networks. Peer-reviewed publications are currently in preparation to present the scientific data in the academic literature.

APPLICABILITY/TRANSFERABILITY:

The H2K program has not been adapted from another jurisdiction—it was developed by researchers at the Maritime Heart Centre. The initiative is theoretically applicable and transferable to other settings, such as schools in rural communities. The research included focus groups and interviews with peer mentors, parents, and teachers to evaluate the peer mentoring experience. Peer mentoring was received positively was thought to encourage physical activity. The later phases of the H2K multi-year research study focused on further program refinement (e.g., for sustainability, a program volunteer structure using community champions was developed) in 2011/2012, and then on pilot testing the refined program in more schools. Province-wide implementation of the program is planned for the next three to five years. Lessons learned in refining the program for broader implementation include that peer mentoring shows promise as a valuable health promotion tool, that the school-based environment offers opportunity to reach populations of children, and that development of a sustainable volunteer model is critical to the success of program expansion and impact on health.

PRACTICE WEBSITE: http://maritimeheartcenter.ca/h2k-program

CONTACT INFORMATION:

Name: Becky Spencer

Title: Programs Manager

Organization: Maritime Heart Centre

Email address: becky@maritimeheartcenter.ca

Telephone number: (902) 446-3669

Information last updated on: June 27, 2013

Content has been adapted from the following sources and relevant links:)

Personal Communication:

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External Source: http://maritimeheartcenter.ca/h2k-program

Social Work through Hip Hop (BluePrint For Life): Promoting physical and mental health in youth

LOCATION:	National	**HEALTH THEME:**	Aboriginal Health
HEALTH SECTOR:	Public Health	**FRAMEWORK CATEGORY:**	Emerging

SNAPSHOT: This innovative practice addresses the issue of compromised physical and mental health in youth, especially those living in Canada's North and inner cities. This practice was first launched in Nunavut in 2006 and involves hip hop artists and facilitators with social work training, as well as community members to support the event and follow-up activities.

PRACTICE DESCRIPTION:

Social Work through Hip Hop is a mental health promotion workshop that integrates hip hop, traditional practices (such as throat singing and drumming), education, and dialogue. The workshops have been implemented in Canada's North and its major cities. The workshop targets youth at risk of chronic disease, inactivity, and poor mental health, especially Aboriginal youth who live with the adverse health effects of colonization. It also serves as a community development model. It was first launched in Iqaluit, Nunavut , in 2006. Workshops are usually held in schools or community centres. The BluePrint outreach team includes dancers, youth facilitators, cultural artists, and outreach workers, including Inuit youth who are leaders in training. Communities have paid for the workshops via sources such as territorial government grants and land claims funds.

Youth participate in a five-day workshop to learn hip hop, be educated, and engage in discussions about respect, healthy living, cultural pride, bullying, anger management, suicide, drugs and alcohol, abuse, and healing. There is a hip hop performance for the community on the last evening. Parents, elders, community members, and teachers are encouraged to participate in the dance lessons. Complementary workshops include *Healing through Hip Hop* and *Leadership through Hip Hop*. A variety of therapy techniques, such as cognitive behaviour therapy, are used when dealing with complex issues in the education and dialogue aspects of the workshop. The program supports community empowerment and intergenerational healing. This practice is innovative because the "kids come for the dance, but stay for the healing."

IMPACT:

Personal testimonials, observations, and early evaluations suggest the practice has the potential for positive health outcomes, including increased physical activity and reductions in suicidal ideation, bullying, alcohol and drug abuse, violence, and vandalism. Surveys at the end of each workshop are used to continually evaluate, improve, and adapt the program. An assessment of the costs and savings of this practice has not been completed at this time. In 2009, an early program evaluation was held of workshops held in three Nunavut communities, using interviews, focus groups, and an evaluation questionnaire. Results indicated that the collective objectives of both workshops were met: to address wellness issues and physical inactivity among youth, to create a support network, and to teach leadership skills. Both workshops were perceived positively by youth and community members who felt the programs had improved the youths' confidence and self-esteem, communication skills, leadership, and future outlook. The first workshop was thought to have enhanced the youths' physical health. It was also perceived as having helped to bring the community together. Concerns were raised about whether the content "sufficiently supported Inuit tradition and culture" as well as sustainability and funding issues.

APPLICABILITY/TRANSFERABILITY:

Social Work through Hip Hop has not been adapted from another jurisdiction. The program has been implemented in a range of geographic locations (all three Territories, and major Canadian cities) and with non-Aboriginal participants. There are now seven types of workshops offered by BluePrintForLife. Workshops have been customized for groups, such as female Muslim teenagers and Sudanese refugee children. A program variation has been created for children ages 10 to 13. As well, the program has been adapted for youth in correction facilities, with a focus on the themes of anger, rage, and gangs. The Calgary Young Offender Centre, using post-workshop surveys, found that 92% of participants agreed/strongly agreed that they had accomplished something worthwhile, 94% agreed/strongly agreed that they found new talents and abilities, and 96% agreed/strongly agreed they would want to participate in a program like this again.

Challenges and lessons learned for the programs implemented in Northern communities include:

- Early meetings with community Elders were helpful in overcoming their negative impressions of hip hop.
- The presence of parents and Elders was important to youth involvement and healing.
- A small community team is important for successful workshop planning.
- Youth have created hip hop clubs to sustain the program; they need leadership training and mentorship opportunities.
- A story from Nunavut offers insights into implementing and sustaining this initiative: www.youtube.com/watch?feature=player_embedded&v=l1RMVRwrxmw

PRACTICE WEBSITE www.blueprintforlife.ca

CONTACT INFORMATION:

Name: Stephen Leafloor

Title: CEO

Organization: BluePrintForLife

Email address: Steve@BluePrintForLife.ca

Telephone number: 613 592 2220

Information last updated on: June 28, 2013

Content has been adapted from the following sources and relevant links:

Personal Communication:

Leafloor, S. (interview, June 28, 2013). [BluePrintForLife].

Publications:

Forneris, T. (2009) *Evaluation of hip hop workshops in Arctic Bay, Pond Inlet and Leadership Youth Hip Hop Summit in Pangnirtung, Nunavut*. Retrieved from http://www.blueprintforlife.ca/wp-content/uploads/2013/04/Government-of-Nunavut-Evaluation-Final-Report.pdf

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Other:

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External Source: www.blueprintforlife.ca

British Columbia FRIENDS for Life Program: Preventing Childhood Anxiety

LOCATION:	**British Columbia**	**HEALTH THEME:**	**Health Promotion and Disease Prevention**
HEALTH SECTOR:	**Home and Community Care**	**FRAMEWORK CATEGORY:**	**Promising**

SNAPSHOT: This innovative practice addresses the issue of helping children and youth cope with stress and develop emotional resilience by teaching cognitive and emotional skills in a simple, well-structured format. The school-based program was piloted in British Columbia in 2003 and launched provincially in 2004, becoming available to all public and independent schools in the province.

PRACTICE DESCRIPTION:

The FRIENDS for Life program is an evidence-informed, school-based, early intervention and anxiety prevention and resiliency program. It has proven results in reducing anxiety or decreasing the risk of developing an anxiety disorder, and building resiliency in children for life. FRIENDS teaches children how to cope with fears and worries, equipping them with tools to manage difficult situations, now and throughout life.

BC FRIENDS is sponsored by the Ministry of Children and Family Development (MCFD), in cooperation with the Ministry of Education, school districts, independent schools, and the First Nations Schools Association. FRIENDS was first introduced universally in BC elementary schools in 2004 (after a 2003 pilot) in support of the *Child and Youth Mental Health Plan for British Columbia* (2003–08) and is now included in a 10-year provincial health plan, *Healthy Minds, Healthy People: A Ten Year Plan to Address Mental Health and Substance Use in British Columbia* (2010–20). Furthermore, two additional school-based programs targeting different age groups, FRIENDS Youth (grades 6/7) and Fun FRIENDS (kindergarten/grade 1), were launched provincially in 2008 and 2011, respectively.

In BC, the FRIENDS child and youth programs are endorsed by the Ministry of Education as a recommended learning resource, and they fit within the Health & Career Education K–7 curriculum. The program is delivered universally to students at three grades levels (kindergarten/grade 1, grades 4/5, and grades 6/7) by teachers and educators. Following a one-day training course (provided free of charge by MCFD), teachers are eligible to receive the program materials and deliver the program in their respective classrooms. Children and youth participate in 10 or more classroom-based sessions, reinforced by take-home activities.

A parent componentthat involves parent workshops and online resources that have been developed by parents for parents is included. Since 2005, MCFD has partnered with the FORCE Society for Kids' Mental Health (http://www.forcesociety.com) to deliver the parent component. For more information see http://www.friendsparentprogram.com.

IMPACT:

Originally developed in Australia, the FRIENDS for Life program model is supported by over 15 years of comprehensive research evaluation and practice, and is the only anxiety prevention program acknowledged by the World Health Organization (WHO). According to a 2004 WHO report, a 1997 controlled trial showed that enrolling children with pre-intervention elevated levels of anxiety symptoms in FRIENDS reduced the first onset of a diagnosable anxiety disorder from 54% in the control group to 16% in the prevention condition in the six months following the intervention. A second controlled trial published in a peer-reviewed journal in 2001 also demonstrated the effectiveness of FRIENDS at preventing the development of anxiety and depressive symptoms in children aged 10 to 13.

The BC FRIENDS program is now in its tenth year of implementation in BC schools. BC FRIENDS delivers an average of 60 teacher training sessions each school year. To date, all school districts in BC (60) have participated, including many independent and First Nations schools province-wide. Over 6,000 teachers and educators have been trained to deliver FRIENDS, and over 1,000 parents have attended parent workshops in person or online.

MCFD funds the FRIENDS program, and all participating schools are provided with training and materials (such as student

workbooks) free of charge. It is up to each school/district to provide the release time for teachers to attend the required one-day training.

APPLICABILITY/TRANSFERABILITY:

The **FRIENDS for Life program** was originally developed in Australia, and is used in schools and clinics around the world. Well over 500,000 children have completed a FRIENDS program worldwide, and it is currently in use in Australia, New Zealand, The United States, Mexico, South Africa, the Netherlands, Germany, Portugal, Finland, Norway, Sweden, The United Kingdom, and Hong Kong. BC adapted this program to include Canadian references and grammar.

While hundreds of schools across Canada currently use the program, BC is the first province to universally implement the program in all school districts through a ministry-sponsored initiative. In BC, the program grew from a 2003 pilot to provincial implementation in 2004. FRIENDS BC expanded program delivery in 2008/09 with the addition of the FRIENDS for Life Youth Program, targeting grade 6 and 7 students throughout the province. Fun FRIENDS, an early years version of FRIENDS, was piloted in 2009/10 in seven school districts, and is now available to kindergarten and grade 1 students throughout BC.

Other jurisdictions (in Canada and abroad) have approached BC to learn more about the program. Many are interested in BC's model, which involves a partnership between schools and other organizations (including the nongovernmental organization FORCE Society).

PRACTICE WEBSITE: http://www.mcf.gov.bc.ca/mental_health/friends.htm

CONTACT INFORMATION:

Name: Kelly Angelius

Title: Manager, BC FRIENDS For Life Program, Child and Youth Mental Health Services

Organization: British Columbia Ministry of Children and Family Development

Email address: mcf.cymhfriends@gov.bc.ca

Telephone number: n/a

Information last updated on: July 17, 2013

Content has been adapted from the following sources and relevant links:

Personal Communications:

Angelius, K. (Review and feedback, July 2013). [BC FRIENDS For Life Program]

Publications:

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External Source: http://www.mcf.gov.bc.ca/mental_health/friends.htm

Positive Parenting Program (Triple P) International

LOCATION:	International	**HEALTH THEME:**	Health Promotion and Disease Prevention
HEALTH SECTOR:	Public Health	**FRAMEWORK CATEGORY:**	Leading

SNAPSHOT: This innovative practice addresses the issue of behavioural and emotional problems in children and youth by educating and supporting their parents. This practice was launched in Australia over an extended period, in community and primary care settings, using trained health professionals and others as "Triple P practitioners."

PRACTICE DESCRIPTION:

The Positive Parenting Program (Triple P) is a parenting and family support system to prevent, and treat, behavioural and emotional problems in children and teenagers. It was developed and expanded over 30 years by the University of Queensland in Australia. For over 30 years, it has been implemented around the world. Triple P International is a private company that was created by the university to support Triple P training and implementation.

The Triple P system is a range of interventions of increasing intensity, targeting parents with children/youth up to 16 years old. The system supports parents to enhance their parenting knowledge, skills, and confidence, which in turn can reduce behavioural problems in children and teens. Professionals and others who have regular interactions with parents are trained and accredited to be Triple P practitioners. They might include family workers, social workers, psychologists, doctors, nurses, school counsellors, teachers, and clergy. The system has five intervention levels:

- Level 1 is a communications (public awareness) strategy to reach a broad cross-section of the population with positive parenting information and messages. It is not a course or personal intervention delivered directly to parents.
- Level 2 is a "light touch" intervention providing brief one-off assistance to parents of children or teens who are generally coping well but have one or two concerns. Delivery options include seminar series and primary care one-on-one support.
- Level 3 is targeted counselling for parents of a child or teen with mild to moderate behavioural difficulties that deals with a specific problem or behaviour. Delivery options include four brief primary care consultations or two, two-hour, small-group sessions.
- Level 4 is for parents of children/teens with severe behavioural difficulties and offers more intensive counselling and education. Delivery options include education (group, online, or self-directed), with counselling in some cases.
- Level 5 provides Intensive support for families with serious problems. Parents must complete a Level 4 standard or group program before (or in conjunction with) a Level 5 course.

The practice is an innovative parenting program because it tailors information, advice, and professional support to the needs of individual families. It also offers a flexible range of delivery options for implementing the program. Funding for Triple P International comes from training and accreditation activities, ongoing support and technical assistance services, and publishing Triple P materials. In turn, royalty payments are made by TPI to the University of Queensland (UQ) and distributed within UQ.

IMPACT:

The evidence base for Triple P consists of over 250 published papers (including 140 outcome studies), including eight meta-analyses, 68 randomized control trials, 51 effectiveness and service-oriented evaluations, and a number of case studies. Some key research findings include that Triple P

- reduces problem behaviour in children and improves parents' well-being and parenting skills;
- slows rates of child abuse, reduces foster care placements, and decreases hospitalizations from child abuse injuries; and
- in communities where it is widely available, children have fewer behavioural and emotional problems.

A case has been made for cost recovery with a population-based implementation of the Triple P. For example, US-based researchers found the costs of implementing Triple P across a community would be recovered in a single year if the program resulted in a 10% reduction in cases of child abuse and neglect. An Alberta study found that Triple P would pay for itself if conduct disorders in a birth cohort were reduced by 6%.

APPLICABILITY/TRANSFERABILITY:

The Triple P is based on social learning, cognitive behavioural theory, developmental theory, and research on risk factors for the development of social and behavioural problems in children. It was first developed as a small-scale, home-based training program for parents of disruptive pre-schoolers. It has evolved over the years to become a more comprehensive intervention.

The Triple P practice has been adopted in 25 countries as either a population-based implementation or a tailored approach for parents of targeted groups of children. As well, TPI has developed specialized programs, such as

- Stepping Stones Triple P – for parents of pre-adolescent children who have a disability;
- Lifestyle Triple P – a 10-session group program with four telephone support calls for parents of overweight children; and
- Indigenous Triple P – a group program developed with input of elders from Indigenous communities in Queensland.

Some of the challenges for implementing the Triple P include the time and cost commitment to training and accreditation for staff, and program support, especially if a population-based implementation is chosen. As well, supports are recommended for the implementation phase to ensure organizations achieve a successful rollout, including a TPI implementation framework.

CONTACT INFORMATION:

Name: Debbie Easton
Title: Local contact - Canada
Organization: Triple P International
Email address: Debbie@triplep.net
Telephone number: 905 392 6976
Information last updated on: July 4, 2013

Content has been adapted from the following sources and relevant links:

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Other:
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External Source: www.triplep.net

Psychosocial/Psychoeducational Intervention for Persons with Recurrent Suicide Attempts (PISA): A Group Therapeutic Approach to Decreasing Suicidal Behaviour in Ontario

LOCATION:	Ontario	**HEALTH THEME:**	Health Promotion and Disease Prevention
HEALTH SECTOR:	Acute Care	**FRAMEWORK CATEGORY:**	Promising

SNAPSHOT: This innovative practice addresses decreasing suicidal behaviour among people who have attempted suicide at least twice. The practice was launched at a teaching hospital in Toronto, Ontario, in 1999. It is run by two professionally licensed facilitators trained in the intervention and a peer facilitator who has graduated from the program.

PRACTICE DESCRIPTION:

Suicidal behaviour places significant emotional and financial burdens on families, friends, health professionals, and communities, while associated hospitalizations and emergency department visits incur costs to the health care system. The circumstances that lead an individual to attempt suicide are often complex, yet in most cases death by suicide is preventable.

The Psychosocial/Psychoeducational Intervention for Persons with Recurrent Suicide Attempts (PISA) is a 20-week outpatient group therapy program first offered at St. Michael's Hospital in Toronto, Ontario, in 1999. Participants must be over the age of 18, linked with mental health services at the time of referral, and have a lifetime history of at least two suicide attempts. Through support, education, and skills development, PISA addresses potential risk factors and areas of psychological deficit known to characterize persons with recurrent suicide behaviour. Staff work with clients to develop a better understanding of their suicide-related thoughts and behaviours, create safer coping strategies to manage intense emotions, and sharpen problem-solving abilities.

PISA differs from other therapeutic interventions because it

- caters to inner-city residents of lower socioeconomic status;
- emphasizes client participation; and
- addresses the varied needs of each client.

The group is facilitated by an interprofessional team that includes students from a range of health professional disciplines. An intervention team leader supervises all facilitators at mandatory weekly meetings, and a senior clinician maintains adherence to the intervention protocol. Weekly sessions at St. Michael's Hospital typically run for 1.5 hours and consist of 8 to 12 clients. Facilitators, excluding the team leader, volunteer their time.

IMPACT:

A three-year pilot study that was begun in 2000 and published in the *Annals of Psychiatry* evaluated this practice to determine whether suicide-related behaviours were significantly reduced following the program. Cognitive, affective, and impulsivity risk factors were measured using the Toronto Alexithymia Scale, the Beck Hopelessness Scale, and the Barratt Impulsivity Scale, respectively. Participants reported more general life satisfaction, perceived themselves as better problem-solvers, and scored themselves lower on alexithymia (the inability to identify and describe emotions in oneself). Results also showed a significant improvement in depression and hopelessness scores, but overall these scores remained in the severe and moderate range. These results suggest that this intervention may be a first step in engaging the patient to seek longer-term help for problems associated with a high risk for suicide.

The costs and savings of this innovative practice have not been evaluated at this time.

APPLICABILITY/TRANSFERABILITY:

In 2010 the National Film Board released a short documentary, directed by Katerina Cizek, about 12 participants' experience in PISA. This exposure has contributed to an increased awareness of the practice. To facilitate the consistent use and delivery of PISA among providers in different jurisdictions, a fourth edition guide outlining the intervention protocol was produced in 2012.

In 2009, the Suicide Research Team at the School of Nursing in Dublin City began a three-year project to implement and evaluate the effectiveness of PISA at decreasing suicide-related behaviour in an Irish context. This will be the first work in Ireland that specifically targets individuals with a history of recurrent suicide attempts. An analysis of the data is currently under way and results are expected to be released in October 2013.

Piloted in November 2010, the Skills for Safer Living program uses a similar model as PISA but offers the group therapy sessions in a community setting, rather than a hospital. With funding from the Waterloo-Wellington Local Health Integration Network ,the program is now offered in Kitchener, Cambridge, and Guelph. A group specifically for youth aged 18 to 30 will run in June 2013, and there are additional plans to run a group for rural residents.

In Vancouver, S.A.F.E.R. (Suicide Attempt Follow-Up Education and Research) ran a version of PISA facilitated by Dammy Albach-Damstrom, president of the Canadian Association for Suicide Prevention. The first cycle ended in May 2013, and a second iteration began in June. In Prince George, the Crisis Prevention, Intervention and Information Centre is in the process of establishing a program for suicide survivors based on the PISA model of group therapy.

CONTACT INFORMATION:

Name: Yvonne Bergmans
Title: Suicide Intervention Consultant
Organization: St. Michael's Hospital – University of Toronto
Email Address: Bergmansy@smh.ca
Telephone Number: 416-864-6060 ext. 4078
Information Last Updated On: June, 2013

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Partners for Life Program/ Solidaires pour la vie

LOCATION:	Quebec	**HEALTH THEME:**	Health Promotion and Disease Prevention
HEALTH SECTOR:	Public Health	**FRAMEWORK CATEGORY:**	Emerging

SNAPSHOT: This innovative practice aims to address the issue of undiagnosed depression in youth, which could lead to suicide.This program was launched across the province of Québec in 1998. Teams of trained “animators” provide education sessions and follow-up in high schools across the province.

PRACTICE DESCRIPTION:

This program was launched in Québec in 1998 by the Mental Illness Foundation, in response to a series of youth suicides in Québec’s Eastern Townships. The Québec coroner found that the common element among all five teenagers was their undiagnosed depression. The underlying premise for Partners for Life is that depression in adolescence can be prevented through education and early detection. Partners for Life is a school-based program that primarily targets youth 14 and older, as well as their parents, teachers, and health professionals. The goals of the program are to (1) teach all target groups to recognize the signs and symptoms of depression, and (2) help them refer those in distress to appropriate resources.

Teams of trained young animators provide 50- to 75-minute education sessions with information about mental illness, role-playing, screening tools, advice, and resources. There are three types of sessions for teens, parents, and school staff. The sessions have also been adapted for health professionals and others. The staff consists of five teams, each staffed by two supervisors and 10 trained animators. The focus is on conveying information and making a connection with the participants. At the end of the sessions, there is a question and answer period. As well, team members make connections with teens who appear to be at risk based on their response to the workshop or identification by school staff. From there connections with mental health resources can be made.

Since 1998, the program has helped build awareness among more than 835,000 teens, 10,000 parents and 25,000 teachers and advocates in 690 Québec schools. Among the teens, more than 15,000 were treated or followed up for depression, while 1,000 were hospitalized. The program facilitators have also conducted 3,900 direct interventions in school settings, reported 73 young people in distress, and carried out 180 emergency calls. Initially, the Québec Government provided funding for three years. Currently, private-sector donations provide most of the funding. The estimated cost of delivering the program is $10 per person.

This program is considered to be innovative because it combines strategies to promote mental health literacy among target groups with follow-up activities to connect at-risk youth with school supports and other mental health resources.

IMPACT:

A study to evaluate the implementation of the initial pilot project was completed from 1999 to 2000. The results included that 93% of students completing a survey indicated they would recommend the workshop to their peers, and all of the students considered it important to talk about teen depression. As well, school staff reported an increase in student consultation after participating in Partners for Life workshops, but believed this extra workload was feasible for the school for the school.

A second evaluation was conducted to investigate how the program influenced youths’ attitudes and knowledge about depression. A group of 197 students in five high schools completed a questionnaire before and after participating in a Partners for Life workshop. The questionnaire consisted of 17 questions evaluating knowledge and 11 questions evaluating attitudes.The results indicated that the program led to statistically significant increases in knowledge about depression in young people, and changed their attitudes about consulting necessary resources. As well, the study conducted a comparative evaluation of students from the intervention group against a control group of 88 teenagers.

Finally, in Québec, the rate of youth suicide has declined since the year of the program’s conception (1998) for both males (29 vs. 11 suicides per 100,000 persons aged 14 to 19) and females (10 vs. 3 suicides per 100,000 persons aged 14 to 19). However, the program sponsors note that it is not possible to link the decline in youth suicide directly to the program.

APPLICABILITY/TRANSFERABILITY:

Solidaires pour la vie / Partners for Life Program has not been adapted from another jurisdiction. While this program has not yet been implemented outside of Québec, it is theoretically applicable and transferable to other settings. In 2011 Québec researchers Lesage and Moubarac did an analysis of the program and concluded that it met all seven criteria identified for a good scientific program for promoting health. Extensive research on the target group—youth in the third, fourth, and fifth years of high school (ages 16 and up)—informed program development, and the program design was based on evidence-based theoretical models that demonstrate the direct link between depression and suicide in adolescents.

Ongoing program evaluation via analysis of workshop survey responses has led to program adjustments. Initially the program was focused on mental health literacy only, and staff members were recruited for their communication skills. However, in 2004, the program added a staff responsibility to approach at-risk teenagers who were identified after the workshops. Thereafter, recruitment has sought staff with a broader skill set, and there has been an increased focus on quality control in content delivery. Staff training has evolved from two and a half weeks to four weeks in length. A standard set of scripted questions and answers is in place. Supervisors have clinical supervision duties on a regular basis. Another adjustment is revised workshop content that doesn't create general alarm among the participants that the school must address after the workshop is over. Workshops have also been modified to be easily implemented in the schools; for example, technology is not used to give presentations. Written information materials are left with the schools to distribute, as desired, to parents.

CONTACT INFORMATION:

Name: Catherine Burrows
Title: Director, Youth Programs
Organization: Foundation des Maladies Mentales / Mental Illness Foundation
Email address: cburrows@fondationdesmaladiesmentales.org
Telephone number: 514-529-5354
Information last updated on: July 2, 2013

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The Reitman Centre CARERS Program: Equipping carers with practical skills and emotional support to provide better care for individuals with dementia

LOCATION:	**Ontario**	**HEALTH THEME:**	**Health Human Resources**
HEALTH SECTOR:	**Home and Community Care**	**FRAMEWORK CATEGORY:**	**Promising**

SNAPSHOT: This innovative practice addresses the need to equip professional and community carers with practical and emotional coping skills to enable them to effectively provide care to individuals with dementia. The program launched in an academic teaching hospital training centre in Ontario in 2008 with a focus on community-based carers, but is now expanding to provide workplace-based training to carers engaged in the workforce (working carers).

PRACTICE DESCRIPTION:

Alzheimer's disease and related dementias pose significant challenges to the well-being of patients, but also to the health of family carers as they struggle with the emotional and physical stress of providing ongoing care. The Cyril & Dorothy, Joel & Jill Reitman Centre for Alzheimer's Support and Training at Mount Sinai Hospital (MSH) delivers therapeutic skills training that address the needs of family carers providing care to individuals with dementia. The centre offers individual and family training, access to an outpatient geriatric mental health clinic, and training programs for both professionals and community carers dealing with dementia.

The Reitman Centre CARERS Program (Coaching, Advocacy, Respite, Education, Relationship, and Simulation) gives carers practical skills and emotional support to deal with the complexities of caregiving. The centre is staffed by social workers, psychiatrists, a psychologist, occupational therapists, group leaders, an educator, researchers, and administrators.

After an assessment phase, CARERS involves a 10-week small-group program that includes education, problem-solving therapy, and skills training using simulation, followed by a maintenance group (one hour per month) for one year after the intervention. The simulation phase includes live encounters with a standardized patient, a professional simulator trained to simulate real-life situations the carer is currently encountering. Carers are guided by expert clinical coaches and can learn to deal with their specific challenging situations. The goals of the program are for carers to enhance practical skills, improve coping and problem-solving, improve management of difficult emotions and communication with the care recipient, reduce anxiety and depression, optimize their health and social interactions, and access professional support if necessary.

The CARERS program has been funded in part by the Government of Canada's Social Development Partnerships Program (SDPP). The services are offered to carers enrolled in the program at no additional cost.

IMPACT:

The effectiveness of the CARERS approach has been demonstrated through a formal outcome evaluation completed by participating carers (*n*=61). Eight scales were administered pre- and post-intervention to assess whether the program was meeting its key goals: improved coping/problem-solving, emotional regulation, and self-efficacy, and reduced caregiver burden. Pre- and post-scores were significantly improved for measures of emotion-oriented stress coping and caregiving competence. Carers with more compromised baseline scores also experienced statistically significant improvements in measures of depression, task-oriented coping, mastery, and caregiver burden.

Satisfaction surveys revealed almost all participants believed the groups were important and effective, and reported that skills training had changed their behaviour, attitudes, and feelings. The professional support and camaraderie were highly valued, and the practice and repetition allowed in simulation exercises was deemed the most helpful component of the intervention.

The program leaders estimate the cost to run a 10-week CARERS group is approximately $1800 (or $360 per carer, or equivalently $12.00 an hour per carer). This is based on an estimate that assumes an hourly rate of $30/hour for both the community-based mental health clinician leading a CARERS group and a paid standardized patient over 10 weeks (3 hour sessions/week). From the original four staff the program has grown to a staff of 14 and space has been doubled.

APPLICABILITY/TRANSFERABILITY:

The Reitman Centre was founded through a private grant from the Cyril and Dorothy, Joel and Jill Reitman family. The goal was to create a centre dedicated to the care of carers, not as adjuncts to the management of the person with dementia but as a primary target of intervention. MSH strongly supported the concept of a community-focused program for carers, providing space and technical help. A purpose-built facility was constructed. A small interprofessional team from the department of psychiatry at MSH determined the key factors that contribute to caregiver burden and breakdown, based on the best available research data. To address these factors, evidence-based treatment interventions were created or adapted. Each burden factor was operationally defined prior to starting the program, and then evaluated in every carer using specific validated research instruments.

Much attention was paid to promoting this program and to making it accessible to carers living in the community. A barrier-free referral process was initiated to ensure ease of access for all.

To date, the Reitman Centre has run 30 CARERS groups (300 small-group sessions). The model has been modified and streamlined to make it financially viable for use in the community, including non-medical community services and programs. In Toronto satellite groups are underway at the Yee Hong Geriatric Care Centre, MSH Wellness Centre, St Christopher House Toronto, and Holy Blossom Temple.

The core MSH CARERS program was crafted to be scalable, and Human Resources and Skills Development Canada (HRSDC) has provided support for further development of the model and its dissemination more broadly elsewhere in Canada. To facilitate dissemination, MSH offers courses for professionals and has produced educational tools, such as manuals and e-learning modules. The CARERS program has been adopted in Calgary, Alberta, with the Calgary Chinese Elder Citizens' Association and the Alzheimer Society of Calgary each starting Reitman Centre CARERS groups.

In June 2013, MSH was awarded a five-year, $2.84 million grant from the Government of Canada's SDPP to develop the first comprehensive program in Canada devoted to supporting working carers (carers currently engaged in the workforce). The Working CARERS Program will be offered through a partnership of the federal government, MSH, and private-sector partners. Launching in fall 2013, it will be delivered to employees by employee assistance professionals from Ceridian Human Capital Management (HCM), an employee assistance service at BMO Financial Group.

CONTACT INFORMATION:

Name: Dr. Joel Sadavoy
Title: Head of Geriatric Psychiatry, the Reitman Centre for Alzheimer's Support and Training; Head of Community Psychiatry Services
Organization: Mount Sinai Hospital
Email address: Jsadavoy@mtsinai.on.ca
Telephone number: 416-586-5262
Information last updated on: August 8, 2013

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External Source: http://www.mountsinai.on.ca/care/reitman

Mental Health First Aid Canada

LOCATION:	National	**HEALTH THEME:**	Health Promotion and Disease Prevention
HEALTH SECTOR:	Public Health	**FRAMEWORK CATEGORY:**	Leading

SNAPSHOT: This innovative practice addresses the need for better mental health literacy within the general population, which facilitates early recognition of mental disorders and actions for prevention and intervention.

PRACTICE DESCRIPTION:

The Mental Health Commission of Canada (MHCC) describes Mental Health First Aid (MHFA) as the "help provided to a person developing a mental health problem or experiencing a mental health crisis." In 2006, the Alberta Mental Health Board brought the MHFA program to Canada from Australia. In 2010, the program's operation was transferred to the MHCC. Mental Health First Aid Canadateaches people how to recognize the signs and symptoms of mental health problems and illnesses, as well as how to provide initial help and guide individuals towards appropriate professional support. MHFA Canada offers two types of courses, each with a standard curriculum, the Basic Course (four sessions) and the Adults Who Interact with Youth Course (seven sessions), as well as instructor training courses. Funding comes from the MHCC and course fees.

The goals of the MHFA Canada program are to

- preserve life where a person may be a danger to themselves or others;
- provide help to prevent the mental health problem from developing into a more serious state;
- promote the recovery of good mental health; and
- provide comfort to a person experiencing a mental health problem.

MHFA Canada is innovative for its focus on mental health literacy—knowledge and beliefs about mental disorders that aid their recognition, management, or prevention—among the general population. The program is suitable for a wide target audience, from the general public to families affected by mental health problems, teachers, health service providers, emergency workers, front-line workers who deal with the public, volunteers, human resources professionals, employers, and community groups.

IMPACT:

Canadian evaluation studies have included a 2008/2009 study of participant perspectives about the effectiveness of the program. Most of the respondents found the course easy to understand, well presented, and relevant. Another evaluation (in 2010) assessed whether the program increased mental health literacy among staff in a student affairs and counselling department in a university. This study used pre-/post-test standardized surveys, structured interviews, and a control group. The study found that the training resulted in statistically significant increases in mental health knowledge, enhancements to staff sensitivity (except openness), and increases in confidence in recognizing mental health issues and responding to them appropriately. Another 2010 evaluation investigated the effectiveness of MHFA training on 302 people in 25 First Nations communities in Alberta. The evaluation used surveys and interviews to gather quantitate and qualitative data. It found positive changes in general mental health knowledge, knowledge of appropriate responses, referrals for and responses to people with mental illness or in a mental health crisis, and attitudes towards persons with mental illness. However, participants generally did not see course's conceptual framework as a strength, and the evaluators recommended the program be adapted.

APPLICABILITY/TRANSFERABILITY:

MHFA was developed in Australia and the program has been adapted for use in 18 countries, including Canada, the US, Scotland, England, Ireland, Finland, Sweden, Cambodia, Japan, Thailand, Nepal, China, and South Africa. It has also been adapted for the Maori people in New Zealand. Both Australia and Scotland have made MHFA part of their national mental health strategies. A number of randomized controlled trials (RCT) to evaluate the effectiveness of the MHFA program have been completed, for the most part in Australia. Results generally indicate that people who have had MHFA training had greater recognition of mental health disorders, greater likelihood of advising people to seek professional help, increased agreement with professionals about helpful interventions, and increased confidence in helping others; they also provided more help. RCT have

been conducted for programs in rural areas, in the workplace, and in a high school setting.

In adapting the program in 2006 for Canada, it was reviewed by experts in the mental health field and adapted for the Canadian population, incorporating Canadian statistics and ensuring the material was culturally relevant.

CONTACT INFORMATION:

Name: Meaghon Reid
Title: Director, Mental Health First Aid Canada
Organization: Mental Health Commission of Canada
Email address: mhfa@mentalhealthcommission.ca
Telephone number:613-683-3738
Information last updated on: June 25, 2013

Content has been adapted from the following sources and relevant links:

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Post-Traumatic Stress Disorder Service Dog Program

LOCATION:	Manitoba	**HEALTH THEME:**	Health Promotion and Disease Prevention
HEALTH SECTOR:	Public Health	**FRAMEWORK CATEGORY:**	Emerging

SNAPSHOT: This innovative practice addresses providing support for Canadian Forces members (retired or active) suffering with post-traumatic stress disorder (PTSD). The practice was launched in Winnipeg, Manitoba, and involves a lead service-dog trainer and several volunteer trainers.

PRACTICE DESCRIPTION:

MSAR Search and Rescue (previously known as Manitoba Search and Rescue, and Manitoba Rural Search and Rescue) was started by George Leonard in partnership with Aboriginal elders, First Nation leadership, and dedicated volunteers to address the growing concern of missing Aboriginal persons. The Association is a non-governmental organization that is partnered with a registered charity in good standing. MSAR is the only agency directed by Aboriginal elders, advisors, and First Nation leadership. For the past 10 years, MSAR has been working on the research, development, and implementation of service dogs in all capacities—autism, dementia, PTSD, seizure dogs, therapy, bipolar, depression (and forms of), disability, and assistance. This practice has focused on the mental health service dogs, with over 371 dogs trained in over 200,000 hours of operational time. The program started with the Elite Therapy Dog program and expanded to service-dog status due to its dramatic positive results.

MSAR started the Courageous Companions program to start working specifically with PTSD soldiers after one of its members, a former Canadian Forces member, stepped forward and asked for assistance from the Association. It is estimated that 7% of Canadian soldiers who return from Afghanistan experience PTSD.

This innovative practice is provided by volunteer dog trainers and is not funded by Veterans Affairs Canada or the National Defence, although these bodies do endorse the program. The Canadian Legion and other donors help to pay the $1,200 dollars for the custom-made vests that identify these service dogs, and soldiers using the service are responsible for veterinary care and food costs. MSAR also receives funds from sponsors, partners, fundraising drives, and chargeable services.

IMPACT:

In 2012, 37 service dogs across Canada were in the field helping veterans with PTSD and the program was profiled on CTV's *W5*, in segments called "Canine Comrades." Since then MSAR has received $50,000 in donations and the number of service dogs has almost doubled to 70; there is currently a waiting list for trained dogs. The program has shown to reduce the number of medications needed by Canadian soldiers with PTSD for them to function.

This innovative practice has been implemented since 2002 and does not have a completed evaluation at this time. However, observed impacts that trainers have noticed with the working group of veterans and active combat soldiers who have received an MSAR dog include

- increase in patience, impulse control, emotional regulation, and emotional stability;• improved ability to display affect and a decrease in emotional numbness (emotions less bottled up);
- improved sleep;
- significant decrease in suicidal thoughts;
- decreased depression and an increase in positive sense of purpose;
- fewer startle responses;
- increased sense of belongingness/acceptance (less of the loner mentality);
- increase in assertiveness skills without aggression (but confident);
- improved parenting skills and family dynamics;

- fewer war stories, fewer flashbacks, and more in-the-moment thinking; and
- lower stress levels and an increased sense of calm

APPLICABILITY/TRANSFERABILITY:

The Courageous Companions program has not been adapted from another jurisdiction or implemented elsewhere. However, this initiative is theoretically applicable and transferable to other settings. The American and British military have been using dogs to treat PTSD for years, but this is a first for Canada. The US Department of Veterans Affairs has a similar guide- and service-dogs program. However, after a recent cut to funding for service dogs for mental illness, the US program covers veterinary fees only for veterans with physical disabilities. Similar programs also exist in the United Kingdom across jurisdictions—there is no dedicated government funding for PTSD service dogs, which poses a challenge to implementing this practice widely.

CONTACT INFORMATION:

Name: George Leonard
Title: MSAR Master K-9 Trainer
Organization: MSAR Search and Rescue
Email address: GL@msar.ca

Content has been adapted from the following sources and relevant links:

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Pan-Canadian Joint Consortium for School Health (JCSH) Healthy School Planner

LOCATION:	National	**HEALTH THEME:**	Health Promotion and Disease Prevention
HEALTH SECTOR:	Public Health	**FRAMEWORK CATEGORY:**	Emerging

SNAPSHOT: This innovative practice addresses the need for healthy school environments to help students succeed academically and to make healthy choices. The updated Healthy School Planner has been used by over 400 schools across Canada.

PRACTICE DESCRIPTION:

A growing global movement of health-promoting schools "recognizes the direct influence schools can have on positive student health." In Canada this movement is called comprehensive school health. The Pan-Canadian Joint Consortium for School Health (JCSH), a partnership of Canadian provincial, territorial, and federal health and education ministries, has been formed to support this movement in Canada. An evidence-based comprehensive school health framework has been developed by the JCSH, which builds on four pillars: (1) social and physical environment, (2) teaching and learning, (3) healthy school policy, and (4) partnerships and services.

To support the advancement of healthy school communities across Canada, the JCSH has developed the Healthy School Planner. It is a free, web-based tool that elementary and secondary schools can use to assess their school's current health environment and make an improvement plan to address gaps in priority areas. The Healthy School Planner was developed for the JCSH by the Propel Centre for Population Health Impact at the University of Waterloo. Launched in 2009, the purpose of the Healthy School Planner is to help individual schools EVOLVE: **E**valuate current conditions, **V**alidate untapped resources in the community, **O**rganize increased support for change, **L**ead the decision-making process to determine action steps, **V**isualize outcomes through shared success stories, and **E**valuate progress over time.

The narrative in the Healthy School Planner describes a process that includes a school team, a team leader, a foundational assessment, a review of school results against standard indicators, completion of other assessment modules of interest, and development and implementation of an action plan for improvement. The online *Foundational Module* introduces the four pillars of the framework, familiarizes users with the school health planning process, and prompts users to do a foundational assessment. The other online learning modules are *Physical Activity*, *Healthy Eating*, *Tobacco Use*, and *Positive Mental Health*.

This tool is considered innovative because it provides practical support for individual schools to advance their efforts to apply a comprehensive approach to school health.

IMPACT:

This innovative practice was implemented in 2009 but completely revised in 2013. Formal evaluation has not been completed at this time. Personal testimonials, observations, and related research suggest that this practice has the potential for positive outcomes on health. For example, the Healthy School Planner builds on the success of evidence-based approaches to health-promoting schools internationally, and the comprehensive school health framework in Canada. General and systematic reviews of the research literature, conducted by the JCSH and the WHO respectively, have provided evidence of potential impact. Researchers would like to pursue an outcome evaluation of the impact of the Healthy School Planner at some point in the future.

APPLICABILITY/TRANSFERABILITY:

In 2009, the JCSH engaged researchers at the Propel Centre to develop a pan-Canadian tool in response to requests for practical help in creating a health-promoting environment in schools across the country. In its revised form, the Healthy School Planner has demonstrated satisfactory validity and reliability. Its development incorporated a review of literature and stakeholder interviews to identify priorities and underlying concepts from which a set of related indicators was derived. Then, a reference group of researchers and JCSH representatives provided input to support the refinement of the Planner's content and format.

Pairings of teachers and administrators from across Canada participated in evaluating test/re-test reliability and content validity. More than 400 schools in each province and territory across urban and rural locations have used the revised Healthy School Planner. Research conducted on the Healthy School Planner has shown that school environments vary significantly and these variations are related to student health. JCSH is working to increase the use and uptake of Healthy School Planner across the country. Together, JCSH and Propel continue to develop new, and revise existing, items for the Healthy School Planner.

As well, the Healthy School Planner builds on standardized data collected at the Propel Centre via the School Health Action Planning and Evaluation System (SHAPES). Since 2000, SHAPES has been used to collect information from over 2,500 Canadian schools on student behaviours and attitudes in the areas of tobacco use, physical activity, healthy eating, and mental fitness.

CONTACT INFORMATION:

Name: Ms. Katherine Kelly
Title: Executive Director
Organization: Pan-Canada Joint Consortium for School Health (JCSH) Secretariat
Email address: kakelly@gov.pe.ca
Telephone number: 902-888-8029
Information last updated on: July 2, 2013

Content has been adapted from the following sources and relevant links:

Personal Communications:
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Manske, S. (Interview, July 2, 2013; feedback, July 5, 2013). [Propel Centre for Population Health Impact].

Publications:
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External Source: http://eng.jcsh-cces.ca

Bounce Back: Reclaim Your Health

LOCATION:	**British Columbia**	**HEALTH THEME:**	**Chronic Disease Management**
HEALTH SECTOR:	**Primary Health Care**	**FRAMEWORK CATEGORY:**	**Emerging**

SNAPSHOT:
This innovative practice addresses the issue of mild to moderate depression in primary care patients by using self-help materials and telephone health coaching. It was launched in British Columbia in 2008.

PRACTICE DESCRIPTION:

Cognitive behavioural therapy (CBT) is an intervention for mild to moderate depression that is not readily accessible for primary care patients in Canada, particularly in rural areas. As one strategy to address this issue, the government of British Columbia has funded a mental health promotion and intervention initiative called Bounce Back: Reclaim Your Health. This initiative, which is operated by the BC Division of the Canadian Mental Health Association, is currently being offered throughout British Columbia.

The target group of the Bounce Back program is adults with mild or moderate depression, low mood, or stress, with or without anxiety. This mental health service is available to patients in their own homes. The program provides two forms of support: a *Living Life to the Full* video on DVD and workbook-based telephone coaching, available in English and Chinese (Mandarin or Cantonese). The video provides practical advice on how to recognize and address depressive symptoms.

Trained telephone coaches support patients (in English or Cantonese) in using the self-help materials. Coaches assist in teaching problem-solving and other skills to overcome patients' difficulties, including inactivity, unhelpful thinking, worry, and avoidance. Telephone coaches are non-specialists who are trained and monitored by a registered psychologist. A primary care physician's referral is required for the telephone coaching component of the program. To be eligible for referral, patients must be assessed by the PHQ-9 tool and have a score of 5 to 19, with no contraindications for low-intensity cognitive behavioural intervention. Family physicians may claim a community patient conferencing fee from the government if they consult with a Bounce Back coach as part of collaborative care planning.

This practice is innovative in that it expands access to mental health services and promotes mental health literacy, especially in rural areas.

IMPACT:

This innovative practice was implemented in 2008. It is based on a cognitive behavioural therapy approach, which the Canadian Network for Mood and Anxiety Treatments Clinical Guidelines recommend as a treatment for depression. A three-phase implementation evaluation (2011) of the Five Areas Approach (which informed the Bounce Back Program) was carried out by Jeanne Legare and Associates, covering the period from June 2008 to March 2010. As well, the program asks participants to complete a short online survey to provide program feedback. Personal testimonials and observations suggest that this practice has the potential for positive outcomes on health. The Canadian Institutes for Health Research and the Canadian Mental Health Association have funded research for a randomized controlled trial in 2013 to evaluate (1) whether the program is more effective than usual treatment by general practitioners; and (2) whether the program's results can be attributed to the telephone coaching component. A secondary objective is to assess the cost-effectiveness of the telephone support. The research is being conducted in BC and in pilot sites in Alberta.

APPLICABILITY/TRANSFERABILITY:

The *Bounce Back: Reclaim Your Health* program content was developed in part from the work of **Dr. Chris Williams' Living Life to the Full** program, which includes an educational DVD and a self-help book first published in 2006 called ***Overcoming Depression and Low Mood:*** *A Five Areas Approach*. The content of these self-help materials was adapted to a BC context for use in the Bounce Back program.

There was a staged roll-out of the program in BC. It was launched in five Interior communities in June 2008, and by April 2010 it

was providing service to the whole province. By the end of October 2010, over 49,000 DVDs had been distributed and over 9,100 participants had been referred for telephone coaching. The program has established a Participant Advisory Committee (PAC), involving former program participants, to provide suggestions, feedback, and recommendations on how to improve the Bounce Back program across the province.

CONTACT INFORMATION:

Name:
Title:
Organization: Canadian Mental Health Association, British Columbia Division
Email address: bounceback@cmha.bc.ca
Telephone number: 604-688-3234
Information last updated on: July 4, 2013

Content has been adapted from the following sources and relevant links:

Publications:

BC Ministry of Health. (2011, June 10). *Self-management support: A health care intervention*. Retrieved from http://www.selfmanagementbc.ca/uploads/What%20is%20Self-Management/PDF/Self-Management%20Support%20A%20health%20care%20intervention%202011.pdf

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External Source: www.bouncebackbc.ca

Mental Health Works

LOCATION:	National	**HEALTH THEME:**	Health Promotion and Disease Prevention
HEALTH SECTOR:	Primary Health Care	**FRAMEWORK CATEGORY:**	Leading

SNAPSHOT:
This innovative practice addresses the issue of mental health in the workplace. The practice was launched in Ontario and has now been implemented in multiple organizations by trainers who educate employers.

PRACTICE DESCRIPTION:

Each day, 500,000 people in North America are away from work due to a mental health issue of some kind, costing workplaces and the health care system billions each year. Mental Health Works (MHW) is a nationally available program of the Canadian Mental Health Association (CMHA). Its head office at CMHA Ontario builds capacity in workplaces to address effectively the many issues related to mental health in the workplace.

MHW helps organizations build capacity to be more effective with

1) intervention when mental health of employees is affecting performance;
2) prevention of mental health issues through building socially supportive workplaces; and
3) promotion of mental health through strategic approaches to employee health and performance issues.

MHW offers training and education programs that raise awareness, deepen understanding, reframe the issues, and provide tools and strategies so that individuals in various workplace roles are more effective in addressing mental health issues.

MHW began in 2001 as a partnership research project. In 2004, MHW began selling products and services to the business community. MHW is dedicated to advancing the field of workplace mental health through skills enhancement training, awareness education, and stigma-reduction efforts in both English and French. MHW has expanded into the United States and is developing international ties with other workplace mental health programs.

MHW improves working lives by helping people in various roles in the workplace provide effective support to individual employees who are struggling with mental health issues. They also address organizational factors that affect overall workplace mental health with an emphasis on creating psychologically safe and healthy work environments benefiting all workers.

The program uses multimedia approaches, including a website, publications, a self-study CD, training videos in the workshops and presentations, online audio clips, and an e-newsletter. MHW trainers receive rigorous training from North America's leading experts on workplace mental health and bring a high degree of competency and experience in management, human resources, vocational rehab, or interpersonal communication skills. In all the training products, videos of real people who share their experiences of having a mental illness are used to break down the stigma and misconceptions about mental illness in the workplace.

This innovative practice is unique because it tailors its services to each employer and organization in order to best meet their needs. It also equips them to meet their new and emerging responsibilities under the law and the new National Standard of Canada for psychological health and safety in the workplace. MHW receives no operational funding; it sustains efforts through its products, services, and sponsorship support.

IMPACT:

In 2012, MHW was awarded the Mental Health Commission of Canada's Workplace Award, and has received awards from the Canadian Council on Learning and the Canadian Society for Training and Development. A number of evaluations have been carried out and published on MHW, its training workshops, and its programs both internally and by third-party evaluators. Through the Mental Health Commission of Canada's Opening Minds project, the Mental Health Works management workshop was evaluated and found to be an effective stigma-reduction program. The results of the evaluation showed that out of the 3,000 participants involved in 49 sessions,

- 96.8% agreed or strongly agreed that the workshop was valuable;
- 93.8% agreed or strongly agreed with the statement "I learned something new";
- 95.4% agreed or strongly agreed they would be able to apply this knowledge to their position;
- 94% said the workshop had increased their knowledge about mental health in the workplace; and
- 96.65% stated they would recommend the workshop to others.

Similarly, another evaluation that was published in a peer-review journal showed that 89% of the respondents indicated that they agreed with statements in the Value of Information and Presentation sections of the participants' evaluation forms. This suggests that the participants found the information presented in the workshop to be valuable and relevant, and that they would recommend the same training to their colleagues.

APPLICABILITY/TRANSFERABILITY:

MHW is based out of CMHA Ontario with clients that include the City of Brampton, Canadian Blood Services, Regional Municipality of Peel, Upper Canada District School Board, and many other organizations across Canada. Since the service is catered to the client, this practice is likely very transferable across jurisdictions and has been implemented in the majority of Canada's provinces and territories. Representatives from the California chapter of Mental Health America began collaborating with MHW staff in 2012 to facilitate the implementation of a similar program called Wellness Works, which finished its first round of training 18 trainers in the United States in March 2013. MHW has also had recent conversations with representatives from Arkansas in the United States as well as inquiries from the United Kingdom and Australia.

CONTACT INFORMATION:

Name: Kathy Jurgens
Title: National Program Manager
Organization: Mental Health Works
Canadian Mental Health Association, Ontario Division
Email address: kjurgens@ontario.cmha.ca
Telephone number: 416-977-5580 ext. 4120
Information last updated on: June 4, 2013

Content has been adapted from the following sources and relevant links:

Personal Communications:
Jurgens, K. (interview and feedback, May 14, 2013). [Canadian Mental Health Association]
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Publications:
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External Source: http://www.mentalhealthworks.ca/about

Targeted Newborn Screening for Treatable Genetic Disorders in the Old Order Amish Population of Southwestern Ontario

LOCATION:	Ontario	**HEALTH THEME:**	Health Promotion and Disease Prevention
HEALTH SECTOR:	Primary Health Care	**FRAMEWORK CATEGORY:**	Emerging

SNAPSHOT: This innovative practice screens and identifies presymptomatic newborn infants at risk for genetic disorders.

PRACTICE DESCRIPTION:

The Old Order Amish in southwestern Ontario are a distinct, self-defined population with unique health care needs. The Amish are quite knowledgeable about inherited diseases and keep excellent genealogical records. They are also interested in health maintenance and disease treatment, especially for their children. However, they tend to seek medical advice late in the course of illnesses, which may mean treatment is less effective. Through previous research, we had identified the specific DNA mutations causing juvenile glaucoma, cystic fibrosis, galactosemia, and cystinosis in the Amish. All of these disorders are amenable to treatment that may ameliorate or delay the onset of symptoms. In 2003, a targeted newborn screening program was developed with funding from the Change Foundation to identify presymptomatic newborn infants at risk for these disorders.

The targeted newborn screening program entailed (1) screening this under-serviced population using DNA molecular methods to identify the four specific treatable disorders, (2) involving community elders as advisors in the planning process to ensure acceptance of the program, (3) educating health care providers in the community, (4) collaborating with various health care providers in the region to inform Amish families about the project, (5) including a member of the community in the organization of community education events, and (6) providing screening in homes where deliveries occur. Pregnant women are informed about the Newborn Screening Program, primarily by midwives and public health nurses. They receive information about newborn screening and decide whether to participate. Blood samples are obtained through umbilical cord sampling after delivery and relevant DNA mutation analysis and enzyme analysis are carried out in the biochemical genetics laboratory.

IMPACT:

The screening project has been widely accepted by the Old Order Amish community with over 90% of pregnant women referred to the project opting to have newborn screening. DNA testing detected an extremely high carrier rate for each of the four disorders. Over the past eight years, over 300 babies have been tested and four babies who have one of the disorders have been identified.

An unexpectedly high rate of other rare genetic disorders has also been noted. Research is ongoing in association with a Canada-wide consortium to identify causative genes. The Amish, Mennonite, and Hutterite Genetic Database (http://www.biochemgenetics.ca/plainpeople/) is a useful reference for physicians who work with any of these populations.

At this time, the program has not undergone formal evaluation. However, due to the high uptake of screening, targeted newborn screening has been incorporated into routine practice in the community. Key lessons learned from the design and implementation of this program were that (1) sensitivity to cultural differences was essential in project planning and delivery, and (2) collaboration between health care providers in the hospital (London Health Sciences Centre) and in the community led to improved coordination of care, not only with newborn screening but in the management of other rare disorders as well.

APPLICABILITY/TRANSFERABILITY:

The project team is applying for grant funding to expand the screening program and provide carrier screening to the Old Order Mennonite population of southwestern Ontario.

The targeted newborn screening model designed for this program would be appropriate and applicable for any genetically

distinct populations in Canada.

CONTACT INFORMATION:

Name: Dr. Victoria Mok Siu
Title: Medical Director, Medical Genetics Program of Southwestern Ontario
Organization: London Health Sciences Centre and Schulich School of Medicine and Dentistry, University of Western Ontario
Email address: vmsiu@uwo.ca
Telephone number: 519-685-8140
Information last updated on: March 27, 2013

Content was adapted from the following sources and relevant websites:

Other:

Siu, V.M. & Rupar, C.A. (2012). Content developed from an abstract submission for the Health Council of Canada's National Symposium on Integrated Care.

External Source: http://www.biochemgenetics.ca/plainpeople/

Neonatal Transition Team: Specialized Nursing Team for Vulnerable Infants

LOCATION:	**Alberta**	**HEALTH THEME:**	**Health Promotion and Disease Prevention**
HEALTH SECTOR:	**Home and Community Care**	**FRAMEWORK CATEGORY:**	**Emerging**

SNAPSHOT:

This innovative practice aims to facilitate the transition of vulnerable (premature or very low birth weight) newborns from acute care to the home environment and community supports.

PRACTICE DESCRIPTION:

Each year, Public Health Nurses (PHNs) provide community-based nursing follow-up for approximately 15,000 Calgary newborns and their families. A small portion of these newborns are born prematurely weighing < 1250 grams. These newborns require long term hospitalization to stabilize multisystem prematurity and illness. Following hospital discharge, these infants and their families face feeding, growth, behavioral, and developmental challenges.

The Neonatal Transition Team (NTT) was launched in 1999 in Calgary, Alberta by a specialty team of PHNs in Calgary with neonatal nursing experience and expertise with this population. The team serves as a “bridge” between the acute care setting, home environment and community resources. Facilitation of discharge and support through transition home yields positive outcomes for the infant and family, as well as decreased acute care costs.

The Neonatal Transition Team consists of a Clinical Nurse Specialist, Public Health Nurses with neonatal experience, and Dietitian consultant. The team offers unique services across acute and community settings. The team becomes acquainted with infant and family needs prior to the infant’s discharge. Following discharge, the team meets the infant and family in the home or clinic environment and provides: neurodevelopment assessments, breastfeeding/feeding/growth assessment & support, role modeling & mentoring, infant care teaching, special care needs, as well as telephone support, community referrals and hospital contacts if the infant is re-admitted to hospital.

IMPACT:

In 1999-2000, NTT completed a randomized control trial with 71 infants (≤2000 grams birth weight) in the intervention group (received 4 months NTT followup) and 64 in the control group. Significant findings included: the case group had fewer contacts with other health care professionals, received more breast milk during the six-month follow-up, demonstrated accelerated growth at the two-week post-discharge follow-up period, had fewer unscheduled primary care physician visits and demonstrated more appropriate utilization of post-discharge vitamin supplementation. The low birth weight case group required fewer scheduled primary care physician visits than control infants, and overall although not statistically significant the case group required approximately 20% fewer physicians’ visits than the control group. Mothers whose infants were in the case group and were followed by the NTT identified that they were more knowledgeable and satisfied with the health care system in the post-discharge period than mothers of control infants, while control mothers believed their infant was healthy and normal more often than case mothers. Control infants received more total formula feedings than case infants.

More recently, comparing retrospective data from the 2011 NTT cohort against published research studies with respect to key variables showed NTT clients had more positive outcomes. This evaluation also indicated superior growth, breast milk intake, and less reliance on acute care (emergency department visits, rehospitalizations) in the NTT group. It is believed that these outcomes demonstrate the benefit of matching client needs with nursing expertise; a neonatal nurse in a public health nursing role is an effective way to meet the needs of ex-VLBW infants and their families. Given that a second randomized control trial would not be ethically feasible in Calgary as the program has existed for over 12 years, we are pursuing a pilot retrospective study. This study will evaluate 2 years of ex-VLBW infant outcomes over 8 months post-discharge. The purpose of this study will be to examine the differences in key short term outcomes for VLBW infants who receive home follow-up by the NTT in Calgary compared to VLBW infants who receive standard community based follow-up in an area of Toronto. The research question is to determine the differences in growth, breastmilk intake and health care resources utilization between VLBW infants who receive

NTT services compared to VLBW infants who do not receive NTT services.

APPLICABILITY/TRANSFERABILITY:

The NTT program was originally conceived by three neonatal clinical nurse specialists in Calgary. An NICU-outreach program was the initial impetus for this program as described by Dorothy Brooten from Philadelphia. A community-based model was believed to be more suitable for Calgary and the Canadian health care system. There are no other known similar community-based nurse-led neonatal health care programs.

The NTT Program has received multiple queries from neonatal specialists (nurses, neonatologists) and several have come for a site visit. Some Canadian neonatal followup clinics have modified their followup by connecting with families periodically after NICU discharge (and will see the infants early if concerns present). There is a lot of interest in the continuation of specialized neonatal support and surveillance beyond the NICU.

The Neonatal Transition Team is currently the only such program in Canada. However, the model it presents for the integrative care of VLBW infants, including discharge and follow-up could be readily applicable in other jurisdictions within Alberta and throughout Canada.

CONTENT WAS ADAPTED FROM THE FOLLOWING SOURCES AND RELEVANT WEBSITES:

Sherrow, T. Content developed from an abstract submission for the Health Council's National Symposium on Integrated Care (2012).

CONTACT INFORMATION:

Name: Tammy Sherrow
Title: Assistant Professor
Organization: Mount Royal University
Email address: tsherrow@mtroyal.ca
Telephone number: 403-813-1924

Name: Karen Lasby
Title: Clinical Nurse Specialist Neonatal Transition Team
Organization: Alberta Health Services
Email address: Karen.lasby@albertahealthservices.ca
Telephone number: 403-944-7410

Information last updated on: April 24 2013

ColonCancerCheck

LOCATION:	Ontario	**HEALTH THEME:**	Health Human Resources
HEALTH SECTOR:	Public Health	**FRAMEWORK CATEGORY:**	Promising

SNAPSHOT: This innovative practice is a population based colorectal screening program. Launched in Ontario in spring 2008, it aims to increase capacity of primary care providers (PCPs) to facilitate the screening tests.

PRACTICE DESCRIPTION:

Colorectal cancer is the third most common cancer in Canada, and is diagnosed in 423 Canadians every week. In Ontario, it is even more prevalent, ranking as the second leading cause of cancer. In efforts to improve screening rates with a population-based screening approach, the Ministry of Health and Long-Term Care (MOHLTC) of Ontario, together with Cancer Care Ontario (CCO), committed a $193.5 million investment to colorectal screening in 2007. This led to the launch of an innovative, province-wide program called ColonCancerCheck (CCC) in the spring of 2008. The aims of the CCC are to

- screen every Ontario citizen between the ages of 50 and 74 at an average risk for colorectal cancer with the guaiac fecal occult blood test (gFOBT), and with a colonoscopy for people with abnormal gFOBT results or who have a family history of colorectal cancer; and
- increase capacity of primary care providers (PCPs) to facilitate the screening tests.

This is the first population-based colorectal screening program in Canada. Practices are founded on evidence collected from published literature, and all gFOBTs and colonoscopies delivered are regulated to meet Cancer Care Ontario's standards of practice. The over-arching goal is to reduce mortality from colorectal cancer through a comprehensive and pre-emptive strategy.

IMPACT:

CCO publishes ColonCancerCheck program reports with updates on progress made to date. During the 2010/2011 fiscal year, the percentage of endoscopists in Ontario reaching CCO's volume standard (200 colonoscopies annually) increased to 79%. Based on 2010 statistics, participation has risen to 53% of the population aged 50 to 74 being up-to-date with their colorectal tests. Detection outcomes were positive, showing that

- for every 1,000 people aged 50 to 74 screened using gFOBT in 2010, 1.5 cancers were detected;
- for every 1,000 people aged 20 to 74 with a family history of CCC screened in 2010, 4.3 cancers were detected; and
- for every 1,000 people aged 50 to 74 who were negative for colorectal cancer in the 2008 screening but were re-screened in 2010, 1.7 cancers were detected.

CCO captures progress and data on efficiency through a rigorous framework that enables Ontarians to be tracked, updated on their results, and re-screened for data acquisition. Screening and information gathering protocols are in line with the standards of the International Agency for Research on Cancer, and the quality determinants of the Canadian Partnership Against Cancer are being used for reporting purposes. Currently, up to 85% of hospital colonoscopies are being captured in the data, with new efforts being made to capture colonoscopies performed in non-hospital facilities.

Communication with patients is a well-established component of the program, with data management tools in place to ensure information sharing is bilateral and continuous. Correspondence has improved since 2008 via update letters to patients with abnormal gFOBT results, recall letters for repeat screening, and invitation letters for new participants.

APPLICABILITY/TRANSFERABILITY:

Similar programs have existed since 2006 in England and Australia. However, Ontario is the only jurisdiction to begin screening at age 50 using a strongly evidence-based approach to the screening process. Colorectal cancer screening programs have now been adopted to varying degrees of implementation in British Columbia, Alberta, Saskatchewan, Manitoba, and Nova Scotia,

which demonstrates that the CCC program is easily transferable to the remaining provinces and territories. Various organizations such as the Ontario Hockey League and The Giant Colon have teamed up with Cancer Care Ontario to continue promoting CCC throughout Ontario.

Content was adapted from the following sources and relevant websites:

http://www.mybettermedicare.ca/provincial-primary-care-and-cancer-engagement-strategy.html

https://www.cancercare.on.ca/cms/One.aspx?portalId=1377&pageId=226298

CONTACT INFORMATION:

Name: Jill Tinmouth
Title: Scientific Lead
Organization: ColonCancerCheck Program, Cancer Care Ontario
Email address: jill.tinmouth@sunnybrook.ca
Telephone number: 416-480-6100, ext. 5910

Information last updated on: March 4, 2013

External Source: http://www.health.gov.on.ca/en/public/programs/coloncancercheck/

Primary Outreach Services in British Columbia

LOCATION:	British Columbia	**HEALTH THEME:**	Access and Wait Times
HEALTH SECTOR:	Primary Health Care	**FRAMEWORK CATEGORY:**	Promising

SNAPSHOT: This innovative practice addresses supported housing and emergency shelter residents' overall health by delivering clinical services on-site, improve residents' access to health services, create a strong partnership model in delivering health services, and reduce non-urgent hospital emergency department visits. Implemented in the Vancouver Coastal Health Authority since 2007, the program targets individuals who are chronically homeless, live chaotic lifestyles, and have multiple chronic health conditions, including mental health conditions and addiction.

Practice Description:

In 2007, Vancouver Coastal Health Authority (VCH) created Primary Outreach Services (POS) to deliver a full range of integrated primary care, mental health services, and addiction services to residents in supported housing and emergency shelters. The objectives of the program were to improve residents' overall health by delivering clinical services on-site, improve residents' access to health services, create a strong partnership model in delivering health services, and reduce non-urgent hospital emergency department visits. POS are provided to clients who live in the downtown core and the downtown eastside. They serve clients who are housed in supportive low threshold housing or are chronically homeless and need clinical interventions. As of 2012, the program was in 19 supported housing sites and nine emergency shelters and was supporting over 1,205 individuals. These sites primarily house individuals who are chronically homeless, live chaotic lifestyles, and have multiple chronic health conditions, including mental health conditions and addiction.

POS are provided by interprofessional clinical housing teams (CHT) that include a physician, nurse practitioner, nurses, case manager, and other health care workers. Services include medication management; wound and skin support; management of chronic disease problems such as diabetes, mobility issues, hepatitis C, and HIV/AIDS; mental health and addiction assessment and treatment; and relationship building, connection, and decrease in stigma and social isolation. The CHT acts as the primary point of care integration for acute care, community partners, and family and social agencies.

A nurse practitioner, family physician, and nurse hold clinics at housing sites on certain days of the week, and ongoing care and support are provided by case managers, nurses, counsellors, and health care workers who help patients get to their medical appointments or access community resources. In addition, non-profit organizations that manage the housing and shelter sites are funded by VCH to have on-site tenant support workers who maintain a safe and secure environment; link tenants with medical, mental health, and addiction treatment and social/community services; and assist patients with basic living skills.

IMPACT:

The program was evaluated in 2008 and 2010. Both quantitative and qualitative methods were used to evaluate the practice. The quantitative components utilized a pre-test/post-test design. The qualitative component included conducting interviews and focus groups with service providers and administrators/managers.

The results of the initial evaluation of the CHT (2008) showed that the CHT was able to connect with 74% of clients living in the initial eight sites. POS teams increased health service access—41% percent of clients had not accessed any VCH health services in the 12 months prior to the CHT contact. Thirty percent of clients seen six or more times by CHT were referred to other VCH health services. In clients seen six or more times by CHT, visits to the emergency department had decreased by 30%. CHT interventions also reduced semi/non-urgent emergency department visits by 55% among previously high-frequency users.

Results of the 2010 POS evaluation showed that in the 120-day period after initiation of POS treatment, clients had 20% fewer emergency department visits compared to before POS treatment. The greatest reduction was with the most frequent users of the emergency department, who had 58% fewer visits. Urgent visits declined by 22% overall, while less urgent visits decreased by 15%.

Non-profit organization partners and other health providers identified POS as a successful model to reach individuals who have

challenges connecting with health services. The program received a VCH award in Interprofessional Practice. Factors that contributed to the program's success are leadership to implement change in care delivery, resources made available to create outreach teams, and personal characteristics of team members, which include adaptability, flexibility, being solution focused, and being respectful of clients and tenant support workers. Challenges included making the teams diverse to meet the needs of clients and communicating to make other care providers aware of the role of the teams and how they can work together. What worked was the ability of teams to build relationships with clients that made clients more willing to receive health services. The key lesson learned is that meeting people where they are geographically, emotionally, and mentally improves access to services and reduces utilization of emergency departments.

APPLICABILITY/TRANSFERABILITY:

The program has not been replicated elsewhere, but it may have informed or inspired intensive home-based treatment programs such as those for mental health and for patients discharged from hospital with complex care needs.

CONTACT INFORMATION:

Name: Anne McNabb
Organization: Vancouver Coastal Health Authority
Email address: anne.mcnabb@vch.ca
Telephone number: 604-730-7605 x 7605

Information last updated on: February 4, 2013

External Source: http://www.vch.ca/home/

Red Deer Primary Care Network—Chronic Disease Management Program

LOCATION:	**Alberta**	**HEALTH THEME:**	**Chronic Disease Management**
HEALTH SECTOR:	**Home and Community Care**	**FRAMEWORK CATEGORY:**	**Emerging**

SNAPSHOT: This innovative practice addresses that 30% of the population with chronic disease account for 60% of direct health care costs in Alberta. In response, the Red Deer Primary Care Network (RDPCN) developed and implemented an integrated chronic disease management strategy to improve health outcomes and reduce costs. RDPCN used a health promotion philosophy to design an integrated approach to preventing and managing chronic disease. Adapting the expanded chronic care model, chronic disease management programs are integrated with community-based health promotion strategies.

PRACTICE DESCRIPTION:

It is estimated that 30% of the population with chronic disease account for 60% of direct health care costs in Alberta. To respond to population data and family physician needs, Red Deer Primary Care Network (RDPCN) developed and implemented an integrated chronic disease management strategy to improve health outcomes and reduce costs. RDPCN used a health promotion philosophy to design an integrated approach to preventing and managing chronic disease. Adapting the expanded chronic care model, chronic disease management programs are integrated with community-based health promotion strategies. Physician-referred patients are seen by interprofessional practice teams (family nurse, mental health counsellor, pharmacist) located in physician offices to facilitate collaboration, continuity of care, and coordination. Evidenced-based care algorithms (e.g., diabetes, smoking cessation) were developed that emphasize a patient-centred self-management approach.

The team refers patients to community and health resources for help with income support, diabetes care, housing, and other needs. Patients are referred to primary care network group programs (including Health Basics CHOICES, a lifestyle management program; Happiness and Anxiety Groups; and Strong and Steady (falls prevention)). Interprofessional staff teams lead group programs (e.g., the Health Basics team comprises nurses, kinesiologists, and dietitians). Patients who attend groups are followed up in family physician clinics. Patients and their families, along with staff, are encouraged to participate in RDPCN's community-based health promotion activities (such as virtual treks, outdoor gyms, and biking). Subsidies are provided for those in need.

IMPACT:

Formative and summative evaluation supports the continuous quality improvement and results assessment of patient services and programs. In 2011/12, 90% of referred complex chronic care patients (n=1578) were coached by team members. On average, patients presented with 4.3 chronic conditions. Each patient received six interventions, including referral to community resources. Case consultations between RDPCN staff and physicians doubled for complex patients; 30% of these patients were cross-referred to other primary care network programs. Patient feedback was positive regarding attributes of self-management: involvement in action/care planning (>90%), confidence in improving health (>80%), and awareness of RDPCN staff collaboration in their care (90%). The network's patient population had reduced emergency department visits and hospitalizations.

APPLICABILITY/TRANSFERABILITY:

Transferable programs include Happiness, Health Basics CHOICES, and Strong and Steady groups. Community activity partnerships include outdoor gyms, virtual treks, and complex care algorithms. RDPCN recognizes that health is a partnership among patients, families, health professionals, health organizations, and communities that deliver health care services that promote better health, improved chronic disease outcomes, and reduced health care costs.

Content was adapted from the following sources and relevant websites:

http://www.healthcouncilcanada.ca/content.php?mnu=4&mnu1=34#Presentations

CONTACT INFORMATION:

Name: Lorna Milkovich
Title: Executive Director
Organization: Red Deer Primary Care Network
Email address: Lorna.Milkovich@rdpcn.com

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External Source: http://www.reddeerpcn.com/OurPrograms/OurPrograms/Default.aspx

Integrating Supported Post-secondary Education with Supported Employment Program for People with Mental Illness

LOCATION:	**Ontario, International**	**HEALTH THEME:**	**Health Human Resources**
HEALTH SECTOR:	**Public Health**	**FRAMEWORK CATEGORY:**	**Promising**

SNAPSHOT: This innovative practice aims to facilitate successful college education and employment for students with mental health issues via supported education and supported employment. Launched as pilot studies in Israel and Canada, the program demonstrates that integrating supported education with supported employment may benefit people with mental illness to succeed in skilled occupations.

PRACTICE DESCRIPTION:

This collaborative approach between colleges and employment services integrates supported post-secondary education with supported employment. The aim is to facilitate successful college education and employment for students with mental health issues via supported education and supported employment. This program consists of three main phases (phase 1 is optional):

1. Generic Skills Training (computer skills, social skills, etc.) – An interprofessional team provides this training to individuals and groups (of up to eight students) for six hours a day for five days a week. In addition, students are given a vocational assessment and experiential exposure to the various courses offered at the centre/college in order to confirm or revise course selection. Supportive group and individual counselling and liaison are offered weekly, and each student meets with the supported employment worker.

2. Supported Education in a skilled occupation (e.g., secretarial, computer programming, accounting, optician, electrical, high school courses) – Accommodations are provided to the trainees at the college. Further, generic skills training, counselling, and liaison (including with the course instructors) are offered, and the supported employment worker explores supported employment or other vocational options (including unpaid practicums) for each student.

3. Supported Employment in skilled occupation (e.g., job placement, on-the-job supports, liaison with necessary services) – After students complete a course or some coursework successfully, the supported employment worker helps them secure employment, and supports them on the job as needed. In addition, the social worker/psychologist/counsellor continues to provide supportive counselling and liaison. Thus, students could continue to attend counselling and generic skills training even after starting employment.

This innovative program targets college students with mental illnesses who find it challenging to obtain an education degree and a skilled occupation. It specifically targets community colleges because they focus on relatively short-term work-related education and market-ready training (more so than universities), and in Canada they are funded to provide supported education (unlike trade schools). The anticipated outcomes of this innovative approach are:

1. Vocational outcomes: a higher ratio of students employed in skilled work (skilled work consists of work matched with the student's college education and with other skilled work, which are counted separately as well as jointly).

2. Clinical outcomes: a greater reduction in symptom severity with respect to depression, anxiety, and total psychiatric symptomatology.

3. Moderation of negative predictive effects of students' personal factors on vocational outcome, since the program compensates for relevant personal challenges, particularly neurocognitive impairment and poor work history.

4. Satisfaction: specifically work-related satisfaction and general life satisfaction.

IMPACT:

Two pilot research studies (one in Israel and one in Canada) were conducted by Rudnick and colleagues to test the feasibility and effectiveness of such integration using a non-controlled qualitative and quantitative evaluation design. Pilot research was conducted, primarily consisting of co-location of supported employment staff at the college and of structured collaboration between supported employment and supported education staff, combined with aspects of supported employment, such as job development starting before graduation, from supported post-secondary education. One of the pilot studies has already been published in a peer-reviewed academic journal, (Rudnick & Gover, 2009) and the other (Rudnick et al.) is being prepared for publication. In addition to this, another non-controlled descriptive study was conducted in Toronto with similar promising results, (Nandlal et al, 2009), although it was limited to two skilled occupations.

Results from both pilot researches (Rudnick & Gover, 2009, and Rudnick et al., in preparation) were promising; they included a very low attrition rate (7%) and nearly 50% transitioning to skilled employment, suggesting a need for such integration. The findings in the first pilot study conducted in Ra'anana, Israel, (Rudnick & Gover, 2009) demonstrated that 40% of students successfully obtained skilled work within one year, and 55% of students completed generic skills training. Of these, 58% remained enrolled in their course and 28% completed their course within one year.

The second pilot study of such integration in Canada (conducted in London, Ontario) also yielded promising results: the recruitment rate was 100% and all students were very satisfied from the integration (Rudnick et al, in preparation). This pilot research demonstrated that of those who completed the program, 78.4% obtained skilled employment within one year, with 100% working in the industry that they were trained in. Sixty-five percent of employed students successfully remained in their job for at least one year and of these, 55.2% received an average wage of $10.89 per hour (range $8.75 to $18. 17 per hour).

The findings of this pilot research demonstrated that integrating supported education with supported employment may benefit people with mental illness to succeed in skilled occupations. Hence, a methodologically rigorous study of this integration is now in order.

APPLICABILITY/TRANSFERABILITY:

During the period from 2002 to 2010, this innovative practice was implemented at the vocational rehabilitation and training centre in Ra'anana, Israel, and at Fanshawe College in conjunction with LEADS Employment Services in London, Ontario. The vocational rehabilitation and training centre in Ra'anana provides certified courses in skilled occupations for individuals with various disabilities. Fanshawe College provides intensive education supports via Counselling and Accessibility Services and focuses on organizational skills, social skills, confidence, motivation, time management, and so on. It provides general and trades education. The latter program requires co-op placements or other related employment. LEADS Employment Services provides employment assistance for persons with barriers to employment due to physical or mental and developmental or learning disabilities. It also provides job preparation, job and skills development, transitional employment, job coaching, and job retention supports.

This practice was tested in two different settings in Israel and Canada. Despite the differences in the geographical locations and jurisdictions, this innovative practice was found to produce similar outcomes.

Content was adapted from the following sources and relevant websites:

Rudnick, A. & Gover, M. (2009). Combining supported education with supported employment. *Psychiatr. Serv., 60,* 1690.

Nandlal J, Bettazzoni M, Priolo T, McGurk S, Flora N & Perrier C. Augmented education: Effectiveness of a new employment training and support model for people with mental illness. Toronto: Canadian Council on Learning, 2009.

Rudnick et al. (2013). An integration of supported education and supported employment for people with mental illness: a pilot study. [Manuscript in writing]

Rudnick et al.(2013). Barriers, enablers and related strategies in relation to supported post?secondary education for people with mental health challenges: a organizational case study. [Manuscript in writing]

CONTACT INFORMATION:

Name: Dr. Abraham Rudnick
Title: Associate Professor, Medical Director of the Mental Health and Addiction Services (MHAS)
Organization: University of BC; Department of Psychiatry
Email address: Abraham.rudnick@viha.ca
Telephone number: 1-250-370-8396

Information last updated on: December 13, 2012

Hamilton Family Health Team—Mental Health Program

LOCATION:	**Ontario**	**HEALTH THEME:**	**Access and Wait Times**
HEALTH SECTOR:	**Acute Care**	**FRAMEWORK CATEGORY:**	**Leading**

SNAPSHOT: This innovative practice was initially established in recognition that primary care physicians play a central role in delivering mental health care, often with minimal support from mental health services. Since 1994, the Hamilton Family Health Team (formerly Hamilton Health Service Organization) Mental Health Program (HFHT-MHP) has successfully integrated mental health counsellors and psychiatrists into the offices of 150 family physicians in 81 practices across the City of Hamilton.

PRACTICE DESCRIPTION:

Since 1994, the Hamilton Family Health Team (formerly Hamilton Health Service Organization) Mental Health Program (HFHT-MHP) has successfully integrated mental health counsellors and psychiatrists into the offices of 150 family physicians in 81 practices across the City of Hamilton. In 2006, addiction specialists and child mental health professionals were added to the program, serving selected practices. The program was initially established in recognition that primary care physicians play a central role in delivering mental health care, often with minimal support from mental health services. In addition, many individuals fail to seek or receive mental health services when needed, and primary care may be the only opportunity for identifying these problems and initiating treatment. The goals of the HFHT-MHP are to improve access to care, enhance the care experience for patients and providers, improve health outcomes, and increase capacity for primary care. The HFHT-MHP increases access by integrating mental health counsellors and psychiatrists into the practice team. They can see any individual with a mental health problem where the family physician requires assistance with little delay, and provide advice and ongoing support to the primary care team. They also assist primary care physicians to increase their skills and comfort in managing mental health problems, partly by being able to introduce evidence-based practices into their discussion of cases they have seen or informal case reviews. Mental health counsellors are permanently attached to the practices—1 FTE for every 7,200 patients—and a psychiatrist visits a half day per family physician per month. The program uses a “stepped” approach in a shared care model and emphasizes short-term care, although individuals can be seen on an ongoing or intermittent basis. Regular communication allows for better coordinated care and care plans. The model also offers opportunities for case discussions and reviews, continuing education in a brief case-based approach, early detection and intervention, relapse prevention and monitoring of individuals after an episode of treatment is completed, family interventions, and improved access to care, especially for people from ethno-cultural communities.

IMPACT:

Data on referrals, outcomes, and processes of care are collected routinely. An external evaluation of the program was done as part of the 2006 Primary Health Care Transition Fund.[1] Data from the first five years of the program demonstrated that it had improved access to mental health services by 1,100%, especially in underserved communities. It had also reduced the use of secondary and tertiary in-patient and out-patient services by 10% and 70% respectively, compared to the year before the program started. This improvement has been maintained over a 15-year period. The program demonstrated improved outcomes for individuals with mental health problems, better coordination of care, reduced system fragmentation, improved communication, and reduced wait times for services. It is more convenient, comfortable, and less stigmatizing for people using the service, and it has high provider and consumer satisfaction ratings, although this is based on descriptive data, and comparative data from other local mental health services are not routinely collected.

APPLICABILITY/TRANSFERABILITY:

The HFHT-MHP model has been adopted by other programs in Canada and in other countries and has become the prototype for the integration of specialized services within family health teams in Ontario. Program staff participated in the development of a 1997 position paper on shared mental health care in Canada,[2] which led to the establishment of the Collaborative Working Group on Shared Mental Health Care, a joint committee with representation from the Canadian Psychiatric Association and the College of Family Physicians of Canada. The program received a significant achievement award from the American Psychiatric Association in 1999.

Contact Information:

Name: Dr. Nick Kates
Title: Acting Chair, Dept. of Psychiatry and Behavioural Neurosciences
Organization: McMaster University
Email address: nkates@mcmaster.ca
Telephone number: 905-536-0966

Website for innovative practice: http://www.hamiltonfht.ca/i-am-a-patient/mental-health

1. Vingilis, E., Paquette-Warren, J., Kates, N., Crustolo, A.-M., Greenslade, J., & Newman, S. (2007). Descriptive and process evaluation of a shared primary care program. *The Internet Journal of Applied Health Sciences and Practice, 5*(4). Retrieved from: http://ijahsp.nova.edu

2. Kates, N., Craven, M., Bishop, J., Clinton, T., Kraftcheck, D., LeClair K., … Turner, T. (1997). *Shared mental health care in Canada*. Ottawa, ON: Canadian Psychiatric Association and College of Family Physicians of Canada.

External Source: http://www.hamiltonfht.ca/i-am-a-patient/mental-health