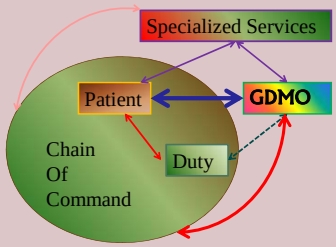
Collaborative Mental Health Care in the CF

Colonel Randy Boddam CD, BSc, MD, FRCPC
National Practice Leader for Psychiatry and Mental Health

Cultural Context

- CF members serve with unlimited liability
- All health care is provided with an occupational perspective
- The focal point of health care delivery is the general duty medical officer
- Members of the Canadian Forces are specifically excluded under the Canada Health Act

A Picture is worth....



Before Project Rx 2000

- With the fall of the Berlin Wall NATO forces began a process of downsizing
- In the early and Mid 90's the CF was also required by the Government of Canada to reduce its size.
- In 1994 Op Phoenix was the CFMS' restructuring plan
  - The 1990 Auditor General report had already questioned the capacity of the CF medical services to meet the demands of a war-time footing
  - Decision to focus on operational health care

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- Medical services downsized
- Civilian health services were also downsizing
  - CF had hoped that civilian health care could be purchased for "in-garrison care"
  - Increased waiting lists
- Romeo Dallaire "came out" about PTSD and alcoholism
- Mental Health services were fragmented
- CRS reviewed the medical services
- Project Rx 2000 was born

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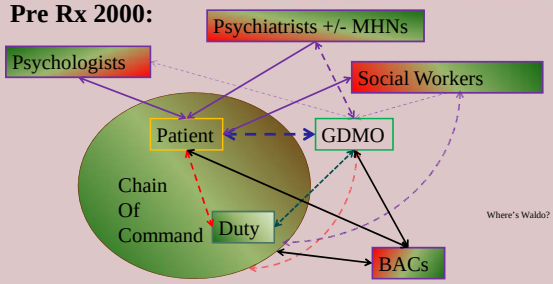
Pre Rx 2000:



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Identified Problems

- MH services, such as they were, were disjointed
- There was dissatisfaction with communication
- Some MH professionals felt isolated
- There was a public perception that MH problems in CF = PTSD and that there was not enough service
  - LGen Dallaire, before he retired, directed nationwide PTSD clinics
- We lacked visibility over external care provision

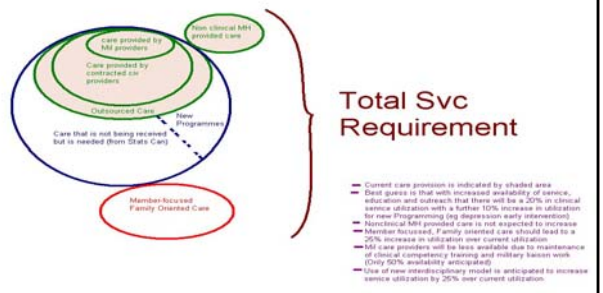
Project Rx 2000

- Omnibus project with goal of addressing shortfalls identified in CRS report, improve health care delivery and anticipate the needs of HS delivery for the future
- MH care was one cell
  - Initially a team of four we grew to fourteen or more
  - Our strategy was to consult with representatives from the organization, use external consultants and literature (such as it wasn't)

- At the same time another cell, PCRI was busy looking at the clinic structure
  - Identified ¼ Social Worker FTE per CDU
- Utilized StatsCan CCHS Ver 1.2 CF Supplement (in conjunction with Parent study and literature epi data)
- Challenged by
  - Unwieldy infrastructure
  - Shortage of MH care providers in general
  - PS hiring freezes
  - Less than ideally responsive 3rd party contractors

CCHS (CF Suppl) Findings

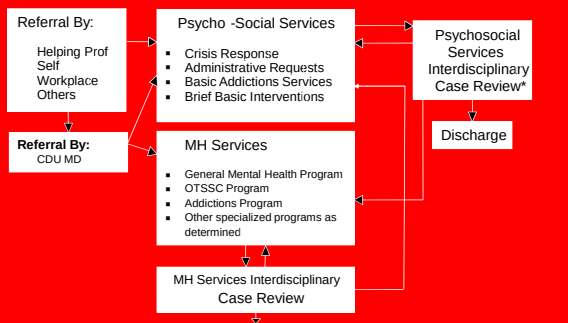
- Almost twice the prevalence (1 yr and lifetime) of depression
- 40% higher 1 yr prevalence of depression
- Prevalence of Substance use, social phobia, PTSD, GAD, suicidal ideation approximated the civilian population
- 1/3 of identified cases did not use MH services
- Only ¼ of those cases felt that the MH services addressed a need that they had



How to employ care providers

- Previously, local level MH care was provided by SWO's, BAC's, primary care providers with referral to external providers and services/programmes
  - There was a tendency to think in terms of disciplines
- There was also CFMAP
- Through a series of focus groups, review of the literature, discussions and considering the work of other cells (eg, PCRI) the cognitive leap was made to a system of two tiers and interdisciplinary care: psychosocial and MH

Mental Health Care Patient Flow



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Components

- Disciplines at Psychosocial are the CDU normal care providers, BAC, SWO, MHN
- Disciplines at MH include BAC, SWO, MHN, clinical psychology and psychiatry
  - Some pastoral counselling available at larger centres
- In both instances care is provided via interdisciplinary programmes
- Only access to MH is through GDMO
- GDMO apprised if PS service identifies health problem

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From the Patient's perspective

- OTSSC satisfaction survey found that patients were satisfied with the care that they received
- Patients receive interdisciplinary care with required care providers when needed
- There is no longer stove piping of care delivery

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From the provider's perspective

- Support from a team of care providers
- More care providers now present
- Ability to work in different programmes to provide interesting clinical work
- Focus of care delivery is upon evidence-based treatments
- Ability to provide care within the context of the work environment

Does it work?

- Final implementation under the project ended March 09
  - There is still a gap between funded positions and hired care providers
- Concept and interim implementation twice reviewed by external agencies both of whom endorsed it

The End