

Consensus Statement On Improving Mental Health Transitions

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IHE

**INSTITUTE OF
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Acknowledgments

As Jury Chair, Dr. Alain Lesage, MD, FRCPC, MPhil, DFAPA, Professor, Department of Psychiatry, at the University of Montreal and Clinician at Montreal University Mental Health Institute, Quebec, led a distinguished panel tasked with summarizing the evidence and developing recommendations to improve policy and practice in improving the transition from institutional care to community-based care for adults with severe and persistent mental illness.

The conference program was developed with advice from a Scientific Committee chaired by Dr. Roger C. Bland, CM, MB, ChB, FRCPC, FRCPsych, and Professor Emeritus in the Department of Psychiatry at the University of Alberta.

This event was the 7th Consensus Development Conference organized by the Institute of Health Economics (IHE) since 2006 when the IHE introduced the conference format to Canada.

The conference was funded by the Government of Alberta.

Conference website: <http://transitions2014.ca/>

Disclosure Statement

All of the jury members who participated in this conference and contributed to the writing of this statement were identified as having no financial or scientific conflict of interest.

Table of Contents

Introduction.....	3
Jury Chair’s Introduction	4
Question 1: What is severe and persistent mental illness (SPMI) and its social and economic consequences?.....	4
Question 2: What is the effectiveness of current interventions for adults with SPMI?.....	6
Question 3: What is the evidence for the role of other support systems, including primary care in effective interventions?.....	7
Question 4: What are the most effective systems for supporting people with SPMI?	9
Question 5: What information tools are required for high-quality system management?	10
Question 6: What further research is needed?	11
Concluding Recommendations	12
Jury Members	13
Expert Speakers	14
Scientific Committee	15
Planning Committee	15
About the Institute of Health Economics.....	16

Introduction

About this Consensus Statement

This Consensus Statement was prepared by an independent 13-member jury of health professionals, academics and public representatives based on: 1) relevant published studies assembled by the Scientific Committee for the conference; 2) presentations by experts in areas relevant to the conference questions; 3) questions and comments from conference attendees during open discussion periods; and 4) the private deliberations of the jury.

The conference was held in Edmonton, Alberta, Canada. The Consensus Statement therefore refers to circumstances in Alberta, although data were drawn not only from Alberta but also from other parts of Canada, the United States and internationally.

This statement is an independent report of the jury and is not a policy statement of the conference partners or the Government of Alberta.

The recommendations were read aloud by the Jury Chair and discussed with delegates at the conference in an open session on the closing day of the conference, November 6, 2014, together with the Jury Chair's Introduction which is included here.

IHE Consensus Development Conferences

IHE delivers a program of Consensus Development Conferences, the only events of their kind in the health care field in Canada. Our conference model is a deliberative process bringing together experts and policy-makers to provide clear findings and recommendations aimed at promoting the integration of scientific evidence into policy and practice.

IHE introduced the Consensus Development Conference format to Canada in Edmonton in 2006. To date, IHE has organized seven Consensus Development Conferences:

Conference Title	Date	Jury Chair
Self-Monitoring in Diabetes	2006	Michael Decter
Healthy Mothers–Healthy Babies: How to Prevent Low Birth Weight	2007	Dr. Shoo Lee
Depression in Adults	2008	Hon. Michael Kirby
Fetal Alcohol Spectrum Disorder – Across the Lifespan	2009	Hon. Anne McLellan
Legal Issues of FASD	2013	Hon. Ian Binnie
Surveillance & Screening for AROs	2014	Dr. Tom Marrie
Improving Mental Health Transitions	2014	Dr. Alain Lesage

The conference model

The Consensus Development Conference has a unique format based on a jury trial, which provides an independent and critical review of issues by an unbiased panel. The conference is a survey of the best available evidence and the views of leading experts, which informs a Consensus Statement that is relevant for policy and practice. The conference involves 20 to 25 experts who deliver scientific evidence addressing 5 to 8 questions in a given field over two days of hearings attended by a jury or panel of about 12 members and an audience of delegates.

The conference model is flexible; for example, it can include a “Town Hall” session with the entire faculty (expert presenters), a question-and-answer session following each presentation, and/or a session with the faculty for each main question following the presentations on that question. Question-and-answer periods provide opportunity for testimonial input from the audience, which can include lay persons and members of the public.

The Jury takes all the conference input into consideration in "sequestered" deliberations following each day of presentations and renders its summary of the evidence and its recommendations in a Consensus Statement. The Statement is read aloud by the Jury Chair at the start of the third and final day of the conference, and then widely disseminated to targeted policy-makers, professionals, and other relevant stakeholders across Canada and beyond. The transparent format of the conference maximizes its impact. The Consensus Statement is written in plain language and designed as a booklet, and published in printed and electronic form.

Jury Chair's Introduction

This consensus development conference was commissioned by the Government of Alberta to improve the transition of its system of care for people with severe and persistent mental illness (SPMI) toward the community. The system, previously hospital- and institution-centered, is moving towards becoming a community-centered, patient- and family-led one. The development and deployment of effective community mental health services has been progressive. Indicators of system failure for this population have been seen in the growing number of people with SPMI found in prisons and among the homeless population, in reduced life expectancy by an average of 20 years, and in the particular toll of SPMI on Aboriginal communities.

We have gathered evidence of effective innovations at the system and individual levels, as well as implementation strategies and financial incentives that we believe can help in the ongoing transition to a community-based system of care for people with SPMI. There is hope for real progress: that with adequate support, employment, education and housing, individuals developing SPMI will experience a better course of life and a more humane treatment and care system than has traditionally been the case.

In discussion with the Scientific Committee, we agreed that the focus should be on people with severe and persistent mental illness, defined as a diagnosis of a psychotic and/or bipolar mood disorder that causes very significant social dysfunction and requires high-intensity health and social support services. This group represents about 1.5% of the general population and accounts for a disproportionate share of expenditures in the mental health and social service systems, as well as in the justice system and communities. An additional 3.5% of the population is estimated to suffer from severe mental illness (SMI), such as schizophrenia, bipolar and major mood disorders, severe personality disorders, and borderline personality disorders, and from comorbidities of these disorders, including substance abuse. Patients with SPMI are found in long-term wards of psychiatric or forensic psychiatric hospitals; they experience repeated admissions and long inpatient stays in acute psychiatric care wards; they live in supervised residential settings such as foster homes and group homes; and they receive services in many forms, including specialized assertive community treatment (ACT) and Intensive Case Management (ICM) teams (both intensive home care teams). Unfortunately, many of these patients also end up homeless and/or cycling in and out of prison.

There are many innovative models of community care for people with SPMI, aimed at successful recovery. While they vary in specific elements, these models all stress the importance of continuity of care for the delivery of effective

pharmacological and psychosocial interventions, psychotherapies, and social interventions (financial and housing). In general, the most promising approaches are those involving multidisciplinary community treatment teams with sufficient resources to serve as a fixed point of responsibility for affected individuals and their families within a given catchment area.

Although this consensus statement focuses only on adults with SPMI, we recognize the importance of well-developed and effective first-onset psychosis programs focused on adolescents and young adults in decreasing the number of patients who will need long-term – and in some cases, lifelong – support. We also recognize the needs of patients affected by other severe mental disorders starting in childhood (e.g., autism spectrum disorders) or in later life (e.g., dementia), and those with other organic brain disorders such as traumatic brain disorder in youth or adulthood, those with intellectual disability and severe behavioural problems, and those suffering from severe mental disorders other than psychosis, such as borderline personality disorder.

Question 1: What is severe and persistent mental illness (SPMI) and its social and economic consequences?

What is the magnitude of the problem?

Severe and persistent mental illness (SPMI) is an umbrella term rather than a diagnosis of a specific illness or set of illnesses. At a given time it may be conventionally understood to refer to a certain range of diagnoses, but its meaning is open-ended and will change over time.

SPMI has been understood for many years to encompass diagnoses of schizophrenia, related psychotic disorders and bipolar disorder; but there are limits and challenges to this approach.

The traditional perspective, narrowly defined, gives a prevalence for schizophrenia and bipolar disorder combined of approximately 1.5% of the population, up to one-third of whom require intensive and continuing care in specialized services and may be more vulnerable to homelessness and incarceration. One problem with this definition is that people may experience other mental illnesses, such as major depression, obsessive compulsive disorder and personality disorder, that are both severe and persistent. Second, not everyone within the traditional cluster may personally experience their illness as either severe or persistent, especially in the context of early intervention and effective, broadly-based treatment. Diagnosis alone does not align perfectly with impairment, distress, persistence and treatment intensity.

An alternative approach is to view SPMI more functionally with regard to duration and degree of impairment. While not ignoring diagnosis or the specificity of treatment needs, this approach includes illnesses with a lower prevalence but higher likelihood of individual burden, such as schizophrenia, as well as illnesses with a higher prevalence but lower likelihood of individual burden, such as depression. This functional approach gives an overall prevalence of Severe Mental Illness of 5% of the general population across the adult lifespan.

Further, defining SPMI epidemiologically provides an opportunity to examine critical modifiable factors which may increase or decrease the prevalence; since there is no absolute “right” definition of SPMI, it should at least be useful and measurable. The prevalence of SPMI is driven by incidence (the onset of illness) and duration (length of episode), and is lowered by positive events such as recovery and by negative events such as death by suicide or medical illness. Preventing suicide and improving physical health care for people with SPMI would actually increase the prevalence of SPMI, while preventing relapse would lower the prevalence.

Living with SPMI: a personal perspective

The jury heard eloquent testimony from an individual who has lived with schizophrenia for decades. While acknowledging his benefit from treatment, he also described the centrality of hope and other factors: “Medications can only take you to a certain point... you need a decent place to live, supports (etc.)” He emphasized the need for provincial formularies to fund a broad array of the best available medications, given the likely genetic variability in response, as well as the need for research to develop better treatments. He also spoke to the need for publicly funded psychological treatments for people with SPMI.

Social impacts of SPMI on individuals and families

The jury was told clearly of the breadth of the social impact of SPMI on the individual (reduced quality of life, emotional distress, vulnerability to developing other conditions, risk of premature death, and the burden of stigma) and on the family (stigma by association, emotional strain, and the persistent worry about who will care for the person when the parents have died).

The jury was also told about the significant economic impact of SPMI on patients, their families, and society as a whole, reaching billions of dollars annually. There are significant patient out-of-pocket costs for medications and often huge indirect costs associated with loss of quality of life, reduced professional productivity by patients and their families, time lost for medical care, and costs related to premature death due to suicide.

This burden can be mitigated by education about SPMI, vocational support (education, employment) and peer support, and by promoting resilience and recovery wherever possible. More needs to be done to improve mental health care for people with SPMI and their families and to fight stigma.

What are the connections between mental illness and homelessness?

Of the estimated 150,000 users of emergency shelters in Canada, the vast majority use these facilities briefly and infrequently. But there is a sub-population of 8% to 12% who stay much longer or more frequently and account for the majority of shelter bed occupancy. Studies of SPMI among the homeless indicate markedly increased levels of psychotic disorders, major depression, personality disorders, and substance dependence compared to the general population.

The best available Canadian data on homelessness and SPMI comes from the recently completed At Home/Chez Soi study, a randomized clinical trial of the effectiveness of an intervention called Housing First compared with treatment as usual for homeless mentally ill Canadians in five cities. Of the more than 2,000 participants, 35% had a psychotic disorder, 52% had major depression, 29% had post-traumatic stress disorder, and 67% had both psychiatric and substance use disorders. This study produced evidence that a supported housing model, featuring regular housing with rent supplementation and support through either Intensive Case Management or Assertive Community Treatment, led to better outcomes than treatment as usual. In particular, supported housing yielded dramatically greater housing stability and moderately improved quality of life and functioning in comparison with treatment as usual. More appropriate use of health and social services was also found, including reduced shelter use and stays in institutions and, particularly for moderate-needs participants, declines in emergency room visits. Qualitative analyses confirmed that the model supported personal choice, empowerment, hope and improved life course.

Although there is some evidence of cost savings in aspects of supported housing, in a closed system where the money will be spent anyway this approach is not about reducing expenditures; rather, it is an opportunity both to do the right thing and to free up resources that will readily be used by deserving others in an overburdened system, thereby reducing gaps in care.

Implications of mental illness within Correctional Services

Our jails and prisons have become the last great asylums, with a significant percentage (36% of men and 62% of women) of offenders screened as needing mental health assessment and the majority also experiencing substance-abuse disorders.

Correctional Services lack an integrated model for treating people with concurrent substance use and psychiatric disorders, and these individuals experience worse correctional outcomes and incur higher costs. These worse outcomes include death in custody, victimization, and prolonged isolation in segregation.

There is a significant shortage of mental health professionals within Correctional Services.

While regional treatment centers exist for inpatient psychiatric care within Correctional Services, they have limited capacity. This constraint in effect applies a different standard to mental health care than to other types of health care, in that offenders who need specialized medical care for other conditions (e.g., cancer) would be transferred to non-correctional health care facilities.

Ultimately, solutions are needed both “upstream,” to ensure that people with SPMI do not end up by default in the correctional system, and “downstream,” to ensure that beyond warrant expiry (when people are no longer under the authority of Correctional Services), people with SPMI are accessing care and support.

Recommendations:

1. The prevalence of SPMI is not a static number; epidemiological studies should be used to measure the influence of modifiable factors that increase and decrease the prevalence over time in order to drive interventions.
2. The stories of people with lived experience of mental illnesses and their families should be made available as these are essential to promoting education and combating stigma and discrimination in the population.
3. The results from At Home/Chez Soi, the largest research study in the world addressing effective interventions for homelessness among people with SPMI, have demonstrated the need to scale up Housing First and other evidence-based interventions to reduce the distressing rates of homelessness among people with SPMI. More action research is needed for those people with SPMI who do not benefit from Housing First.
4. In the corrections system, the disparity between specialized treatment for physical disorders and mental disorders needs to be addressed, and integrated substance abuse and psychiatric care needs to be provided. Disordered behaviour resulting from mental illness needs to be viewed as a treatment issue that is not addressed by prolonged segregation.

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

Outcomes of long-term medication

Medications such as antidepressants, antipsychotics, anxiolytics and mood-stabilizers are effective treatment options for many individuals who suffer from psychiatric disorders. Despite their benefits however, these medications are also associated with various side-effects that can be distressing and sometimes debilitating. Studies have also shown that even when medication is administered according to best clinical practice, however, the long-term treatment outcome remains unsatisfactory for many subjects who struggle with SPMI. New pharmacological treatment options are needed to further improve health related outcomes.

How effective are psychosocial interventions?

The jury heard that psychosocial interventions, in general, are effective and should be an indispensable part of the mental health care system. Family intervention, psychoeducation, social skills training, and residential care are all supported by a strong evidence base. Family intervention integrated with psychoeducation reduces the relapse rate, while individualized non-institutional residential care reduces hospitalization and may also help to alleviate the type of symptoms that result in social withdrawal and related functional deficits in those with psychotic illnesses.

There are clear beneficial effects of supported employment in that people are more likely to find work with this approach. There is some evidence in support of the benefit of arts therapies, sports and other physical activity. Evidence is accruing regarding peer support, but the evidence for the quality of the therapeutic milieu is not yet strong. The evidence for narrowly-defined occupational therapy is relatively weak, showing only modest improvements, but would remain very useful if delivering previously described evidence-based psychosocial interventions.

How effective are psychological therapies?

There is strong evidence for the effectiveness of psychological therapies in combination with medication for people with SPMI. Specifically, there is excellent evidence of the benefit of family interventions in psychosis and good evidence for cognitive behavioural therapy for psychosis. The latter has been shown to have a positive effect on outcomes, including social and occupational functioning, and may be used safely with those who refuse medication. Of note, this evidence is based on therapy at a frequency of at least once every two weeks, an average of 20 sessions over 9 months. However, a shorter

duration of such treatment may also be effective. Additionally, a Canadian review highlights the fact that such treatment may also be helpful for patients who have had an inadequate response to medication.

The role of Intensive Case Management and Assertive Community Treatment

The evidence for case management shows that in general it is effective only when the caseload per health care professional is low (no more than 20 patients). It is then termed Intensive Case Management (ICM).

Assertive Community Treatment (ACT) is a recovery-oriented mental health service delivery model that takes a comprehensive approach to individuals living with SPMI in the community. ACT services are usually targeted to those individuals who make high use of acute-care psychiatric and/or emergency services. The service teams support a shared caseload and include specialists in psychiatry, nursing, social work, vocational recovery (including support with employment, education and training), psychology, addictions medicine, primary care, and peer support. The service model includes integrated dual-diagnosis treatment for co-morbid substance use and attention to primary health care needs. The standard is that there should be no more than 10 patients per health care worker.

The effectiveness of ACT, where a high degree of adherence to the model is maintained, is well established and includes improved patient outcomes and reduced health care costs. These effects have been demonstrated primarily with people who have a history of psychosis and frequent and extensive use of in-patient psychiatric and emergency services and who do not respond well to less intensive services. ACT enables such patients to stay in the community, reducing the need for psychiatric hospitalization, and is also a key component of successful transitioning of patients from the hospital to the community, out of forensic psychiatry, etc. These benefits have been shown more broadly for those with severe mental illness and complex needs (which would include the SPMI subgroup of patients). In Ontario, it was reported that two ACT teams have been tailored to address the needs of Aboriginal patients. In the absence of ACT, client trajectories would generally involve long-stay hospitalization, acute-care revolving-door syndrome, and/or homelessness.

Recommendations:

1. Psychosocial treatments should be integrated into mental health care service provision in both the inpatient and outpatient sector. Family intervention, psychoeducation, social skills training, and residential care should all be prioritized. Other approaches with developing evidence,

such as supported employment, sports and other physical activity, should be implemented as appropriate for each individual patient. Arts therapies may be particularly appropriate for patients who have relatively poor verbal skills.

2. Access to psychological therapies and psychoeducation for families should be improved for those with SPMI. To achieve this, relevant training will be required, and it is recommended that patients, families, and organizations conducting advocacy should be included in a wider context of recovery-focused services. The last relevant Canadian Psychiatric Association Treatment of Schizophrenia Guideline was in 2005; it is recommended that an updated one be drafted.
3. Given the strong evidence for the ACT model, it is recommended that ACT be scaled up. It is essential that this be adequately resourced to ensure proper adherence to the model of care. This will also require training and official verification of fidelity (in an accredited manner) to maintain fidelity in the long term. The ACT model may be adapted to special populations (including, for example, those with developmental disability and those involved in the criminal justice system) and should perhaps be considered as a priority for such. Appropriate culturally sensitive ACT teams, such as the two Aboriginal ACT teams in Ontario, should be developed. The service model includes integrated dual-diagnosis treatment for co-morbid substance use.

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

What are the alternatives to hospital care for people with SPMI? Evaluating the usefulness of crisis teams and homes

Crisis-resolution teams (CRTs) ideally cover the full 24-hour period, 'gatekeep' all acute admissions of individuals ages 18 to 65, and deliver a range of medical and psychosocial interventions to resolve crises over a limited period of approximately three to six weeks. When resourced to do the above, CRTs are a cost-effective alternative to hospital admission that results in reduced bed usage and higher patient satisfaction. The current implementation of CRTs is very variable. A model of best practice has been empirically studied, leading to a measure of fidelity against which teams can be judged and to implementation resources designed to improve fidelity.

In addition to crisis-resolution teams, the jury heard evidence for the potential benefits of crisis houses. Compared with

acute-care wards, crisis houses are intended for patients requiring a short-term admission in crisis care. The cost per day is lower than in the inpatient sector, and an admission to a crisis house is associated with greater user satisfaction than an inpatient admission. Additionally, this alternative to an inpatient admission may enable patients to continue in their occupational functioning and to learn skills for coping with a future crisis. A crisis house may include involuntary patients.

The jury heard that there are alternatives to large psychiatric facilities or hospital wards in small treatment facilities (8 to 15 beds), with much lower cost and greater client satisfaction. These facilities provide access to a team of specialists in a more homelike environment that offers a slower pace, recovery-oriented treatment, longer stays, and greater freedoms, including access to the community.

Integrating Intensive Case Management and ACT teams: the FACT model

Assertive Community Treatment multidisciplinary teams were developed in the United States 40 years ago and provide recovery treatment in the home. ACT has been proven to improve patient outcomes and has high patient and family satisfaction. However, it deals with only the most severe 20% of cases. The jury heard that in the Netherlands, flexible Assertive Community Treatment (FACT) teams deal with a broader base of people. FACT serves high- and moderate-needs people with SPMI, about 200 patients per team, one team per 50,000 inhabitants (staff:patient ratio of 1:20). Over 200 teams have been deployed in the Netherlands and a further 200 teams are planned. In a country of 16 million inhabitants like the Netherlands, this translates in about 0.5% of the population being covered. This estimate corresponds to the third most severe cases of SPMI as was estimated in question 1 to reach 1.5% of the population. More research on the effectiveness of FACT in different health system settings is needed.

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

For people with SPMI, family physicians remain a key and sometimes the only contact point for their primary health care needs. Despite family physicians' offices providing a less stigmatising setting for primary care, people with SPMI attend less frequently than would be expected, resulting in less routine health screening and fewer health interventions to improve their physical health. Family physicians report a lack of support and problems across the interface with specialist services.

How have Mental Health Courts, Diversion Programs, and alternative sentencing been able to assist people with SPMI?

Mental Health Courts provide assessments of fitness to stand trial and may therefore contribute to a very significant reduction in the number of people held in remand. Mental Health Diversion Programs decriminalize people whose problem is mental illness, not criminal intent. They provide treatment and social supports that would not otherwise be available, and reduce cost to the justice system. It has been shown that treatment under incarceration is inappropriate and inadequate.

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

NGOs provide a rich array of services. They work in the areas of supportive housing, supportive work placement, and recreation. They work more intimately with clients than governments can, with more emphasis on peer support and recovery. What is needed is more coordinated planning with health services to create a more comprehensive and collaborative approach for SPMI patients. We need to remove some of the administrative barriers that create additional costs for NGOs. One step forward would be to provide long-term funding, which stabilizes operations and allows for long-term integrated planning.

Aboriginal community organisations and traditional healers indicate that care should be inclusive of treating the spirit, along with mind and body, using culturally-appropriate interventions aimed at complete emotional well-being.

Recommendations:

1. Crisis-resolution teams should be more widely available as a cost-effective alternative to hospitalization that has the potential to be a more patient- and family-centered way of dealing with a patient in a crisis.
2. Consideration should be given to crisis houses and other alternative homes. This may reduce the need for hospital beds and result in better patient satisfaction with services than inpatient admission.
3. Consideration should be given to an expanded ACT model of care. This would include an Intensive Case Management (ICM) function, as per the Dutch FACT model, to cover a broader range of people with SPMI at different levels of need.
4. Mental Health Diversion Programs should continue to be supported and expanded to decriminalize people whose problem is mental illness, not criminal intent, and to increase their access to mental health treatment.
5. A coordinated planning approach is required to ensure better

integration of NGOs into comprehensive and collaborative service provision for SPMI patients.

6. Family physicians, in primary care settings, need to work with people with SPMI. This should be done along with a multidisciplinary team (e.g., nurses, social worker, psychologist, psychiatrist, spiritual leader, elders, etc.) to address the comprehensive needs of their clients.

Question 4: What are the most effective systems for supporting people with SPMI?

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

Despite developments in community-based mental health care and more effective treatments, the jury heard that there are still a substantial number of people with SPMI who require medium- and long-term residential care and who prefer to live in small, homelike settings.

Since the closure of its major psychiatric hospitals, Italy has seen the growth of a large network of residential facilities varying in type, size and cost. In Italy, these small, homelike residential facilities can serve as “homes for life” for persons with severe disabilities who will likely never be able to live independently, estimated to be 3 per 10,000 population. In addition, the jury heard that there is a need for small, homelike residential facilities that can provide intensive treatment for up to one year with the goal of discharging residents to more independent living situations in the community.

Studies from Italy indicate that the success of residential facilities depends on two key variables: the comprehensiveness of surrounding community-based mental health services and the extent of informal family support.

Unanswered questions include: What kind of residential care appears to be most effective for what kinds of residents, as measured by what type of outcomes and in what kind of social and service context? Further questions remain about optimal size, staffing levels and training.

A more controversial question is whether residential facilities should be intensive-treatment centres or merely ordinary homes for residents who receive community-based mental health services.

What is the role of the federal government in planning and funding mental health strategies?

A case was made for continued federal funding of mental health services. While provinces have constitutional responsibility for health care, the federal government has a history going back to the 1940s of cost sharing and providing grants to the provinces

for mental health care. In 2004, the federal government transferred \$41 billion to the provinces for health care, but very little of that was invested in mental health. Indeed, mental health spending as a percentage of total health spending has declined significantly over the past 30 years.

The federal government is responsible for mental health services for people in areas of federal jurisdiction: armed forces, RCMP, correctional services, First Nations and Inuit, refugees and immigrants. It has shared jurisdiction in the areas of employment and social housing.

There is good reason for the federal government to act: 20% of Canadians experience mental illness, and the disease burden, as measured in a major Ontario study, is 1.5 times that of all cancers combined and seven times that of infectious disease. The annual cost to the economy is \$50 billion and is expected to rise to \$2.5 trillion over the next 30 years. Unemployment among people with SPMI is as high as 93%, and 520,000 people living with mental illness are homeless or vulnerably housed. People with SPMI die 20 to 30 years prematurely.

Without additional government funding, wait lists will continue to grow. Police and correctional systems will continue to be the default mental health systems due to failures in civil mental health systems. One estimate is that an additional \$5.3 billion is needed over the next 10 years.

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

Continuity of care (CoC) has been seen as important for good outcomes for individuals with SPMI since the 1960s. It is also known by a variety of other terms, including continuum of care, coordination of care, discharge planning, case management, care management, service integration, and system integration. There are several definitions, but there is agreement that the concept of CoC refers to the organization of patient care to ensure the appropriate, effective, cost-effective delivery of health services that meets patients’ needs in a way that they experience as consistent, coherent, and connected. ACT, case management, shared care, Housing First, integration of mental health and addictions care, and discharge planning are examples of evidence-based interventions designed to improve individual service CoC.

There is strong consensus that CoC is important. Supporting evidence is strong but indirect at the individual service level and weakest at the systems level. No one size fits all and CoC (system integration) is not a cure for inadequate resources. Although it may not save money, importantly CoC has been shown to improve patient outcomes.

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

About two thirds of people with SPMI would like to work, yet surveys show that fewer than 30% of people with SPMI do so.

Study results suggest that working has favourable effects on symptoms, self-esteem and quality of life. Studies also suggest that mental health service costs decrease significantly for people who enter the workforce and have support to help them integrate.

Over the past 20 years, the Individual Placement and Support (IPS) model of supported employment has emerged as an effective approach for helping people with SPMI integrate into the competitive labour market. Evidence shows that it is best at promoting social inclusion for people with SPMI.

The traditional sheltered workplace model puts the emphasis on providing vocational training in a sheltered environment first and placement in the actual workplace second, if at all. While some older people with SPMI still prefer this traditional approach (and should continue to have it available), the jury heard that younger adults prefer the IPS model, which aims to place individuals directly into the competitive workplace and provides supports to help them do well on the job. We heard that it is possible to blend the two approaches.

Recommendations:

1. Given that many people with SPMI have indicated that they prefer to live in small, homelike environments, governments need to consider the role of non-institutional residential facilities. In particular, facilities that create a homelike environment and provide a safe and dignified long-term home for people with SPMI who cannot live independently should be considered. Models from other jurisdictions provide evidence that this is a viable option.
2. Governments should enhance support for interventions shown to improve continuity of care, which include: Assertive Community Treatment (ACT), Intensive Case Management, shared care, Housing First, and integration of mental health and addictions care.
3. A recovery orientation for mental health services should lead to a repurposing of existing vocational services and, if needed, the development of additional ones, so that all individuals with SPMI who want to work in competitive settings have access to programs that closely follow the Individual Placement and Support (IPS) model.
4. Governments at all levels should adhere to the recommendation in the 2012 National Mental Health Strategy that called for an increase in health spending devoted to mental health from 7% to 9%, and a 2% increase in health and social spending related to mental health.
5. Provincial and territorial ministers of health should work

with their federal counterparts to have the issue of continued federal funding for mental health placed on the agenda for federal/provincial/territorial discussion. In particular, consideration should be given to creating a Mental Health Transition Fund to help provinces and territories adequately finance their mental health systems.

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

Basic decision-support tools for mental health system improvement

Health atlases may be useful tools for evidence-informed policy-making; however, decision makers must be well informed of how to use health atlases, and promoters must make sure that these tools are comprehensible to policy makers. Health atlases may be useful in comparing jurisdictions, but data discrepancies between jurisdictions have to be considered.

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

Quality of care may be enhanced by the use of information systems. Sets of indicators developed from routinely collected administrative data can be accessed and linked across service settings to document quality of care, aid in benchmarking among mental health service jurisdictions, support accountability, and serve in quality-improvement efforts. Such data, analyzed over time, can also be helpful in the identification and monitoring of care pathways. Important outcome measures such as life expectancy and causes of death can be obtained, although quality of life and functioning are rarely present in routine administrative data.

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

Effective forms of knowledge translation (KT) exist, but must be adapted to specific target groups, namely clinicians, patients and the general population, and policy or decision makers. Evidence on effective KT for policy and decision makers is lacking, in part due to the small numbers of studies in this group.

Barriers to the success of KT have been well identified in implementation studies and must be taken into account to reduce the risk of failure. How-to guides also exist and may help in developing effective KT strategies.

Finally, there is emerging evidence in support of technical assistance centres, staffed by mental health care professionals,

that promote clinical standards and support clinical teams in aligning their practice to these standards. These technical assistance centres, coupled with patient/family involvement and quality measurement, may lead to effective implementation, training, and monitoring of the quality of mental health care systems and individual psychosocial interventions.

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

There is evidence that financial incentives through provider-payment mechanisms may have unintended influence on the quality of mental health care. Mental health care planners and politicians need to be aware of this, and payment systems may need to be developed that are independent of care settings.

A road map for mental health research

Given the high cost of addressing the mental health issues and concurrent physical health issues of people with mental illness, a road map for mental health research can be used to advance future priorities. Vital to the development of an innovative road map are mechanisms that allow for input from a very broad range of stakeholders, from service users through to policy makers and pioneers and innovators from many different industries. Such a road map may facilitate the planning of research priorities for a 10- to 15-year span and the development of a national perspective, which may be an appropriate strategy for Canada.

Recommendations:

1. Jurisdictions should strive to adopt sets of indicators that ideally allow comparisons of mental health care at local, regional, national and international levels. These sets should include strong community-oriented indicators, given that the vast majority of services are offered in the community.
2. Indicators of performance, quality, etc., should be transparently available to all citizens. They should also allow for the monitoring of human rights in the mental health service context.
3. eHealth and eKT tools must be developed. The use of eData collection tools could also be a promising strategy for the development of patient-satisfaction indicators.

Question 6: What further research is needed?

Recommendations for Research

Overview

Changes in service provision that would alter morbidity and mortality in people with SPMI should affect the prevalence of SPMI. Therefore, fundamental to the evaluation of any service changes is ongoing measurement of the prevalence of SPMI. While there is substantial knowledge about what should be done to help people with SPMI, we are not yet doing these things in many areas in Canada, perhaps at least partly owing to stigma.

It has therefore been said that we suffer from “implementation deficit disorder” (IDD). The best therapy is effective knowledge translation to policy makers and training of service providers, signposted by priorities identified in a mental health research “road map,” and evaluated by good implementation science, including appropriate lengths of follow-up with a biopsychosociocultural approach.

Cultural sensitivity

The cultural approach should be sensitive not only to the needs of Aboriginal populations but also to those of other marginalized groups such as the homeless and recent immigrants. To achieve this, such communities need to be involved in the design of any relevant research. This means federal and provincial jurisdictions will have to cooperate.

Proper involvement

Similarly, research will be strengthened by the proper involvement of service users and carers, NGOs, and other advocacy groups: these currently represent relatively untapped areas of expertise that could be applied to this field to better identify needs and concerns. The manner in which any changes in service provision affect any of the above communities must be evaluated.

Access to services

A crucial area for research is access to services, especially psychological therapies, and to teams with relevant specialist competencies. The evidence base is strong for family interventions in SPMI and good for cognitive behavioural therapy for psychosis; as these are made more accessible, they should be evaluated, including, for the latter, factors such as the number of treatment sessions. The implementation of recommendations in these areas, including adherence to a particular model of care and health economic analyses, is also a vital area for research.

Areas for special focus

Demonstration projects to look at the appalling physical health

outcomes in SPMI are urgently called for. A special focus for research in SPMI should be young people. Emerging electronic applications (e.g., for self-health or psychotherapy) should be evaluated. Economic analysis of the various potential roles of peer workers in SPMI service provision is required. Furthermore, peer workers are not yet sufficiently incorporated in research teams. The classification and quality of residential facilities for people with SPMI – homes for life – and accompanying psychological therapies require further assessment. Other psychosocial interventions that have a relatively weak evidence base, such as arts therapies, also require more in-depth evaluation. In addition, short-term facilities that represent an alternative to hospitalization should be studied in the Canadian context, as should alternatives to the justice system such as mental-health courts. The cost-effectiveness of supported employment, how to enable patients to aim for competitive employment and successfully transition from benefits, should be investigated. Better understanding of individual predictors of response to medications and the safety of discontinuation (for example, during pregnancy or perioperatively) is required. Research into new pharmacological treatment options for SPMI should be put back on the agenda.

Concluding Recommendations

1. Increase funding for evidenced-based and community-based mental health services and housing for people with SPMI. Mental health system funding must be increased to the levels recommended by the Mental Health Commission of Canada. Transition of services to the community within the current Canadian publicly managed system of care requires increased mental health funding overall to help the system integrate community-based services and supported housing for all patients with SPMI, which represent close to 1.5% of the population.
 2. Community Mental Health Teams shall be available for all patients with SPMI and their families as a fixed point of responsibility and shall be instituted first.
 - a. These Community Mental Health Teams must be sufficiently resourced to provide high-intensity support (1 staff per 10 patients) to 10% of people with SPMI, applying the standards of Assertive Community Treatment (ACT) and medium-intensity support (1 staff per 20 patients) to another 20% of people with SPMI, applying the standards of Intensive Case Management (ICM). The rest could receive conventional clinical, rehabilitative and social services with one member of the CMHT acting as case manager (1 staff per 80 patients). These various
 - levels of care may be provided by a flexible ACT team (otherwise known as a FACT team).
 - b. There shall also be the creation of ACT and ICM treatment teams for transition in the community of homeless people with SPMI, including those who have committed crimes and are held in jails, prisons, or the forensic psychiatry system. The number of these teams shall be determined by the standards for ACT and ICM teams and the number of people with SPMI who are homeless or incarcerated. Supported housing offered to all, shall be inspired by Housing First, and its supplement to rent approach. Successful transitions of individual patients to local CMHTs would end the responsibility of these transitional ACT and ICM teams for the individual.
 - c. Funding shall be ring-fenced for community services and supported housing. CMHT, ACT and ICM teams would need to adhere to evidence-based treatment standards for ACT and ICM teams, have access to training and supervision, and accept surveillance of standards and outcomes by a technical assistance center.
3. Seamless, efficient and appropriately timed transfer of resources to community.
 - a. There will be no closure of psychiatric care beds or existing residential facilities before CMHT, ACT and ICM teams are in place and effectively functioning with full caseloads of patients (this requires two to three years, on average, for ACT teams).
 - b. The downsizing of psychiatric hospitals would require fully functioning and fully resourced local CMHT, ACT and ICM teams, affordable supportive housing, and alternative psychiatric residential facilities.
 - c. All people with SPMI should have a family physician delivering the best prevention and treatment for physical disorders. The CMHT, ACT or ICM team shall support both patient and family physician.
 4. Centre for Excellence, Training, Evaluation and Monitoring.
 - a. Create provincial technical assistance centres (PTAC) modelled according to the one in Ontario before the deployment of assertive community treatment teams, or the current Centre national d'excellence en santé mentale in Québec, or the Assertive Community Treatment Advanced Practice Panel in British Columbia, or the one in Indiana (USA). These centres shall approve the creation/maintenance of ACT, ICM and CMHT teams; support their implementation and training; support communities of practice for team leaders and psychiatrists (including at a national level a network

Jury Members

Jury Chair: Alain Lesage, MD, FRCPC, MPhil, DFAPA

Professor, Department of Psychiatry, University of Montreal;
Clinician, University of Montreal- Mental Health Institute, QC

Katherine J. Aitchison, BSc (Hons), MA (Oxon), BM BCh, PhD, FRCPsych

Alberta Centennial Addiction and Mental Health Research
Chair; Professor, Departments of Psychiatry and Medical
Genetics, University of Alberta, Edmonton, AB

Rupert Arcand

Director, Yellowhead Corrections, Edmonton, AB

André Delorme, MD, FRCPC

Director, Mental Health, Ministry of Health and Social
Services, QC

David Goldbloom, OC, MD, FRCPC

Senior Medical Adviser, Centre for Addiction and Mental
Health; Professor, University of Toronto; Chair, Mental Health
Commission of Canada, ON

Kaj Korvela, BA, BFA Arts, BEd. Education

Executive Director, Organization for Bipolar Affective
Disorders (OBAD), Calgary, AB

Gloria Laird

Alberta Health Services Wisdom Council, Co-Chair,
Edmonton, AB

John J. McSorley, MD, MB, MRCP

Family Physician, Airdrie, AB

Fay Orr

Former Mental Health Patient Advocate; Executive Manager,
Government of Alberta; Vice-chair of the Board of Directors,
United Way, Alberta Capital Region, Edmonton, AB

Tom Shand

Past Chair, Alberta Alliance on Mental Illness and Mental
Health; Former Executive Director, Canadian Mental Health
Association, Edmonton, AB

Michel Simard, MA

Director, Centre Le Havre de Trois-Rivières, QC

Sharon G. Sutherland

Mental Illness/Health Advocate, Edmonton, AB

Helen-Maria Vasiliadis, MSc, PhD

Associate Professor, University of Sherbrooke; Researcher,
Centre de recherche —Hôpital Charles LeMoyne (CR-HCLM)

- of PTACs); monitor quality control (including model adherence); and evaluate input, processes and results.
- b. A separate arm of this PTAC shall ensure the identification of academic experts in content and training for effective individual psychosocial interventions and psychotherapies for people with SPMI that have been highlighted at this consensus conference.
 - c. PTACs shall have ongoing links with the academic world to ensure transfer of knowledge about emerging practices and new research, to participate in surveillance and monitoring, to support the evaluation of the performance of the system, and to engage in new research.
5. Train and integrate appropriate staff to support a patient-led, recovery-oriented, trauma-informed, culturally sensitive and competent system of care.
- a. Peer-support workers shall be hired. They shall be part of any CMHT, ACT and ICM team, and work in residential facilities programs, supported housing and acute and forensic care wards. They can be existing team staff if they have the required professional competencies, or be additional to the team staff. As the famous psychiatrist and reformer during the French Revolution, Dr. Philippe Pinel, said of the hiring as superintendent of former in-patient Jean-Baptiste Pussin: “It would ensure a more humane and moral treatment of patients by staff.”
 - b. Continuing training and oversight of peer-support workers shall be part of the mandate of the PTAC.
6. Evaluation and monitoring: a provincial mental health body led by families and people with lived experience.
- a. Financed by the provincial government, a mental health body should independently produce a yearly public report on the performance of the system for people with SPMI. This group shall be led by family members and persons with lived experience, and shall include experienced former decision-makers, academics, provincial representatives of families, patients, Aboriginal (FNMI) and immigrant communities, professional and community organisations.
 - b. A provincial mental health body shall obtain data from the PTAC. The provincial government shall ensure the use and linkage of existing health and social services databases to monitor the performance of the system for people with SPMI.

Expert Speakers

Carol Adair, MSc, PhD

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

Tim Aubry, PhD, MA, BA

Chairholder, Faculty of Social Sciences Research Chair in Community Mental Health and Homelessness; Professor, School of Psychology, University of Ottawa, ON

Thomas Becker, Dr. med

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

Dan Cohen, MD, PhD

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

Philippa A. Garety, MA, MPhil, MA(Ed), PhD, FBPsS

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

Linda Gask, MB ChB, MSc, PhD, FRCPsych, FRCGP

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

Giovanni de Girolamo, MD, PhD

Head, IRCCS Unit of Psychiatric Epidemiology and Evaluation, Brescia, Italy

Elliot Goldner, MD, FRSPC, MHSc

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

Heinz Katschnig, MD

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

Sara Lapsley, BA, MA (Candidate)

Counsellor and Group Clinician, Forensic Psychiatric Hospital; Peer Researcher, Collaborative Research Team to Study Psychosocial Issues in Bipolar Disorder (CREST.BD), BC

Eric Latimer, PhD

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

Gerrit van der Leer

Director, Mental Health and Addictions, Ministry of Health Services, BC

Antonio Lora, MD

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

Steve Lurie, BA, MSW, MM

Executive Director, Canadian Mental Health Association Toronto Branch, ON

Orrin Lyseng

Executive Director, Alberta Alliance for Mental Illness and Mental Health, Edmonton, AB

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

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

Oliver Mason, DPhil, DClinPsy

Senior Lecturer, Clinical Education and Health Psychology, University College London, United Kingdom

David McDaid, BSc, MSc, MSc

Senior Research Fellow, Health Policy and Health Economics, London School of Economics and Political Science, London, United Kingdom

Scott Patten, MD, FRCPC, PhD

Professor, University of Calgary, AB

Thomas Raedler, MD

Medical Director, Psychopharmacology Research Unit (PRU) and Associate Professor, University of Calgary, AB

Luis Salvador-Carulla, MD, PhD

Professor, Disability and Mental Health, Faculty of Health Sciences, University of Sydney, Australia

Howard Sapers

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

Jitender Sareen, MD, FRCPC

Professor, Psychiatry, Departments of Psychiatry, Psychology and Community Health Sciences, University of Manitoba; Director of Research and Assistant Head, Department of Psychiatry, MB

The Honourable Justice Richard D. Schneider, BSc, MA, PhD, LLB, LLM, CPsych

Adjunct Professor, University of Toronto, ON

Richard Warner, MD, DPM

Professor, Psychiatry, University of Colorado; Director, Colorado Recovery, Boulder, Colorado

Scientific Committee

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Department of Psychiatry, University of Alberta, Edmonton, AB

Donald Addington, MBBS, MRCPsych, FRCPC
Professor, University of Calgary, Calgary, AB

Lorraine J. Breault, PhD
Professor, Department of Psychiatry, University of Alberta, Edmonton, AB

Pierre Chue, MB, BCh, MRCPsych, FRCPC
Clinical Professor, University of Alberta, Edmonton, AB

Carolyn Dewa, PhD
Health Systems Research and Consulting Unit, Centre for Addiction and Mental Health, Toronto, ON

Elliot Goldner, BSc, MHSc, MD, FRSPC
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Alan Gordon, MB ChB, FRCPC
Clinical Professor, University of Alberta, Edmonton, AB

Fern Miller
Director, Maternal-Child and Mental Health, Addiction and Mental Health Branch, Primary Health Care Division, Alberta Health, Edmonton, AB

Tonia Nicholls, PhD
Associate Professor, Department of Psychiatry, Faculty of Medicine, UBC-Forensic Psychiatric Services Commission (FPSC); BC Mental Health and Substance Use Services, Vancouver, BC

Scott Patten, MD, FRCPC, PhD
Professor, Department of Community Health Sciences, University of Calgary, Calgary, AB

Peter Silverstone, MB BF, MD, MRCPsych, FRCPC
Professor, Department of Psychiatry, University of Alberta, Edmonton, AB

Michael Trew, MD, FRCPC
Addiction and Mental Health Strategic Clinical Network, Alberta Health Services, Calgary, AB

Doug Urness, MD, LMCC, FRCPC
Alberta Health Services, Edmonton, AB

Doug Watson
Past President, Alberta Psychiatric Association, Calgary, AB

Patrick J. White, MB, BCh, BAO, DCH, Dip OBS, MRCPsych
Clinical Professor, Psychiatry Department, University of Alberta, Edmonton, AB

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Chair: Fern Miller
Director, Maternal-Child and Mental Health, Addiction and Mental Health Branch, Primary Health Care Division, Alberta Health, Edmonton, AB

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Laurie Beverley
Executive Director, Community Treatment and Supports, Addiction and Mental Health, Alberta Health Services, Edmonton, AB

Allison Hagen, CGA, MBA
Director of Finance, Operations and Administration, Institute of Health Economics, Edmonton, AB

Sarah Parkinson
Alberta Health, Edmonton, AB

Cathy Pryce, RN
Addiction and Mental Health Strategic Clinical Network, Alberta Health Services, AB

Helen Ramsey, MSc
Project Manager, Institute of Health Economics, Edmonton, AB

Doug Vincent
Director, Tertiary and Acute Care, Alberta Health Services, Edmonton, AB

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INSTITUTE OF
HEALTH ECONOMICS
ALBERTA CANADA

Institute of Health Economics
#1200, 10405 Jasper Avenue
Edmonton, AB T5J 3N4

Tel. 780.448.4881

Fax. 780.448.0018

info@ihe.ca

www.ihe.ca

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