Alberta Health Services

The Addiction and Mental Health SCN Research Strategic Planning Meeting

February 9th-10th, 2015
Edmonton, AB, Canada

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Acknowledgements

The Addiction and Mental Health Strategic Clinical Network would like to thank the following presenters:

- Dr. Tom Briggs, Senior Program Officer, Planning and Performance, Alberta Health Services
- Alexander Cook, Patient Representative
- Dr. David Hodgins, Professor, Department of Psychology, University of Calgary
- Dr. Nicole Letourneau, Professor, Faculty of Nursing, University of Calgary
- Dr. Scott Patten, Professor, Mathison Centre, University of Calgary
- Tanya Richer, Patient Representative
- Dr. Marianne Stewart, Senior Program Officer, Primary Health Care, Alberta Health Services
- Dr. Pamela Valentine, Chief Partnership Officer, Alberta Innovates Health Solutions
- Dr. Cam Wild, Professor, School of Public Health, University of Alberta

Report prepared by:

- Drs. Victoria Suen & Kay Rittenbach

Introduction

The Addiction and Mental Health Strategic Clinical Network (AMH SCN) in conjunction with the Alberta Addiction and Mental Health Research Partnership Program (AAMHRPP) held its first Research Strategic Planning meeting February 9 and 10, 2015, at the University of Alberta in Edmonton, Alberta, Canada. This meeting was attended by approximately seventy (see attached attendance list) individuals engaged in Addictions and Mental Health Research in Alberta.

The one and a half day meeting had four primary objectives:

1) Consider and provide feedback on how the Addiction and Mental Health SCN and the Alberta Addiction and Mental Health Research Partnership Program (AAMHRPP) can organize moving forward and how to best create and maintain communication within a larger provincial research network
2) Review upcoming PRIHS and CRIO grant opportunities with a representative from Alberta Innovates Health Solutions
3) Review evidence gaps in Addiction and Mental Health Research within the four priority areas identified in the AMH SCN Transformational Road Map: Depression, Addiction and Concurrent Disorders, Child and Youth Mental Health, and Complex High Needs Users
4) Identify potential projects and project leads within four priority areas: Depression, Addiction and Concurrent Disorders, Child and Youth Mental Health, and Complex High Needs Users

For each of the priority areas listed (Depression, Addiction and Concurrent Disorders, Child and Youth Mental Health, and Complex High Needs Users), a presentation outlining the current state of knowledge and research was followed by breakout sessions where SWOT (Strengths, Weaknesses, Opportunities and Threats) analyses were completed and discussions occurred surrounding future SCN focus and potential projects.

Several patient representatives were also in attendance with two speaking formally to the attendees about their experiences with the addiction and mental health systems in Alberta. The AMH SCN would like to particularly thank Tanya Richer and Alexander Cook for sharing their stories.

Overall, the meeting successfully fulfilled its objectives and feedback from the attendees was positive. All attendees were able to contribute to the discussions at hand, and provide feedback and comments based on their individual backgrounds and expertise. The results of the discussions have been themed and outlined below.

How should the AMHSCN and the AAMHRPP organize?

Feedback from attendees:

- Mental health is wider than just the AMH SCN and the AAMHRPP so where do I invest my time among the different groups and different SCNs?
- Clarity is required on roles and responsibilities
- There is a need to make things more simple so that researchers know where to go for what resources
- Smaller strategic research groups that meet more regularly can help keep researchers engaged and interested in moving forward a research agenda in collaboration with the SCN
- Academics want to conduct research but there are many processes that can act as roadblocks to conducting this research in an AHS environment. The hope is that the SCN can help to remove these roadblocks to support researchers.

Alberta Innovates Health Solutions (AIHS)

The proposed role for AIHS in 2015 is to be a "strategic investor". While specific details on the upcoming PRIHS and CRIO grant opportunities were not yet finalized, "appropriateness" has been highlighted as one of the key themes surrounding the PRIHS 3 funding competition. The importance of being proactive and not reactive when it comes to AIHS funding opportunities was emphasized to help increase successful applications, as well as identifying leaders within the addiction and mental health research community to lead the collaborative projects. As more information regarding these funding opportunities comes to light, the SCN will endeavor to keep the research community informed and will work with researchers to prepare potential proposals for submission.

Addiction and Concurrent Disorders

Current State (Dr. David Hodgins and Dr. Cameron Wild):

Findings from the GAP-MAP analysis (2014) found that documented services are less than what are needed for the population, a finding that is consistent with a growing body of international research. Clinically oriented researchers cite a lack of specialty care for addictions as the root of the problem. Based on a population health pyramid, key concepts in research topics and approaches within this area are:

Theme 1: *Optimize specialty care*

a. Develop and test efficacy of new treatments (e.g. pharmacotherapies)
b. Evaluate clinical pathways and care coordination interventions
c. Evaluate interventions designed to enhance client engagement and compliance

Theme 2: *Expand SBIRT in primary health care*

a. Interventions to enhance adoption of SBIRT in primary care
b. Research on case identification and triaging mechanisms into specialty care

Theme 3: *Expand SBIRT beyond primary health care*

a. School-based screening to web for information and brief intervention
b. Public access to SBIRT tools

Theme 4: *Marginalized populations*

a. Care needs of inner city populations
b. Comorbid SUD and mental disorders
c. Harm reduction services

Theme 5: *System-wide surveillance and navigation supports*

a. Population surveys designed to quantify problem severity and size of needed to treat populations
b. Public-access information service

The *Canadian Research Initiative in Substance Misuse (CRISM)* is based on the National Institute on Drug Abuse's Clinical Trial Network, whose mission is to study behavioural and pharmacological treatments that have a high potential for success in community treatment settings and to get these research findings into the hands of clinicians in a timely manner. Alberta is fortunate to be a part of the "Prairie Node" of this initiative. This initiative is currently in Phase 2, where the infrastructure to conduct this research is being built through identification of partners, an online needs survey, and face-to-face meetings with relevant stakeholders. Infrastructure resources being built include: knowledge mobilization tools, registries of providers, research supports/data sharing platforms, intervention supports, and research document templates.

Two future demonstration projects related to CRISM mentioned include:

1) Motivating client engagement: Dropping-out is the most common outcome of specialty substance misuse treatment. Research indicates that both motivational interviewing and contingency management (incentives) can be implemented to increase motivation to complete treatment programs.
2) Building capacity for screening and brief interventions: Only small proportions of substance misusers are diagnosed or receive specialty substance misuse treatment. Exposure to accessible, low-intensity, brief interventions tends to be preferred for those individuals exhibiting moderate-low levels of substance misuse.

SWOT analysis

Strengths:

Timing: This topic was seen as being timely – there is positive restructuring occurring (e.g. the integration of addiction and mental health care together, some shifts into family systems therapy), there is greater public awareness (e.g. Bell campaign), the results of the GAP-MAP can help inform priorities, and there is support for this work from foundations (Norlien Foundation) and the health ministry.

Relationships: There was a sense that there are strong academic relationships, networks (SCN included) and research talent in this topic area within the province that can be leveraged towards developing the infrastructure for both addictions research and treatment within the Alberta context (e.g. CRISM and Brain Canada).

Weaknesses:

Culture: Historically, addiction has not been viewed as a health problem but rather a behavioural or social problem. While the culture is shifting, there is still significant stigma.

Data: While data is becoming more available, there is difficulty in consolidating and interpreting the data (i.e. there is variance in the quality of the data and the type of data collected).

Financial: Health economists' needs to be collaborators on the work being conducted and proposed since effective interventions often increase costs initially. Cost-benefit analyses are required to prove value-for-money.

System: The health system is viewed as difficult to navigate for patients, families, and researchers and is seen as being a "silo'd care system". I.e. lack of consideration of social determinants of health, or the large number of partners and sectors that still need to be connected. In particular, patient representatives noted that there is still a lack of: trauma-informed care, timely access to treatment programs, responses to after hour care, continuity of care, and access to newer technologies for both patients and providers of care. When care needs are unmet, patients often enter into the revolving door and they have nowhere to land. It was also noted that a large proportion of the services are provided outside of AHS so community partnerships are imperative for success.

Opportunities:
Data: There are opportunities to create common data platforms, perform data linkage, and collect outcome measures (CRISM could be a great leader in this area).

Partnerships: Having the CRISM Prairie Node that is working towards building a research infrastructure can have huge effects for the Alberta addictions' research landscape. Given the relationships/partnerships that are being formed, greater collaboration can be expected. It will be important to bring in Pillar 1 researchers to the table (e.g. neuroscientists researching reward centres and pathways of the brain). This is also an opportunity to bring patients and families to the table to help define the problems and their desired outcomes.

Technology: As technology continues to advance there is opportunity to leverage this advancement and use new and innovative technologies to help with treatment and information (e.g. applications for mobile devices, the creation of a patient portal to provide information as well as collect data).

Broader Reach: By focusing on improving addictions services, other areas of medicine will be influenced (e.g. surgery and the emergency departments).

Threats:
Instability: Unstable landscape (i.e. the potential for leadership change at the local, provincial and federal levels).

Funding: There were concerns about amount of funding available to complete the necessary research to improve care and find innovative technologies. Most addictions focused proposals do not tend to fit the desires of the funders, making funding more difficult to obtain. There is the perception that there is unwillingness for funders to take risks on innovation in this area. Additionally, "Addictions" as a whole is underfunded compared to other mental health areas.

Financial: The cost savings accrued from increased effectiveness in treatment of addictions is often seen outside of the addictions realm (i.e. on paper it looks like costs are simply increasing within addictions as it can be challenging to track where savings have occurred in other areas).

Application: Knowledge application has not consistently occurred, better planning and implementation of existing strategies with strong evaluations is required.

Emerging science: Basic science research in addictions could still be defined as "early stages" (e.g. neuroscience research).

Priority discussions

Where should the SCN's research focus be for the next 12-24 months?

Neuroscience: Engage and support Pillar 1 researchers in their exploration of the biological underpinnings of addictions. E.g. How does the brain change both in addiction but also in treatment? What can MRI's, fMRI's and computational modelling tell us about the biological trajectory of addictions? How are the substance abuse and process addictions similar to/differ from one another?

Collaboration: Enable and support the collaboration of academics, clinicians, and patients with lived experiences to inform well-rounded proposals and research. Include other health conditions (e.g. physical health conditions or cancer) and addictions beyond substance abuse (e.g. process addictions). The SCN should support the CRISM initiative and aid in the building of the infrastructure during its' Phase 2 process.

Technology: Investigate the role that technology can play within the system e.g. treatment options, system navigation, improving timely access, decreasing stigma, increasing ability to disclose information and having that data available to researchers and clinicians

Accessibility: Increasing accessibility to treatment for patients, including those with disabilities.

Training: Gaps in training for new and innovative methods of intervention should be filled with clinicians. This should be embedded with the opportunity to evaluate the value of this training and these methods on attitudes, skills and patient outcomes in Alberta.

Data: Manitoba cited as having a good system for aggregating and sharing health care data; Alberta needs to follow in this direction. Having good data enables us to track patterns of service utilization (i.e. who is accessing, how are they accessing, and when are they accessing).

Contextual Factors: Focus on gathering more contextual factors and knowledge to better develop targeted interventions. E.g. Are some interventions more effective at specific time points in the addictions trajectory? What are the age limits of efficacy for interventions being used? Explore best windows of opportunity intervene.

Prevention: Prevention and early intervention programs targeting at risk individuals

Future potential projects:

1) Evaluate the outcome of the Concurrent Capability Curriculum
2) Conduct more research into the types of treatment that incorporate incentives
3) Evaluate acceptability of harm reduction services in Alberta: Methadone services for opioid addictions *(Dr. Katherine Dong identified as potential lead)*
4) What are the predictors for maintaining engagement in treatment? What techniques are most successful in maintaining engagement in treatment?
5) Effectiveness of screening tools for early identification

Child and Youth Mental Health

Current State (Dr. Nicole Letourneau):
According to Unicef's 2013 Report Card, Canada is ranked 17th out of 29 for overall childhood well-being, coming in at 24th in terms of life satisfaction. This puts us in the middle to bottom half of the pack in comparison to other developed nations. When comparing these results from the early 2000s to the late 2000s, Canada's ranking has remained unchanged despite program and policy changes. Twenty-six percent (26%) of Canadian children struggle with some developmental problems with children in lower-income households demonstrating a greater vulnerability compared to those in high-income households. The Mental Health Commission of Canada estimated the lifetime costs of childhood mental health to be $200 billion.

Knowledge and understanding:

- We have the knowledge to predict with good certainty that children exposed to certain kinds of stress are prone to health and developmental challenges
    - Positive Stress: Brief increases in heart rate, mild elevations in stress hormone levels
    - Tolerable Stress: Serious, temporary stress responses, buffered by supportive relationships
    - Toxic Stress: Prolonged activation of stress response systems in the absence of protective relationships
        - Toxic stress affects brain architecture: damaged neurons with fewer connections
- Adverse childhood experiences significantly impacts development and life long health
- Maternal depression reduces mothers' ability to engage in "serve and return" relationships
    - "Serve and return" relationships help to prevent stress from becoming toxic by decreasing infant distress and cortisol levels
- Some evidence points to a 17 fold return on investment for intervening at a school level

SWOT analysis

Strengths:
Timing: Child and youth mental health is a priority for the ministry as well as the public. This has encouraged work within not only Health, but Education and Human Services as well.

Data: There are strong efforts to collect significant cohort data e.g. All Our Babies cohort.

Funding: There are opportunities for funding from both government and non-governmental organizations (e.g. Norlien Foundation).

Partnerships: There are strong networks of researchers already partnered in working in this area within the province. This has allowed for increased depth in research in child and youth mental health within Alberta.

Weaknesses:
Outcomes: While there are multiple projects (e.g. school based projects) ongoing, there is a lack of long-term outcomes. Without these longitudinal results, many of these projects/programs lack sufficient evidence for wide-spread implementation and value for money.

Narrow focus: There is a tendency to focus on youth as individuals rather than part of a larger family system i.e. “acting out” could be the results of family dysfunctions. Family systems research and treatment are important to consider.

Fragmentation: While there are strong networks of researchers, there needs to be more communication and collaboration between researchers, clinicians, families, and government.

Access: Waitlist for specialized services are long and families can have great difficulty navigating the system to the appropriate services.

Opportunities:

Public Interest: As public interest is so great in this area, significant opportunity to provide better education and information for parents and families exists. The high level of interest also means that the public, funders, and government will support the work being undertaken in this area.

Evaluation: With an abundance of school based programs being offered, each should be evaluated to determine efficacy and cost-benefit.

Data: Alberta has initiatives/groups that are collecting and analyzing large amounts of data e.g. Child and Youth Data Lab, All Our Babies cohort

Cross-ministry: There are opportunities to partner outside of health e.g. Justice, Human Services and Education

Threats:

Instability: Unstable landscape i.e. the potential for leadership change at the local, provincial and federal levels.

Sustainability: There is a lack of sustained funding for the large cohort studies. This mimics a pattern that funders are more likely to fund pilot studies but then fail to sustain funding for scaling up or continuation of longitudinal studies.

Stigma: Sensitivities around parents feeling that they are being told how to parent their child exist. There is a fear of a child being labelled as “mentally ill”.

Continuity of Care: There is a gap in treatment and services available when youths are transitioning to adulthood. At the age of 17 where do you go and who do you see?

Priority discussions

Where should the SCN research focus be for the next 12-24 months?

Evaluation: Finding the right programs (through research and evaluation) to scale up while divesting from the other programs, particularly school-based programs. Part of this requires developing an inventory and report card of what different jurisdictions are offering. There is also the opportunity to look to the existing birth cohorts to see which interventions are being most accessed.

Knowledge: Ultimate goal should be to better understand the trajectories of development of mental health issues i.e. the combination of genes and experiences, the impact of early intensive interventions, the effects of adverse childhood experiences, and how to identify and target high-risk children and youth.

Access: To combat long waitlists, other intervention should be considered for the less acute cases (e.g. parenting interventions, school-based interventions, phone interventions). This will allow the more acute cases to be seen in a timelier manner.

Education: Developing opportunities to provide education to parents, families, and teachers on signs or symptoms that the onset of a mental health issue may be approaching and providing support on when to reach out for help. Supporting and educating parents can have family-wide benefits i.e. supporting families to provide early enrichment for their children to support early development. Providing education to children and youth to decrease stigma and to encourage disclosure. Partnering with families and youth to determine what outcomes matter to them vs. what AHS would choose as indicators for success should also be emphasized.

Social Interventions: There is a need to focus on evidence-based relationship-focused interventions that target toxic stressors and early mental health symptoms and development. Recognition needs to be brought to the impact of social interventions on broad health and developmental outcomes

Future potential projects:

1) Evaluation of short phone interventions for youths and parents/guardians
2) Mindfulness training in schools, community clinics and PCNs: Can this increase overall child and youth mental health in both the short and long-term? Will this training decrease the number of youths on the waiting lists for services?
3) Meta-analysis and critical appraisal of the current school-based mental health programs. Which ones have evidence? Which ones show the greatest “value for money”? Should we be standardizing, which involves divesting from some while scaling up in others across the province?
4) Further evaluation of toxic stressors and the effects on development

Complex High Needs Users

Current State (Dr. Tom Briggs and Dr. Marianne Stewart):

Costing information indicates that a complex high needs user population consists of 5% of the population who utilize 66% of costs. Overall demographic data suggests that this population’s average age is 52.3 years, with 57.5% being female and 11.9% living alone. Clusters within this population have been identified with several showing high prevalence of addiction and mental health disorders.

Currently, the Triple Aim framework is being employed within the East Edmonton population. This population shows higher rates of prevalence of mental health conditions, substance use (highest use of cocaine), and social issues. In order to effectively treat and target this population, there is a need to understand who is in the area that requires this additional attention and what the client perspective is. The development of relationships and trust to help individuals navigate through the health system

can have drastic improvement on their care and outcomes. Initial data indicates that implementing the Triple Aim framework may have drastic cost savings and decrease inappropriate service utilization. Key to the success of this intervention is acknowledgement that the social determinants of health play an important part and that continuity of care and leveraging non-AHS resources (e.g. non-profits) must be considered.

Key learnings from Triple Aim at East Edmonton:

1) The importance of permanent supportive housing
2) Beyond housing we must look at social determinants of health
3) The interface between people and the system is complex
4) The process of taking the clients view into consideration is very important
5) Mental health and addictions integration is required
6) Sharing information to improve continuity of care
7) Alternative relevant service providers should be engaged
8) Coordinated care in the community can reduce costs

SWOT analysis

Strengths:

Partnerships: Partnerships exist between researchers, police, non-profits, and clinicians that can be leveraged to improve outcomes for this targeted population. There may now be a critical mass of research opportunities/players (e.g. CDRIN, Campus Alberta Neuroscience, the three major universities). Housing initiatives are also underway.

Economic: Given the amount of data demonstrating the large economic impacts of this population, there is significant motivation to examine and improve treatment and outcomes.

Outcomes: There exists ways to measure quality of life within this population, and the success and reputation of the Triple Aim framework has AHS “buy-in”.

Weaknesses:

Leadership: While some important areas have strong leaders, other areas, such as harm reduction, lack established leadership.

Data: While administrative data is available, this set of data is not inclusive of all relevant data or outcomes that are meaningful to this population. Data is also dependent on the accuracy of diagnosis provided which can be variable in such a complex population.

Implementation: PCN engagement and implementation can be difficult, especially given their heterogeneous nature. Even if “buy-in” is obtained at the executive level, training and understanding of the relevant and often complex pathways throughout those who work within the PCN is not a simple task. Fidelity to the models would be in question. Capacity within all PCNs is also an issue.

Stigma: Many of the housing initiatives are based on abstinence models limiting the usefulness for those who are entering recovery. This population is often part of the “exclusion criteria” for research and treatment leading to health inequities.

Opportunities:

Culture: Shifting the culture to look beyond symptoms, but to the overall context that the patient is living in. This means understanding and acknowledging the social determinants of health.

Education: Enhancing mental health literacy among providers (e.g. comorbidities) and involving those with lived experiences. Peer support models embedded in both the health services system and the community.

Integration: Research needs to be integrated with clinical practice and operationalized. This also means that the front-line workers and resources need to be considered when undertaking research.

Communication: Open communication between all systems can enable informed research and enhance the care provided to this population as well as increase collaboration. Better data sharing opportunities can also arise.

Threats:

Instability: Unstable landscape i.e. the potential for leadership change at the local, provincial and federal levels.

Heterogeneous: A single solution is unlikely to fit throughout the province since there is significant variation in the services available. If the same strategy is applied on a broad range of symptoms, we may miss what is important to the individual.

Funding: Proposals to conduct research within this area are often not considered "flashy" enough to attract large funding opportunities. While PRIHS could be an avenue in which to pursue funding for initiatives, timing could be difficult as such research requires many players at the table.

Sustainability: Many of the existing collaboratives are based on the leaders that founded that collaborative. If these leaders were to leave how would the collaboratives be sustained?

Methodology: Doctors are generally accustomed to randomized controlled trials; however, this methodology does not lend itself to studying this population.

Priority discussions

Where should the SCN research focus be for the next 12-24 months?

Needs: Understanding what the needs are for this population (i.e. client perceived needs) beyond what are the traditionally health system desired outcomes. Asking families/patients what services are being accessed and at what times to determine patterns of access.

Primary Care: Development of teams within primary care and tools that can be used (i.e. a distress tool). Ensuring that there is effective continuity of care.

Clusters: This is a wide and varied population and we know that there are many clusters that can be teased out. Can these clusters be targeted with certain interventions or pathways? What are the effects with rural populations and how should their care be altered?

Lifespan: Focus across all ages – youth, adult, and seniors' health. Determine trajectories and determine how interventions and pathways need to shift throughout the lifespan.

Future potential projects:

1) Harm reduction: How do we best reframe harm reduction and provide harm reduction services/programs?
2) The addition of peer support initiatives being integrated into mainstream healthcare
3) EMS: heavy users of ambulance services
4) Measurement of multigenerational effects
5) Adapt PCAP model for the Complex High Needs Users population
6) Development of more patient-focused measures with the input of those with lived experiences (i.e. we need to consider that there are those for whom the measures we currently use are not appropriate)
7) Study of resilience: What are the factors that lead those who have "the cards stacked against them" to not become high service users? A qualitative study of stories and lived experiences, identifying factors that lead to resiliency
8) Develop an affective model of car for rural settings

**Mixed models approach necessary for research in this area

Depression

Current State (Dr. Scott Patten):

Depression costs society upwards of $51 billion per year and has an annual prevalence of 4.8%.

There are three overarching perspectives that can be taken on research priorities:

1) We need to know more about what depression really is
2) We need to know what really works
3) We need to learn to deliver what really works

There are multiple clinical trials showing modest effectiveness of various strategies (e.g. cognitive, behavioural, pharmacological, or neurostimulation treatments) and in Alberta one such strategy to deliver evidence-based medicine was to include behavioural health consultants in primary care networks. The challenge to implementing the research is that there is heterogeneity in terms of episode duration, recurrence rates, and seasonality effects.

A stepped-care model for managing depression has been proposed in the NICE guidelines and a depression pathway created within Alberta modeling a stepped-care approach. Implementation however remains a challenge.

A cognitive behavioural interpersonal skills manual (CBIS manual) has been developed as a training tool to increase capacity within primary care to diagnose, screen for, and treat mental illness while engaging with patients in a partnership through listening and hearing what the patient is sharing. This training tool provides not only assessment tools to physicians, but also three supported self-management, non-medication, cognitive behavioural therapy options for patients. This training is currently being rolled out in British Columbia to astounding results. Family doctors cited increased comfort and confidence in using the screening and diagnostic tools, increased pleasure in working with patients with mental illness, increased ability of their patients to go to and stay at work, decreased prescribing behaviours, and increased job satisfaction.

SWOT analysis

Strengths:
Knowledge: There is an abundance of information and research within this area. We have done a lot of research about potentially effective interventions, both pharmaceutical and non-pharmaceutical thus there are a variety of treatments that could be provided.

Talent: Alberta is home to world-class researchers and there are significant initiatives to bring these researchers together to form networks (e.g. CDRIN and CAN).

History: Alberta has a track record of developing care pathways that can be evaluated.

Weaknesses:
Assessment: Screening tools and diagnostic assessments are different and this is not always taken into consideration. Screening in children is difficult and labeling them with the results of screening tools before proper diagnosis is problematic.

Integration: While we have knowledge about depression and treatment there is difficulty integrating this information into treatment (i.e. online resources have evidence for effectiveness but are challenging to get a response outside of research settings so they need to be part of a complex intervention). Concerns were raised about excessive non-evidence based use of medications in children.

Co-morbidity: Co-morbidity of depression with other health concerns complicates treatment and research. Studies of various medical populations may show that different treatment for depression is required depending on what other co-morbidities are present.

Opportunities:
Data: Electronic medical records based tools to collect consistent data across the province. There is potential to implement some online or pre-appointment screening that feeds into the EMR so that physicians can quickly view this information and proceed with a more in depth examination.

Variance: With the abundance of current knowledge and ongoing research, variations in care across the province can be decreased.

Primary care: Described as the “golden age” for primary care, there is the opportunity to engage an entire team towards comprehensive/multi-disciplinary care.

Pan-SCN: Since depression can affect various groups, other SCNs are looking for help with how to diagnose and treat depression within their patient populations. There is the ability to partner with other SCNs to conduct meaningful research in each patient subgroup.

Networks: Campus Alberta Neuroscience (CAN) and the Canadian Depression Research and Intervention Network (CDRIN) are working to define a depression research strategy in Alberta and would like to work closely with the SCN towards increasing the contribution of research addressing depression in Alberta.

Threats:
Funding: Need to be increasingly innovative in order to secure funding. Implementation science, which many funders are interested in funding, is not as interesting to academics.

Accountability: There is a need to be directly accountable to those who have lived experience.

Complexity: Care pathways can be seen as complex, burdensome and resource intensive. Despite evidence in favour of implementation, there are significant challenges to scaling these up.

Priority discussions

Where should the SCN research focus be for the next 12-24 months?

Access: Increasing access to therapists with trauma-informed lens and an evaluation of this compared to the standard care. Increasing behavioural support and treatments for those diagnosed with depression. With youth in particular, supporting the CASA-type model of treatment and support for this population.

Implementation: Work towards the implementation of pathways that have been sufficiently researched and other knowledge that has been accumulated. Though standardizing care is not as straightforward as one would like, providing more training and education around the evidence in treatment of depression will likely reduce some variations in care. Look at models such as the Wellness Recovery Action Plan (WRAP) and possibility of embedding this in schools and evaluating the effects. Rather than the SCN taking on brand new projects or pathways, the SCN should work with existing projects and teams to ensure that the evaluation component and KT components are meaningful and feasible.

Awareness: Continuing to increase awareness and public understanding of depression and measuring the effects that this will have on decreasing stigma. Ensuring that physicians and clinicians are aware of the effects of trauma and adverse childhood experiences and understand how to treat these populations.

Technology: Use of technology and social media to reach youth population as well as potentially screen this population.

Future potential projects:

1) Implementation and evaluation of peer support to assist those with postpartum depression
2) Dive deeper into the apparent increase in Major Depressive Episodes occurring in the winter months and interventions targeted to this population.
3) Local implementation of the cognitive behavioural project for family physicians (in reference to the CBIS manual project that Dr. Scott Patten is attached to)
4) Practice level supports for implementation: is fee for service remuneration significantly more effective for engagement of clinicians and physicians for uptake?

Next Steps

This meeting was an opportunity to bring together researchers in the addiction and mental health field in order to inform the AMH SCN on what gaps and priorities need to be the focus for the upcoming months and years. There was a commitment to further discussion between the AMH SCN and the AAMHRPP to integrate the two teams, while ensuring that both mandates were protected. The meeting also provided an opportunity to discuss upcoming funding opportunities, such as PRIHS and encouraged the research community to evaluate all projects on an ongoing basis for appropriateness for that competition. This report serves as the first step towards disseminating the results of the discussion that occurred and will be shared with the Core committee members of the

AMH SCN and used to inform the research agenda of the AMH SCN and allocation of resources and research support.

List of Registered Attendees

	First Name	Last Name
1	Alexander	Cook
2	Allan	Donsky
3	Amanda	Newton
4	Andrea	Allen
5	Andrew	Bulloch
6	Andrew	Greenshaw
7	Barry	Andres
8	Bonnie	Lee
9	Cam	Wild
10	Carmela	Hutchison
11	Carmen	Rasmussen
12	Cathy	Pryce
13	Courtney	McNeil
14	David	Hodgins
15	Denise	Milne
16	Diane	Kunyk
17	Frank	MacMaster
18	Gail	Andrew
19	Ginetta	Salvalaggio
20	Glen	Baker
21	Grant	McIntyre
22	Heather	Scarlett-Ferguson
23	Jacqueline	Pei
24	Jaideep	Bains
25	Jessica	Muller
26	Julie	Drolet
27	Kathryn	Dong
28	Kathryn	Todd
29	Kathy	Aitchison
30	Kathy	Hegadoren
31	Kathy	Huebert
32	Keith	Dobson
33	Kelly	Hartle
34	Kit	Johnson
35	Liana	Urichuk
36	Lonnie	Zwaigenbaum
37	Marni	Bercov
38	Marnie	MacKay
39	Marti	Rustulka
40	Matthew	Hill
41	Michael	Trew
42	Nicholas	Coupland
43	Nicholas	Mitchell
44	Nicole	Letourneau
45	Nicole	Sherren
46	Nikolai	Malykhin
47	Orrin	Lyseng
48	Pamela	Valentine
49	Paula	Harvalik
50	Rebeccah	Marsh
51	Roger	Bland
52	Rona	Li
53	Ryan	Lacanilao
54	Scott	Oddie
55	Scott	Patten
56	Shelanne	Hepp
57	Shireen	Surood
58	Stephanie	Donaldson
59	Suzanne	Tough
60	Tanya	Drescher
61	Tanya	Park
62	Tanya	Richer
63	Tom	Briggs
64	Tom	Shand
65	Victoria	Suen
66	Vivian	Lillico
67	Xinjie	Cui
68	Xinmin	Li

Meeting Agenda

Addiction and Mental Health Strategic Clinical Network
Research Strategic Planning Meeting Agenda
February 9-10th, 2015
Lister Hall, Wild Rose Room, University of Alberta

Objective: To bring together researchers in Addictions and Mental Health to help inform and prioritize research in our province.

Monday February 9th, 2015
Agenda:

Time	Agenda Item	Speakers
1000-1005	Welcome and Introductions	N. Mitchell C. Pryce
1005-1200	Setting the Stage for the Meeting • What are we attempting to achieve? (5 min) • Refresher: objectives, accomplishments, and future goals for the SCN and the Research Partnership (30 min) • PRIHS and CRIO Grants (30-45 min) • How do the SCN and the Research Partnership organize moving forward? (30 min)	C. Pryce N. Mitchell A. Greenshaw P. Valentine
1200-1300	Lunch	
1300-1330	Addiction and Mental Health Services Through the Eyes of a Patient	T. Richer
1330-1415	Current State: Addiction and Concurrent Disorders Research	D. Hodgins C. Wild
1415-1515	Breakout groups: • SWOT analysis of current state • Where should the research focus be for the next 12-24 months? • What are future potential projects in this area that you can lead? • Report Back	
1515-1530	Break	
1530-1600	Addiction and Mental Health Services Through the Eyes of a Patient	A. Cook
1600-1635	Current State: Child and Youth Mental Health	N. Letourneau
1635-1735	Breakout groups: • SWOT analysis of current state • Where should the research focus be for the next 12-24 months? • What are future potential projects in this area that you can lead? • Report Back	

Tuesday February 10th, 2014
Agenda:

Time	Agenda Item	Speakers
0800-0825	Breakfast Networking	
0825-0830	Welcome	
0830-0915	Current State: Complex High Needs Users	T. Briggs M. Stewart
0915-1015	Breakout groups: • SWOT analysis of current state • Where should the research focus be for the next 12-24 months? • What are future potential projects in this area that you can lead? • Report Back	
1015-1030	Break	
1030-1115	Current State: Depression Research	S. Patten
1115-1215	Breakout groups: • SWOT analysis of current state • Where should the research focus be for the next 12-24 months? • What are future potential projects in this area that you can lead? • Report Back	
1215-1245	Wrap Up/Next Steps	
1245-1345	Lunch	