reorganization of DPD clinics

Memorandum

To: Dr. P. Leichner
Program Director, CPC

From: Directeur Clinique des Soins Continus

Date: Mercredi 01 août 1990

Subject: Plan de restructuration pour les cliniques externes; your memo of 5 Apr 1990

Thank you for your memo, requesting proposals for restructuring the clinics. Attached please find my suggestions for reorganizing the sectorized teams and the specialty clinics, as we've discussed previously. I'd like to use this memo to respond specifically to the questionnaire.

1. Accessibilité aux services

1.1 How should we reduce waiting lists? I suggest we set absolute standards for the upper limit, ie 8 weeks maximum between first telephone call and a complete evaluation interview. We need to be able to collect good statistics to monitor whether teams are staying within the limits; furthermore, each team needs an individual who functions in some sort of leadership capacity who has the responsibility (and authority) for ensuring that this standard is met.

1.2 Should we standardize or organize differently, our procedures for registering and evaluating patients? Yes, we should standardize; registration is a clerical task, and procedures should be written so that this is done in a uniform way. Regarding evaluation of new patients: I concur with your idea regarding the creation of a specialized "Contact" Evaluation Clinic, which would do all new patient assessments. Trainees, students, and residents would be attached to this clinic; staff who want to do evaluations themselves or provide supervision would also join the clinic, normally on a very part-time basis. I suggest that time-limited psychodynamic psychotherapy also be done by this clinic.

1.3 Should clinicians be redistributed to improve accessibility? Yes, but not to improve accessibility for new patients, only for those already evaluated. If we create an evaluation clinic, then there will be only

one waiting list for evaluation of new patients. A crunch could develop if individual teams experience problems accepting evaluated patients into their caseload. Current statistics (see attached graphs) show large variations in indices such as number of dossiers per clinician, number of interventions per clinician, etc. It seems, given the poor quality of current statistics, that we should initially redistribute clinicians to equalize putative workloads based on the most reliable indicator: population served by each team. If, at the same time, we begin collecting better statistics through the new computerized system, we can finetune the clinician distribution as time goes on, based on reliable workload indices. The attached spreadsheets show one way of redistributing staff to equalize population loads, based on reducing the number of sectorized teams.

1.4 Should the presence of trainees with certain teams be rethought? Yes. In general, we have three kinds of trainees with outpatient teams: psychology interns, who do patient evaluations and are supervised in dynamic psychotherapy; medical students, who do evaluations and follow patients on medication; psychiatry residents, who do evaluations, dynamic psychotherapy, and followup of patients on medication. I suggest that for training in doing evaluations or dynamic psychotherapy, all trainees be attached to the new specialized "Contact" Clinic. Followup of patients on medication could take place either in the Case Management Teams, or by having medical students and residents rotate through the Mood & Anxiety Disorders Clinic or the Psychotic Disorders Clinic.

2. Répartition des "case loads"

2.1 How can we obtain an equitable sharing of case loads among professionals and teams? Given the poor quality of currently obtained statistics, this is impossible. My recommendation is given in 1.3, above.

2.2 How can we better coordinate and prioritise the different activities in which an individual clinician may wish to participate? Many clinicians may view work in the Case Management Teams as being less desirable than the more glamorous specialized clinics. Accordingly, we might set a condition that all clinicians work at least half of their outpatient clinic time in a Case Management Team, and may in addition work in not more than one specialized clinic. This would ensure that Case Management Teams have adequate staffing, and by limiting the number of work settings for individual clinicians, it will be possible to avoid fragmentation.

2.3 Should the number of teams, their geographic coverage, or the assignment of clinicians be reconsidered? Yes. My proposal (attached) details one possible restructuring.

3 Equipe multidisciplinaire sur-spécialisée

3.1 How can our resources be structured to offer a complementarity between ultra-specialized and general psychiatric services? I propose reducing the number of Case Management Teams to improve efficiency (fewer team meetings, fewer coordinators to go to coordination meetings, easier communication with other services, eg inpatient units & day hospitals) and to free up staff who wish to work in specialized clinics. Creation of additional specialized clinics will centralize teaching activities, help to promote research, and hopefully attract additional psychiatrists and trainees who want to do research or teaching.

3.2 What types of clinics and specialized activities should we offer? The attached proposal recommends a mix of Case Management Teams, responsible for providing long-term followup (ie case management, medications, and supportive psychotherapies) and a number of specialized clinics (a new "Contact" Evaluation and Brief Therapy Clinic a new Psychotic Disorders Clinic, a merge of the two existing specialized clinics into a Mood & Anxiety Disorders Clinic, and for the future, possibly an Assertive Outreach clinic). Specialized clinics can provide brief psychosocial treatments, consultations, and medication management. Given the resource limitations, long-term insight-oriented psychotherapy should not be offered within CPC.

4 Communication et collaboration ave les ressources communautaires et alternatives

4.1 What linkages should we attempt to create with CLSC's? CLSC's have a mandate to provide primary (first-line) psychiatric services. Accordingly, we should encourage them to do initial screening of new patients, and to do long-term followup of cases which can be managed by multidisciplinary teams that include GP's, supported by psychiatric consultation as needed.

I agree with your proposal that the "Contact" Team could work out of the CLSC's. I suggest also that the Case Management Teams be organized along CLSC geographic sectorization, that they also where possible make use of CLSC offices, and that they hand over the case

management role to the CLSC's as the latter develop their own in-house programs

4.2 How can we ensure a smooth transition in areas where CLSC's have not yet developed first line psychiatric services? In order to permit these CLSC's to generate the statistics they require to support requests for additional resources for first line services, we should either collect statistics on those patients that we see that should have been seen in the CLSC's, or alternatively, refer those patients to the CLSC's even if services are not yet in place, so that the CLSC's become aware of the population. In either case, the approach should be agreed to by both ourselves and the CLSC involved.

4.3 What mechanisms should we put in place to ensure a closer collaboration with the community? The new "Contact" Clinic would have as part of its mandate to provide psychiatric consultation and teaching to community GP's and CLSC's. An Assertive Outreach team would go to see patients in their setting in the community: in foster homes, transition houses, room-and-board homes, supervised apartments, shelters, families, etc. and thereby forge links with proprietors, landlords, families, and alternative resources. By emphasizing the case management role of the Case Management Teams, existing links with the community would be strengthened. Finally, a smaller number of Case Management Teams means less fragmentation and easier representation via our Community Relations Agent.

Thank you for this opportunity to express my views on the reorganization of the clinics. I would be pleased to meet with you to discuss it.

Henry Olders, MD

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