Canadian Collaborative Mental Health Initiative

Initiative canadienne de collaboration en santé mentale

Collaboration between mental health and primary care services

A planning and implementation toolkit for health care providers and planners

PROVIDERS AND PLANNERS

AUTHORS FOR THE GENERAL TOOLKIT

Group responsible for the development of this toolkit

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OUR GOAL

The Canadian Collaborative Mental Health Initiative (CCMHI) aims to improve the mental health and well-being of Canadians by enhancing the relationships and improving collaboration among health care providers, consumers, families and caregivers; and improving consumer access to prevention, health promotion, treatment/intervention and rehabilitation services in a primary health care setting.

Table of contents

Preface

Welcome to the CCMHI toolkit series!

The Canadian Collaborative Mental Health Initiative (CCMHI) is led by 12 national organizations representing community services; consumers, families and caregivers; self-help groups; dietitians; family physicians; nurses; occupational therapists; pharmacists; psychiatrists; psychologists; and social workers. Funded through Health Canada's Primary Health Care Transition Fund, the goal of the CCMHI is to improve the mental health and well-being of Canadians by increasing collaboration among primary health care and mental health care providers, consumers, families and caregivers.

The CCMHI toolkits contain practical tools to:

- Assist providers and planners in the implementation of collaborative initiatives.
- Help mental health consumers and their family members understand mental illness and work with other members of the care team.
- Inform educators of the benefits of interprofessional education and provide tools to teach about collaborative mental health care.

Each toolkit was developed with an interprofessional expert panel and guided by a working group representing a number of key stakeholder groups. We hope that readers of any of the toolkits in the series will recommend them to others (e.g., consumers referring toolkits to their providers and vice versa).

In addition to this series of 12 toolkits, the CCMHI has developed a Charter of principles and commitments that will influence the future of mental health care in Canada and a series of reports that capture the current state of collaborative mental health care. The reports highlight health human resource issues, provide an annotated bibliography, summarize best practices, review initiatives from across the nation and summarize provincial and territorial mental health and primary care reform. These documents guided the development of the toolkits and are available at www.ccmhi.ca.

Implementation toolkits

Collaboration between mental health and primary care services. A planning and implementation toolkit for health care providers and planners is a guide for providers wishing to establish or enhance the mental health services they provide through collaboration. This general toolkit offers readers a guide to all aspects of planning, implementing and evaluating a collaborative mental health care initiative, including assessing need, setting goals and objectives, developing a budget, building a team, maintaining a well-functioning team, managing change and monitoring the initiative.

Eight population-specific toolkits, entitled *Establishing collaborative initiatives between mental health and primary care services*, are designed to be used in conjunction with the general toolkit. They offer tips on adapting the general toolkit for Aboriginal peoples,

children and adolescents, ethnocultural populations, rural and isolated populations, seniors, individuals with serious mental illness, individuals with substance use disorders and urban marginalized populations. There is some overlap in the toolkits; for example, information about collaborative mental heath care and the homeless may be found in at least three toolkits: individuals with serious mental illness, individuals with substance use disorders and urban marginalized populations. Readers are encouraged to consider all the toolkits that may be relevant to their needs.

The general and population-specific toolkits are not intended as clinical practice guides but offer practical advice on different aspects of establishing successful collaborative initiatives.

Consumer, family and caregiver toolkits

Consumers, families and caregivers developed both of these toolkits for consumers and their loved ones.

Working together towards recovery: Consumers, families, caregivers and providers is intended for all consumers, families and caregivers wishing to know more about mental health and mental illness, how to access services and the type of professionals that can assist them in their recovery. This toolkit also offers an outline of complementary therapies and self-care as well as the contributions and needs of caregivers. Finally, this toolkit includes a guide to "getting involved", describing how government and boards of directors work, and why consumers and families should participate.

Pathways to healing: A mental health guide for First Nations people is a toolkit that offers a basic overview of mental health and mental illness along with a contextual section outlining the impact of history, social, economic and political conditions on the mental health of these peoples. There are tools in this toolkit to foster holistic care.

Education toolkit

Strengthening collaboration through interprofessional education: A resource for collaborative mental health care educators serves as an educational resource to assist in the implementation of educational initiatives and programs that promote collaborative mental health care in primary health care settings. The toolkit is targeted to education program developers in regulatory agencies, professional associations, regional health authorities, family health teams, governmental departments, and educators within both academic (universities and colleges) and care delivery settings.

This toolkit highlights the importance of interprofessional education in promoting collaborative care. It offers four case studies and several activities accompanied by a sample lesson plan and other useful tools to aid educators in the implementation of educational events.

Introduction

What is collaborative mental health care?

Collaborative mental health care describes models of practice in which consumers, their families and caregivers, together with health care providers from a variety of primary health care and mental health settings – each with different experience, training, knowledge and expertise – work together to provide better co-ordinated and more effective services for individuals with mental health needs. These services include mental health promotion, illness prevention, detection and treatment of mental illnesses, rehabilitation and recovery support.

Collaborative mental health care can encompass a broad range of activities, such as regular visits by a mental health care worker to a primary health care setting; unified programs that offer mental health and physical health care through one administrative and financial entity; regular telephone consultations between primary health care and mental health care providers; the integration of specialized care providers such as psychiatrists, psychologists, nurses, social workers, occupational therapists, dietitians and pharmacists within primary health care settings; development of treatment plans jointly by consumers and providers; incorporating mental health interventions into the management of general medical conditions such as diabetes; meeting the primary health care needs of individuals with a severe and persistent mental illness; and strategies to improve access to community mental health services.

Collaborative mental health care can take place in a variety of settings including community health centres, health care providers' offices, mental health clinics, homes, schools, correctional institutions and community locations such as shelters. Collaborative mental health care can be based on a number of different models depending on the providers involved, the services provided and the degree of collaboration. (For a comparison of different models of collaborative mental health care, please see Appendix A.) Providers may be co-located and able to meet face-to-face but even if that is not the case, collaboration can still take place via telephone, fax, Internet, teleconferencing, videoconferencing or educational interventions. Providers may offer joint assessments, case discussions and advice, educational opportunities, consultation, back-up/support or direct care to consumers. The Canadian Collaborative Mental Health Initiative has published *Collaborative mental health care in primary health care: a review of Canadian initiatives Vol II: Resource Guide* (Pauzé and Gagné, 2005) which describes and synthesizes approximately 90 collaborative initiatives in Canada; the publication is available on their Web site, www.ccmhi.ca.

Key elements

Collaborative mental health care is characterized by four key elements:

- Accessibility
- Structures and systems which support collaboration
- Richness of collaboration
- Consumer-centredness

Fundamentals

The success and ease of implementation of collaborative mental health care will be determined, in part, by four external factors:

- Congruent policies, legislation and funding regulations
- Sufficient funds
- The current evidence base
- Community needs

More detailed information about the key elements and fundamentals may be found in Appendix A and in the Canadian Collaborative Mental Health Initiative document *What is collaborative mental health care? An introduction to the collaborative mental health care framework* (Gagné, 2005) available on their Web site, www.ccmhi.ca.

Basics of collaboration

In collaborative partnerships, mental health and primary care providers and consumers share:

- Common goals or purpose
- A common language
- A recognition of and respect for respective strengths and differences
- Equitable decision-making
- Clear and regular communication

Benefits of collaborative mental health care

Federal, provincial and territorial jurisdictions across Canada have recognized the importance of improving the organization and delivery of primary health care: making it more accessible, comprehensive, interdisciplinary, co-ordinated and oriented to health promotion. This is particularly critical for mental health services, which are often poorly co-ordinated, stigmatized and not easily accessible.

An increasing body of evidence accumulated over the last 10 years indicates that collaboration can improve access to mental health care, especially for populations who traditionally underutilize mental health services; improve continuity of care; increase communication and co-ordination of care; potentially reduce mental health costs (although this may be offset by finding new cases); reduce the use of other health services;

make more efficient use of available resources; and increase the capacity of both the mental health and primary health care systems.

Satisfaction ratings with such services are high on the part of primary health care providers, mental health care providers and consumers using the services. There is also evidence that outcomes are better than routine care by the family physician and equivalent to outcomes delivered in mental health services for many but not all populations seen. For a comprehensive annotated bibliography of research publications (2000 - 2004) related to the integration of mental health and primary health care, please see *Annotated bibliography of collaborative mental health care.* (Pautler and Gagné, 2005), available at www.ccmhi.ca.

Limitations of collaborative mental health care

Collaborative mental health care should be seen as part of a continuum of care, with a smooth flow between primary, secondary and tertiary services. Some kinds of problems may be treated more effectively in specialized mental health services which have access to a wider range of resources. These can include individuals with complex diagnostic or management needs, or who require a specific treatment such as CBT, more comprehensive rehabilitation services or more intensive case management. Some services for children and adolescents and for seniors may also require more comprehensive resources. There is also likely to be variation in the comfort of family physicians in managing specific problems in their office, even with the support of a mental health care provider. Supporting a comprehensive range of mental health services or providers may be challenging for smaller initiatives.

Other possible limitations include available space, time constraints and the readiness of all partners to participate in collaborative models.

Barriers to collaborative mental health care and strategies to address them are explored in the Canadian Collaborative Mental Health Initiative document *Collaborative mental health care in primary health care: a review of Canadian initiatives Vol. I: Analysis of initiatives* (Pauzé et al, 2005) and *Vol. II: Resource guide* (Pauzé and Gagné, 2005), available at www.ccmhi.ca. Barriers cited by the approximately 90 Canadian collaborative mental health initiatives surveyed include funding/remuneration, structures/systems, buy-in, human resources, skill, geography, evaluation, and policy and legislation.

About this toolkit

This toolkit has been developed to assist health care providers, managers, consumers and community services interested in developing and implementing collaborative mental health care initiatives, primarily through the integration of specialized services in primary health care settings. It offers practical advice on different aspects of establishing a successful collaborative initiative from identifying need to evaluation and includes

checklists, work pages and resources. It may be used by individuals or groups interested in starting an initiative "from scratch" or wishing to change or expand an existing initiative. It is not intended as a guide to clinical practice or management.

Central to the approaches suggested in this toolkit is an understanding of the principles of managing "chronic" diseases in primary care settings and the need for system changes if these problems are to be managed optimally.

Common to models of chronic disease management (also known as the chronic care model or the comprehensive care model) are six key functions, which need to be in place to deliver optimal care. These are:

- A comprehensive range of available services in a well-co-ordinated service delivery model
- A strong emphasis on self-management and a new partnership between an informed and empowered consumer and a well-prepared and supportive provider
- Evidence-based guidelines incorporated into a treatment setting through treatment algorithms or the presence of a specialist
- Information systems that allow records to be shared easily between different providers involved with an individual's care and enable individuals at risk of developing a problem to be monitored over time
- Organizational changes that share the vision and support the goals of the initiatives being developed, including the provision of adequate resources
- The integration of health services with community resources, looking at health from a population as well as an individual perspective

Central to the success of any initiative, therefore, is the ability to recognize that any specific intervention needs to be seen as part of a system of care, and to consider other system adjustments or changes that need to be made to support the planned initiative. This should always be borne in mind when contemplating any of the guidelines outlined in this toolkit.

Collaborative mental health care is an emerging area of practice with a need for guidelines based, as much as possible, on the best available evidence (best practices). The advice and recommendations contained in this toolkit are based on a review of the current literature, reports from successful initiatives and interviews with individuals who have been involved with collaborative initiatives.

While this toolkit is designed in a sequential, step-by-step format, change is not always linear. You may find that some steps do not apply to your initiative or need to be approached in a different sequence. This toolkit is intended to be a guide and to suggest options, rather than present the one and only way to do things.

The resources and capacity of health care providers, the needs of consumers and the specific problems presented will vary by initiative. The toolkit will offer a range of

options that bridge the "ideal" (what could be achieved if funding/resource availability were not an issue) and the "reality" (what can be done with available resources).

We hope this toolkit will also serve as a resource for health care planners and funders as primary health care and mental health care reforms proceed. The implementation of collaborative mental health care can be significantly facilitated by reform strategies and policies which are co-ordinated across jurisdictions and by the availability of adequate and sustained funding.

This toolkit is intended for use with a general population. It has eight companion toolkits, each of which looks at issues to consider when planning, implementing and evaluating collaborative mental health care initiatives involving eight specific populations: Aboriginal peoples; children and adolescents; ethnocultural communities; rural and isolated communities; seniors; individuals with serious mental illness; individuals with substance use disorders; and urban, marginalized populations. The complete toolkits are available at the Canadian Collaborative Mental Health Initiative Web site, www.ccmhi.ca.

The information in the population-specific toolkits complements and augments that in the general toolkit; it does not repeat or replace it. The general and population-specific toolkits should be used together.

A Glossary of terms used in this toolkit may be found in Appendix C. We have used the term "consumer" rather than "patient" or "client" to refer to individuals (and their families/caregivers, where applicable) who either directly or indirectly make use of health care or related support services. A toolkit by and for consumers, *Working together towards recovery: Consumers, families, caregivers and providers* (Canadian Collaborative Mental Health Initiative, February 2006) is available on the Canadian Collaborative Mental Health Initiative Web site, www.ccmhi.ca.

Planning

> *"If you don't know where you are going, you might wind up someplace else."*
>
> *Yogi Berra*

Whether you are developing a new initiative or extending an existing one, certain planning and preparation tasks need to take place before implementation begins. Steps in the planning of a collaborative initiative include:

Establishing a planning and implementation team

Identify the key partners and stakeholders for your initiative. Team membership may change from the planning to the implementation phase but may include:

- Clinicians/staff providing service in the new initiative
- Consumers
- Community services (including those that will be affected by the new initiative)
- Possible funders (present or future) or organizations who may be asked to provide other means of support to the planned initiative
- Local community mental health services
- Local primary care services

Partners should be:

- **Involved** from the outset
- **Informed** as the initiative proceeds
- **Representative** of providers, consumers and community

The team's tasks may include:

- Selecting a leader within the planning and implementation team who is committed to the initiative
- Ensuring that the team has a clear shared vision and that services being considered fit within this vision
- Developing clear and realistic timelines for planning and implementing the initiative
- Deciding how frequently the team should meet
- Establishing regular meeting times when team members are less likely to be disrupted
- Analyzing current functioning to determine whether the working environment can support and will continue to support the initiative
- Considering how to address any current problems in the working environment

- Clearly defining roles, responsibilities and accountability of team members, including responsibility for maintaining working relationships
- Clarifying expectations in new working agreements, policies and guidelines

✓ Ensure that all team members have an opportunity to share their perspective.

Identifying opportunities for consumer involvement

Consumer/family/caregiver involvement is a key component of comprehensive care. Strategies to promote participation include:

- **Invite consumers to be members** of the planning and implementation team.
- **Include the experiences and viewpoints of consumers** when assessing the strengths and weaknesses, gaps and capacity of services currently available and services being planned.
- **Inform consumers** about any new initiative, to get their opinions or to find individuals interested in sitting on the planning and implementation team.
- **Solicit the views of consumers** regarding initiative goals and priorities.
- **Compensate consumers** for their time and travel costs commensurate with others involved in the initiative.

Consumers may be recruited through:

- A flyer in a public area
- An invitation sent to all people using a service inviting comments/suggestions
- Directly approaching specific individuals who might be able to contribute to the initiative
- An open meeting

For more information about consumer involvement, please see *Working together towards recovery: Consumers, families, caregivers and providers,* a toolkit produced by consumers for consumers as part of the CCMHI toolkit series. It is available at www.ccmhi.ca.

Conducting a needs assessment

Any new initiative should have clear goals which outline what the project is trying to accomplish. The development of these goals should be based upon the needs of the population(s) to be served.

✓ When conducting a needs assessment, encourage broad-based participation including primary health care providers, mental health care providers, consumers and family members, and community groups.

A needs assessment can gather information about areas such as:

- Current resources
- Current capacity
- Current patterns of utilization
- Services currently offered by community mental health programs, including secondary and tertiary centres
- Gaps in existing services
- Provider and consumer satisfaction with current services
- Providers' underlying assumptions about collaborative care
- Providers' readiness for change
- Barriers to access for consumers and families

A needs assessment can involve one or more of the following strategies:

- Reviewing existing data on indicators such as
  - Demographic characteristics of the population to be served
  - Community prevalence rates of specific disorders
  - Presenting problems
  - Current utilization and referral patterns
- Conducting surveys of groups such as primary health care providers, specialized care providers, consumers and family members, and community groups
- Organizing meetings of groups of providers, stakeholders or consumers to address specific questions related to need or to respond to open-ended questions
- Reviewing current practices to identify areas which may require improvement
- Analyzing problems with access to services currently offered
- Analyzing the existing skills of current staff

This information will allow the planning group to:

- Assess the fit between current services and the needs of consumers and providers
- Identify gaps/opportunities for current services to be more effective
- Determine additional resources that may be required
- Determine goals and priorities for the new initiative

See Appendix B for a sample needs assessment.

Developing goals and objectives

Goals are broad, long-range statements regarding general aims and purposes which provide direction and overview.
Objectives are brief, specific statements describing the actions that will be required to achieve your goals.

The development of goals for the initiative will represent a clear, mutually agreed-upon statement of what the initiative is trying to achieve. Goals can be simple and brief. Developing short-term (what can be done immediately) and long-term (what you would eventually like to be able to do) goals will help shape a comprehensive plan for the management of a specific need or problem. If goals overlap with the mandate of another community resource, consult with that service about opportunities for collaboration and ways to minimize duplication and conflict.

Goals for collaborative mental health care might include:

- Improving access to mental health services
- Increasing the range of mental health services available
- Improving clinical outcomes
- Improving self-management of at-risk individuals
- Developing comprehensive programs of care for prevalent problems such as anxiety, depression or alcohol abuse
- Enhancing early detection
- Facilitating referrals/initiation of treatment
- Increasing the skills and comfort of primary health care providers in the use of a wide range of health promotion, prevention, assessment and treatment strategies, including appropriate medications
- Improved monitoring of individuals at risk
- Appropriate identification and referral of individuals who require specialized mental health treatment
- Changes in utilization of mental health services

Goals should be realistic and attainable. The acronym **SMARTER** summarizes the main characteristics of well-formulated goals.

S Specific
M Measurable
A Attainable
R Realistic
T Time-specific
E Evaluated
R Re-appraised as the initiative proceeds

Once goals have been established, develop specific objectives to guide the implementation and evaluation of the new initiative. The objectives will reflect the steps that need to be taken to achieve the goals.

Contacting other initiatives offering similar services

✓ Establish contact with staff working in similar initiatives in your community or elsewhere to learn from their experience and help identify potential pitfalls. This information can then be adapted to the needs and resources of the initiative being planned.

Staff working in similar initiatives can provide advice at different stages of the planning and implementation process. These contacts could be reinforced by:

- Visits to your location(s) to provide advice or meet with members of your team
- Opportunities to visit other initiatives to see how they operate
- Opportunities to utilize forms or other evaluation materials similar initiatives have already developed

Considering which services to offer

Think of the entire "span" of the problem(s) you will be addressing and the spectrum of services that might be offered. Ideally, and consistent with the concepts of chronic disease management, collaborative mental health care presents opportunities to work towards the creation of a comprehensive range of services, from health promotion to rehabilitation. These may include:

- Health promotion and primary prevention
- Early detection and secondary prevention
- Consultation and treatment
- Self-management/consumer education
- Rehabilitation
- Monitoring and tertiary prevention
- Provider education/training

✓ Resource availability may determine the range of services that can be offered, which will make it essential to identify priorities.

Identifying possible demand for the new initiative

Try to predict the expected utilization of the new initiative by reviewing the literature or descriptions of similar projects, or contacting providers with experience working in similar initiatives. This will enable you to estimate the time/resources the initiative will require and to determine whether additional resources will be needed.

If it appears that demand will outstrip available resources, it may be necessary to adjust the objectives, the scope of the initiative or the population(s) to be served to ensure project viability.

> ✓ It is usually preferable to begin with a smaller initiative with attainable goals which can be expanded, rather than an overly ambitious initiative that overextends staff or fails to meet its goals.

Funding and budget

a) Identify possible sources of funding and other resources

Sometimes, an initiative may be developed in response to a specific request or the availability of funding. More often, a proposal is developed and then the search for funding begins.

Possible sources of funding include:

- A primary health care setting, which is willing to set aside resources to support an initiative
- The mental health sector, either through secondment or a re-allocation of resources from a community program
- A short-term grant, particularly if this is a demonstration initiative that may lead to further opportunities for funding down the road

b) Consider sustainability

> ✓ Consider strategies for sustainability in the planning phase and review them as implementation proceeds, especially if funding is time limited.

Sustainability includes:

- Maintaining the vitality and effectiveness of an initiative
- Retaining team members
- Obtaining continuing funding

Continuing funding is more likely to be provided if the following are present:

- Evidence to support ongoing need
- Demonstrable benefits of the initiative
- Provider and consumer satisfaction
- Responsibility and accountability to stakeholders and funders
- Efficient use of resources
- Cost savings or at least cost-neutral to the overall system
- Consistency with the goals of the potential funding source
- The initiative complements rather than duplicates other available services

c) Develop a budget

Human resource costs

Planners should consider human resource costs from the outset of the initiative. These costs will vary depending on the individuals hired and how they are to be paid. Specific funding may need to be designated for a manager or co-ordinator as clinicians may not have time to dedicate to this aspect of the initiative. [See **Members of the team** and **Co-ordination** sections below.]

Operational costs

In addition to staffing costs, other costs to take into consideration may include:

- Office space [See **Physical location** section below]
- Access to secretarial/administrative assistance
- Use of a telephone line
- Use of computers for charting, if applicable
- Printing and other office supplies
- Educational materials
- Stipends and/or expenses for consumer/community involvement
- Travel costs
- Evaluation costs
- Administration costs for co-ordinating/supporting the initiative

One-time start-up costs

- Capital equipment purchases
- Meetings, workshops, meals, accommodations and travel for planners or invited guests
- Set-up of a central location/office space
- Creation of new space for the initiative or alteration of existing space
- Clinician, consumer or physician participation
- Advertising for new staff

Please see Appendix B for a sample budget.

Developing an evaluation component

An evaluation provides information about how well an initiative is meeting its goals and objectives and the needs of consumers. It need not require a substantial amount of time to complete.

- Build in an evaluation component at the outset.
- Base the evaluation on the goals and objectives you expect to achieve.
- Develop a timeline for the evaluation.
- Keep the evaluation simple.
- Make sure the information you are collecting will be used.

An evaluation can measure five different sets of outcomes:

- **Consumer outcomes** (symptoms, functioning)
- **Process outcomes** (what services are delivered, by whom, to whom and how)
- **Satisfaction measures** (providers and consumers)
- **Utilization measures** (of internal and external services)
- **Cost analyses**

Any or all of these can be considered depending on the results expected/ desired from the initiative.

[See **Evaluation** section below.]

Identifying potential barriers

The planning and implementation team should identify potential barriers, especially those related to access, so that strategies to address and overcome these can be developed. Barriers may be:

- Individual (transportation, childcare)
- Organizational (lack of space)
- Societal (stigma, cultural beliefs, health care restructuring)
- Provider (time constraints)

Planning checklist

- ❑ Establish a planning and implementation team.
- ❑ Identify opportunities for consumer involvement.
- ❑ Complete needs assessment.
- ❑ Set clear, measurable and realistic goals and objectives.
- ❑ Contact other similar initiatives.
- ❑ Determine services to be delivered.
- ❑ Assess demand for the new initiative.
- ❑ Identify and secure the financial and other resources necessary.
- ❑ Consider how the initiative could be sustained.
- ❑ Build in an evaluation component.
- ❑ Identify and address potential barriers.

Members of the team

> *"Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that ever has."*
>
> *Margaret Mead*

Competencies required by mental health care providers

Recruiting mental health care providers with the skills to work collaboratively in primary health care and preparing them adequately for what may be a new style of practice is crucial to the success of an initiative. Identify the expertise which will be required and consider the qualities you desire in a clinician you will be working with on an ongoing basis. Flexibility, excellent communication skills and the ability to function well as a team member are of key importance. Qualities to consider which are generally applicable to a variety of disciplines and types of initiatives could include some or all of the following:

Clinical skills

- Ability to implement health promotion and educational approaches
- Assessment and management of common mental health problems
- Group and educational interventions skills
- Ability to work with a broad range of populations and problems
- Ability and willingness to implement clinical guidelines/best practices
- Ability to look at all factors affecting an individual, including biological, psychological and social
- Case co-ordination skills
- Consultation skills
- Ability to work collaboratively with consumers and family members/caregivers
- Ability to implement self-management strategies

Knowledge

- Roles, skills, priorities, values and cultures of different clinicians providing care in the primary health care setting
- Demands and expectations of primary health care
- Professional, ethical and legal issues related to primary health care
- How primary health care functions and its role in the overall system
- Familiarity with local health and community resources
- General understanding of commonly used medications and their side effects and interactions
- Planning and evaluation skills
- Research skills

Interpersonal qualities

- Respectfulness
- Sensitivity to cultural and other individual differences
- Good communications skills
- Sensitivity to and respect for challenges faced by individuals with mental illnesses
- Flexibility
- Ability to work independently
- Ability to work as part of a team
- Willingness to work in what may sometimes be less-than-ideal office conditions
- Ability to use time efficiently and effectively
- Conflict resolution/negotiation skills
- Openness to participation in knowledge exchange activities
- Good organizational skills (important for clinical records and completing initiative evaluation materials)

Mix of providers

The services delivered will need to be adjusted according to the amount of specialized service provider time available. With less time available, there may need to be a greater emphasis on consultation, short-term care and case discussion with primary health care providers. More time might allow for more ongoing care.

Consider the competencies required as well as the disciplines that can deliver the services, as many competencies are shared by different disciplines. Factors such as availability, cost and fit with the initiative may all influence the hiring decision. Determine whether current staff possess or could develop the required competencies. Thinking in terms of competencies can also assist with recruitment in communities where there may be a shortage of specialized service providers from specific disciplines.

The skills and knowledge of the mental health care provider should also match the needs of the population to be served. If, for example, the initiative will see large numbers of seniors or children, it may require a clinician with some expertise in geriatric or children's mental health.

A grid like the one below enables a group developing an initiative to identify who might have the required competencies for a given role. The list of providers is not exhaustive but can serve as a starting point.

ACTIVITY	Dietitian	Family physician	Nurse	Nurse practitioner	Occupational therapist	Peer support worker	Pharmacist	Psychiatrist	Psychologist	Social worker	Other
Assessment											
Care navigation											
Consultation											
Consumer education											
Co-ordination of care											
Diagnosis											
Early detection											
Health promotion											
Pharmacotherapy											
Psychotherapy											
Rehabilitation											
Utilization of community resources											

Time requirements

Although no definitive staffing ratio has been established, the experience of other initiatives provides some guidelines to follow. An optimal ratio for mental health care providers other than psychiatrists would be a provider:consumer ratio of between 1:7,500 and 1:10,000. For psychiatrists, consider an average of 1 half-day per month per 2,000 to 2,500 patients. These ratios are quoted as full-time equivalents (FTE) as a position may sometimes be shared by two or more individuals, each possessing complementary skills.

✓ Services can be adapted according to the resources available, particularly clinician time, by adjusting the scope or expectations of an initiative.

In addition to mental health care providers, initiatives may also be able to collaborate with other providers such as pharmacists, dietitians, peer support workers and

rehabilitation specialists. The ratio will vary depending on the number of primary health care providers, the consumer population and the scope of the role.

Recruitment

The availability of mental health care providers interested in working in primary health care can be affected by the size and location of the community and the proximity to specialized services.

The most effective method of recruitment is through personal contacts. Speak to colleagues working in similar initiatives to see if they can suggest potential candidates. Other avenues for recruitment include:

- Advertisements in local newspapers
- Advertisements on professional discipline-specific Web sites or e-mail groups
- Advertisements on employment Web sites such as 'workopolis'
- Word-of-mouth (i.e., get the word out that the initiative has a specific position open)
- Educational institutions for recent or soon-to-be graduates

> ✓ Even if there is no current vacancy, keep an ongoing list of potential candidates interested in a position, in case a vacancy occurs at a future date.

Develop some standardized interview questions to allow for comparison among applicants. Some questions to consider may be found in Appendix B. Ideally, have more than one interviewer present, with representation from more than one discipline. If possible, include an interviewer from the same discipline as the applicant. The interview should assess:

- Profession- or discipline-specific skills
- Skills, training and experience relevant to the initiative
- Ability to work in a primary health care setting
- Ability to work effectively within an interdisciplinary team
- Knowledge of community resources/programs, if applicable

Additional training might be required to help a potential candidate develop skills that the initiative will require. If an initiative is already established, this can be provided by spending a day or two "shadowing" the person currently in the position. If this is not possible, or if the initiative is new, try to arrange for the candidate to visit a similar existing initiative to spend a day or two observing someone who has experience doing the same job and who can answer any questions they may have. Some funding may be needed to support this.

Employment options

There are three possible arrangements:

- Becoming a salaried employee of the sponsoring organization
- Working on a contract as an independent practitioner
- Being seconded to the initiative from another service

There are pros and cons in each arrangement and each has different implications for accountability, reporting relationships, liability and possibly for team functioning.

Remuneration

The level of reimbursement should reflect an individual's training and experience and be commensurate with what they could earn in other settings.

Remuneration needs to be competitive to ensure that skilled individuals can be recruited.

Psychiatrists can be paid in one of two ways. They can be paid a fixed half-day rate (sessional fee) equivalent to what they would make in a half-day of office practice (fee-for-service) with a small additional increment (15%) as an incentive to induce them to participate and to cover transportation costs. This will cover both billable (individuals seen) and non-billable (case discussions, education sessions, telephone time) services. Alternatively, they could be remunerated through a combination of billings for individuals seen and sessional funding to cover non-billable activities. This may be a more practical model for initiatives with limited resources.

For providers paid by salary, the equivalent level of remuneration can be determined from collective agreements or by speaking to Human Resources Department staff in tertiary facilities, who will also have information about benefits offered (usually about 20% of the total salary). These include vacation pay, sick leave and statutory holidays as well as legally required benefits such as CPP contributions, Employment Insurance and Employer Health Tax.

Independent (contracted) employees should receive total remuneration that is approximately the same as a salary plus benefits package. They will be responsible for arranging their own benefits. In these situations, check carefully that employees meet the Canada Revenue Agency definition of being self-employed.

Memorandum of understanding/contract

A memorandum of understanding/contract should be developed between the primary health care provider and the mental health care provider(s). It should clearly outline:

- Method(s) and amount of remuneration, including benefits, if appropriate
- Amount of clinical time available
- Accountability and responsibilities
- Reporting relationships

- Clear descriptions of the roles and functions of all parties
- Professional development opportunities within the initiative
- Time available for education outside the initiative
- Responsibilities for participation in the evaluation process
- Requirements regarding registration in an appropriate college
- Requirements regarding malpractice insurance
- Termination clause stating the length of time needed for notification of termination
- Any other terms specific to the initiative which you wish to include

Liability

These issues should be checked with the appropriate governing/regulatory bodies for each discipline. In addition to governance issues, there are three aspects of clinical liability to take into account.

a) ***Liability for each individual's clinical practice***. Each individual needs to have their own malpractice insurance coverage, which can be arranged individually or as a group. Liability may differ if a mental health care provider initiates treatment after a referral from a primary health care provider, or following a direct contact with a consumer.

b) ***Each discipline's liability when working in a collaborative relationship***, for example, making recommendations in instances when the consumer isn't seen. In these situations, it is recommended that the practitioner provide advice that is within the scope of practice and accepted standards of practice of his or her professional guidelines.

c) ***The delegation of responsibility by one professional*** (usually but not always a physician) and the liabilities of each party.

Team checklist

- ❑ Identify competencies required.
- ❑ Determine mix of providers.
- ❑ Identify time requirements.
- ❑ Develop recruiting strategy.
- ❑ Determine hiring arrangement(s).
- ❑ Determine remuneration.
- ❑ Prepare contract/memorandum of understanding.
- ❑ Consider liability issues.

Clinical team functioning

> *"A successful team is a group of many hands but of one mind."*
>
> *Bill Bethel*

Successful collaborative initiatives are built upon personal relationships. These will develop over time as clinicians from different backgrounds get to know each other, become familiar with each other's roles and expertise, and provide care collaboratively. A key to successful collaborative arrangements is the development of well-functioning teams.

A commonly accepted definition of a team is "a small number of people with complementary skills who are committed to a common purpose, performance goals, and approach for which they are mutually accountable." (Katzenbach and Smith, 1993)

Well-functioning teams are based upon the following assumptions:

- No single provider is able to meet all the needs of the consumer over time.
- Disciplines bring different skills and experiences that can enrich the care an individual receives.
- The consumer is an integral member of the health care team.

Characteristics of a well-functioning team

- Clear goals and a shared sense of purpose and commitment to achieving them
- Clearly understood roles and responsibilities
- Clear and regular communication
- Mutual trust, respect, understanding and support
- Recognition and appreciation of contributions of all team members
- Effective leadership
- Mechanisms and strategies for team tasks, including conflict management and resolution
- Appropriate organizational structures, including regular meetings

Clear goals and purpose

The goals of the initiative need to be clear and understood by all involved. The focus of the team needs to remain on meeting the needs of the population(s) being served (consumer-centred) rather than on issues related to individual team members. One approach to developing this is based around five questions:

1. Where are we now?
2. Where do we want to be?
3. How are we going to get there?
4. How will we know when we get there?
5. What will change in our environment in the future?

Clear roles and responsibilities

> ✓ Roles and responsibilities of team members need to be clear, explicit and understood by all other team members.

It is particularly important that potential areas of overlap in the roles of different team members be identified and decisions made as to who will be doing what. These decisions need to be reviewed periodically to make sure they are working and the division of tasks is still appropriate.

Team members need to know to whom they are accountable and for what, and their competencies need to be appropriate to the tasks assigned or taken on. There needs to be flexibility in role allocation and the opportunity to negotiate roles, as different team members may be able to take on similar tasks.

Clear and regular communication

Communication takes place at two levels within a team. The first is through meetings, formal announcements or publications that inform team members of what is taking place or of new developments. When such discussions take place, team leadership needs to be clear as to whether this discussion is to make a decision, for consultation purposes or to explain a decision that has already been made. It is important that this communication is two-way, with all team members having the opportunity to ask questions or contribute to the decision making.

The second level is the informal communication that takes place between team members on a day-to-day basis. Team members need to be willing and able to listen, to express their ideas to each other and respond to what they hear. This is easier if team members feel comfortable sharing information with one another and in addressing issues as they arise, in a style that is clear and direct.

Mutual trust, respect, understanding and support

In well-functioning teams, members have a sense of common purpose and trust in each other. There is an understanding of and respect for each other's professional and personal strengths and limitations, valuing of diversity and confidence in each other's ability to achieve the team's goals.

Recognition and appreciation of the contributions of all team members

Effective teams share the same understanding of group/team norms and the team attempts to be inclusive, with all team members being involved in activities and decisions being made. This should be supported by ongoing training and skill development of team members to enable them to expand the contributions they can make. [See **Continuing education** section below.]

Effective leadership

Effective leaders have personal credibility and communicate regularly and clearly with team members. They are able to involve all team members and encourage them to develop their skills and potential. They are able to help the team manage change and to lead a review of goals and objectives as necessary. They ensure team members are accountable and complete assigned tasks. In more mature teams, leadership can be shared, with different team members being able (and allowed) to take on responsibility for specific tasks according to the skills and competencies they possess and the demands of the task.

Mechanisms and strategies for team tasks

Teams need to have explicit processes and procedures for issues they will face such as solving problems as they arise, managing and resolving conflict, evaluating the performance of individuals and the team, and reviewing initiative goals and planning.

Appropriate organizational structures, including meetings

An integral part of collaboration is the opportunities it presents for clinicians to meet to discuss cases, issues or community resources. In addition to formal meetings, there will be many other opportunities for team members to meet to discuss clinical issues. In larger initiatives where mental health care providers may be working in a separate location from the primary health care provider(s), this may not happen unless planned in advance. How this will work should ideally be clarified at the beginning of the initiative.

Formal meetings should also be arranged. They may include a number of different potential "teams", especially in larger groups or initiatives based in multiple locations. These can include:

- All individuals working in the primary care setting
- One or more family physicians and the nurse(s)/nurse practitioner(s) working with them who provide "core care"

- Mental health care providers who are likely to be involved with specific sub-populations. These individuals may be involved in regular meetings or on a case-by-case basis
- Other specialized staff likely to be involved with a smaller number of cases
- Other resources available in the community who can be involved in case discussions on a case-by-case basis, or who may be attached to a practice or program

> ✓ However a team is defined, members of the team should meet on a regular basis.

Meetings should be kept to a minimum and run efficiently, usually at lunchtimes or before or after clinical hours. While some team members may need to be at every meeting, others may only need to attend periodically, depending on the nature of the initiative and the purpose of the meeting. Reasons for team meetings can be:

- Clinical (to review cases)
- Educational (presentations or problem-based learning)
- Administrative (looking at how the initiative or the team is functioning and whether it is meeting its goals)
- Planning (developing new initiatives or initiative components)

> ✓ It is often helpful for all members of the mental health team (including primary health care providers) to meet briefly at the start of each day to review the individuals coming in that day and discuss each team member's likely involvement in these individuals' care.

Building a team

Every group or team will go through a number of stages as members get to know each other and learn about their respective skills and potential contributions, build a sense of trust and common purpose, establish effective roles and working relationships, and gradually take increasing responsibility for decisions and activities.

Establishing roles and working relationships

In the earliest stages, members of a forming team may be unsure as to their roles, the purpose of the team and how they will work together. The team will need to learn about each other, their roles and the contributions they can make and to develop a sense of common purpose, with individual contributions increasingly being channelled towards common goals. The team will also develop "norms" for social and professional behaviours and a common sense of values that will shape their activities. As the team resolves these issues, it becomes a more effective working unit. Team members become

more comfortable with their working relationships and their relationships with the team as a whole. Increasingly, they share a common purpose and pride in their collective accomplishments and develop a feeling of loyalty to their colleagues and the initiative.

Becoming more autonomous

As a team matures and working relationships strengthen, the team is able to take on greater responsibility for decision making, implementation and self-regulation. In the early stages, individuals will be more dependent on identified leaders, most tasks will be delegated and members may be competing to outperform each other or to gain attention from leaders or supervisors. As the team evolves, members become less competitive and better able to work collaboratively and take on greater responsibility for making and implementing decisions. Leadership and administrative responsibilities are increasingly shared, and all team members will take responsibility for ensuring the team is meeting its goals and functioning effectively.

Maintaining a well-functioning team

It is challenging for any team to maintain their sense of effectiveness and togetherness indefinitely. Attention needs to be paid to maintaining this level of performance and to recognizing and adjusting to challenges the team may face such as the departure of key members, changes in goals, the addition of new members, initiative expansion, emerging interpersonal or interprofessional conflicts or other changes in the external environment. To maintain the highest level of performance and interprofessional collaboration, initiatives need to ensure:

- Maintenance of a shared focus
- Regular re-appraisal of goals
- Regular ongoing communication
- Resolution of difficulties or conflicts as they arise
- Regular meetings where all feel involved
- Recognition of the contributions of all team members
- Acknowledgement of the impact of the arrival and departure of team members
- Appropriate orientation of new team members
- Opportunities for team members to meet socially

Identifying barriers

Barriers to effective team functioning may include:

- Ineffective leadership
- Lack of clarity or disagreement about program goals or priorities
- Poor or inconsistent communication
- Interprofessional differences or different agendas
- Interpersonal conflicts
- Competing organizational priorities

- Different conceptual approaches
- Fear of change
- Reluctance to accept new team members
- Failure to work towards agreed-upon goals or targets
- External factors such as funding cuts, health system inertia or policy changes

Signs of a poorly functioning team

There are many warning signs that a team may not be working well. Such signs need to be identified and addressed as soon as they arise. All team members and organizational managers as well as the leaders of the initiative share this responsibility. Signs that a team is not functioning well may include:

- Members don't have a clear purpose, goals or expectations.
- Team members are unclear about their roles or role boundaries.
- The team is not able to make decisions.
- Disagreements occur at team meetings and are not resolved.
- Team performance drops off for no obvious reasons: Targets are not being met or waiting time for services increases.
- Team members stop attending meetings.
- Leadership is reluctant to allow others to take leadership on projects on behalf of the team.
- Team members are more reluctant to support/assist each other.
- There is increasing dissatisfaction with decisions made by leaders or administrators.
- Small groups develop that have their own agendas and they begin to function autonomously within the initiative.

Tips for team building

Team functioning can be improved if attention is paid to a few simple principles as the team develops.

- Ensure all new team members are well oriented to the initiative and, if necessary, to how primary health care functions. Orientation of new team members should include opportunities to meet on a 1:1 basis with all team members; an explanation of team/project goals and vision, group norms and expectations of the individual; the provision of key documents; and an explanation of contextual factors that might influence a team's performance.
- Recruit individuals who, in addition to their discipline-specific skills, appear to be comfortable and effective when working collaboratively or in teams. [See **Members of the team** section above.]
- Clarify role descriptions, especially where there may be potential overlap between different providers. This needs to be clarified before starting a new initiative or when integrating a new team member, but also needs to be reviewed regularly as initiatives advance to make sure everyone is satisfied with their role and feels they are being used optimally.
- Ensure team members meet together regularly, with a clear agenda for the meetings.
- Make sure each team member has the opportunity to raise issues or concerns either directly with the leadership/administration or, if appropriate, at a team meeting.
- Ensure all team members are involved from the outset in planning for activities in which they will be involved.
- Provide opportunities for team members to get to know each other and find out what each can contribute or is looking for.
- Ensure there is a shared vision. Ideally, all team members will be involved in its development. If there are disagreements, identify and resolve these early on.
- Create opportunities for team members to get together socially, when the focus is not on work-related tasks but on building or enjoying relationships between team members.
- Acknowledge collectively the contributions and accomplishments of all team members.
- Consider a regular (brief) newsletter for all staff, keeping them informed as to what is going on.
- Identify and address potential conflicts between team members as early as possible. These may reflect interpersonal difficulties but are more likely to arise from misunderstandings about roles or scope of practice.

Continuing professional development

Continuing professional development enables providers to keep up to date on clinical and collaborative issues as well as alleviating some of the professional isolation that can be experienced by mental health care providers working on their own. In addition to informal opportunities for providers and consumers to learn from one another, some initiatives will want to organize regular educational or training sessions for primary health care staff and mental health care providers. These may have an external "expert" or "facilitator" but can also be conducted by the primary health care providers themselves. Sessions should be problem based and use case examples provided by the clinicians. Rather than solely relying upon a formal presentation, this should serve as a brief introduction, with every opportunity for case discussion. A list of possible topics to consider, based on successful continuing professional development activities in different settings, may be found in Appendix B. For more information, please see the Canadian Collaborative Mental Health Initiative education toolkit, *Strengthening collaboration through interprofessional education: A resource for collaborative mental health care educators*, available on the CCMHI Web site, www.ccmhi.ca.

Team performance checklist

Initiatives can use the following checklist to assess performance:

Goals

- ❑ There is an agreed-upon vision of where the initiative wishes to be.
- ❑ The goals support the strategic direction/vision of the initiative.
- ❑ The goals are clear, specific and written.
- ❑ Work assignments are clear, with time frames for their completion.
- ❑ There is a process for follow-up to ensure goals are being met.
- ❑ Accomplishments and achievements are celebrated.
- ❑ There is a long-term planning process in place.

Roles

- ❑ The roles of all initiative members are clear.
- ❑ Job descriptions exist for all team members.
- ❑ There is an orientation procedure (and packages) for new team members.
- ❑ There are recruitment criteria when hiring new team members.
- ❑ There is a process for identifying/clarifying role overlap.

Communication

- ❑ Team members are polite, courteous and friendly to each other.
- ❑ Communication is effective during stressful situations.
- ❑ Issues are confronted and problems resolved as they arise.
- ❑ Meetings remain task focused.
- ❑ There is an environment of openness and trust.
- ❑ Leaders/administrators are available and willing to listen.
- ❑ Confidentiality is respected.
- ❑ There is a newsletter for all staff.

Processes for team tasks

- ❑ There is an effective decision-making method.
- ❑ There is an effective problem resolution mechanism in place.

Working together

- ❑ Personal and professional differences amongst team members are valued.
- ❑ Team members demonstrate sensitivity to one another's feelings, problems and needs.
- ❑ Team members have the necessary skills to function effectively.
- ❑ New team members are welcomed.
- ❑ Team members have a sense of mutual trust and willingness to share.
- ❑ The contributions of all team members are acknowledged.
- ❑ Training and skill enhancement are readily available.
- ❑ There are opportunities for staff to meet socially.

Leadership

Leader(s):

- ❑ Are visible and available.
- ❑ Communicate regularly and clearly.
- ❑ Are committed to high-quality, consumer-centred care.
- ❑ Encourage the participation of all team members.
- ❑ Invite feedback on their performance.
- ❑ Provide specific feedback on team members' work.

Organizational structures/meetings

- ❑ Meetings have a clear agenda which is completed during the meeting.
- ❑ Meetings start and finish on time.
- ❑ All team members attend meetings on a regular basis and have an opportunity to participate in the discussion.
- ❑ Decisions made are documented.
- ❑ Educational events occur.

Organizational adjustments to support a collaborative initiative

> *"Things do not change; we change."*
>
> *Henry David Thoreau*

Managing the anticipated changes

The impact of new initiatives may be minimal, but may also have significant implications for team members (including some not involved directly with the initiative) and other services. Implementing a new initiative will always require some organizational adjustments.

- ✓ The planning group needs to ensure that everyone involved, especially those with administrative responsibilities, are aware of the goals and purpose of the initiative and will support these, even if they are not involved on a regular basis.

Traditional approaches may need to be adapted to make them relevant to providers and consumers working together in new ways and in different settings. A new style of practice may mean changing people's traditional roles, working relationships, responsibilities and reporting relationships, and individuals involved with an initiative are likely to embrace change at different rates.

Change is more likely to be accepted when there is:

- A willingness to explore new ideas, perspectives and approaches
- An understanding of the rationale for and benefits of doing things differently
- A strong, ongoing commitment to implement and sustain change
- A plan with clear goals
- An identified leader(s) to guide the project
- Opportunities to take stock of progress made and adjustments required as the project proceeds

In many instances, the challenge of managing change is to "unfreeze" what may be longstanding patterns, behaviours and cultural norms; negotiate a transition to new patterns, behaviours and norms; and integrate these changes into the processes, structures

and culture of an organization or practice. Managing these changes successfully involves five general steps or tasks:

- Analyze the current state of the practice or organization.
- Predict the likely consequences of the proposed changes and take steps to manage them effectively and in a timely manner.
- Ensure the planning and implementation proceeds in a planned and systematic manner.
- Ensure everyone involved is well informed and has an opportunity to participate in all stages of the project.
- Address issues that might affect the change process as they arise.

Analyze the current state of the practice or organization

including:

- Previous experiences with change
- The culture of the organization (norms, values, expectations) and the extent to which these may be (perceived to be) threatened by the new change
- Current organizational structures and processes and changes required to support the new initiative
- External factors that may influence the success of, or be affected by, a new initiative
- The adequacy of resources available to support the project

Predict the likely consequences of change

- Prior to implementing an initiative, discuss with all team members the potential implications both for the initiative as a whole and for their individual activities.
- Predict potential problem areas for both individual team members and the system.
- Predict which individuals might resist the proposed changes and why this might be.
- Predict the impact of changes on work patterns and loads.
- Predict the impact of changes on other services in the community.
- Be sensitive to individual as well as collective issues.

Ensure planning and implementation proceed in a systematic manner

- Ensure there are clear goals and objectives that are shared with all team members who are involved.
- Ensure that the objectives and goals are reviewed at least annually.
- Develop a clear plan for implementation of the initiative, including delineation of responsibilities and timelines.
- Identify a leader/change manager for the project.
- Ensure team members moving into new roles are adequately prepared, trained and supported.
- Develop a communication strategy that is two way, i.e., team members have a chance to contribute to decisions regarding the changes, as well as being informed of decisions made by others.

Involve and inform all team members working in the initiative

- Ensure team members who will be involved with implementing different parts of the initiative, including the evaluation, are fully informed at each stage of its design and implementation.
- Provide opportunities for all staff to review the progress of the initiative at pre-determined points in time.
- Inform all individuals and services who are likely to be affected by the initiative as to what is taking place. Meet with them on a regular basis to review what is happening and any impact it may be having.

Address issues as they arise

- Make changes as required in organizational structures or processes.
- Deal with individuals who might resist these changes on a 1:1 basis.
- Reinforce the reasons for making these changes and the consequences of leaving things as they were.
- Adjust the pace of change if it is taking the organization longer than expected to adjust.
- Clarify new roles.

Preparation of primary health care staff before an initiative begins

All primary health care staff need to be fully informed about the goals and directions of a new initiative and have an opportunity to comment on the design of the initiative or practical issues in its implementation. Issues to be discussed can include:

- Who the mental health care providers are and what roles they will play
- The goals of the initiative
- The limitations of the initiative, i.e., what cannot be done due to resources or time
- How the initiative is going to be monitored
- Space requirements
- Telephone and message-taking requirements
- Meeting expectations
- Sharing office space
- Impact on workloads
- Sharing responsibility for care
- Potential scope of practice - "who does what" – issues

Preparation of mental health care providers for working in a new initiative

Before they begin work, mental health care providers need to be adequately prepared for what they are likely to encounter, such as:

- The role primary health care plays in the health care system
- The pace, demands and sometimes unpredictable nature of primary health care
- The roles of specific primary health care providers

- The most common problems seen in primary health care
- The culture of primary health care, including charting
- Scope of practice issues

New team members should meet with the existing team before the initiative begins to get to know one another and to be clear about the expectations within the relationship and what each individual is looking for from the other. This can be done either in a single meeting or a series of meetings, at which the following should be covered:

- Goals of the new initiative
- Limitations of the new initiative
- Information required when making a referral
- The kinds of cases that may be referred
- How information about shared cases should be exchanged
- The frequency of contact expected
- How brief or lengthy informal discussions during clinical time should be
- Whether family physicians and other primary health care providers wish to be interrupted while seeing a consumer
- The kind of information that needs to be exchanged to make a decision
- How the provider of specialized services will be briefed/prepared by the primary health care provider regarding individuals they are seeing
- What should be done if an unforeseen issue arises
- How and when cases can be handed back to the primary health care provider
- Telephone availability [See **Telephone availability** section below]
- Charting and record-keeping

> ✓ If there is an opportunity, it can be very helpful for staff to visit a similar initiative already underway in order to observe how other clinicians doing similar kinds of work function. They can also discuss with both primary health care and specialized staff ways in which the model can work most effectively and some of the problems that may arise. This provides them with a "real" frame of reference when working in their own setting.

If more than one team member is being hired or starting at the same time, the orientation can be done together. This can also provide an opportunity for team members to begin to understand one another's skills, perspectives and work styles, particularly if they come from different disciplines.

Telephone availability

If providers of specialized services are only available in the primary health care setting for part of the week, it is helpful if they can be available by phone (if needed) in between visits. Calls by primary health care providers do not usually need to be returned

immediately but within the same working day. This offers additional support for primary health care providers when handling complex cases.

- ✓ Be clear about liability issues when providing recommendations or advice over the telephone and document these contacts. The primary health care provider can make a notation in the chart/electronic health record which can be co-signed by the mental health care provider at the next visit.

Problem resolution mechanism

Ensure that there is a clearly detailed and understood mechanism for resolving problems that may arise. It may be a responsibility that is delegated to an individual or the working group, or to an *ad hoc* group that may need to be formed depending upon the nature of the problem.

Ongoing review meetings/reports

It is important to ensure that everyone involved with the initiative is kept updated about its progress and has an opportunity to raise specific concerns they might have or problems they perceive. In many instances, this will be done on an ongoing basis through personal contacts. In addition, it is worth providing brief, periodic written updates on the initiative's progress for all staff and holding a review meeting – either as a separate meeting or as part of another initiative meeting – on an annual basis, or more frequently if problems have developed.

Informing consumers

Inform potential consumers of the new service(s) available using printed pamphlets, letters, posters or a combination of all three. The material should clearly outline the services provided, including specific examples, and how to gain access to these services. The name of the mental health care provider and type of service provided can also be posted on the front entrance or in the reception/waiting area of the primary health care setting.

When they are referred to a mental health care provider, consumers should receive specific information in the form of a one-page flyer or brochure outlining the nature of the service, the referral process, expectations (if any) of the consumer and other relevant background information.

Organizational adjustments checklist

- ❑ Develop a change management strategy.
- ❑ Prepare primary health care providers and staff.
- ❑ Prepare mental health care providers.
- ❑ Negotiate telephone availability.
- ❑ Build in a problem resolution mechanism.
- ❑ Consider organization of meetings and reports.
- ❑ Inform consumers of the new initiative.
- ❑ Prepare a handout describing the new initiative.

Other implementation issues to consider

> *"Everything should be made as simple as possible, but not simpler."*
>
> *Albert Einstein*

Co-ordination

✓ Even for a small initiative, it is important to identify someone to oversee and assist with co-ordination.

The scope of co-ordination will depend on the number of staff involved in the initiative, the number of sites involved and the range of activities being proposed. The co-ordinator will work closely with all members of the mental health team to ensure there is day-to-day or week-to-week monitoring of the initiative and an opportunity to identify and resolve problems as they arise. Costs associated with this role need to be built in from the outset.

Potential roles for a co-ordinator can include:

- Overseeing the implementation of an initiative
- Assisting with resolving practical issues in setting up an initiative
- Ensuring performance indicators/continuous quality improvement methods are in place
- Overseeing completion of the evaluation
- Resolving problems that cannot be resolved by the individuals involved
- Co-ordinating recruitment of staff
- Setting professional standards
- Linking with similar services in the community
- Preparing reports
- Linking with funding sources

In a smaller initiative, responsibility for overseeing the clinical and administrative dimensions could lie with a manager or administrator, another primary health care team member or someone involved with the new initiative. In a larger initiative, or one which bridges a number of primary health care providers working in partnership, or one where a variety of mental health care providers are working in a single larger primary health care setting, it may be necessary to identify and fund a co-ordinator's position even though the responsibilities may take a minimal amount of time per week. This

administrative role could be taken on by someone within the primary health care setting or be contracted out to an external body such as a community mental health service. In this instance, clarify the reporting relationship of the co-ordinator to the initiative and the management team.

Physical location and scheduling issues

In many instances, particularly with smaller initiatives, it may be possible to use existing office space at the primary health care provider's location with little additional cost. All involved will need to be flexible to free up space for 1-2 half-days per week when the specialized service provider is in the primary health care setting.

If the mental health care provider is going to be in the primary health care setting more than 2 days a week, they will probably need dedicated space; this can be shared with other team members if the scheduling does not conflict. If space is not available within the primary health care setting, additional space (close by, if possible) may need to be rented, although this is a less desirable option. An alternative arrangement is for a number of primary health care providers to get together to identify a single, convenient shared location. This may be unused existing space or a new space which is rented, with each provider that will be using the service contributing to the cost.

Other issues to consider include space for meetings with families or groups, possible increased utilization of the waiting room area, and the need for extended hours to accommodate consumers' and mental health care providers' schedules.

Working in different locations

For initiatives that involve primary health care providers based in different locations, specialized staff may find themselves working in more than one location during their work week. In some instances, there may be some distance (more than 15 minutes of travel time) between locations. To make this work as efficiently as possible:

- Consider increasing the length of a visit but decreasing the frequency, i.e., 1 day every 2 weeks rather than half a day per week.
- Group locations so that the specialized service provider can be working in the same area on the same day.
- If a number of primary health care providers are located in a single building, try to find a central location convenient to all locations, rather than moving from one primary health care provider to another every half-day. The electronic health record will be available in this location and it is usually easy for the specialized service provider to walk to the appropriate primary health care provider to discuss a case or issue.

Documentation

Referral process

The referral process needs to be kept as simple and informal as possible, although some paperwork may be necessary for record-keeping. There are many advantages to all referrals to the mental health team going through the primary health care provider (usually the family physician) so that they are kept informed of the process.

The referral form should include the following information:

- Source of referral
- Basic demographic information
- Reason(s) for referral
- Major presenting problems
- Current medications

See Appendix B for a sample referral form.

Charting

Ideally, all charting, whether by primary health care providers or mental health care providers, should be in the same clinical record. In many instances, this will be an electronic health record. Mental health notes can also be integrated within a paper chart, either as part of the continuing health record or as a separate section at the front or back of a chart. Using differently coloured paper (e.g., yellow) can make these notes easier to find.

✓ Charting should be succinct. There is no need to summarize history that is already available either in other summary notes in the chart or in the primary health care provider's record. Forms or templates can also be adapted from those being used by other established initiatives to assist with charting.

Treatment Plan

The most important part of the consultation or mental health note is the treatment plan. This should include:

- Practical "how-to-do-it" advice
- Instructions that are easy to follow and relevant to primary health care
- Recommendations specific to the individual or family in question
- Contingencies in case the initial plan does not work
- A clear definition of the respective roles of the specialized service provider, primary health care provider, consumer and others involved

Privacy and confidentiality of records

In Canada, federal and provincial/territorial legislation govern the collection, use and disclosure of personal information held by government agencies. Generally, individuals have the right to gain access to and correct personal information held by government and other sectors. Some provinces have passed legislation to deal specifically with the collection, use and disclosure of personal health information by health care providers and other health care organizations. It is important to ensure that confidentiality is maintained, and that consumers are made aware of, and consent to, any collection, use and disclosure of information, in accordance with provincial/territorial confidentiality requirements.

> ✓ All mental health notes compiled in primary health care should be treated as if they were compiled in a psychiatric facility. They should not be released without an authorized release of information in accordance with that province's or territory's Mental Health Act and privacy legislation.

If notes are requested by a third party without there being a formal release in the chart, the person requesting the information should be informed either that such a release is required or that the notes being sent do not include the mental health notes.

Requests for information

Specialized staff working in primary health care are likely to receive frequent and numerous requests for information. These include:

- Insurance forms
- Insurance letters
- Disability forms
- Disability letters
- Legal letters
- Letters to support an individual's participation in community activities
- Other forms

Many of these will involve the mental health care provider working as an advocate for individuals who have been denied benefits or entitlements. In these instances, the mental health care provider should submit more than just a cursory note, however time consuming this may be. There is often a lot of weight attached to mental health or psychiatric reports; they can have a significant bearing on the outcome of an appeal or review, and on an individual's financial and emotional well-being.

> ✓ When completing requests for information, be aware of and follow all relevant privacy and confidentiality legislation and policies.

Ethics requirements

Each initiative should review the ethics, privacy and confidentiality requirements in all the disciplines that will be involved with the collaboration. Everyone involved should also be aware of any specific guidelines that are available (provincially) regarding the collection, transmittal and sharing of any consumer information.

If there is any likelihood that the data being gathered by the initiative may be used for publication, seek approval by a Research and Ethics Board (REB). If the data are being gathered solely for internal continuous quality improvement purposes, REB approval is not usually essential (this may vary by province) but can be helpful.

Implementation checklist

- ❑ Identify initiative co-ordinator.
- ❑ Identify and address location issues.
- ❑ Consider how and where charting should take place.
- ❑ Determine expectations for the content of consultation and follow-up notes.
- ❑ Ensure guidelines are in place for releasing notes prepared by mental health care providers.
- ❑ Determine whether REB approval is required.

Evaluation

> *"Facts are stubborn things, but statistics are more pliable."*
> *Mark Twain*

Evaluation options

To evaluate the effectiveness of the new initiative and to ensure that it is meeting the needs of consumers and providers, it requires an evaluation component, which should be built in from the beginning. The information collected in an evaluation may be required for funding purposes and to ensure that services delivered and time spent are meeting expectations.

The major ways of monitoring what is taking place will include some or all of the following:

- Logs of clinician activity and performance indicators (see Appendix B)
- Forms to gather data routinely at the time of referral, assessment or completion of treatment (see Appendix B)
- Outcome measures to assess a consumer's progress
- Satisfaction questionnaires completed by service providers and staff
- Satisfaction questionnaires completed by consumers/families (see Appendix B)
- Regular meetings of all involved to review how the initiative is going and to look at any adjustments that may need to be made
- Meetings with consumers to determine their satisfaction with the services being provided and suggestions for improvements
- A formal review at a predetermined time to assess whether the goals of the initiative are being achieved
- Measuring changes in services being utilized in the initiative or in other settings
- Measuring changes in the costs of delivering services

Performance indicators

The performance indicators to be monitored will vary from one initiative to another but can include:

- The number of people being referred to the service
- The characteristics of people being referred/seen
- The major reasons for referral
- Time from referral to individual being seen
- The outcomes of treatment including
  - Symptom reduction
  - Changes in functioning

- Changes in service utilization within the initiative or in the community
- Utilization of other services both during and after treatment
- Provider satisfaction with the new initiative
- Consumer/family satisfaction with the new initiative
- Utilization of other services both during and after treatment
- Specific services delivered. These will vary from initiative to initiative but can include:
  - Individual assessments or consultations
  - Individual treatment
  - Different kinds of therapies
  - Couple or family therapy
  - Group treatment
  - Time spent on the telephone
  - Time spent discussing cases and with whom

The Continuous Enhancement of Quality Measurement in Primary Mental Health Care: Closing the Implementation Loop project is developing a series of tools to support improvement in primary mental health care services. For more information, please see their Web site at: http://www.mheccu.ubc.ca/ceqm/index.cfm.

✓ If possible, gather baseline (pre-initiative) data on current services being delivered, utilization of other services, satisfaction with current services or outcomes for a 2- to 3-month period before the new initiative is implemented. This will provide essential comparative data when evaluating the impact of the new initiative.

Tips for an effective evaluation

An effective evaluation should:

- Be brief
- Be easy to complete
- Use check boxes rather than text fields as much as possible
- Involve those who will be filling in the forms in their design and in discussions about practical obstacles to implementation
- Fit into the flow of primary health care, i.e., it is easier to ask a consumer to arrive 5 to 10 minutes early for a scheduled appointment and complete a form while they are waiting to be seen than at the end of the visit when they may be rushing off
- Only collect information that will be used by the initiative, i.e., it is better to begin with a smaller database and expand it once the questions to answer are identified than to start with a larger database and find that most of the fields are not being completed, or the data are not being analyzed or utilized
- Be easy to analyze, i.e., use the existing electronic health record or a program like Access or Excel
- Be reviewed and, if necessary, adjusted on an annual basis

✓ Talk to other programs that have developed similar evaluation strategies or analyses. You can learn from their experience and possibly utilize materials/software already developed. Using similar fields/analyses as other initiatives allows a comparison to be made.

Consumer evaluation of the initiative

Consumers can evaluate different aspects of the initiative through telephone surveys, written surveys, focus groups or personal interviews. Written surveys, distributed in person or by mail, tend to be the most cost-effective and reliable option. An initiative may choose to create its own questionnaire or use one that has been tested, validated and benchmarked. Some evaluation materials are in the public domain; others are available for purchase.

You may wish to collect some basic consumer demographic data or decide that the evaluation should be anonymous. Questionnaires for consumers should:

- Be brief
- Be specific
- Use clear and unambiguous wording
- Be easy to understand
- Use a consistent scale or check boxes to answer most questions

- Provide an opportunity for narrative comments with some open-ended questions or blank space

See Appendix B for a sample consumer evaluation.

Identifying key ingredients of success

Use the data you collect to assess the key factors and strategies that have contributed to the findings (positive and negative) of your evaluation. This can be used in a number of ways.

It can be used for continuous quality improvement, recognizing both what is working well and any obstacles or challenges faced and strategies to address them. It should provide evidence for changes that need to be made to the system of care or in the way individual providers practice.

It can inform a report to the sponsoring organization or funding body, not only to justify the continuation of a project, but to support requests for additional funding to maintain or expand the initiative. It can also provide guidance to individuals in other communities who are interested in establishing similar initiatives.

Key findings and implications should also be reported back to all providers working in an initiative. Implications of these findings should be discussed and achievements and accomplishments celebrated. This also provides an opportunity to review the goals and objectives of the initiative and re-define priorities.

A summary of the successes of a new initiative can also help raise the profile of the initiative among providers, consumers and the community.

Evaluation checklist

- ❑ Identify the reasons for the evaluation.
- ❑ Base evaluation on initiative goals.
- ❑ Collect baseline data, if possible.
- ❑ Ensure that the data collected will be utilized.
- ❑ Involve everyone responsible for planning and implementing the initiative in the design of the evaluation.

Links with the community

Linking with the community will help:

- Ensure that your initiative reflects community needs and priorities
- Monitor the impact your initiative is having on community services
- Problem-solve issues of flow and capacity in the system overall

Establishing links with the community

Establishing links or partnerships with the community is an essential ingredient of comprehensive primary health care. It enables individuals to reach services they require and involves community partners in activities within the primary care setting. Every initiative should ensure that it is aware of local community services and organizations and how they might link with them. Such links can provide:

- Opinions and suggestions about gaps, needs, impact and capacity-building when planning an initiative
- A partnership to develop a joint initiative, especially if this can avoid duplication of services
- Information about specific resources in the local community
- Expedited access to community programs
- The integration of selected community programs within the primary care setting

When working with community services:

- Consider inviting representatives of community services to sit on the planning and implementation team.
- Ensure that the initiative will build on existing community strengths and resources and help fill gaps in service.
- Consider linking with local initiatives that may have similar goals.
- Consider the possible impact of the new initiative on these services, such as changes in referral patterns or flow between services.

Exchanging information with community services

- As you approach the implementation phase, provide community services with a description of your initiative, the services you will be offering and the proposed start date via mail, e-mail, personal meeting or telephone contact.
- Distribute information about your initiative and services offered to community programs on a regular basis.
- Ensure that staff of your initiative receive updates about community resources regularly.

- Meet with staff of community agencies to inform them of the progress of the new initiative and to elicit their views on the impact of the initiative.
- Clearly define the process for referral to and discharge from community services and ensure that providers have appropriate referral forms.
- Link with resources within the community that provide support services to families and consumers, e.g., an information and resource centre to support families and consumers to utilize self-help and community-based services could be jointly created.

Integrating community services within primary care settings

Consider inviting staff from a community program to your initiative to assist consumers address a specific issue. This could be:

- A worker from a provincial benefits programs who could visit monthly to help consumers complete intake/application/assessment forms
- A case manager from a community nursing program who could visit primary care monthly to discuss cases being managed jointly
- Staff seconded from a community rehabilitation program or other specialized service who would visit primary care regularly to discuss specific problems or assess individuals who may benefit from the services of that agency
- A representative of a community program who could provide information on specific services their agency offered

Self-management

Self-management is an important component of care and should complement services offered by health care providers. Self-management encourages consumers to actively participate as partners in making decisions about their health care and treatment plans, and to take responsibility for following through with agreed-upon recommendations. There are a number of ways this can be fostered in clinical relationships but the most important is the ability to see the consumer as a partner in their own care, able to share in decision-making.

Self-management can be supported by:

- Providing information and resources in an easy-to-understand and easy-to-use format, and reviewing these materials with the consumer and their family to ensure they understand the information and their management options and to answer any questions they may have
- Listening to the consumer and identifying their goals and concerns
- Working with the consumer to set treatment goals and a strategy to implement them
- Developing a specific care plan that the consumer carries with them, and which will be reviewed and updated at subsequent visits
- Offering the opportunity for peer support from individuals who have experienced/overcome the same or a similar problem
- Involving different team members who may be able to assist with different parts of the management plan
- A provider who is well prepared for each visit and for the expectations of the consumer
- Including lifestyle changes, e.g., changes in diet, exercise, sleep regimens, etc., as a complement to other treatments being offered

Involving the consumer as an active participant in their own care requires more than just providing them with information about their problems and treatments and setting collaborative goals. It is important to ensure that the consumer is familiar with the ways that care may be delivered, who may be responsible for different aspects of their care, how referral processes work and what to do if they can't reach someone they need to talk to, or if calls are not being returned.

A consumer who feels empowered and encouraged to inquire about what is happening with his/her care plan is key to the concept of self-management. To promote this, it can be helpful to provide the consumer with copies of consultation or other notes that they can keep for their own information and bring to any future appointments. These issues are covered in the CCMHI toolkit *Working together towards recovery: Consumers, families, caregivers and providers*, available at www.ccmhi.ca.

Collaborative initiatives to consider in primary health care settings

Mental health promotion

- Development of resource library in primary health care
- Web-based educational materials
- Programs to change lifestyle
- Bibliotherapy
- Educational materials available in public places
- Use of the electronic health record to identify individuals at risk of developing a specific problem

Early detection

- Use of screening instruments
- Use of screening questions
- Identification of individuals at risk of developing a specific problem

Treatment and management

- Assessments and consultations
- Brief, focused therapies, e.g., cognitive-behavioural therapy (CBT), solution-focused therapy, interpersonal therapy
- Ongoing supportive therapy
- Couple and family therapy
- Care navigation
- Case co-ordination
- Telephone treatment
- Routine monitoring after completion of treatment
- Peer support
- Groups
  - Psychoeducational
  - Support
  - Cognitive-behavioural therapy
  - Skill building
  - Parenting

Monitoring care

- Rosters of individuals at risk
- Routine follow-up after treatment
- Booster sessions where an individual is seen routinely a specific number of months after treatment

Rehabilitation

- Ongoing case management
- Care navigation
- Access to resources with specific expertise in employment, meaningful activity, housing and recreation programs

Education sessions

- Regular interdisciplinary case reviews
- Regular interdisciplinary educational presentations
- Web-based education
- Telephone "mentoring" or back-up to the primary health care provider
- Incorporation of evidence-based guidelines into primary health care linked with the community
- Periodic visits by community agencies to the primary health care centre to assist with specific problems
- Developing easy access to community resources for consumers

Other opportunities for collaboration

In addition to integrating mental health services in primary health care settings, there are many other ways in which mental health and primary health care services can work collaboratively. Examples include:

Improving access

Making intake procedures user friendly

Developing easy-to-use referral forms containing essential information only. These can be faxed to a program by the primary health care provider.

Consultation visits by mental health care providers in the primary health care provider's office

Occasional, one-time assessments, where the mental health care provider visits the primary health care setting and meets with the consumer, often with the family physician in attendance, for part of the visit.

Consultation to the waiting list

Consultation by a community mental health care provider while an individual is waiting for treatment. Treatment recommendations would be relayed to the family physician, who could contact the mental health care provider for further guidance, if needed. The individual would remain on the waiting list.

Telephone back-up

Mental health care providers make themselves available to respond to telephone calls from primary health care providers, either on a one-to-one basis, i.e., mental health care providers linked with a particular practice or group, or on a roster basis where the mental health care provider is available a predetermined number of times a week.

Planning

Involvement in planning initiatives

One or more primary health care representatives participate in mental health planning initiatives, whether at a program, hospital or community level. Similarly, mental health care providers become involved in planning taking place in the primary health care sector.

Discharge planning/transfer of care

Discharge information

Preparing speedy and useful discharge summaries which focus on the treatment plan and contingencies. The treatment plan should be detailed and in point form, giving exact dosages or sequences of changes that are easy to follow. It should also detail the respective roles expected of the mental health care provider, primary health care provider and consumer in continuing care over the ensuing months, and a plan in case of relapse or if the care plan is not working well.

Discharge visits to primary health care settings
The last visit with a consumer being seen by a mental health care provider can take place in the primary health care setting, rather than the mental health provider's setting. In this way, everyone involved with long-term care of that individual knows what the plan is and what their respective roles and responsibilities are likely to be.

Educational activities

Organizing a series of educational seminars
A mental health service can organize a regular series of educational sessions, usually at lunchtime or at the end of the day, that can be held at the mental health service or a central convenient location. Topics should focus on the management of mental health problems that are commonly encountered in primary health care; for a list of suggestions, please see Appendix B.

Organizing joint educational rounds
These can involve either staff from hospital departments of primary health care and mental health care or learners from either program. Topics relevant to both sectors can be identified, e.g., recent advances in the management of depression, changes in child welfare legislation, implications of changes in privacy legislation and confidentiality, evidence regarding the use of new medications. The major goal is to create a forum where providers from different sectors can meet, exchange ideas, get to know each other and learn about a range of approaches to the management of common mental health problems.

Education sessions in the primary health care setting
Mental health care providers visit the primary health care setting periodically to provide educational sessions – ideally case-based – to primary health care providers.

Developing information sheets
Mental health services can prepare one-page sheets with practical information on a specific problem, treatment, medication or information for the consumer. These can be sent to local primary health care providers or even attached to discharge summaries.

Community resources

Preparing a guidebook of local resources
Consider preparing a guide to local community resources which could be made available to primary health care providers. The guide can describe programs and services of particular interest to primary health care providers and provide practical information on how to effectively navigate the mental health system. In its simplest form, the guidebook can include a listing of key services in a problem-based approach (i.e., listing services by their function (counselling and related services, support and self-help groups, emergency services and crisis lines, out-patient mental health services), rather than the name of the agency). It can also be more elaborate, providing details such as intake procedures/contacts, exclusion criteria and specific services delivered.

Integrating primary care services in mental health programs

Many individuals with mental illnesses don't have access to a primary care physician, and this often leads to inadequate treatment of their physical health problems. One way of addressing this is to integrate a primary health care provider – often an advanced practice nurse (APN) – into a mental health setting. In these models, the advanced practice nurse will be present in the mental health setting on a regular basis, the exact amount of time depending upon the number of consumers using that setting and the funding support that is available.

The APN will provide first contact primary health care as well as being able to develop screening or health promotion programs. Ideally, the APN will be backed up by a local family physician or group of physicians who are willing to either visit the mental health setting every 1-2 weeks to see individuals who don't have a family physician or to see those mental health consumers in their own office.

After completing their assessment, the APN will select one of the following four options: complete treatment themselves; suggest the individual visit their family physician (if they have one), contacting the family physician directly to expedite the referral; ask the linked physician to see the individual at their next visit; or, if the problem seems more urgent, suggest the individual visit an emergency clinic.

If a mental health program is located in close proximity to, or even in the same building as, a primary care practice, it may be possible to negotiate an arrangement whereby that practice will see mental health consumers who don't have their own family physician.

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Appendix A: Key elements and fundamentals of collaborative mental health care

Key elements

Collaborative mental health care is characterized by four key elements:

- Accessibility
- Collaborative structures and systems
- Richness of collaboration
- Consumer centredness

Accessibility

One of the goals of collaborative mental health care is to increase access to mental health services by providing these services in primary health care settings. This may involve providing services directly (where the individual is seen) or indirectly (case reviews), formally or informally, as well as innovative strategies such as telemedicine.

It is important to identify and, where possible, minimize or eliminate potential barriers to access, particularly for populations that have traditionally been underserved or have higher needs for both primary and mental health care. Barriers may include:

- Lack of resources (human resources, funding, time, interest, the right tools)
- Limited knowledge and skills
- Stigma and discrimination associated with mental health problems
- Language and culture
- Geography

To increase access, specialized service providers will collaborate on the care of any referral, providing advice and/or seeing the individual for treatment, as requested. Specialized service providers are also available to provide ongoing advice and support to the primary health care provider or assist with other aspects of case management such as referral to a community agency. The primary health care provider remains involved in an individual's care while they are being seen by the specialized service provider.

Collaborative structures and systems

Organizational structures provide the framework for the ways in which people agree to work together, either formally (service agreements, collaborative networks) or informally (verbal agreements). Systems provide the framework for accomplishing many key functions of collaborative mental health care such as referral and consultation, information technology and evaluation.

Effectively working together as a team is key to the success of collaborative mental health care. Building a well-functioning team takes time, as team members with different backgrounds and perspectives combine their skills, knowledge and abilities to achieve common goals. A well-functioning team has the following characteristics:

- Clear and regular communication

- Mutual trust, respect and understanding
- Shared sense of purpose and commitment to achieving goals
- Mutual support
- Clearly understood roles and responsibilities
- Shared decision making and accountability
- Mechanism and strategy for conflict management
- Effective leadership
- Recognition and appreciation of contributions of all team members

Richness of collaboration

A central feature of effective collaborative mental health care is the richness of collaboration among primary and mental health care providers, consumers and community. Professionals from a wide range of disciplines including nurses, social workers, dietitians, psychologists, pharmacists, family physicians, psychiatrists, occupational therapists and peer support workers; consumers and their families; and community agencies and organizations may all be involved in different aspects of planning, providing and monitoring care.

Different providers, consumers and community services have a wide range of skills, knowledge, expertise and experience. Combining these can improve the quality of care, increase the range of services offered and create opportunities for more comprehensive care across the life span. Clearly defined, co-ordinated and complementary roles, responsibilities and activities of providers, consumers and community are integral to successful collaborative mental health care. Effective collaboration is supported by clear and regular communication and ongoing knowledge exchange through educational events and materials.

Consumer centredness

For the purposes of this document, a consumer refers to a person with significant direct experience with the mental health system, a person with a significant mental health problem and/or a person who is likely to benefit from the initiative being planned.

Meeting the needs of consumers and their families/caregivers is at the core of collaborative mental health care. Consumer centredness includes not only consumers (and, where appropriate, members of their family or support network) being involved in all aspects of their care, from treatment choices to self-management, but also their involvement in program development and evaluation, and in the development of peer support programs.

Consumer involvement is built upon mutual respect and empowering the consumer to take responsibility for decisions that may affect his/her well-being. When involving consumers:

- Negotiate types of involvement that will be acceptable to everyone.

- Involve consumers from the outset and at every stage of the initiative, whenever possible.
- Support the ability of consumers to make decisions that positively affect their health.
- Clearly identify financial and other resources at the outset. Consumers should be reimbursed for expenses incurred and time, if other team members are compensated.
- Reduce stigma and dispel stereotypes associated with mental illness that hinder and/or negatively impact full consumer participation.
- Avoid tokenism. Consumer participation should be about working in true partnership to achieve better outcomes, not "doing to" or "for" consumers.

The Canadian Collaborative Mental Health Initiative (CCMHI) has published a toolkit for consumers/families/caregivers entitled *Working together towards recovery: Consumers, families, caregivers and providers*. The toolkit contains information about consumer involvement, what different providers can bring to a collaborative team, recovery and self-management, complementary therapies, culturally competent care, and a host of print and electronic resources. The complete toolkit is available on the CCMHI Web site, www.ccmhi.ca.

Fundamentals

The success and ease of implementation of collaborative mental health care will be determined, in part, by four fundamentals:

- Congruent policies, legislation and funding regulations
- Sufficient funds
- Expanding the evidence base
- Community needs

Congruent policies, legislation and funding regulations

Policies and regulations which are co-ordinated at all levels will facilitate the implementation of collaborative mental health care, reduce fragmentation of services and minimize gaps and overlaps in service. This is particularly important at a time of primary health and mental health care reform. Policies and regulations must also address issues related to remuneration, scope of practice and liability.

Sufficient funds

Adequate and sustained funding needs to be made available. Strategies need to be developed to address issues of reimbursement for time spent co-ordinating care, communicating with team members and providing more comprehensive care.

Expanding the evidence base

Collaborative mental health care should be evidence based and reflective of best/better practices. Health Canada (1998) defines best practices as "activities and programs that are in keeping with the best possible evidence about what works." To date, there is only limited evidence as to the optimal models of delivering specialized services in primary health care or of how to adapt projects that have been conducted under "research"

conditions to the "real world" of primary health care. There is also insufficient evidence to date regarding which services can be delivered more efficiently or effectively in the primary health care sector and which can be delivered more effectively in the secondary or tertiary care sectors.

Two Canadian Collaborative Mental Health Initiative documents are relevant to expanding the evidence base: a comprehensive annotated bibliography of research publications (2000 - 2004) related to the integration of mental health and primary health care (Pautler and Gagné, 2005) and *Better Practices for collaborative mental health care in primary health care: An analysis of the evidence base* (Craven and Bland, 2006). Both are available on the CCMHI Web site, www.ccmhi.ca.

The lack of current evidence highlights the importance of evaluating new initiatives as they are established. Even descriptions of the design of successful initiatives and the key ingredients of their success can be important stepping stones to further investigative initiatives as well as assisting practitioners interested in setting up similar initiatives.

Community needs

A community is a specific group of people who share a common culture, and common values, interests, experiences or needs. Community can refer to a wide range of services and programs including other health and mental health services, social services, advocacy and support groups and community development projects. These can be partners in an initiative or a resource able to provide services to individuals, sometimes bringing these services into the primary health care setting.

Collaborative mental health care is based upon and responsive to the needs and resources of individual communities.

Differences between models of collaborative mental health care

	Co-location model (Services located in same building or clinic, but not linked administratively)	**Consultation-liaison model** (Mental health care providers visit the primary care setting on a regular basis)	**Integrated model** (Mental health care providers are permanently attached to a primary care setting)
Location	In or adjacent to primary care	In primary care setting	In primary care setting
Time in location	Varies	Visits periodically	Permanently attached
Team involvement	Providers work independently; may have intermittent contact	Involved with team when on site	Part of team
Referrals	Formal referral process	Referrals triaged by primary care	More flexible and inclusive referral process
Criteria for accepting cases	May have their own exclusion criteria	Limited because of time availability; primary care must prioritize	Anyone primary care requests assistance with
Activities	Comprehensive range of services to consumers who are accepted	Case discussion	Comprehensive range of services
Liaison	May or may not occur	Central to the model	Central to the model
Support for primary care providers	Not built in	By telephone	On-site
Funding	Usually just from mental health sources	Can be funded by mental health or primary care sources	Can be funded by mental health or primary care sources

Appendix B: Tools and resources

I. Sample needs assessment

This assessment is directed at primary care providers to assess current mental health resources, satisfaction with current services, gaps in existing services and interest in collaborative activities. Depending on the information to be collected, needs assessments could also include participation on the part of consumers, community groups, mental health care providers and allied health professionals.

1. Can you rate the extent to which the following present problems to you when handling individuals with mental health problems in your practice?

(1 = no problem, 7 = severe problem)

Access to consultation from a psychiatrist	1	2	3	4	5	6	7
Receiving discharge information in a timely manner from mental health facilities	1	2	3	4	5	6	7
Opportunities to discuss cases with a psychiatrist	1	2	3	4	5	6	7
Opportunities to discuss cases with a mental health counsellor (social worker, nurse, or psychologist)	1	2	3	4	5	6	7
Access to (or waiting time for) treatment for individuals requiring psychotherapy	1	2	3	4	5	6	7
Access to (or waiting time for) services for couple and family therapy	1	2	3	4	5	6	7
Access to (or waiting time for) services for children with mental health problems	1	2	3	4	5	6	7
Access to (or waiting time for) services for individuals with depression or anxiety	1	2	3	4	5	6	7
Access to (or waiting time for) case management services	1	2	3	4	5	6	7
Access to (or waiting time for) other community programs such as housing, employment or financial support	1	2	3	4	5	6	7
Opportunities to attend continuing educational activities on mental health topics	1	2	3	4	5	6	7
Access to current treatment guidelines for mental health problems	1	2	3	4	5	6	7
Access to emergency psychiatric assessments for adults	1	2	3	4	5	6	7
Access to emergency psychiatric assessments for children and adolescents	1	2	3	4	5	6	7
Access to inpatient general hospital beds for individuals with acute mental health problems	1	2	3	4	5	6	7
The intake systems of local mental health services	1	2	3	4	5	6	7
Communication with local mental health services	1	2	3	4	5	6	7
Involvement of primary care providers in discharge planning by local mental health services	1	2	3	4	5	6	7
Availability of information on local services	1	2	3	4	5	6	7
Timeliness of sending consultation or other reports	1	2	3	4	5	6	7
Receiving regular updates on an individual's progress from mental health services	1	2	3	4	5	6	7

2. Can you rate your interest in participating in any of the following activities?

(1 = not interested, 7= very interested)

A psychiatrist visiting your office for consultation	1	2	3	4	5	6	7
A psychiatrist visiting your office to discuss/review cases	1	2	3	4	5	6	7
A listing of local psychiatrists accepting cases	1	2	3	4	5	6	7
A listing of local mental health services and their intake criteria	1	2	3	4	5	6	7
A mental health counsellor based in your office	1	2	3	4	5	6	7
Regular CE activities on mental health topics	1	2	3	4	5	6	7
Access to Web-based information through a single portal	1	2	3	4	5	6	7
Telephone advice from a psychiatrist	1	2	3	4	5	6	7
Receiving references on relevant mental health topics on a regular basis	1	2	3	4	5	6	7
An outpatient clinician accompanying a consumer to your office for their final visit.	1	2	3	4	5	6	7
E-mail consultation from a psychiatrist	1	2	3	4	5	6	7
Joint rounds between mental health and primary care providers	1	2	3	4	5	6	7
A standardized intake form used by all mental health services	1	2	3	4	5	6	7
Half-day workshops on topics of interest	1	2	3	4	5	6	7

II. Sample budget – Items to consider

Account number	Item	Start-up year annualized	Monthly
	Human resources	$	$
	1) In primary care Mental health care providers Psychiatrist fees Administrative costs for the practice		
	2) Program co-ordination Program director Program co-ordinator Database/evaluation co-ordinator Data entry clerk Administrative support		
	Operational Expenses	$	$
	Education and training (staff) Educational materials (consumers) Equipment lease Evaluation supplies Internet access Legal/audit fees Maintenance contracts Office supplies Other expenses Postage Printing and photocopying Rent and utilities Telephone and long distance Travel		
	One-time start-up costs	$	$
	Advertising and recruitment expenses Capital equipment purchases Location expenses (building, moving, renovating) Meetings and travel expenses Stipends for planners and participants		

III. Questions to consider when interviewing a potential mental health care provider

Clinical skills, knowledge and interpersonal qualities

What role do primary care providers play in managing mental health problems?

How would you describe the role of a (state discipline) in primary care?

What previous experiences have you had that equip you to work in primary care?

How do you think your role will differ from working in a traditional mental health service?

What personal qualities do you think a (state discipline) in primary care may require?

What do you think are the most common problems you will see in the primary care setting?

If you begin to develop a waiting list, what strategies could you utilize to increase patient access to care?

Are you familiar with community resources and the mental health system in this community?

What does the term self-management mean to you?

What is consumer-centred care?

Training

Have you had formal training in any of the following? If so, please describe the training.

Interpersonal therapy	☐	_____
Cognitive-behaviour therapy	☐	_____
Problem-solving therapy	☐	_____
Brief solution-focused therapy	☐	_____
Marital/couple therapy	☐	_____
Family therapy	☐	_____
Dialectical behaviour therapy	☐	_____
Group treatment	☐	_____
Clinical behaviour science courses	☐	_____

Scenarios
How would you handle the following scenarios?

1. During an interview, a person tells you they are suicidal.
2. The family doctor asks you to see an older, slightly confused woman who lives alone but is reluctant to come to the office.
3. You need to discuss a problem with the family physician, but s/he tells you s/he is too busy to discuss the case with you and suggests you do whatever you think best.

Skills and comfort (on a scale of 1 to 10)
1. How would you rate your **level of experience** assessing and treating individuals with the following problems? (Choose whichever problems, e.g., depression, anxiety disorders, substance use disorders, psychosis, Axis II personality disorders, etc., may be applicable.)
2. How would you rate your **comfort** in assessing and treating individuals with the following problems? (Choose whichever problems may be applicable.)
3. How would you rate your **level of experience** assessing and treating the following populations? (Choose whichever populations, e.g., children and adolescents, seniors, urban marginalized individuals, ethnocultural populations, couples, etc., are applicable.)
4. How would you rate your **comfort** assessing and treating the following populations? (Choose whichever populations are applicable.)

IV. Possible continuing professional development topics

This list is based on topics covered over a 5-year period in one problem-based learning group.

Principles for managing anxiety disorders
Social anxiety
Generalized Anxiety Disorder
Post-Traumatic Stress Disorder
Panic disorders
Somatization Disorder

Psychopharmacology overview
Use of new mood stabilizers
Use of novel neuroleptics

Bipolar and related disorders
Major Depressive Disorder
Managing treatment-resistant mood disorders

Addictions (identification, assessment, treatment, follow-up)
Alcohol use and dependency
Management of substance use disorders in primary care
Managing substance abuse

Managing children and adolescents with multiple behaviour problems
Depression in adolescents
Teen suicide
ADHD in children and adolescents
Educational resources for adolescents

Women's reproductive health and women's mental health
Perimenopause and premenstrual symptoms

Management of chronic pain
Eating disorders
Managing sleep problems
Attention deficit in adults

Solution-focused brief therapy
Grief/bereavement counselling

Strategies for working with couples in primary care
Strategies for working with families in primary care
Managing sexual problems in primary care

Assessing and treating cognitive impairment in the elderly

Privacy, confidentiality and competency issues
Changes to mental health legislation

Vocational issues for individuals with mental illnesses

Completing insurance and disability forms

Managing chronic diseases in primary care

V. Clinical log

This activity sheet was developed by the Hamilton HSO Mental Health & Nutrition Program for use by mental health counsellors.

Mental Health Program – Counsellor Activity Sheet Page____ of____

Instructions: 1. Please print clearly 2. See reverse for codes & explanations 3. Complete time spent in MINUTES.
4. To be completed and MAILED to the program on a Weekly basis.

Practice

Counsellor (Use surname only)

Time Period

Date(s) Away

Counsellor's Signature:

Physician/ Manager :

	DD	MM	YYYY	MHR#	Code	Minutes spent
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
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20.						
21.						
22.						
23.						
24.						

White copy to program Yellow copy to counsellor ©H HSO MHP Revised: April 2003

Activity Codes

Activity Sheet Guidelines

The following codes require an MHR #, date and number of minutes spent in that activity.

01	Crisis Intervention
02	Assessment: Individual
02d	Assessment: Couple
02e	Assessment: Family
02A	Co-Assessment / Therapy: with Family Physician
02B	Co-Assessment / Therapy: with FP & Psychiatrist
02C	Co-Assessment / Therapy: with Psychiatrist
02G	Co-Assessment / Therapy: with Other (formerly code 2D)
03A	Therapy: Individual
03B	Therapy: Couple
03C	Therapy: Family
04	Patient / Family Education
13	Referral to / Clinical Discussion with another service / agency
22	Discharge Planning Meetings with in/out patient facilities (includes travel)
23	Home visit (includes travel)
NS1	No Show One - Code all patients who have not arrived for the first scheduled appointment. If the first appointment is rescheduled and the patient continues to not arrive, proceed to code as NS1 (as long as there is no face to face contact).
NSO	No Show Other - Code all patients who fail to arrive for scheduled appointments without notification, after they have been seen at least once.
C1	Cancellation One - Code all patients who have called to cancel the first scheduled appointment. If the first appointment is rescheduled and the patient calls to cancel, proceed to code as C1 (as long as there is no face to face contact).
CO	Cancellation Other - Code all patients who have called to cancel scheduled appointments, after they have been seen at least once.

The following codes do NOT require an MHR #. Report weekly the number of minutes spent in that activity.

05A	Group Facilitation
05B	All other group activity (preparation, screening, evaluation)
06	Phone contact with patient or family: Therapeutic
08	Other Clinical Service
09A	Chart Review / clinical charting / progress notes
09B	HSO Evaluation Forms (clinical forms, activity sheets, scoring outcome measures)
09C	Administrative phone contact and patient appointments
10A	Case Discussion / verbal update
10E	Advice to family physician re: non-referred patient
14A	Central Program Educational Event (only time billed to HSO)
14B	Office Administration (including practice staff meetings, filing, photocopying, correspondence and requests)
15	Personal Education (only time billed to HSO)
17	Central Program Administrative Meetings (includes Counsellors' Meetings)
24	Peer Supervision / case discussion with peers (this is part of alloted personal education time.)

Revised: April 2003

VI. Mental health referral form

This referral form was developed by the Hamilton HSO Mental Health & Nutrition Program to initiate referrals by family physicians, other health care providers or consumers to mental health care providers (mental health counsellors or psychiatrists).

Mental Health Referral Form

MHR#

Patient

Instructions: **1**.Use Ink & press firmly. **2**. Use an X to indicate your choice(s).

DOB DD MM YYYY HIN

Physician Gender M F

Referral Date DD MM YYYY Previously Referred Yes No Patient's Phone

Referral Initiated By: Family Physician | Other Primary Care Provider | Family | Other Mental Health Service | Agency | Patient

Referral To: HSO Counsellor | HSO Psychiatrist | HSO Group

Instructions: **1**. **X** the appropriate box(es) relevant to this episode of care.
2. Place an **X** on the line next to the **Problem Most Responsible for this Referral**

Psychiatric Symptoms

- Depressed Mood
- Elevated Mood
- Fluctuating Mood (Mood Swings)
- Suicidal Thoughts/ Actions/ Behaviour
- Obsessive Thoughts
- Compulsive Behaviour
- Phobia(s)
- Panic Symptoms or Attacks
- Social Anxiety
- Other Anxiety Symptoms
- Flashbacks/Other Post-Traumatic Stress Symptoms
- Excessive Somatic Symptoms
- Sleep Disturbance
- Delusions
- Paranoia
- Hallucinations
- Disorganized Thought Processes
- Memory Impairment/Concentration
- Confusion
- Attention Deficit/Hyperactivity
- Personality Problems
- Unusual Behaviour
- Alcohol Abuse in Self
- Other Substance Abuse in Self
- Gambling
- Abnormal Eating Behaviours
- Learning Disability
- Developmental Delay (MR)

Psychosocial Issues

- Marital/Common-Law /Partner Problem
- Separation/Divorce
- Other Relationship Issues
- Sexual Problem
- Self Esteem
- Anger/Temper Control
- Bereavement
- Parenting Issues
- Child Behaviour Problem
- Other Family Problems
- Illness in Family Member
- Burden of Caring for Another
- Menopause - Related Issues
- Pre-Menstrual Symptoms
- Pregnancy-Related Issues
- Alcohol Abuse in Family Member
- Past Alcohol Abuse in Self
- Past Substance Abuse in Self
- Lack of Social Supports/Social Isolation
- Physical/Sexual Abuse During Childhood
- Past Physical/Sexual Abuse (Victim)
- Current Physical/Sexual Abuse (Partner)
- Emotional/Verbal Abuse
- Other Current Abuse
- School Problems
- Work Problems
- Motor Vehicle Accident Issues
- Accommodation
- Unemployment
- Financial Issues
- Legal Issues
- Other Stressful Events
- Insurance Form/Letter to be Prepared
- Legal Letter/Report to be Prepared
- WSIB Issue
- Needs Instrumental Assistance

Medical / Physical Issues

- Chronic Pain
- Medication Side Effects
- Physical Symptoms Other Than Chronic Pain
- Significant Medical/Physical Illness
- Difficulty Coping with Physical Illness

Interventions Requested

- Assessment
- Urgent Assessment/Crisis Management
- Clarification/Confirmation of Diagnosis
- Individual Counselling/Therapy
- Marital/Couple Counselling
- Family Counselling
- Group Program

Advice Regarding :

- Management
- Medication
- Individual Counselling/Therapy
- Risk to Self/Others
- Community Resources
- Family/Marital Problem
- Medico-Legal Issues
- Education re: Illness/Treatment

Current Psychotropic Medication / General Comment

White copy to chart Yellow copy to program © H HSO MHP Revised: Nov. 2002

VII. Assessment and intervention plan

This form was developed by the Hamilton HSO Mental Health & Nutrition Program for use by mental health cousellors.

Assessment and Intervention Plan

MHR# ____

Patient ____

Instructions: **1**.Use Ink & press firmly. **2**. Use an X to indicate your choice(s).

DOB ____ DD ____ MM ____ YYYY HIN ____ Gender ☐ M ☐ F

Date of First Appointment ____ DD ____ MM ____ YYYY Date of First Visit ____ DD ____ MM ____ YYYY

Instructions: 1. **X** the appropriate box(es) relevant to this episode of care.
2 . Place an **X** on the line next to the **Problem Most Responsible for this Referral**

Psychiatric Symptoms

- ☐ Depressed Mood __
- ☐ Elevated Mood __
- ☐ Fluctuating Mood (Mood Swings) __
- ☐ Suicidal Thoughts/ Actions/ Behaviour __
- ☐ Obsessive Thoughts __
- ☐ Compulsive Behaviour __
- ☐ Phobia(s) __
- ☐ Panic Symptoms or Attacks __
- ☐ Social Anxiety __
- ☐ Other Anxiety Symptoms __
- ☐ Flashbacks/Other Post-Traumatic Stress Symptoms __
- ☐ Excessive Somatic Symptoms __
- ☐ Sleep Disturbance __
- ☐ Delusions __
- ☐ Paranoia __
- ☐ Hallucinations __
- ☐ Disorganized Thought Processes __
- ☐ Memory Impairment/Concentration __
- ☐ Confusion __
- ☐ Attention Deficit/Hyperactivity __
- ☐ Personality Problems __
- ☐ Unusual Behaviour __
- ☐ Alcohol Abuse in Self __
- ☐ Other Substance Abuse in Self __
- ☐ Gambling __
- ☐ Abnormal Eating Behaviours __
- ☐ Learning Disability __
- ☐ Developmental Delay (MR) __

Psychosocial Issues

- ☐ Marital/Common-Law /Partner Problem __
- ☐ Separation/Divorce __
- ☐ Other Relationship Issues __
- ☐ Sexual Problem __
- ☐ Self Esteem __
- ☐ Anger/Temper Control __
- ☐ Bereavement __
- ☐ Parenting Issues __
- ☐ Child Behaviour Problem __
- ☐ Other Family Problems __
- ☐ Illness in Family Member __
- ☐ Burden of Caring for Another __
- ☐ Menopause - Related Issues __
- ☐ Pre-Menstrual Symptoms __
- ☐ Pregnancy-Related Issues __
- ☐ Alcohol Abuse in Family Member __
- ☐ Past Alcohol Abuse in Self __
- ☐ Past Substance Abuse in Self __
- ☐ Lack of Social Supports/Social Isolation __
- ☐ Physical/Sexual Abuse During Childhood __
- ☐ Past Physical/Sexual Abuse (Victim) __
- ☐ Current Physical/Sexual Abuse (Partner) __
- ☐ Emotional/Verbal Abuse __
- ☐ Other Current Abuse __
- ☐ School Problems __
- ☐ Work Problems __
- ☐ Motor Vehicle Accident Issues __
- ☐ Accommodation __
- ☐ Unemployment __
- ☐ Financial Issues __
- ☐ Legal Issues __
- ☐ Other Stressful Events __
- ☐ Insurance Form/Letter to be Prepared __
- ☐ Legal Letter/Report to be Prepared __
- ☐ WSIB Issue __
- ☐ Needs Instrumental Assistance __

Medical / Physical Issues

- ☐ Chronic Pain __
- ☐ Medication Side Effects __
- ☐ Physical Symptoms Other Than Chronic Pain __
- ☐ Significant Medical/Physical Illness __ ____________
- ☐ Difficulty Coping with Physical Illness __

Clinical Impression

____

Treatment Plan (X all that apply)

- ☐ Assessment and Recommendations
- ☐ Supportive Therapy
- ☐ CBT
- ☐ IPT/Problem-Solving Therapy
- ☐ Psychodynamic Therapy
- ☐ Bereavement Counselling
- ☐ Other Individual Counselling
- ☐ Client Education
- ☐ Marital/Couple Counselling
- ☐ Family Counselling
- ☐ Parenting Skills
- ☐ Referral to HSO Psychiatrist
- ☐ Referral to HSO Group
- ☐ Referral to Community Program
- ☐ Referral to Community/School Counsellor or EAP
- ☐ Referral to Outpatient Psychiatry
- ☐ **CASE CLOSED**

____ (Please print name)

____ DD ____ MM ____ YYYY
Date Completed

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VIII. Treatment outcome

This form was developed by the Hamilton HSO Mental Health & Nutrition Program for use by mental health cousellors at the end of an episode of care.

Treatment Outcome

MHR# |_|_|_|_|_|

Patient ______________________

Instructions: **1**.Use Ink & press firmly. **2**. Use an X to indicate your choice(s).

DOB |_|_| DD |_|_| MM |_|_|_|_| YYYY HIN |_|_|_|_|_|_|_|_|_|_| |_|_|

Total number of visits for this Episode of care |_|_|_| (includes all visits relating to this patient's episode of care)

Date of last Scheduled Appointment |_|_| DD |_|_| MM |_|_|_|_| YYYY

Instructions: **1**. **X** the appropriate box(es) relevant to this episode of care.

Patient Not Seen

☐ Patient did not follow through
☐ Patient no longer requires service
☐ Patient sought help elsewhere

During this episode of care which of the following took place? (Please X all that apply)

☐ Assessment & Recommendations
☐ Supportive Therapy
☐ CBT
☐ IPT/Problem-Solving Therapy
☐ Psychodynamic Therapy
☐ Bereavement Counselling
☐ Other Individual Counselling/Therapy
☐ Client Education
☐ Marital/Couple Counselling
☐ Family Counselling
☐ Parenting skills
☐ Other Management Strategies
☐ Seen by HSO Psychiatrist
☐ Seen by Community Counsellor, School Counsellor or EAP
☐ Seen in Crisis/EPT/COAST
☐ Referral to HSO Group
☐ Referral to Other Group (Non-HSO)
☐ Referral to Community Program
☐ Referral to Outpatient Psychiatry
☐ Patient Dropped Out of Therapy/Did Not Complete
☐ Psychiatric Inpatient Admission

Disposition of Patient after Treatment Completed (Please X all that apply)

☐ FP to continue Counselling/Support for this problem
☐ Referral to Community Mental Health Program
☐ Ongoing care being provided by Community Counsellor / School Counsellor or EAP
☐ New Referral to Community Counsellor / School Counsellor or EAP
☐ Unknown
☐ Referral to other Community Program
☐ HSO Psychiatrist to see
☐ HSO Group
☐ No further treatment required
☐ Moved/Changed FP

Clinical Impression

|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

|_|_|_|_|_|_|_|_|_|_|_|_|
(Please print name)

|_|_| DD |_|_| MM |_|_|_|_| YYYY
Date Completed

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IX. Psychiatric consultation form

This form was developed by the Hamilton HSO Mental Health & Nutrition Program for use by psychiatrists.

Psychiatric Consultation Form

MHR# _____ 1 of 2

Patient _____ Instructions: **1**.Use Ink & press firmly. **2**. Use an X to indicate your choice(s).

DOB ___ ___ (DD) ___ ___ (MM) ___ ___ ___ ___ (YYYY) HIN _____ _____ Gender ☐ M ☐ F

Family Physician _____ Psychiatrist _____

Patient Currently Seeing HSO Counsellor ☐ Yes ☐ No

Has Patient Previously Been Seen by Non HSO Mental Health Service/Psychiatrist ☐ Yes ☐ No

Date of Consultation ___ ___ (DD) ___ ___ (MM) ___ ___ ___ ___ (YYYY)

Referral Initiated By: ☐ Family Physician ☐ Other Primary Care Provider ☐ Family ☐ Patient ☐ HSO Counsellor ☐ Other Mental Heath Service ☐ Agency

Was Patient discharged in the last 6 months? ☐ Out-Patient Psychiatric Service ☐ In-Patient Psychiatric Service ☐ EPT

Reason for Consultation (X all that apply)

☐ Clarification/Confirmation of Diagnosis ☐ Legal or Insurance Assessment/Documentation

Advice Regarding :

☐ Management ☐ Risk to Self/Others ☐ Family/Marital Problems ☐ Medication ☐ Community Resources ☐ Psychotherapy

Instructions: **1**. **X** the appropriate box(es) relevant to this episode of care.
2. Place an **X** on the line next to the **Problem Most Responsible for this Referral**

Psychiatric Symptoms

☐ Depressed Mood ☐ Elevated Mood ☐ Fluctuating Mood (Mood Swings) ☐ Suicidal Thoughts/ Actions/ Behaviour ☐ Obsessive Thoughts ☐ Compulsive Behaviour ☐ Phobia(s) ☐ Panic Symptoms or Attacks ☐ Social Anxiety ☐ Other Anxiety Symptoms

☐ Flashbacks/Other Post-Traumatic Stress Symptoms ☐ Excessive Somatic Symptoms ☐ Sleep Disturbance ☐ Delusions ☐ Paranoia ☐ Hallucinations ☐ Disorganized Thought Processes ☐ Memory Impairment/Concentration ☐ Confusion ☐ Attention Deficit/Hyperactivity

☐ Personality Problems ☐ Unusual Behaviour ☐ Alcohol Abuse in Self ☐ Other Substance Abuse in Self ☐ Gambling ☐ Abnormal Eating Behaviours ☐ Learning Disability ☐ Developmental Delay (MR)

Psychosocial Issues

☐ Marital/Common-Law /Partner Problem ☐ Separation/Divorce ☐ Other Relationship Issues ☐ Sexual Problem ☐ Self Esteem ☐ Anger/Temper Control ☐ Bereavement ☐ Parenting Issues ☐ Child Behaviour Problem ☐ Other Family Problems ☐ Illness in Family Member ☐ Burden of Caring for Another

☐ Menopause - Related Issues ☐ Pre-Menstrual Symptoms ☐ Pregnancy-Related Issues ☐ Alcohol Abuse in Family Member ☐ Past Alcohol Abuse in Self ☐ Past Substance Abuse in Self ☐ Lack of Social Supports/Social Isolation ☐ Physical/Sexual Abuse During Childhood ☐ Past Physical/Sexual Abuse (Victim) ☐ Current Physical/Sexual Abuse (Partner) ☐ Emotional/Verbal Abuse ☐ Other Current Abuse

☐ School Problems ☐ Work Problems ☐ Motor Vehicle Accident Issues ☐ Accommodation ☐ Unemployment ☐ Financial Issues ☐ Legal Issues ☐ Other Stressful Events ☐ Insurance Form/Letter to be Prepared ☐ Legal Letter/Report to be Prepared ☐ WSIB Issue ☐ Needs Instrumental Assistance

Medical / Physical Issues

☐ Chronic Pain ☐ Medication Side Effects ☐ Physical Symptoms Other Than Chronic Pain ☐ Significant Medical/Physical Illness _____ ☐ Difficulty Coping with Physical Illness

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Psychiatric Consultation Form

MHR# ☐☐☐☐☐ 2 of 2

Have you at any point discussed this problem with: ☐ Family Physician ☐ HSO Counsellor ☐ Other

Were any of the following present at interview ? ☐ Family Physician ☐ HSO Counsellor ☐ Learner / Student ☐ Family Member(s) ☐ Agency Staff

Was a medico-legal or insurance form completed? ☐ Yes ☐ No

List up to three DSM IV Diagnoses:

1. _____ ☐ new ☐ recurrent

2. _____ ☐ new ☐ recurrent

3. _____ ☐ new ☐ recurrent

Global Assessment of Functioning

☐☐

Refer to scale on back.
Write Score in box

RECOMMENDATIONS (X all that apply)

Medication
- ☐ Initiate or change medication
- ☐ Recommended medication(s) remain unchanged
- ☐ No recommendations made

Management
- ☐ Supportive Therapy
- ☐ IPT/Problem-Solving Therapy
- ☐ Parenting Skills
- ☐ Psychodynamic Therapy
- ☐ Other Individual Counselling/Therapy
- ☐ Bereavement Counselling
- ☐ Client Education
- ☐ Other Management Strategies
- ☐ Marital/Couple Counselling
- ☐ Family Counselling
- ☐ CBT

Follow up with ☐ Psychiatrist ☐ Family Physician ☐ HSO Counsellor

Referral to
- ☐ HSO Counsellor
- ☐ HSO Group
- ☐ Outpatient Psychiatry (group)
- ☐ Outpatient Psychiatry (excluding group)
- ☐ Community Counsellor, School Counsellor or EAP
- ☐ Community Program
- ☐ Medical Specialist

Time spent on this visit (in minutes) ☐☐☐ Direct ☐☐☐ Indirect & Charting

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X. Psychiatric follow up form

This form was developed by the Hamilton HSO Mental Health & Nutrition Program for use by psychiatrists.

Psychiatric Follow Up Form

MHR# | | | | |

Patient | | Instructions: **1**.Use Ink & press firmly. **2**. Use an X to indicate your choice(s).

DOB | | (DD) | | (MM) | | | | (YYYY) HIN | | | | | | | | | | | | Gender ☐ M ☐ F

Family Physician | | | | | | | | | | | | Psychiatrist | | | | | | | |

Date of follow up visit | | (DD) | | (MM) | | | | (YYYY) Patient Currently Seeing HSO Counsellor ☐ Yes ☐ No

Was follow up planned? ☐ Yes ☐ No

Reason for follow up visit (X all that apply)

- ☐ Completing initial assessment
- ☐ Monitoring of clinical status/response to treatment
- ☐ Clinical status deteriorating
- ☐ Clinical status not improving as expected
- ☐ Supervening crisis
- ☐ Need for family/partner involvement
- ☐ Possible adverse effect of medication or drug interaction
- ☐ Legal or insurance assessment/documentation

Were any of the following present at the session? ☐ Family Physician ☐ HSO Counsellor ☐ Learner/Student ☐ Family Member(s) ☐ Agency Staff

Was a medico-legal or insurance form completed ☐ Yes ☐ No

Clinical Status: ☐ no change ☐ improved ☐ deteriorated

Global Assessment of Functioning

Refer to scale on back.
Write Score in box

RECOMMENDATIONS (X all that apply)

Medication
- ☐ Initiate or change medication
- ☐ Medication(s) unchanged
- ☐ No recommendations made

Management
- ☐ Supportive Therapy
- ☐ IPT/Problem-Solving Therapy
- ☐ Parenting Skills
- ☐ Psychodynamic Therapy
- ☐ Other Individual Counselling/Therapy
- ☐ Bereavement Counselling
- ☐ Client Education
- ☐ Other Management Strategies
- ☐ Marital/Couple Counselling
- ☐ Family Counselling
- ☐ CBT

Follow up with ☐ Psychiatrist ☐ Family Physician ☐ HSO Counsellor

Referral to
- ☐ HSO Counsellor
- ☐ HSO Group
- ☐ Outpatient Psychiatry (excluding group)
- ☐ Outpatient Psychiatry (group)
- ☐ Community Counsellor, School Counsellor or EAP
- ☐ Community Program
- ☐ Medical Specialist

Time spent on this visit (in minutes) | | Direct | | | Indirect & Charting

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XI. Professional fee invoice

This form was developed by the Hamilton HSO Mental Health & Nutrition Program for use by psychiatrists.

HAMILTON HSO MENTAL HEALTH PROGRAM
PROFESSIONAL FEE INVOICE

PSYCHIATRIST NAME: _____ MONTH: _____ PRACTICE: _____
(Please Print) (ONE FORM PER PRACTICE PLEASE)

	Week 1		Week 2		Week 3		Week 4		Week 5		Total # of Patients	Total # of Min
	#	Min	#	Min	#	Min	#	Min	#	Min		
Direct Clinical Service Consultations												
Follow Ups												
Number of No Shows/Cancellations												
Case Discussion With Family Physician and/or Counsellor												
Telephone Advice												
Charting, Paperwork, Letters, Correspondence												
Administrative Meetings												
Education With Family Physician and/or Counsellor												
Education With Clinical Clerks / Residents												
Continuing Medical Education												

PLEASE NOTE: 1 Session = 3.5 hrs

TOTAL MINUTES	
TOTAL # OF SESSIONS	

Please return to:

Program Use Only
Total $ _____
Dept. # _____
Account # _____

Signature: _____

ONE FORM PER MONTH

White and Canary - Program Manager Pink - Program Evaluation Goldenrod - Psychiatrist's File ©H HSO MHP Revised: Apr 2005

XII. Sample consumer evaluation

The questionnaire below is adapted from the Visit Satisfaction Questionnaire (Rubin et al, 1993).

Visit satisfaction questionnaire

Here are some questions about **the visit that you just made**. In terms of your satisfaction, how would you rate each of the following?

	Excellent	Very good	Good	Fair	Poor
How **long** you waited to get this appointment.	1	2	3	4	5
Convenience of the **location** of the office.	1	2	3	4	5
Getting through to the office by phone.	1	2	3	4	5
Length of time waiting **at the office** for this appointment.	1	2	3	4	5
Time spent **with the person you saw.**	1	2	3	4	5
Explanation of what was done for you.	1	2	3	4	5
The **technical skills** (thoroughness, carefulness, competence) of the person you saw.	1	2	3	4	5
The **personal manner** (courtesy, respect, sensitivity, friendliness) of the person you saw.	1	2	3	4	5
This visit **overall**.	1	2	3	4	5
Being seen for mental health care **in your family physician's office**.	1	2	3	4	5
Your **major concerns being addressed** during this visit.	1	2	3	4	5

If you would like to make any comments, please write them on the back of this form. Thank you for your assistance.

Appendix C: Glossary of terms

Best practices – Activities and programs that are in keeping with the best possible evidence about what works [Interchangeable with 'Better Practices', 'Positive Practices' and 'Good Practices'] (Health Canada, 1998).

Chronic disease management (CDM) - A systematic approach to improving health care for people with chronic disease that emphasizes helping individuals maintain independence and keep as healthy as possible through prevention, early detection and management of chronic conditions (British Columbia, Ministry of Health Services, 2004).

Collaborative primary health care - The delivery of services at the first point of contact with the health system by two or more different stakeholders (health professionals, consumers, families, primary health care organizations, community agencies) working together in a partnership that is characterized by:

- Common goals or purpose
- A common language
- A recognition of and respect for respective strengths and differences
- Equitable and effective decision-making
- Clear and regular communication

in order to:

- Improve access to a comprehensive range of services (treatment, health promotion, disease and injury prevention, management of chronic diseases and self-help), delivered by the most appropriate provider in the most suitable location
- Deliver high-quality and effective health care
- Make the most efficient use of resources
- Improve outcomes for the consumer

Determinants of health - Factors in an individual's living and working environment that can affect their health (e.g. housing, education, income, employment, culture, physical environment, equity).

Health promotion – The process of enabling people to increase control over and to improve their health (WHO, 1986).

Interdisciplinary – A range of collaborative activities undertaken by a team of two or more individuals from varying disciplines applying the methods and approaches of their respective disciplines.

Mental health promotion - The process of enhancing the capacity of individuals and communities to take control over their lives and improve their mental health (Health Canada, 1998).

Mental health specialist **–** An individual with mental health expertise, be it related to health promotion, prevention, diagnosis, treatment or rehabilitation.

Prevention – Interventions that target risk factors for specific illnesses in order to prevent the initial occurrence of a disease, arrest or retard an existing disease and its effects, or reduce the occurrence of relapses.

Primary health care - An individual's first contact with the health system characterized by a spectrum of comprehensive, co-ordinated and continuous health care services such as health promotion, diagnosis, treatment and chronic disease management.

Primary mental health care – Mental health services provided in a primary health care setting. Settings where primary health care can be delivered include the offices of health care providers, community clinics, workplaces, schools, homes, health care institutions, homes for the aged, nursing homes, correctional facilities and day care centres**.** Primary mental health care may also be available by telephone, health information services and the Internet.

Recovery – A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness (Anthony, 1993).

Toolkit Series

This toolkit belongs to a series of twelve toolkits.

Implementation toolkits for providers and planners

1. Collaboration between mental health and primary care services. A planning and implementation toolkit for health care providers and planners

A series of companion documents to the CCMHI planning and implementation toolkit for health care providers and planners. Establishing collaborative initiatives between mental health and primary care services for:

2. Aboriginal peoples
3. Children and adolescents
4. Ethnocultural populations
5. Individuals with serious mental illness
6. Individuals with substance use disorders
7. Rural and isolated populations
8. Seniors
9. Urban marginalized populations

Toolkits for consumers, families and caregivers

10. Working together towards recovery: Consumers, families, caregivers, and providers.
11. Pathways to healing: A mental health guide for First Nations people

A toolkit for educators

12. Strengthening collaboration through interprofessional education: A resource for collaborative mental health care educators

A series of documents examining aspects of collaborative mental health care support these toolkits:

1. Barriers and strategies
2. A framework
3. Annotated bibliography
4. Better practices
5. Canadian initiatives
6. A policy review
7. International initiatives [unpublished]
8. Health human resources
9. Mental health prevalence and utilization
10. Interprofessional education
11. Aboriginal mental health [unpublished]
12. The state of collaborative mental health care

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