Canadian Collaborative Mental Health Initiative

Initiative canadienne de collaboration en santé mentale

Establishing collaborative initiatives between mental health and primary care services for *individuals with serious mental illness*

A companion to the CCMHI planning and implementation toolkit for health care providers and planners

PROVIDERS AND PLANNERS

INDIVIDUALS WITH SERIOUS MENTAL ILLNESS EXPERT PANEL

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A Toolkit

February 2006

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.

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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 htt://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.

Executive summary

Introduction

Much has already been accomplished, through the work of consumer advocates, family organizations and mental health organizations, in re-defining issues relevant to people with serious mental illness (SMI). Historically, this population has often been stigmatized and dehumanized. By contrast, it is now assumed that consumers with SMI will be supported to attain and maintain normal roles within the context of living with a serious illness and that services will be organized and delivered to support these roles. The emphasis is on citizenship, empowerment, community integration and recovery.

The purpose of this toolkit is to assist service providers and other key stakeholders to work collaboratively to meet the mental health needs of individuals with SMI. Highlights of the toolkit include: a list of recommended articles; descriptions of four positive practice initiatives; key websites, tools and resources; and 10 key issues for consideration when planning and implementing an initiative.

Defining the population

Serious mental illness is the presence of a mental health problem that is serious enough to significantly disable a person across a number of social and functional domains and that requires significant system resources to enable the person to set and achieve fulfilling life goals and successful community integration. This toolkit is focused on people with SMI such as schizophrenia and bipolar affective disorder and two other groups that have been identified as meeting the criteria for this population: individuals with borderline personality disorder and aging individuals with psychotic disorders.

Consultation process

An Expert Panel was established and prepared a draft document which was reviewed by a consumer advisory committee, consumer, family members and a range of providers. In addition, a focus group with consumers was held, and 12 shared/collaborative care programs providing services to this population were consulted.

Key issues for consideration

- In developing collaborative projects, **providers need to have a conceptual framework** for understanding what is needed to support people with SMI to live fully and successfully in their community. This framework needs to situate the consumer at the centre of care, promote consumer recovery and integrate not only medical/ psychiatric care but linkage with other providers, e.g., housing, income, education.
- The **recovery paradigm** assumes that people with SMI are citizens with rights and responsibilities, and services should be organized to support full community integration.

- **Key challenges** include accessibility, working with individuals with addiction/substance use disorders and/or personality disorders, communication between providers, language/cultural issues, poverty/homelessness, physical health comorbidity, complexity of needs and engagement with services.
- **Consumer involvement in the design of programs** is fundamental to ensuring that their needs are met (e.g., input about where they are comfortable receiving services and what kinds of services they have had difficulty obtaining).
- **Relationship-building amongst the wide range of providers** who can support the individual is key.
- **Both process and outcome evaluations need to be considered**.
- **The literature describes four approaches** to improving physical and mental health care for people with SMI:
  - Shifting the locus of mental health care into the primary care setting
  - Providing primary care within a mental health setting
  - Providing a fully integrated continuum of mental health and primary care within the same organization and/or location
  - Increasing the connections between mental health and primary care providers where such services jointly have responsibility for individual consumers
- **Local conditions have helped shape existing models**, e.g., factors such as the availability of resources, desire to collaborate and capacity of organizations with a commitment to working with people with SMI.
- **Unique functions of successful collaborative models** for people with SMI include self-management support, advocacy, rapid access, case management/system navigation; outreach/engagement, individualized care/treatment plan, concurrent disorders capable (i.e. ability to screen, assess and treat concurrent substance use problems) and rehabilitation supports (such as housing, vocational and educational).
- **Examples of collaborative initiatives** include:
  - Specific clinics and physicians designated to provide primary care to people with SMI within a large mental health system
  - Nursing-based primary care centres within a large rehabilitation-focused mental health centre
  - A multidisciplinary mental health team providing services within a primary care setting
- **Key elements** in building a collaborative service for people with SMI include:
  - Common vision and clearly articulated 'shared' goals for collaboration
  - Involvement of all partners as equals in the collaboration

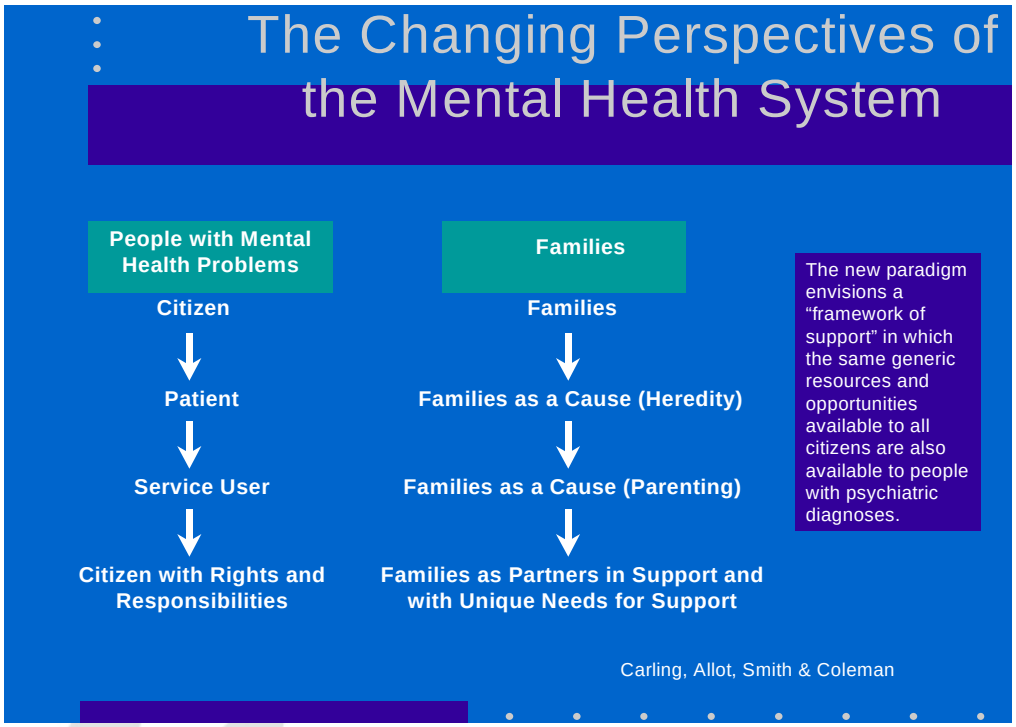
- Mutual respect for the roles of each provider and the consumer
- Strong linkages to hospital programs
- Clear memoranda of understanding/agreement
- Clear roles and responsibilities of team members
- Ensuring staff have strong commitment to, and experience working with, people with SMI
- Clear protocols for sharing information

These elements should be in place prior to any delivery of services.

Introduction

Much has already been accomplished, through the work of consumer advocates, family organizations and mental health organizations, in re-defining issues relevant to people with SMI. Historically, this population has often been stigmatized and dehumanized. By contrast, it is now assumed that consumers with SMI will be supported to attain and maintain normal roles within the context of living with a serious illness and that services will be organized and delivered to support these roles. The emphasis is on citizenship, empowerment, community integration and recovery. This evolution in the mental health system is summarized below in Figure 1 (Carling, 1995).

Figure 1: The Changing Perspectives of the Mental Health System



As the system and its values have changed over time, there has been considerable focus on the way in which services are delivered. This process of mental health reform has involved significant consultation with a range of stakeholders in developing policies and approaches across a number of jurisdictions, including the local, provincial and federal levels. This work is recognized and used as the basis of this toolkit's approach.

Defining the population

Serious mental illness is **the presence of a mental health problem** that is serious enough to **significantly disable a person across a number of social and functional domains** and

that requires significant system resources to enable the individual to set and achieve fulfilling life goals and successful community integration. The diagnoses may include a full range of Axis I and II disorders, recognizing that severity rather than diagnosis is more predictive of the need for long-term supports.

Functional domains include family, friends, work, education, housing, activities of daily living, recreation and other meaningful activities. System resources include hospital or community mental health services, social services and income supports, and may also include programs for the homeless and those who are in conflict with the law.

This toolkit is focused on people with SMI such as schizophrenia and bipolar affective disorder and two other groups that have been identified as meeting the criteria for this population: individuals with borderline personality disorder and aging individuals with psychotic disorders.

Lessons from the literature

For additional information on lessons from the literature consult two CCMHI reports available at www.ccmhi.ca:

- *Annotated bibliography of collaborative mental health care*
- *Better practices in collaborative mental health care: An analysis of the evidence base*

There are high rates of co-morbid medical conditions amongst the SMI population and concern that these conditions are not being detected or addressed in terms of prevention or treatment (Lester et al, 2004). For example, for individuals with schizophrenia, the rate of diabetes is much higher than the general population (6.2-8.7% compared with 1.1%) and risk of cardiac death is double to triple that of the general population. The risk of diabetes, and hence cardiovascular disease, is particularly increased by some of the new atypical antipsychotic drugs (Lean & Pajonk, 2003). Treatment may be challenging: patients with psychoses have difficulties with diet and lifestyle interventions for diabetes and weight management, and withdrawal from antipsychotic medication will often be inappropriate if hyperglycemia develops (Lean & Pajonk). Seventy-eight percent of people with SMI are smokers (Crews et al, 1998). The mortality rate amongst the homeless mentally ill is quadruple that of the general population (Crews et al).

In working with people with SMI, particular attention should be paid to the high rates of concurrent mental health and substance abuse problems. Canadian literature reports rates of concurrent disorder of 56% amongst people with bipolar affective disorder and 47% amongst people with schizophrenia (Skinner et al, 2004). Health Canada reports a lifetime prevalence for concurrent disorders of 40-60% amongst people with SMI. The risk for alcohol problems is triple the population risk and for drug use is five times the population risk. People with concurrent disorders have poorer outcomes with high rates of suicide, self-harm, homelessness, involvement with the criminal justice system, family problems, child abuse and neglect, difficulty with daily living and role performance, and increased risk for HIV/AIDS.

People with personality traits that impact on their care are estimated to comprise 20-30% of the primary care population. One study found a rate of 6.4% for those with a diagnosable personality disorder (Gross et al, 2002). The same study also documented high rates of suicidal behaviour (21.4%) and psychiatric symptoms (71.4%) and rates of completed suicide of 3-9.5%. People with personality disorders who have comorbid medical conditions have poorer health outcomes (Ward, 2004). People with personality disorders seen in primary care also have higher rates of concurrent disorders (Norton, 2000).

There is a relative paucity of literature about SMI in older adults. For example, only 1% of the literature on schizophrenia is relevant to the aging population. The move to reform

mental health care and to de-institutionalize those with longstanding illness presents communities with the challenge of meeting the needs of people with complex mental health issues who also have significant physical health issues. This population is at higher risk for premature death (Cohen et al, 2000). Issues of types of medication used and drug combinations are significant in this population (Bartels et al, 2002).

The literature also reports that providing care to people with SMI requires particular attitudes on the part of care providers (Burns & Kendrick, 1997a; Lester, Glasby et al, 2004; Toews et al, 1996).

Identified needs of this population include:

- Regular monitoring of physical health
- Ability of providers to distinguish symptoms as physically or mentally based (which often requires regular contact over time)
- Specific programs for diabetes management, dyslipidemia management, weight management, nutrition counselling, physical activation and smoking cessation
- Regular medication review and adjustments
- Assistance with medication adherence and management of side effects
- Assistance with social and occupational functioning
- Assistance with activities of daily living
- Substance abuse intervention
- Education to enable providers to work collaboratively with one another

Serious mental illness and primary care

There is evidence that people with SMI are more likely to be in contact with their family doctor than with their psychiatrist (Keks et al, 1998; Meadows et al, 2001). In addition, this population has higher rates of primary care visits than the general population (eight vs. three annually) (Burns & Kendrick, 1997a). There is also evidence that people with SMI believe that primary care is useful and usually do not question physician advice; there is little evidence to suggest that consumers are unwilling or reluctant to engage with the medical system (Levinson et al, 2003). This suggests that, although people with SMI are more likely than the general population to use emergency and urgent care (Crews et al, 1998), if services are provided in primary care in a manner that meets consumers' needs, they will utilize them.

There is discussion about the degree to which the complex needs of people with more enduring and disabling illness may be met within a primary care setting. In part, the issue is one of demand. The literature suggests that family physicians may serve between one and six patients with SMI, though in areas where there is a specialized psychiatric facility, the number of patients is higher. Family physicians practicing in urban areas are also more likely to have more patients with SMI (Craven & Bland, 2002). The low rates of people with SMI seen in primary care makes it more likely that family physicians will

look for support to assist in managing their care or that, over a particular geographic area, some practices will take on a more specialized role in serving this population.

Collaborative models and initiatives

The literature describes four approaches to integrating physical and mental health care:

- Shifting the locus of mental health care into a primary care setting
- Providing primary care within a mental health setting
- Providing a fully integrated continuum of mental health and primary care within the same organization and/or location
- Increasing the connections between mental health and primary care providers where such services have responsibility for common clients.

For additional information on positive practice initiatives in Canada, consult the following document available at www.ccmhi.ca:

- *Collaborative mental health care in primary health care. A review of Canadian initiatives: Volumes I and II*

Programs in Canada provide a wide range of collaborative approaches including fully integrated mental health and primary care programs, agreements to bring mental health care into primary care, and primary care practitioners providing services within mental health and social service settings. The range of models has grown out of local conditions including the availability of resources, desire to collaborate and commitment to working with people with SMI.

Both practitioners and consumers consulted for this toolkit (see Appendix A) favoured a model that is fully integrated with an array of services provided - a 'one-stop shopping' model. There is some evidence that 'one-stop' types of approaches increase the likelihood that people will receive preventive care (Crews et al, 1998).

Though this may be the most desirable arrangement, it may not be feasible in many settings based on available services and funding. Nonetheless, a collaborative approach to providing care for this population can develop in any community where the following are present:

- Identification of the underserved population
- Commitment to improve the health of this population
- Availability of physicians and allied health professionals with a particular interest in working with people with SMI
- Availability of partners willing to collaborate
- Clearly identified reasons for collaboration (such as a belief that costs will otherwise be higher or provider frustration with inability to meet needs)
- Capacity to build on existing health systems

A survey of 12 shared/collaborative care programs across Canada, conducted as part of the consultation process for this toolkit (see Appendix A) identified several key elements in designing collaborative models of care, particularly for those initiatives that are not fully integrated programs with a common governance structure. These elements should be in place prior to any delivery of services.

- Develop a common vision amongst the partners. This vision should clearly articulate the goals of the collaboration.
- Involve all partners as equals in the collaboration. There must be mutual respect for the roles of each provider and for the consumer (and their family or caregiver, if requested).
- Build strong linkages to hospital programs.
- Develop clear memoranda of agreement.
- Clarify the roles and responsibilities of all team members.
- Ensure that staff have a strong commitment to, and experience working with, people with SMI.
- Develop clear protocols for sharing of information.

See Appendix B for examples of positive practice initiatives.

Key elements and fundamentals of collaborative mental health care

Accessibility

Access to, and engagement with, services and providers may be particularly challenging for this population, especially for individuals who are homeless or living in poverty. Strategies to address barriers may include:

Figure 1 Framework for collaborative mental health care

Services

- Individualized care based on consumer goals
- Stepped care approach, starting with least intrusive interventions
- Avoiding coercive treatment
- Setting smaller goals
- Universal screening to ensure concurrent problems are identified
- Integrated mental health and addictions treatment
- Harm reduction approach for substance use disorders
- Highly skilled interdisciplinary teams to address complexity of needs
- Welcoming other support providers, family or friends into clinical encounters at the consumer's request
- Case management function to navigate social service system
- Strong links with community resources such as food banks, Community Kitchens programs
- Making food (e.g., boxed lunch) available for those who might attend groups or other more time-consuming activities
- Assertive outreach, e.g., home-based appointments for those who do not attend at clinics or for the frail elderly

Providers

- Providers, particularly physicians, who are comfortable working with people with SMI

- Willingness to develop relationship with consumer (and family member/caregiver, if requested by the consumer) before attempting treatment
- Peer support providers
- Staff who are friendly and speak to the person by name
- Concurrent disorders-capable staff
- Cognitive-Behaviour Therapy (CBT)- and Dialectical Behaviour Therapy (DBT)-trained staff

Contact

- Rapid access to appointments (e.g., same-day/urgent appointments)
- Flexible hours, including evenings
- Longer appointments, as needed
- Increased frequency of contact
- Telephone as well as in-person contact
- Active follow-up for missed appointments

Language / cultural issues

- Making services available in multiple languages
- Using cultural and language interpreters

Location / environment

- Providing services at convenient sites
- Providing bus tickets
- Warm, welcoming, calm environments

Collaborative structures

Communication between providers must be in accordance with federal/provincial/territorial privacy legislation. Communication can be facilitated through:

- Use of integrated electronic medical records
- Use of electronic communication between providers
- Brief, clear care plans indicating responsibilities

Richness of collaboration

Any collaborative approach needs to account for the complexity of both the consumers being served and the system of services that supports them. As noted above, consumers frequently use multiple community services for a range of issues, including housing, income supports, social/recreational activities, substance abuse, food security, vocational programs and peer support, as well as health services. Attention must be paid to developing and sustaining relationships with the full array of providers who can support an individual. Regular meetings with other providers should be encouraged to identify problems and solutions.

Particular attention should be paid to supporting primary care providers. Many programs, for example, ensure the primary care provider has rapid access to psychiatric consultation. Involvement of members of a consumer's social network should be facilitated at the consumer's request.

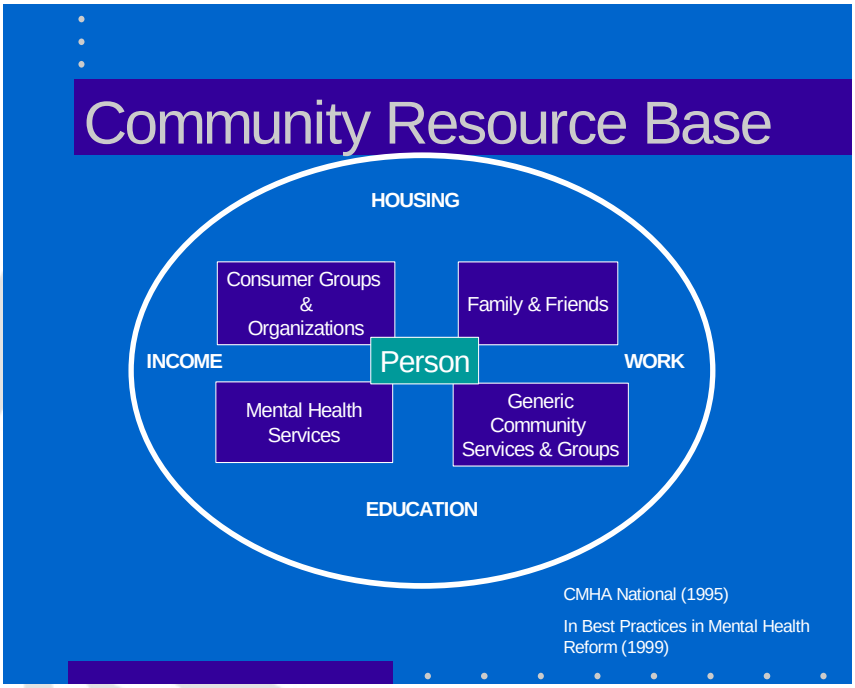
Consumer centredness

Recovery and the framework for support

Recovery is a paradigm that assumes that people with SMI are citizens with rights and responsibilities and services should be organized to support full community integration. In the recovery paradigm, a person with a SMI is expected and encouraged to want and be able to function in roles such as parent, friend, partner, worker, volunteer or student, the same as anyone else. The role of the health and social service systems is to assist people with SMI to live meaningful and productive lives.

The Canadian Mental Health Association's Framework for Support (Trainor et al, 1993) (Figure 2) provides a clear conceptual framework for understanding what is needed to support people, including those with SMI, to live fully and successfully in their community. The framework clearly situates the consumer at the centre of their care and suggests that medical/psychiatric care is a necessary but not sufficient intervention to promote consumer recovery.

Figure 2: Framework for Support



In planning a collaborative initiative, attention should be paid to how the key framework components will be addressed – either through the program or brokered through linkages with other providers. Attention should particularly be paid to how housing, income, education or work will be provided. The framework also provides a useful guide to the range of stakeholders who might be involved in planning.

Deegan (2003) suggests the following are key elements of the relationship between professionals and consumers in supporting recovery from mental illness: shared power, a true sense of partnership and the free exchange of information. In this relationship, the professional is an 'expert consultant' to the consumer's journey of recovery, and decision-making is shared.

Principles and values that are particularly important in working with people with SMI include:

- Promoting self-determination and recovery (managing one's illness/disability while living a satisfying and meaningful life)
- Respect
- Patience
- Empathy
- Flexibility
- Reducing or eliminating stigma
- Creating welcoming environments

Funding

Funding must account for both the clinical and the non-clinical time required to provide direct care and to develop and maintain collaborative relationships amongst partner organizations and within interdisciplinary care teams.

Community needs

Developing collaborative approaches in working with people with SMI is challenging in part because there are multiple care providers across the social, health and voluntary sectors. In developing collaborative approaches, even if the collaboration is formally only between two providers, other providers should be involved in the planning process. This will be important, for example, in ensuring that there is ease of access to basic needs such as income supports and housing. Consumers must have input into the planning, implementation and evaluation of initiatives as they hold key information, such as where they are comfortable receiving services, how to create a welcoming environment and what kinds of services they have had difficulty obtaining.

Monitoring and evaluation

It is suggested that a continuous quality improvement evaluation framework be built into the initial design of the collaborative initiative. The scope will depend on available resources, however the following areas should be considered:

Process evaluation should be focused on answering the question, "Are we doing what we said we would do?" For example, indicators might include such factors as:

- Number of people seen
- Number of people seen who fit target group criteria
- Whether screening mechanisms have been implemented
- Number of people who remain engaged with treatment
- Satisfaction amongst the partners

Outcome evaluation should be focused on answering the question, "Are we making a difference to consumers' lives?" An outcome evaluation should cover the following four areas:

- Functioning: This includes indicators such as housing stability, paid or volunteer employment, ability to carry out activities of daily living and ability to manage medication
- Clinical status/Symptom change
- Quality of life
- Satisfaction with services

Key issues for consideration

Necessary and unique functions of a collaborative approach for consumers with SMI include:

1. ***Self-management support***

   Some models integrate this aspect of a chronic disease management model. This is consistent with a recovery model in which the consumer is empowered, through the use of a range of tools and approaches, to understand and be responsible for managing their illness.

2. ***Advocacy***

   This population is more likely to be poor, live in substandard housing, lack food security, be stigmatized and to have few social supports. Advocates ensure that consumers have access to entitlements and that the needs of this population are broadly understood.

3. ***Rapid access***

   People who fit the SMI definition have ongoing support needs and are often easily discouraged from seeking timely, appropriate care for a variety of reasons including:
   - Characteristics of their illness (e.g., psychotic or manic symptoms make it intolerable to sit in crowded waiting rooms, onset of symptoms may be rapid with a narrow window in which help is sought, and insight may be lost with the onset of psychosis)
   - Negative experiences related to stigma or discrimination
   - Negative experiences from previous contact with the health care system
   - Traumatic experiences of involuntary care

   Best practice programs have implemented same-day appointments to deal with this barrier.

4. ***Case management/system navigation***

   People with SMI have complex needs which are often served through a variety of sources. Case managers are intimately knowledgeable about the person, their needs and their individual system of care. Case managers provide services over time, enabling them to develop a strong alliance. They have expert knowledge of the wider systems of care and are adept at obtaining and/or co-ordinating services. Case managers will assist the consumer to gain access to the full range of services or programs consistent with his/her goals. These will include entitlements such as income supports and regular or specialized (supported) housing.

5. ***Outreach/engagement***

   It is recognized that people with SMI benefit from assertive outreach to become engaged in care. Outreach may be useful when consumers are too ill to attend office-based visits or when they are reluctant to make use of services. Engagement may be a longer process than for other mental health consumers. Some programs have identified the need for providers to be flexible in the timing of interventions, first assessing the degree to which the consumer is receptive and trust has developed. In some instances, this means a series of contacts before a treatment plan is discussed.

6. ***Individualized care/treatment plan***

   The individualized plan is negotiated with the consumer, based on their personal goals. This may include a crisis plan, rehabilitation goals, illness self-management strategies, work or educational goals, lifestyle management (e.g., exercise, diet), relationships, spirituality and leisure.

7. ***Concurrent disorders-capable***

   There are high rates of concurrent substance abuse amongst this population. The interaction between substances and illness symptoms is complex. Many consumers use substances such as alcohol and marijuana to deal with symptoms. Having concurrent disorder capability implies the ability to screen, assess and treat concurrent substance use problems amongst this population.

8. ***Rehabilitation supports***

   These may be provided within a comprehensive collaborative arrangement or brokered from other providers. Particular areas of need include vocational (including educational) rehabilitation and housing supports.

9. ***Recovery framework***

   It is critical that services be oriented to a recovery framework. Such a framework assumes that consumers with SMI can lead meaningful lives as productive citizens who are fully integrated into their communities. People with SMI do, for example, work, attend school, volunteer, marry and parent. In order to do so, however, many will need intensive professional supports, either continuously or episodically. The need for such supports must be accounted for in collaborative models. The recovery framework requires an approach to service delivery that is empowering and considers all biopsychosocial-spiritual aspects of the person. Services should be non-stigmatizing.

10. ***Primary health monitoring***

With such high rates of co-morbid medical conditions, health prevention and screening are very important. Likely co-morbid conditions include diabetes, hypertension, obesity, dyslipidemia, respiratory and cardiac disease, thyroid disease, visual and hearing problems, and sexual and physical violence. Nutrition counselling is an essential component of care for this population. See Appendix D for a sample protocol for monitoring the health of individuals who are prescribed atypical antipsychotics.

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Appendix A: Consultation process

A draft of this toolkit was reviewed by the following:

- Hamilton Addiction and Mental Health Network (a network of consumers, family members and providers)
- Psychiatrists working in shared/collaboratiave care and tertiary settings
- Consumer advisory committee of a tertiary mental health program
- Staff of a shared/collaborative care program in Calgary

A focus group was held with consumers in Ontario to discuss issues raised through the literature and to highlight concerns which might not have identified.

The Expert Panel also consulted with 12 shared/collaborative care programs, identified through the CCMHI's *Collaborative Mental Health Care in Primary Health Care: A Review of Canadian Initiatives: Volume II,* who work with individuals with SMI in order to generate ideas and explore problems and solutions. Broader review by national organizations is invited.

Appendix B: Positive practice initiatives

- Crews et al (1998) developed a collaborative model within the **Mental Health Corporation of Denver, Colorado**. In this model, specific clinics and physicians were designated to provide primary care to people with SMI within a large mental health system. Clinics operated one-half day per week and were staffed by internists interested in working with this group of patients. The model used telephone consultations between psychiatrists and internists, and made same-day appointments. Mental health staff members were welcome to accompany clients to the clinic.

  The clinics detected high rates of previously untreated substance abuse and medical co-morbidity. Critical to the success of the project was selecting physicians whose focus was creating respectful and trusting relationships, even before providing treatment. This model was thought to be particularly useful in serving a large mental health system as well as the indigent population.

For additional information on positive practice initiatives in Canada, consult the following document available at www.ccmhi.ca:

- *Collaborative mental health care in primary health care. A review of Canadian initiatives: Volumes I and II*

- **Thresholds and The Centre for Integrated Care Partnership, Chicago, Illinois** (Marion et al, 2004). This collaborative program provides nursing-based primary care centres (using advance practice nurses) within the Thresholds Centers. Thresholds is a large rehabilitation-focused mental health care provider. The program uses a chronic disease management model. The clinics have developed minimum standards of care (e.g., annual physical exam, STD screen, nutrition and medication education, exercise and health education). They have reported a 62% increase in primary care encounters for Threshold clients and also positive outcomes in diabetes and hypertension management. This project is also included in the Bazelon Report.
- **Wilkinson and colleagues (1995)** evaluated a collaborative model in a more rural setting. In this model, a multidisciplinary mental health team provided services within primary care settings in collaboration with the primary care physician. The mental health services included assertive outreach and home-based care.
- **The Bazelon Report** (Koyanagi, 2004) describes a number of models: programs in which primary care services are provided within mental health programs; unified or fully integrated programs (providing the full range of primary and mental health care within one program); co-location of mental health services within primary care; and improved collaboration between separate providers.

Appendix C: Websites

http://www.bazelon.org
Includes an executive summary of the report *Get it together: how to integrate physical and mental health care for people with serious mental disorders* (Koyanagi, 2004) and a very good critical review of various models of shared/collaborative care for those with serious mental illness

http://www.schizophrenia.ca
Information for consumers and families from the Schizophrenia Society of Canada.

http://www.psychosocial.com
International Journal of Psychosocial Rehabilitation website with information for practitioners about rehabilitation.

http://www.cmha.ca
Useful information for providers and consumers from the Canadian Mental Health Association.

http://www.rainbowhealth.ca
Information about providing health care for gay, lesbian, bisexual and transgendered persons.

http://www.parentingwell.org
A website for consumers who are also parents. Includes resources that can be used as educational tools in primary care.

http://www.nami.org
American site of the National Alliance on Mental Illness with good general information about serious mental illness.

Appendix D: Tools and resources

The following protocol was developed by the Capital Health Community Mental Health Clinics in order to monitor clients on atypical antipsychotics.

All clients being prescribed an atypical antipsychotic will undergo baseline screening and will receive follow-up monitoring regarding metabolic disease and/or dysfunction.

Rationale

Second-generation (atypical) antipsychotics have many benefits and are an important component in the management of many psychiatric conditions. The use of second-generation (atypical) antipsychotics has been associated with an increased risk for obesity, diabetes and dyslipidemia. These conditions are, in turn, closely associated with cardiovascular disease. As a result, the American Diabetes Association, the American Psychiatric Association, the American Association of Clinical Endocrinologists and the North American Association for the Study of Obesity have developed a consensus statement that recommends:

a) That the likelihood of developing severe metabolic disease should be an important consideration in deciding if and which atypical antipsychotic should be prescribed for a specific patient, and
b) When prescribing an atypical antipsychotic, a commitment to baseline screening and follow-up monitoring is essential.

Procedures

1. Baseline screening will be done prior to any client being commenced on an atypical antipsychotic medication.

2. Baseline screening will include:
   a) Personal and family history of obesity, diabetes, dyslipidemia, hypertension and/or cardiovascular disease
   b) Weight and height measurement (so that BMI can be calculated)
   c) Waist circumference measurement (at the level of the umbilicus)
   d) Blood pressure measurement
   e) Fasting plasma glucose
   f) Fasting lipid profile
   g) ECG and electrolytes (if above maximum advisory limits)

3. When clients are prescribed atypical antipsychotics, they will receive systematic follow-up monitoring. Follow-up monitoring will include:
   a) Weight (BMI) re-assessment at 4, 8 and 12 weeks after starting or changing an atypical antipsychotic. Weight (BMI) should be monitored quarterly after Week 12.

b) Blood pressure, fasting plasma glucose, fasting lipid profile and ECG and electrolytes (if indicated) should be repeated at 12 weeks.
c) Waist circumference should be monitored annually (after baseline).
d) Blood pressure and fasting plasma glucose should be monitored annually (after the first quarter – 12th week).
e) Fasting lipid profile should be monitored once every 5 years (after the first quarter – 12th week).

4. Baseline and follow-up monitoring as well as client, family and caregiver support requires collaboration between all members of each individual client's treatment team. The monitoring flow sheet should be used to track both due dates and findings. While the specific roles and responsibilities of treatment team members may vary from client to client, in general,
   a) The prescribing psychiatrist/physician is responsible for explaining and ordering all laboratory and diagnostic tests for the client.
   b) The primary therapist/nurse will ensure that weight, height, waist circumference and blood pressure are accurately completed and documented on the monitoring flow sheet. Non-nursing therapists should ask nursing colleagues to complete blood pressure measurements for their clients.

See also:

Approved by:	**Effective Date:** April 2005
Senior Operating Officer, Mental Health	**Cancels & Supersedes:**

Atypical antipsychotic monitoring flow sheet

Client: _____ **Psychiatrist:** _____ **Therapist:**_____

	Baseline Date	4 weeks Date	8 weeks Date	12 week Date	Quarterly Date	Quarterly Date	Quarterly Date	Annually	Every 5 years
Personal/Family History									
Height									
Weight									
BMI									
Waist circumference									
Blood Pressure									
Fasting Plasma Glucose									
Fasting Lipid profile									
ECG & electrolytes (if above maximum advisory limit)						`			

Appendix E: Glossary of terms and Index of acronyms

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 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 and 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, coordinated 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 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).

Index of acronyms

AIDS	Acquired Immune Deficiency Syndrome
BMI	Body Mass Index
CCMHI	Canadian Collaborative Mental Health Initiative
CDM	Chronic Disease Management
HIV	Human Immunosuppressive Virus
SMI	Serious mental illness
STD	Sexually transmitted disease
WHO	World Health Organization

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