Canadian
Collaborative
Mental Health
Initiative

Initiative
canadienne de
collaboration en
santé mentale

Establishing collaborative initiatives between mental health and primary care services for *urban marginalized populations*

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

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New Hope
New Places
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Making mental health care work
Canadian Collaborative Mental Health Initiative

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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 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

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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.

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Executive summary

Introduction
When one is marginalized from normal supportive structures mentally, physically, socially, spiritually and financially, the social determinants of health are all detrimentally affected. The published literature is replete with findings linking urban marginalization and poor health outcomes. When a service provider is concerned with the health and well-being of the urban marginalized consumer, it is essential to view the consumer as a whole and to take a collaborative approach to primary health care service delivery.

This toolkit is focused on aiding the development of collaborative mental health care for the urban marginalized, to spur the creation of new initiatives, share the teaching of leaders in the field and ultimately provide more relevant, equitable, cost-effective, quality care to this population. Highlights of the toolkit include: ten key issues for consideration when planning and implementing an initiative; descriptions of five positive practice initiatives; key websites (Canadian, American and international); and important tools and resources.

Defining the population
The urban marginalized are an extremely heterogeneous population. This toolkit defines urban marginalized as including individuals who are homeless, living with addiction, living with disabilities, street youth, sole support parents, Aboriginal Peoples, mentally ill persons, gay/lesbian/bisexual/transgendered individuals, and racial minorities (including immigrants and refugees), who live in an urban setting and share the common determinants related to social exclusion and poverty. Not all members of these groups are necessarily marginalized but they have a higher likelihood of marginalization than others.

Consultation process
An Expert Panel was formed with representatives from across Canada, which included leaders in collaborative mental health care for this population. Consumer input was obtained and community agencies were consulted.

Key messages
- **Barriers to appropriate health care for this population occur at both 'macro' and 'micro' levels.**

  - Lack of address, identification, transportation, telephone, social support to negotiate layers of red tape and minimal control over activities of daily living, along with the complication of fee-for-service payments that require a health card number for billing, and lack of drug coverage all hinder access and treatment options for this population. The need for advocates for this population is paramount.

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- Funding is one of the most frequently reported barriers and points to the need to broaden the base of funding by establishing key partnerships and ensuring the involvement of the entire community.

- Other factors complicate the therapeutic relationship and referrals of the marginalized including high susceptibility to ailments, severity of ailments, unintentional injury, prevalence of concurrent disorders, lack of a social support network, history of violence, distrust and feelings of powerlessness.

- **Elements that maximize successful outcomes** include strong reciprocal communication and linkages through formal or informal partnerships with all pertinent supportive structures/services such as shelters, outreach, housing, social services, pharmacy and addiction services.

- **Treatment stability is facilitated when staff members working directly with consumers develop a high level of trust and social history.** Consumers must be placed at the centre of treatment planning to ensure they are willing, capable, understanding and supportive of all aspects of the proposed strategy.

- **Accessibility to services is a key element that needs to be considered when developing policies at the program level.** Consumers must be involved as equal partners in the development process. Because the services of many agencies need to become intertwined, memoranda of understanding and service agreements need to be considered.

- **The collaborative team may include a wide range of individuals, and its composition should be tailored to the unique needs of the consumer.** Common team members could include: nurse/nurse practitioner with mental health/public health expertise; outreach worker with mental health expertise; social worker; translator; counsellor (addiction); housing worker; case manager; family therapist; peer support worker; pharmacist; occupational/physical therapist; dietitian; psychologist; volunteers; dentist; family physician/psychiatrist.

- **The most effective collaborations** are formal, institutionalized interprofessional/ interdisciplinary care teams which tend to work best when team members are co-located under one roof with satellite outreach arms. Services should be provided in a location which maximizes consumer access, such as at an inner-city community health centre with outreach components or shelter-/drop-in-based initiatives with links to primary care providers. An assertive outreach interdisciplinary component can bring hard-to-reach consumers into treatment.

- **Building a collaborative foundation of care for the urban marginalized requires**:
  - Consumer-centred, holistic integrated care built upon trust and consumer input

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- Service delivery design including multiple sites
- Interdisciplinary teams
- Flexibility of service in components and intensity, and access to mainstream health services
- Outreach and engagement including outreach on the streets and to other places where services are received
- Outreach workers and case managers to promote engagement of the consumer
- Nonjudgmental and supportive consumer interactions with the team
- Incentives to promote consumer engagement
- Evidence-based standard of care as provided to those who have more resources

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Introduction

> *"True compassion is more than flinging a coin to a beggar. It comes to see that an edifice which produces beggars needs restructuring."*
>
> *Martin Luther King, Jr.*

People of every age, religion, gender, sexual orientation, physical or mental attribute, culture and country of origin can be touched by marginalization. It is a matter of degree. When service providers are fortunate enough to have the opportunity to work with these often-overlooked members of our community, they soon realize how easy a line it is to cross and find themselves on the other side. Being marginalized from society can be an insurmountable burden to bear in any circumstance. When surrounded by the affluence, excess and resources of an urban environment, the gap between impoverishment and prosperity is increased many fold.

When one is marginalized from normal supportive structures mentally, physically, socially, spiritually and financially, the marginalization permeates every aspect of one's life. The social determinants of health are all detrimentally affected. Given their interconnectedness, finding a solution to improve one aspect (such as physical health), without considering the others (such as mental health, housing or addiction), will lead to a quick regression and ultimately one more loss or failure. Such events continually draw upon a person's reservoir of hope, decreasing their capacity for positive gains in the future.

Therefore, when a service provider is concerned with the health and well-being of an urban marginalized consumer, it is essential to view the consumer as a whole and to consider all the factors at play which have led to the issues that are being presented. A collaborative approach to primary health care has many potential benefits for urban marginalized populations.

This toolkit was part of a national objective to integrate evidence-based best practices, lessons from the field and the voices of experts, those on the ground working with the issues on a daily basis such as service providers, advocates and most importantly, consumers themselves. This information is focused on aiding the development of collaborative mental health care for the urban marginalized in order to spur the creation of new initiatives, share the teachings of leaders in the field and ultimately, provide more relevant, equitable, cost-effective, quality care to this population.

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Defining the population

The difficulty with defining the urban marginalized population is their lack of specificity. The urban marginalized are an extremely heterogeneous population dealing with a wide spectrum of issues in diverse combinations. Urban marginalization can touch any individual regardless of environment, personal attributes or cultural background. Therefore, any attempt to define such a subset risks over-specificity or over-generalization. The Expert Panel in this case attempted to be as inclusive as possible given that this toolkit is designed to apply to any setting across the country.

Urban marginalized populations may include individuals who are homeless (absolute or relative), individuals living with addiction, those living with disabilities, street youth, sole-support parents, Aboriginal Peoples, gay/lesbian/bisexual/transgendered individuals, mentally ill persons and racial minorities (including immigrants/refugees). They reside within an urban setting and share the common determinants related to social exclusion and poverty. It is important to note that all members within these groups are not necessarily marginalized but, in some instances, have a higher likelihood of marginalization than others. Those individuals who are marginalized within these groups have lives that tend to be characterized by unstable living conditions due to a lack of financial, social, spiritual and physical resources and inadequate support. Within this environment, these vulnerable members of the community tend to be overwhelmed by powerlessness, voicelessness, a lack of recognition and sense of belonging, limited options, diminished life chances, despair and frequent 'opting out' behaviour, all of which combine to create authentic and/or perceived barriers and may lead to a perpetual cycling of instability.

Factors specific to the urban marginalized

Individuals finding themselves in a situation of marginalization combat a multitude of daily challenges: finding adequate shelter and clothing; finding somewhere to perform basic hygiene measures and the toiletries to do so; an inability to control their nutritional intake as they accept what is available; the risk of foodborne illnesses; no secure storage for belongings and medications; no place to acquire rest and relaxation; and little ability to engage in daily recreational activities. On top of this, transportation is difficult to come by, as are identification and other basic endeavours such as obtaining a bank account, storing important documents and so on. If one then adds an acute or chronic illness, physical disability, emotional or mental disturbances and addiction or mental illness, how can one cope with little to no personal support in an already thinly stretched social and health service safety net?

Of necessity, health concerns may become a lower priority for the urban marginalized. The actual physical conditions present in this population can be relatively common but

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are complicated by their over-crowded or under-resourced living conditions and lifestyle, making such issues more intractable and of higher public concern. Conditions which begin as relatively innocuous and easily treatable can develop into complex, intensive and expensive-to-treat ailments and may lead to secondary health problems before professional consultation is sought.

For many urban marginalized, especially within populations of Aboriginal Peoples, former correctional services residents, sexual minorities and immigrant or refugee populations, alienation, stigma and institutionalization have resulted in a lack of trust in, and fear of, authority figures, such as health care providers.

These factors create a complex diagnostic challenge which can negatively affect prevention efforts, treatment planning and follow-up options. A single provider, with limited time in an already hectic clinical environment, is easily left feeling overwhelmed and under-resourced to manage effective care. The need for an integrated team approach, with its ability to increase expertise, resources, shared responsibilities and consumer-centred case management, is clear. Investing in developing strong partnerships in care and building a trusting relationship with reciprocal communication are also vital.

The following factors are key in the successful support of the urban marginalized in obtaining healing and well-being:
- Consumer-centred care with a treatment plan developed through consumer input anchored to *their* perception of their own well-being and quality of life (what's important to them)
- Integrated holistic care
- Flexibility of service in components and intensity
- Engagement and continuity of care through outreach
- Therapeutic relationship built on trust
- Providers' advocacy for the consumer's well-being in the community
- Team members' openness to new roles and cross-training in each other's disciplines
- Low staff to consumer ratios (1:10)
- Ongoing rehabilitation in all areas of instability (housing, finances, employment/education, social ties, recreation, spiritual growth and physical/mental health)

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Lessons from the literature

It is not surprising that the level or complexity of health issues tends to be strongly correlated to living conditions or place of residency (Hwang, 2001). Not only does the circumstance of marginalization lead to complex health issues but it further complicates health problems that are already present. The urban marginalized, and specifically the homeless, carry a very heavy burden of illness, usually involving a complex interplay of comorbidities. This may be further exacerbated by lack of community links, social supports, and the burden of addiction and/or mental illness.

> 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*

Chronic diseases can become the most tenacious and suffocating burden carried by this population. The most common of these are respiratory ailments such as chronic obstructive pulmonary disease (COPD), liver and kidney degeneration, and infectious diseases such as HIV, AIDS, TB and Hepatitis A/B/C (Hwang, 2001). Sexually transmitted diseases can also increase the disease burden and threaten public health if not addressed through prevention, education and treatment. Homeless individuals can be seen with illnesses generally present only in individuals decades older (Frankish et al, 2005) and with issues usually seen only in developing countries under conditions of deprivation.

Skin conditions such as lice/scabies infestations, impetigo and fungal infections are rampant, especially in the overcrowded conditions of local shelters. Foot problems from lack of appropriate and clean socks and footwear, lack of hygiene, prolonged periods of walking or standing and environmental exposure are frequently observed. Tinea pedis, trench foot, fungal infections and other chronic afflictions progress into hard-to-manage cases further complicated by difficulty in ensuring appropriate resources for self-care (Frankish et al, 2005).

Dental and oral health problems are another commonplace health issue, due to a lack of proper hygiene and access to the resources for carrying out daily hygiene care (Frankish et al, 2005). This can lead to issues of self-confidence and a barrier to employment, along with further physical complications from abscesses, infections and an inability to masticate. Homeless individuals are also more susceptible to foodborne illnesses as some obtain their food from strangers and garbages (Tarasuk et al, 2005).

With high levels of stress, lack of steady nutrition, burden of chronic disease and inadequate living conditions, many urban marginalized community members become immune compromised, amplifying their susceptibility to further complications. Non-

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compliance with health care advice or medication administration can often occur, due to living conditions and competing priorities. Along with adverse interactions with other unreported substance use, this has contributed to a high rate of drug resistance found with certain illnesses in this population.

The seasonal environment can also be a factor affecting the well-being of this population. Without access to appropriate attire and shelter, homeless individuals experience a high incidence of environmental trauma, such as heat stroke or frostbite.

Poor health also compounds the risks faced by homeless women who become pregnant. In one large, cross-sectional survey of homeless youth in Toronto, one quarter of the women sampled were pregnant (Dematteo et al, 1999).

In addition to physical vulnerabilities, addiction and mental illness are rampant in the urban marginalized community. It has been reported that upward of 60% of the population deal with problems with alcohol consumption; illicit or prescription drug misuse estimates range from 20-30% (Hwang, 2001). These figures can be highly correlated with the large percentage of mentally ill individuals in the urban marginalized population due to self-medicating behaviour or self-control issues.

The prevalence of schizophrenia in this population is estimated at 6% (Hwang, 2001). Affective disorders are far more common, ranging from 20-40% (Hwang). There are numerous underlying factors that could contribute to these conditions. Many individuals have reported a high rate of childhood physical, emotional and sexual abuse. There is an enormously increased risk of being a victim of violence on the street. An alarming 40% of male members of the homeless community report being victims of assault; 21% of females report being victims of rape during the past year of being on the street (Frankish et al, 2005). Montreal street youth were reported to be at 9 times the risk of being victims of homicide and the risk of traumatic brain injury was a disturbing 24% compared to 1% in the general population (Frankish et al). With addiction, disability and mental illness, unintentional injury is a leading cause of morbidity and mortality (Hwang).

Most health care for the urban marginalized is provided through emergency departments and, once attention is sought, homeless individuals are 5 times more likely to be hospitalized and for longer periods of time (O'Connell, 1999).

Collaborative models and initiatives

Descriptions of initiatives from across the country are presented in Appendix C and offer many lessons on developing a model of collaborative mental health care. The examples presented include community health centre (CHC)-based initiatives with outreach components, and shelter-based initiatives with links to primary care providers and outreach to other agencies and the streets.

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The CHC-based model allows, in general, for stronger resource support and staff comfort without as strong concerns for safety. Certain consumers may prefer to gain access to health services away from the chaotic environment of their regular settings to provide a sense of confidentiality and accomplishment. Operations may run more smoothly in these settings and provide for fluid continuity of care. The disconnection with other agencies on a daily basis, however, may cause some fragmentation in service. This may be overcome to a certain degree by assertive outreach. The literature supports the Assertive Community Treatment model as effective.

> 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*

With shelter-based or drop-in centre-based care, front-line members of the care team (usually a nurse and an outreach worker) act as triage and primary care providers. They are the gatekeepers to the family physicians and psychiatrists that visit on a weekly basis. This can be quite cost effective as the doctors are used sparingly and efficiency is gained by maximizing the skills present in the front-line team.

With shelter-based initiatives, getting a holistic view of the consumer, including physical/mental health, housing, finances, spirituality, social ties, employment, etc., is facilitated through direct daily observation. In these settings, care team members may observe the consumer functioning in their daily life and gain insight into areas of concern not readily reported or perceived by the consumer in a community health centre. Trusting relationships can be built when the care team is observed daily by potential consumers, but fear of the team's influence over other shelter matters such as residency status, etc. may be a deterrent to seeking their care. This setting may also create access issues for consumers that fear/loathe shelters/drop-ins or are barred from their services due to past behaviour. Outreach to other agencies and the street by the outreach worker and nurse, and creating a network of referral advocates become imperative to overcome this barrier.

The initiatives described in Appendix C report increases in consumers' quality of life and continuity of care. These findings can be misleading, however, as the indicators for evaluation were different for each initiative, making direct comparison difficult. Also, any improvement in the integration of services provided can demonstrate substantial improvements in the consumer's well-being. Therefore, without comparison, any integration model can look promising.

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The following are key principles for any initiative:
- The urban marginalized are a diverse group of community members generally suffering from multiple affronts to their well-being.
- Care and team composition must be flexible and anchored to resource availability and to the severity of comorbidities afflicting the individual consumer.
- The consumer must be engaged and empowered to obtain a sense of control over their own well-being.
- Outreach is essential for engagement.
- Care should be provided where and when access is optimized through consideration of the consumer's comfort and life circumstance.
- Interprofessional and interagency communication and co-ordination are critical to effective treatment.

Though there is little in the literature on collaborative mental health care initiatives for the urban marginalized, an important reference of special note, excerpted in Appendix E, can offer some significant points on providing interprofessional care for this population (Bonin et al, 2004).

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Key elements and fundamentals for collaborative mental health care

Figure 1 Framework for collaborative mental health care

Accessibility

> *"A barrier of poverty, social isolation, fear and lack of trust needs to be overcome."*
>
> *Consumer advocate from Toronto*

Barriers to care can be found at all levels from policy and legislative concerns at the systems level to individual issues that impede access to appropriate health care. Most collaborative initiatives will concern themselves primarily with direct service barriers for the urban marginalized. This may involve exploring different approaches to service delivery which support and empower consumers to overcome individual challenges unique to their life circumstance.

In the United States, it has been found that a strong barrier to service is financial: lack of insurance coverage or inability to pay for needed medical services. Though this is not necessarily the case in Canada with universal health care, a similar circumstance exists when consumers lack proper identification to prove coverage, either through loss or theft, an all-too-common occurrence. A study in Toronto found that 7% of homeless individuals were refused health care services due to a lack of identification (Hwang, 2001). Obtaining replacement identification presents another challenge due to expense, lack of proof of residency and bureaucracy.

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Fee-for-service payment schedules may also be a barrier to access as they require a health card number for appropriate billing. As well, many urban marginalized community members have no drug coverage or cannot afford prescription medications in provinces where these are not universally covered. Even when coverage is provided for some consumers, such as through the Ontario Disability Support Program, there may be problems receiving a drug card if the consumer has no permanent mailing address. Coverage can also be revoked if the bureaucratic criteria are not followed properly, which can be difficult for the mentally or physically incapacitated consumer without strong support from a social service advocate or a case manager. Ensuring that the proper pharmacy receives the drug card presents another challenge.

Even once a prescription is filled, a lack of control over physical access to their medication can be difficult to overcome due to regulations meant to guard against illicit use in such service agencies as shelters and drop-ins. Within these organizations, having an appropriate location to store medications, such as insulin, can also be a barrier to effective pharmacotherapy.

Depending on place of residence, the ability to follow other prescribed regimens such as appropriate rest, exercise and nutritional requirements can be impossible to control. Because soup kitchens, shelters, etc. have scarce resources and a large clientele, and often rely on donations, they usually operate on limited menus that do not always provide adequate or appropriate nutrition for consumers on restricted or modified diets. Some shelters, operating over capacity, may require barring access to beds during certain hours of operation. These organizations may, at times, deem it necessary for the safety of staff, consumers or property to prohibit certain individuals from their services. This creates another difficulty if that organization's services are a key component in a consumer's treatment plan. In any case, shelters cannot provide a 'permanent' home for any individual, thus compromising consumers' health status.

A referral that is inappropriate to a consumer's readily available resources may also create substantial challenges to effective health care. The urban marginalized generally lack access to transportation to get them from one medical appointment to another or to travel between referrals for such secondary needs as lab work or rehabilitation services. Simply providing a transit pass through social services may not overcome such an issue for physically or mentally challenged individuals. In addition, when a consumer has difficulty coping with the responsibilities of seeking health care due to personal or environmental issues, piling on numerous appointments with a diverse and geographically distant group of health care providers can be insurmountable.

Hours of operation have been shown to play a role in consumers' use of services. Despite a common perception that some urban marginalized, such as homeless individuals, do not engage in productive activities during regular business hours, many can be quite busy

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during this time in endeavours they deem extremely important for daily survival. Crisis situations or the need for support do not end at dinner time or at the start of the weekend, especially for those without any other supportive structures to lean on such as family, partners and friends. When considering this population, the need for after-hours access to health care services is all the more critical.

> *"Stigma makes it difficult to take care of some health issues. Outreach in the community and receiving health care in my own home, by far, would be the most comfortable."*
>
> *Urban marginalized consumer from Halifax*

Many urban marginalized consumers have extreme difficulty operating in an environment that is generally geared towards consumers of a much higher socio-economic class. This can lead to a decision not to return for follow-up due to a feeling of inferiority or stigma.

Mental illness and mental health care can also carry a significant stigma within the community and this is ever present in the urban marginalized. Privacy and confidentiality are key factors in opening doors for treatment. One method of normalizing mental health care is through integration into a primary care setting. By developing a primary care team with a mental health component, the consumer may feel more comfortable using such services.

Collaborative structures

> *"The structure needs to fit the local need. It would be different in each community."*
>
> *Health care provider from Halifax*

A collaborative initiative that brings together service providers, advocates and consumers with different backgrounds, skill sets and agendas can take on a number of different structures. They can be *ad hoc* collaborations that are developed *in situ* to deal with issues of immediate concern and then disbanded after the resolution of the acute problem. They can be brokered service models where a primary care provider has developed informal relationships with other providers and, through referral or interagency service agreements, gains access for the consumer to external services without actual reciprocal collaboration.

> *"The most practical approach to this issue would be one resource pool all under one roof."*
>
> *Health care provider from Toronto*

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Initiatives might also provide diverse services under one roof with complete integration of operations, shared resources and budgets and formal reciprocal accountability. With such a collaborative effort, services are streamlined, frequent case conferencing is possible and a shared approach to care develops over time. This model of collaboration tends to involve strong collaboration outside the core service group with such important services as shelters, drop-in centres and other advocacy groups or service providers. It creates a strong community environment, building a framework for consumer centredness and social accountability with a rich reservoir of different points of view and a well-rounded approach to care. This type of arrangement tends to be most successful with full integration of services with flexibility to treat a wide spectrum of illness severities.

Communication, negotiation and a written shared vision complete with a mission and objectives are the key to any successful collaborative mental health care initiative. Within the initiative, the services of numerous agencies will be intertwined. This involves bringing all key stakeholders, including consumers, to the table. For the urban marginalized population, this can involve a diverse group of players, addressing issues such as addictions, mental health, housing, financing, employment, etc. Agencies and service providers who care for this community often have limited resources and must find creative solutions which make the most of community resources.

It will be important to have detailed, well thought-out memoranda of understanding and service agreements that outline which resources are brought to the table, by whom and how they will be integrated (as one entity or brokered), and an accountability structure which includes all stakeholders. Working together in partnership, common charting and communication tools for direct care and referral need to developed, keeping in mind all the potential needs of an urban marginalized consumer, the diversity of services utilized and the service resources within the community. These communication tools should be developed in such a manner that they aid the consumer and their advocates in navigating the often-cumbersome bureaucracy of community social and medical services.

Effective collaboration includes:
- Information management
  - Common care plans/records
  - Responsive communication tools
- Frequent care co-ordination meetings
- Clear goals
- Clearly defined roles with responsibilities to other team members and consumer outlined
- Educational workshops given by each team member (cross-training)

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> *"We have a lack of co-ordination of care between separate agencies."*
>
> *Health care provider from Vancouver*

Inadequate collaborative structures between sectors or organizations can create a barrier to effective care. One issue which can pose a huge challenge for the maintenance of recovery is the lack of discharge planning when consumers are released from hospital. Consumers may be discharged without the knowledge of their primary care provider or support 'safety net' such as shelter staff. In some instances, they show up on a shelter's doorstep with no discharge notes due to the legal constraints around confidentiality, creating a gap in proper treatment, follow-up and care management. The place to which they are discharged can also be totally inappropriate given their condition, especially when there is no-one to aid the consumer 'at home' with needed care such as dressing changes, returning for follow-up appointments or medication administration.

Many providers and advocates have attempted to initiate respite or convalescent care programs for short durations to aid those consumers who are healthy enough for discharge but still too ill to recover on their own and fend for themselves within the general shelter system or on the street. Service fragmentation becomes an impossible barrier for these consumers to overcome without strong, active support and interagency communication with formal confidentiality agreements in place for each consumer and agency.

Richness of collaboration

A collaborative mental health care initiative designed to work with urban marginalized community members can have a fairly expansive composition for the core team. Given the multitude of factors that affect the well-being of this underserved population, it is important to consider a number of potential team players that will cycle in and out of the core team that surrounds and supports an individual consumer, responsive to his/her unique current needs. Team members could typically include:

- Nurse/nurse practitioner with mental health/public health expertise
- Outreach worker with mental health expertise
- Social worker
- Translator
- Counsellor (especially with addiction/concurrent disorder expertise)
- Housing worker
- Case manager
- Family therapist
- Pharmacist
- Occupational/physical therapist

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- Dietitian
- Peer support worker
- Psychologist
- Volunteers (including drivers)
- Dentist
- Family physician/psychiatrist (used sparingly but consistently)

Outside of this core group of service providers that will be fully integrated into a shared/collaborative approach to service provision, other community agencies or resources could be sought as potential partners to help support consumers when special needs arise. Service agreements or situational referral through brokered services can be enlisted.

Potential community partners could include:

- Housing programs
- Addiction programs
- Food banks
- Social services
- Immigrant/refugee services
- Legal Aid
- Police
- Emergency departments
- Corrections
- Hospital discharge planners
- Shelters/drop-ins

- Public Health
- Home care services
- Veterans Affairs
- Employment/vocational services
- Long-term care facilities
- Public Guardian and Trustee's Office
- Meals on Wheels
- Community kitchens
- Community gardens/kitchens
- Voluntary organizations

Consumer centredness

> *"Affordable housing, long-term support, and financial barriers are the patient's issues."*
>
> *Health care provider from Toronto*

To have a responsive, consumer-centred delivery system, the life circumstances of consumers must be used to inform resource allocation and integration. Service providers must work hand-in-hand with consumers to identify all the factors influencing their ability to achieve or maintain good health. Factors such as access to shelter, clothing, medication, nutrition, recreational activities, a place to rest, support within the community and even the ability to communicate (i.e., a point of contact through telephone or an advocate) for follow-up must be taken into consideration. Many within this population are transient and therefore at risk of 'falling through the cracks'.

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"Ensuring that care is provided for patients is very difficult when clients have no fixed address. We simply can't follow up on them."

Consumer advocate from Calgary

Frequently, the consumer experiences fear and a lack of trust of authority figures such as health care providers. Taking the time to build a therapeutic relationship of reciprocal trust and partnering in treatment decisions is essential. Collaborating with other community providers with whom the consumer has already developed a strong bond can aid in the successful initiation and maintenance of a therapeutic relationship.

Starts and stops with engagement of particular consumers can be frequent as the need for physical and mental well-being slides up and down the consumers' priority list as they attempt to provide for their daily necessities. In this sphere, the process of care, instead of just positive outcomes in the traditional sense, needs to be the focus of treatment.

Some urban marginalized community members, due to fear, distrust, addiction or mental illness, may not engage with health services even with integrated services. Assertive outreach and collaborating with other consumer-engaged community providers may aid in bringing these individuals into the care setting.

The intensity of service must be matched with the severity of ailments, maintaining a responsive, flexible model of care. 'One size fits all' does not provide an effective treatment regimen for these community members. Given their situational instability and lack of support, an 'open door' policy for walk-ins and consistent appointments tailored to the consumer's needs should be ingrained in the model.

Length of treatment must be flexible as well. Transferring consumers too soon to less intensive treatment quickly erodes all gains that were made and may leave the consumer worse off than before treatment was initiated.

The urban marginalized have generally experienced many false starts and failures in their relationships and personal goals, leaving them with a sense of powerlessness and loss of hope. Therefore, empowering the consumer to engage in the management of their own well-being through compassionate, consumer-defined goal setting and relationship building is imperative to increase his/her self-confidence and sense of control.

For some consumers, their ability to be effective partners in their health care and gain access to appropriate services may be affected by literacy, or physical or mental incapacity. Proper evaluation of competency and level of functioning should be carried out to negotiate a comfortable level of involvement for the consumer in his/her health care management. Tactful negotiation of acceptable conduct should be attempted with the

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entire collaborative care team. The objective should always be to build a relationship that aids in the development of growing empowerment of the consumer regarding his/her health and how services are best provided.

> *"We need to start by asking and continuing to ask the specific population we are trying to meet the needs of…involve direct input from those [we are trying] to serve."*
>
> *Consumer advocate from Halifax*

Consumers must be brought to the table as equal partners at every stage of the initiative to provide a sense of ownership and a responsive, relevant program that builds on their needs and view of well-being. An appropriate incentive structure should be maintained for consumer involvement that ensures equality with other members of the care team. Short- and long-term objectives should be clearly outlined as benchmarks for progress and revisited as the initiative matures in order to allow tailoring to the changing needs of the population.

To promote consumer involvement:

- Support a consumer advisory board, held accountable within the organizational model of the initiative. The board may collaborate in planning, operations, evaluations and training. They may also initiate peer support programs for helping fellow consumers who lack traditional family or social ties.

- With active involvement from consumers, draw up a charter of consumer rights and post it in all areas consumers frequent. This document should contain a statement on confidentiality. In a collaborative mental health care initiative, the sharing of consumer information to facilitate effective care within an interprofessional team environment is imperative. This process of sharing, however, must be well planned and a detailed confidentiality and release of information agreement will need to be worked out with the consumer to allow the right information to get to the right provider at the right time for optimal care provision. All possible collaborating agencies should be stated and the consumer provided the opportunity to select with whom s/he is comfortable sharing information. The agreement should allow for revocation at any time by the consumer and have an expiry date for review. Without full disclosure of such a procedure to the consumer and their collaboration on the appropriate manner in which information is shared, a breakdown in the open, trusting therapeutic relationship and feelings of betrayal may occur. With these community members, trust can take a lot of hard work to build but can be shattered with one simple oversight.

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A national network of providers in the United States has produced some very helpful clinical guidelines to aid primary care providers in working with the homeless (Bonin et al, 2004). Please see Appendix E for the summary of recommendations.

Policies, legislation, regulation and funding

> *"Linkages – more collaboration with other mental health service providers. More importantly, a huge shift in human attitudes regarding marginalized people is needed in the government and formal system."*
>
> *Consumer advocate from Halifax*

Any policies planned at the program level must take into consideration the impact they will have on the consumer's access to and comfort with the services being provided. The policy structure must create a supportive, welcoming environment for providers and consumers to allow the nurturing of a partnership in healing and well-being. Policies should be consumer-centred and anchored to best practices in community-oriented primary care.

> *"We need a collaborative approach with a permanent team that is all under one roof, but first, there is the funding issue."*
>
> *Health care provider from Toronto*

Funding is the most frequently reported barrier to building and maintaining a collaborative mental health care initiative, both within the literature and on the consultation questionnaires sent out to providers, advocates and consumers for this toolkit (see Appendix B). A lack of resources to support such an initiative can certainly hamper or halt progress before one even gets past the planning stage.

> *"A great deal of time is spent unpaid on the phone speaking to other team members, family members, pharmacists, etc. There should be some financial compensation."*
>
> *Health care provider from Toronto*

The needs of a collaborative program require creative remuneration for professionals and tend not to be conducive to the traditional fee-for-service payment structure. This is due to the importance of care co-ordination and team meetings necessary for proper team functioning and quality, consumer-centred care.

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"Alternate funding models for physicians and the collaborative care team may help overcome some barriers."

Health care provider from Halifax

In general, sessional fees or salary packages are the most equitable pay structures. It has also been proposed that new billing codes in the fee-for-service system could be instituted that allow for the team approach to consumer service.

There are tools that can be used to leverage support financially and operationally for an initiative. These include:
- Funding stream identification and government contacts
- Evaluation and research framework
- Reporting framework
- Community partnerships
- Academic partnerships
- Volunteer recruitment and retention framework

Funding for health care generally will come from government Requests For Proposals (RFPs) at the federal and provincial level. It is important to keep abreast of new RFPs and novel funding streams surfacing, and to stay informed of trends in government allocations. Because working with the homeless on an interprofessional level may involve a wide spectrum of departments from health care, social services, housing, employment, etc., many different funding avenues may be possible.

Incorporating evaluation and research frameworks into the initiative may build its reputation as a leading-edge, evidence-based, socially accountable service provider; that may add weight to requests for resources from current funders or potential funders in the community. By investing in advocacy, the initiative may help break down the barriers of social exclusion experienced by the urban marginalized.

Another avenue to build capacity for funding the initiative is through the core partner agencies and other community partners. Each agency acquires their own niche within the community and their own advocates and partners that gain access to different gates within the funding system. By acting in concert and leveraging their assets to fulfil a shared vision, many more entry points for funding streams can surface.

Local academic institutions such as universities or colleges can be excellent partners. They can provide volunteer labour through service learning programs, internship or residency rotations, research capabilities and professional development opportunities. They can be a wealth of resources as observed with the Halifax Shared Care Program and their partnerships with numerous professional departments and colleges (see Appendix C for a description of this initiative).

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Lastly, and probably most importantly as a resource base, community volunteers provide an invaluable service to any initiative from administrative aid to peer support to transportation to appointments. By investing in proper volunteer recruitment, screening and retention, and providing the necessary supports for volunteers, an initiative's capacity can increase significantly. Not only do community volunteers provide inexpensive help, but, through a volunteer program, the initiative becomes embedded in the community - a true part of the community that cannot be allowed to fail. It is a way to gain the full support of the entire community to ensure the sustainability of the initiative.

Community needs

> *"There is a need to get involved with the communities."*
> *Urban marginalized consumer from Halifax*

The involvement of the entire community is paramount in a collaborative mental health care initiative to work with the urban marginalized. Because marginalized community members deal on a daily basis with social exclusion that robs them of a positive self-image and creates social isolation, bringing as much of the community behind them as possible will aid in their empowerment and subsequent control over their own well-being.

The stakeholders that can be brought on board, either formally or informally through open reciprocal communication are:
- Local government
- Public health
- Consumer advocacy groups
- Academic institutions
- Not-for-profit organizations (NPOs)
- Health coalitions
- Housing, addictions, mental health support (both public and non-profit)
- Hospitals for emergency care
- Shelters, drop-ins, native healing/well-being centres

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Planning

The initiative should develop a clearly outlined vision and mission shared by all stakeholders within the community. An initiative may, in addition, develop a logic model which clearly outlines the key inputs, activities, outputs and short- and long-term outcomes for the initiative. Throughout this process, the appropriate mix of stakeholders should be represented on the planning committees, especially consumers, and they should be equally compensated for their time and energy. It is important to note, once again, the heterogeneity of the consumer population, the need to avoid tokenism during collaboration, and the need for support for optimal contribution without fear of not being heard and respected.

A community-wide needs assessment should be carried out, involving an inventory of the services currently being provided, the consumers' satisfaction with the system, barriers to service and the unmet needs of consumers. Other stakeholders such as advocates and providers should be consulted as part of this process. Without such an assessment, the initiative would risk providing duplicate or inappropriate services that do not add to the community's capacity to care for the urban marginalized.

A needs assessment should be tailored to the community. It may include:
- Ethnographic observation
- Focus groups
- Semi-structured interviews
- Surveys
- Relevant documents and data (articles, medical records and reports from community agencies)
- Town hall meetings

Planning meetings within the care team must be provided to ensure everyone involved understands how the process of care will occur, how responsibilities of each member will complement the others, specific duties and job descriptions and how the team will function as a unit (i.e., communication, referral, care co-ordination, etc.). Detailed accounting of job responsibilities will not only facilitate comfort and empowerment within the workplace but also provide a resource for proper hand-off during staff turnover.

Appropriate reporting and communication tools between team members will avoid loss of knowledge should someone leave their position, and provide for a smoother transition and less consumer anxiety during changeover. It is also imperative during this time to designate a team leader for both clinical and administrative detailing. A team without a leader can quickly become fragmented and discouraged, eventually affecting consumer

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care, as witnessed during staff turnover with the Calgary Urban Project Society (CUPS) initiative in Calgary (see Appendix C for a description of this initiative).

Special consideration should be given to the vulnerability of the proposed targeted consumers: the urban marginalized. Consumers must also be supported appropriately throughout the process so that they may participate fully to the best of their abilities. Through partnerships with the local academic institution or local regional health authority, one must obtain ethics approval for any investigations involving consumers. Ethics approval can be a long, arduous process, as experienced by the Halifax Shared Care Program (see Appendix C for a description of this initiative), and therefore, careful forethought and contingency planning should be made.

Another area of interest for a collaborative mental health care initiative is caring for its staff and volunteers. In order to bring on board the most talented and well-suited providers, an incentive and professional development package may be necessary. As further incentive, cross-training programs within the care team could be instituted, allowing for reciprocal teaching and learning. This would not only provide an avenue for continuous professional development, increasing the core capacity of each individual team member, but also encourage group cohesion and respect.

A significant amount of time must be allotted for thorough planning to avoid large systemic and operational issues arising down the road during the critical implementation phases. Most of the work must be put in at the beginning. Community consultation during this time is key. Community anxiety over a new initiative for the urban marginalized will be common as their fear of the unknown and thought of having more 'unstable' individuals close to their work or homes plays on insecurities. A strong effort should be made to quell these fears and gain community support by advocating for the urban marginalized. Public education is essential.

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Implementation

During the implementation phase of the initiative:
- Stay anchored to the initiative's vision, mission and objectives (use along with the logic model as a guide for decision-making).
- Involve all stakeholders in pushing through the implementation barriers.
- Hold true to change management principles.
- Adhere to the plan of action while remaining flexible to adjust what isn't working.
- Foster continued buy-in and relationships from staff to community supporters.
- Nurture leaders in all collaborative partner organizations.
- Evaluate the initiative on an ongoing basis.
- Communicate progress to all stakeholders.
- Ensure adequate long-term funding is in place.

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Evaluation

Ensure that a continuous quality improvement framework is in place with periodic evaluation and needs assessments. Time and money are often cited as key barriers, however, an evaluation component should be built into the initiative and made a deliverable for year-end reporting. It provides community accountability and is often a requirement for funding. Proper evaluation and reporting can pay for themselves through expanded funding stream opportunities and community buy-in.

The evaluation process will be similar to that outlined for the needs assessment (a type of evaluation). The same approaches will be used but the area of concentration (organizational climate, operational processes, clinical integration, etc.) will depend on the type of evaluation being carried out. Again, consumers should be involved in the planning and implementation of the evaluation.

Indicator development is essential to an effective evaluation and provides excellent opportunities for consumer involvement. Indicators should measure what consumers consider to be important to their quality of life and well-being. Depending on what areas the initiative concentrates its efforts and the characteristics of the consumers, there are a wide number of indicators and outcomes that could be measured such as days of sobriety, employability, residential status, activities of daily living, etc. Instruments that have been used for such measurements are noted in the initiative descriptions found in Appendix C. Within the literature, no clear tool has been used consistently and tools are sometimes adapted for a specific initiative. One must keep in mind, however, that modifying validated tools decreases their validity and generalizability for comparison to other initiatives. Many of the provincial and national agencies such as the Canadian Mental Health Association (CMHA) and the Centre for Addiction and Mental Health (CAMH) in Ontario have developed indicator databases which may be useful in creating an evaluative framework.

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Key issues for consideration

1. **The urban marginalized are a heterogeneous population with multi-faceted marginalization that carry the common denominators of social exclusion and poverty.**

   It is imperative to approach all health-related concerns from a holistic perspective. One must consider the reality of the consumer's life environment - finances, social support, housing, addictions, past history and ability to follow a 'normal' treatment protocol - from a biopsychosocial viewpoint.

2. **Instability exists in all areas of life, and gains in one area (e.g., physical health) are quickly lost due to instability in other areas (e.g., mental health, social support, housing, etc.).**

   The movement towards successful intermediate outcomes may be maximized through strong reciprocal communication and linkages through formal or informal partnerships with all relevant supportive structures/services such as shelters, outreach, housing, social services, pharmacy, addiction services, etc. Staff who work directly with the consumer and have developed a high level of trust and social history will be key players and can help support more stable treatment progression. One must place the consumer at the centre of treatment planning to ensure he/she is willing and capable of proceeding with treatment and understand and support all aspects of the proposed strategy.

   Collaborative Frameworks: Evaluative research has shown that the most effective collaborations are formal, institutionalized interprofessional/interdisciplinary care teams. These tend to work best when team members are co-located under one roof (with satellite outreach arms). The care should be provided where access is maximized for consumers, such as at an inner-city community health centre or shelter-/drop-in-based offices. An assertive outreach interdisciplinary component can bring hard-to-reach consumers into the care setting and help build the trusting relationships required.

   The composition of the care team should be anchored to the multi-dimensional determinants of health that act as destabilizers for this population. Treatment should be approached from an inclusive 'stepped' care perspective that is tailored to the unique needs of the consumer. Other community assets can also be brought to bear on holistic treatment through less formal partnerships and relationship-building with service agencies that provide needed services on a less frequent basis. These can take a 'brokered' services approach to care.

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3. **Distrust and powerlessness are ingrained, complicating the therapeutic relationship and referral process.**

Empowerment of consumers through collaboration on all aspects of care is essential. Active listening and compassionate support for their definitions of issues, concerns and those they want involved in the collaboration are required to build a trusting, reciprocal relationship that maximizes efficacy of treatment. This may involve bringing in key sources of information or advocates when discussing options for care and support and foresight on appropriate referral.

4. **Unintentional injury is the leading cause of morbidity and mortality.**

This is important to keep in mind when assessing loss of consciousness (LOC) and physical ailments, and when planning for activities of daily living around functional status and current living environment.

5. **This population is highly susceptible to ailments more generally seen in underdeveloped nations and tends to present long after first symptoms appear leading to increased severity due to delay and living conditions.**

This expands the scope of differential diagnosis beyond that seen in regular practice and highlights the need to focus on the realities of their living conditions and the consumer's social/professional supports. Outreach becomes an important option for timely connection and treatment. This also speaks to the competing priorities when trying to survive in a life of social exclusion and poverty, especially when addiction is of concern. Healthy living and improved health status may not be the top priority when one needs to find security, food, money and shelter. One must take an active role in consumer education to improve their health literacy and stress the impact of poor health on other facets of life.

6. **Severity of ailments is highly correlated to residency status.**

This factor outlines the importance of not only caring for physical and mental ailments but also the requirement for advocacy and support to aid the consumer's movement towards stable, suitable and realistic living arrangements. This process is facilitated through collaboration with advocates and professionals in the fields of outreach, housing, addictions, social services, etc.

7. **Prevalence of concurrent disorders is high.**

When a concurrent disorder is present, evaluative evidence in the literature has strongly recommended not separating mental health and addiction treatment. An integrated strategy was shown to increase effectiveness. Therefore, formal collaboration between the two care plans is necessary. Having addiction layered on

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mental illness may make it more difficult to identify causal relationships and diagnosis.

8. **History of/susceptibility to violence complicates mental health stability.**

This may directly impact trust and vulnerability issues and will complicate the development of a therapeutic relationship. Root causes of health-related issues may also be difficult to distinguish and require tactful, intensive probing. A strong investment in building the foundation of a trusting relationship is needed.

9. **Lack of address, identification, transportation, telephone, social support and control over activities of daily living complicate treatment regimens or recommendations.**

These factors - especially a lack of identification, which in turn is hindered by a lack of permanent residency - can create direct barriers to health access when providers are on a fee-for-service remuneration schedule. These will directly impact treatment options and require negotiation with such supportive services as shelters and landlords around activities of daily living and access to medications and rest. A move to sessional or salary remuneration is important to consider.

10. **Social service policies/bureaucracy can severely limit accessibility.**

An impoverished consumer lacking social support and burdened with mental illness will find it difficult to negotiate the layers of red tape that block access to required or entitled benefits. Reporting requirements can be prohibitive. It is imperative to have experienced advocates and mental health care providers on the treatment team to support the consumer through such processes. Advocacy also becomes an important support in improving the therapeutic relationship.

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Appendix A: Expert panel

Expert Panel members included key stakeholders involved in collaborative mental health care for the urban marginalized. Leaders of collaborative mental health care programs, members of advocacy groups, service providers and consumers from across the country were approached to become part of the core Expert Panel.

The Expert Panel lead was **Dr. Peter Granger**, a family physician. Dr. Granger is the physician leader at Three Bridges Community Health Centre in Vancouver, BC and Director of the Division of Inner-City Medicine, Faculty of Medicine, University of British Columbia. Dr. Granger's support staff for the project were **Sean Nixon** and **Aleksi Suo**, project assistants, from the Division of Inner-City Medicine, and **Jamie Maskill**, project co-ordinator.

Dr. John Fraser, a family physician and **Ms. Pam Chisholm**, a registered psychiatric nurse, both with the North End Community Health Centre in Halifax, work with the shared mental health care program caring for the urban marginalized in that city. They were instrumental in providing evaluative research on their own program and enlisting key informants from their municipality to share their views on collaborative mental health care.

Dr. Lorne Tugg, a psychiatrist with the University of Toronto at St. Michael's Hospital in downtown Toronto, shared his insight and relevant documents on their shared mental health care initiative. He also worked with key Toronto stakeholders who are part of improving the health of the urban marginalized in their downtown core and surrounding areas.

Ms. Suzanne Rauda, a social worker from the Calgary Urban Project Society (CUPS), shared invaluable information outlining their shared mental health care program serving that city's homeless community. The CUPS program presented a thorough evaluation report of their initial pilot program and a strong literature review of relevant research into the health of the homeless, treatment modalities and the effectiveness, efficacy and applicability of different approaches to collaborative mental health care.

Mr. Rick Gremm, RSW, from Prince George, British Columbia, has embarked on a new initiative in collaborative mental health care for his municipality and is actively working with all levels of key stakeholders to design an evidence-based, consumer-centred initiative for the Northern Health Authority. He was integral in providing insight into developing such a model of care for the urban marginalized as well as documentation on the consultation and planning process involving local stakeholders.

A strong effort was made to enlist a consumer representative as a core member of the Expert Panel. It was felt that it was imperative to provide the consumer's point of view

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from the ground up when creating such a national toolkit. Unfortunately, it was not possible to locate such a member with all the proper support in place within the time constraints of the project. Every effort was made to obtain valuable insights from this stakeholder group in order to ensure suggested models of care would be responsive and relevant. In the future, as the toolkit evolves to meet the changing health care environment and needs of the population it seeks to serve, strong collaboration will be sought from consumers to give a consumer-centred approach to care.

This same concept must be considered when planning individual collaborative initiatives. Any attempt to better meet the needs of a population must seek collaboration with that population. From the initial vision to planning to implementation to evaluation, any project must be consumer oriented or it will be doomed to irrelevancy. This can be a difficult process but will increase the richness and accountability of the initiative and increase the potential for overall support and buy-in from all stakeholders. It will also work to legitimize the approach in the eyes of consumers and empower them to take control of their own health care and that of others in their community.

Different methods and tools for building such collaboration are outlined in this document. True collaboration seeks partnership on equal footing, not simply consultation. It is an open-ended dialogue and synergy that allows for reciprocal learning and growth as equals.

Published articles on the subject of working with urban marginalized community members living with mental illness consistently report the need to consider the individual consumer's unique life circumstance and the importance of creativity and flexibility to develop a consumer-centred, successful collaborative initiative. In light of this, initiatives must be directed by all key stakeholders involved, most importantly consumers, to maintain relevant, effective, equitable, high-quality treatment. Therefore, the Expert Panel felt it imperative to listen to the experts, those involved in the daily struggle for improved health, empowerment and capacity building for the urban marginalized population. Each member of the Expert Panel sought to elicit the feedback of key informants within their communities on their definition of effective collaborative mental health care and how it might best be provided. In addition, the input of individual consumers, service providers, advocates linked to organizations from across the country (such as shelters, drop-ins, social service agencies, mental health services, community health centres, affordable housing, addiction services and consumer advocacy groups) was obtained through teleconferencing and electronic correspondence to shape this toolkit. Most of their feedback has been woven into the body of this document but, in certain instances, direct quotations from these important contributors are included.

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Appendix B: Consultation process

1. Consumers, consumer advocates and local health care providers were contacted and asked to complete their respective questionnaires through the social and professional networks of the Expert Panel members within their own communities: Vancouver, Prince George, Calgary, Toronto, Ottawa and Halifax.

2. Feedback from workshop participants where the preliminary toolkit was presented was obtained at the National Shared Care Conference held in Ottawa in June 2005.

3. Community agencies were also contacted for consultation by the Expert Panel members. Below is a list of these agencies and organizations.

- Adsum House
- Ark Outreach
- Barry House
- Brunswick St. United Church
- Calgary Urban Project Society (CUPS)
- Centre for Addiction and Mental Health Shared Care Program
- Canadian Mental Health Association, Ottawa
- Community Outreach (St. Mike's)
- Contact Mental Health Outreach Service
- Direction 180
- Fred Victor Hostel
- Lookout
- Mainline
- Metro Non-Profit Housing Support Centre
- Metro Turning Point
- Regent Park Community Health Centre
- Robertson House
- Salvation Army
- Seaton House
- Sharing and Caring Social Club (CMHA Halifax)
- Sherbourne Health Corporation

- St. Michael's Family Medicine Program
- St. Michael's Community Advisory Panel for Mental Health
- Street Health Coalition
- Streethaven Hostel
- Three Bridges Community Health Centre

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Appendix C: Positive practice initiatives

Three Bridges Community Health Centre

Location

Urban core of Vancouver, BC

Purpose

To improve the mental and physical health of the centre's patients through collaborative models of care

> 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*

Introduction

The Three Bridges Community Health Centre has been in existence for approximately 10 years and is noted for the development of new initiatives and pilot projects in primary health care delivery. Originally, the clinic started as a pilot project designed to serve marginalized populations in the inner city community. Over time, sub-populations were identified with specific needs, and programs were developed to meet those needs. Approximately 1 year ago, it became possible to put in place a shared care model for mental health.

Target population
- Inner city consumers with various psychiatric disorders
- Youth with dual diagnoses (concurrent care)
- Youth with crystal methamphetamine psychosis

Team composition
- Family physicians
- Psychiatrists or psychiatry residents
- Nurse practitioner
- Registered nurses
- Addiction counsellors

Model

Family physicians refer suitable individuals to one of three part-time psychiatrists/ psychiatry residents both formally and informally. All providers enter clinical encounters on a common chart. Care co-ordination meetings are held at the request of any team member. Consumers are not required to have health care coverage to receive services.

Evaluation
- Charts are reviewed to determine the nature of the visits and whether or not consumers are now being seen less frequently in the emergency department.

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- Limitations of funding and time have made it difficult to carry out detailed evaluations. The initiative recently established a quality improvement committee and hope to include evaluations of the collaborative care component.

Successes
- Although the collaborative model has only been in place for a little over 1 year, the family physicians and psychiatrists are very pleased with the success achieved so far and believe that consumers are receiving much more comprehensive care.
- A concise, easy-to-use guide to care, outlining relevant health and social services found in the area, was created for street youth and has been in high demand, being used as a template for other information sources.
- Psychiatry residents have been found to assist in the program.

Limitations/barriers
- Despite best efforts, 15-20 drop-in consumers have had to be turned away on a daily basis. The addition of a nurse practitioner will help solve this concern.
- The Centre has been endeavouring for several years to fund a mental health counsellor to no avail but they continue to put that position in budget submissions.
- It has been very difficult to find psychiatrists able and willing to provide this model of care. Even though some limited funding has been found, generally, in Vancouver, all the psychiatrists are already overextended. When psychiatrists or residents are on leave, it is almost impossible to replace them.

Community partners
Community development offices provide liaison between the Centre and the neighbouring communities.

Funders
The majority of the funding is provided by the Vancouver Coastal Health Region. This includes space, salaries, administrative support and sessional funding for the physicians. Some of the psychiatrists utilize blended funding; the fee-for- service component is billed to the Ministry of Health.

Prince George collaborative initiative
This collaborative initiative of mental health and addictions service providers in Prince George, British Columbia aims to improve access to psychiatric consultation in a collaborative primary care framework for persons requiring concurrent treatment for a psychiatric disorder and a substance use disorder.

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Location
Prince George, Northern Health Authority (NHA), British Columbia

Phase of implementation
Planning – preliminary stakeholder discussions, resource assessment and framework/model design

Purpose
To provide a sustainable and effective primary care service for persons with mental illness and addictions

Objectives
- To implement the shared care model in which psychiatrists provide consultation to support family physicians in providing primary care in liaison with interdisciplinary teams in mental health and addictions
- To ensure effective recruitment and retention of psychiatrists
- To provide primary care supports/linkages to specialty consultation through interdisciplinary teams to implement care plans
- To plan for and co-ordinate the effective use of outreach psychiatrists visiting NH communities and using telepsychiatry in order to stabilize service and reduce demands placed on psychiatrists residing in communities
- To build the capacity of family physicians to provide primary care with the support of teams, access to psychiatrists for consultation, education and mentorship as well as sessional compensation and administrative support
- To enhance the role of shared care family physicians in emergency psychiatry, detox (family physician participation in psychiatry MOCAP) and inpatient care as well as making them an integral part of all mental health and addictions services across the community
- To improve access to acute care for the most ill by reducing demand on acute care through early intervention and community stabilization strategies
- To support referring hospitals, physicians and communities to work towards stabilization of consumers with mental illness and addictions issues locally
- To engage in partnerships with First Nations communities to assist them with linkages and working with primary care for mental health and addictions issues so crisis stabilization and case management approaches/linkages will be available within communities, enabling people to link more effectively with NH services before a person is in crisis

Introduction
This initiative is a broad-based approach with numerous components. It is being developed to increase recruitment and retention of psychiatrists for northern BC consumers by overcoming the barrier created by high service demands on those already

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practicing in this area. It is also meant to build capacity within the service provider population presently engaged with these communities through training and supportive structures for family physicians and interdisciplinary care teams providing primary mental health care.

This is being accomplished through numerous arms of the initiative such as telepsychiatry, outreach psychiatry and specialized training from UBC's Family Practice Department in the Faculty of Medicine. This Department provides the Enhanced Skills Training in Mental Health Program to general practitioners to equip them to provide primary care in mental health. This is a flexible program that can be tailored to each physician's learning needs and circumstances.

This initiative aims to build a responsive, foundational approach to community- and consumer-centred primary mental health care through community collaboration and anchoring to community assets and resources.

It is being organized around best practices for community mental health care outlined in a number of key documents:

- Minkoff, K. Developing standards of care for individuals with co-occurring psychiatric and substance use disorders. *Psychiatr Serv* 2001; 52:597-9.

- British Columbia Ministry of Health and Ministry Responsible for Seniors. *B.C.'s Mental Health Reform. Best Practices for Inpatient/Outpatient Services. 7. Shared Care: Linking Family Physicians with Mental Health Specialists*. Vancouver, BC: British Columbia Ministry of Health and Ministry Responsible for Seniors, 2002.

- *Connections: Clinical Partnerships for Mental Health and Addictions Services in NHA*. Northern Health Authority Position Paper, December 2003.

- Health Canada. *Best Practices - Concurrent Mental Health and Substance Use Disorders*. Ottawa, ON: Health Canada, 2002.

Target population
The initiative is aimed at individuals and families suffering from concurrent disorders who are consumers within the Northern Health Authority of British Columbia. This population of consumers, who live in urban areas such as Prince George, is characterized by a high prevalence of homelessness, HIV/Hepatitis C infection, mental illness and substance use disorders.

Model
Consulting Psychiatrist
- Provides consultation to physicians and other clinicians to ensure effective treatment of mental illness

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- Is available for emergency as determined through local protocols
- Recommends admissions to psychiatry units and participates in efforts to improve bed utilization
- Provides clinical leadership to interdisciplinary shared care team through clinical rounds, joint interviews and informal consultation
- Provides clinical education to physicians and other clinicians and recommends therapeutic interventions

Family Physician
- Conducts medical assessment, refers to psychiatrists and other specialists and consultants, prescribes and reviews medication
- Participates in care planning and providing medical approval for same
- Conducts initial assessment of individuals presenting in ER or community with acute symptoms of mental illness and/or addictions
- Directs all acute stabilization in consultation with psychiatrists, other specialists and care teams

Interdisciplinary Care Teams
- Includes mental health, addictions, special teams, non-NHA partner agencies
- Co-ordinate and implement care plan (assign care manager)
- Involve consumer and family in care planning
- Monitor and evaluate clinical interventions in consultation with physicians

Community Partners
- Central Interior Native Health Society (an interdisciplinary primary care clinic)
- Prince George Alcohol and Drug Services (NHA)
- Community Response Unit (NHA Mental Health and Addictions)
- B.C. Schizophrenia Society (BCSS activity center)
- Northern Interior Regional Mental Health Advisory Committee (mental health consumer advisory group based in Prince George)
- Department of Family Practice, University of British Columbia
- University of Northern British Columbia

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CUPS Shared Care Mental Health (SCMH) Program

Location

Calgary Urban Project Society (CUPS) Community Health Centre, Calgary, Alberta

Phase of implementation

Service began in June 2000, starting with a pilot phase and formative evaluation period of 3 years; an evaluation report was tabled in September 2003.

Purpose

- Integration of primary health care and mental health services to the homeless and those living in poverty
- The opportunity for individuals with mental health concerns to be assessed, diagnosed and treated within their context of living

Objectives

- To improve access and provide comprehensive mental health and primary health care services through effective co-ordination of service delivery and systems
- To create a shared care demonstration site that addresses and integrates the larger systems at the program, policy, and organizational levels

Introduction

This initiative grew out of a recognition, based on a pilot study of mental health services within Calgary, that there was a large sub-population within the community whose mental health concerns were not being adequately addressed.

Target population

The absolute and relative homeless and those individuals living in poverty requiring support for mental health issues

Team composition

Primary health care team

- Family physicians, nurse practitioner, registered nurses, licensed practical nurses, receptionist

Mental health care team

- Psychiatrist, mental health nurse, mental health social worker

Auxiliary support system

- Medical and social service teams within the CUPS community health centre

Model

The shared care model is health care delivery that includes the provision of multilevel mental health services and primary health care, based on the knowledge, skills and competencies within a team of interdisciplinary professionals. The team is collaborative in

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practice and functions at a highly integrated level that can address holistic care as determined within the determinants of health.

Evaluation

Evaluation was incorporated into the original proposal for funding of the initiative. The original evaluation team created a few stumbling blocks with unrealistic evaluation instruments that became prohibitive to complete and the creation of inclusion/exclusion criteria that were not consistent with CUPS' mandate to serve all consumers that required aid. These criteria were dropped at the end of the second year to allow entry of all consumers dealing with mental health concerns.

The evaluative instruments used for data collection were numerous. Some 15 different forms were brought forward and became a hindrance to productive evaluation efforts and service provision. These tools were also revamped numerous times by staff and were often left incomplete. To overcome this obstacle, the evaluation team employed various other data collection techniques such as interviews, focus groups, document reviews and literature searches in order to triangulate information and improve congruency. An evaluative report was tabled in 2003, which complemented numerous interim and annual reports during the previous 3 years of program implementation.

Successes
- The intent of the project has been realized and continues to evolve over time.
- Members of the SCMH team report and demonstrate increased knowledge, skills, and competencies in mental health. Thus, there is earlier detection and prompt intervention for mental health issues.
- Despite a substantial turnover in staff and leadership, the SCMH program has endured the instability, and has continued to develop and provide excellent service to the target population.
- Barriers to services and resources were removed, and there was increased access to mental health and primary health care services through collaborating and connecting consumers to the appropriate professional.
- Anecdotal reports of consumer progress by SCMH staff testify to improved daily functioning, better symptom control, increased compliance with medications, fewer consumer crises and hospitalizations, and increasing engagement with the program.
- Interdisciplinary respect and collaboration facilitates a more holistic approach to a comprehensive range of mental health conditions, enhancing the outcomes for consumers and satisfaction for team members.
- The evaluation was re-aligned with the inclusive spirit of CUPS and the SCMH program attended to all consumers who presented with mental health issues.
- Increased linkages within the community have improved resource availability.

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- The integration of mental health specialists offers an additional level of expertise and service while managing time, and its associated costs, efficiently.

Limitations

- The lack of a clear description of the shared care model intended for implementation and definition of the population created confusion for both the SCMH team and evaluators.
- The evaluation design was inconsistent with CUPS' mission to "serve all persons".
- Frequent turnover within the SCMH team resulted in loss of project knowledge, collaborative experience and service gaps that threatened integration and development within the team and the project itself.
- The complexity of working with individuals with concurrent conditions was challenging.

Community partners

Project partners

- The United Way of Calgary and Area
- Alberta Health and Wellness
- The Alberta Medical Association
- The Alberta Mental Health Board
- The Calgary Health Region
- The University of Calgary

Community affiliations

Partnerships were created within the community to address the multifaceted needs of consumers. This included multiple service agencies and other health care providers that addressed a wide range of complementary services that ensured continuity of care.

Funders

- Health Innovation Fund
- United Way of Calgary and Area
- Alberta Medical Association

Shared Care Clinical Outreach Service

Location

Various host sites in inner-city Toronto, Ontario

Phase of implementation

Fully operational in December 1999; descriptive evaluation completed October 2001; sustainability and enhancement of services continues

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Purpose
To deliver services to treat the physical and mental health needs of homeless people in a comprehensive, accessible and respectful manner

Objectives
- To provide continuous medical treatment to people who are homeless and mentally ill
- To provide continuous mental health treatment and care
- To promote personal safety
- To assess for substance abuse
- To help consumers gain access to community supports by providing reports, letters, medical and psychiatric documentation as required
- To help consumers connect with local office-based physicians, when appropriate
- To provide on-site support to help host site staff engage and work with large numbers of consumers
- To reduce hospitalization but, when necessary, provide access to beds
- To optimize people's potential for independent community living

Introduction
Funding for the Shared Care Clinical Outreach Service began in February 1998, and the program became fully operational in December 1999. During the planning phase, key stakeholder involvement was obtained to design a responsive service delivery model. Memoranda of understanding and service agreements were brokered with the host sites and an evaluation component was outlined in the funding applications. Evaluative data collection began immediately, allowing for interim analysis and reporting to stakeholders and the program planners to increase accountability and responsive, continuous quality improvements. Essentially, small, independent shared care teams were formed and worked out of satellite offices within the walls of host sites in an integrated, collaborative manner.

Six key elements were integrated into service provision (as outlined by the Shared Care Clinical Outreach Program):

- **Accessibility**
  As a single, streamlined point of access, the shared care team works with staff at the host site to help bridge the gap between services ranging from health care to income assistance, legal aid and housing.

- **Trust**
  Being on site every day allows the nurse and outreach worker to slowly build relationships of trust and respect with all consumers at the host site. The nurse and outreach worker can then determine which people are not being reached by other services. Consumers see the shared care team for treatment of acute physical health

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problems, such as foot care or strep throat, as well as diagnosis and treatment of serious mental health problems.

- **Familiarity**
  On-site care, in a familiar environment, helps consumers avoid the stigma of entering a psychiatric treatment facility and allows them to be seen on a regular basis

- **Site-specific service**
  Each site becomes a customized service, varying with the needs and resources of that particular location (all-men, all-women, etc.). The team works with host site staff to bring services to consumers, rather than bringing the consumers to the service.

- **Connections**
  Seeing consumers in their own environment every day allows the team to recommend treatment options that are acceptable to consumers and to work as their advocates. Staff can make referrals for consumers and conduct follow-up work out of one office.

- **Integration**
  The team is pivotal in co-ordinating consumers' service needs and developing treatment plans. The shared care office is often the initial point of contact for consumers and other agency staff.

Target population
Individuals frequenting the shelter host sites of Toronto's Shared Care Outreach who suffer from mental illness and/or physical health conditions that are not being cared for by other community programs or services

Team composition
- General practitioners
- Psychiatrists
- Psychiatric nurses
- Outreach workers
- Housing support workers
- Shelter staff

Model
All team members hold salaried or sessional positions allowing for compensation and flexibility with care co-ordination, educational sessions and other generally non-billable services required for effective collaboration and team functioning. The registered nurse and outreach worker act as the foundation of the team for consumer engagement, examination, treatment and referral to the GP or an external community service. They refer consumers deemed appropriate to the GP who visits the host sites routinely throughout the week. The psychiatrist is a salaried staff consultant who also makes

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regular visits to the host site and works with consumers directly or through team consultation, education, care co-ordination and program development. Other service workers are engaged in this holistic model as situational collaborators for the care of the unique needs of the consumer being served. Funding for housing support workers has also been obtained, and they have been integrated into the well-rounded care provided to this population.

Evaluation

Evaluation was built in as a key component of the initiative at the funding stage prior to completing the planning and implementation phases. Using a mixed-methods approach for triangulation (qualitative and quantitative research methodology), a descriptive report was tabled in October 2001. The instruments used for data collection were daily contact logs that tracked consumer service contact, personal history forms, client satisfaction questionnaires (CSQ-8), observations, focus groups, semi-structured interviews and literature review. Interim data analysis and reporting were conducted from the beginning of the project to provide stakeholders and service providers with information on successes, needed improvements, resource use and required re-allocation for an accountable, relevant service model.

Successes
- Stakeholder engagement, education, empowerment and collaboration in designing services during the planning phase prior to implementation
- Consumer engagement, empowerment and reciprocal trust-building
- Integration of host services and shared care services into a fluid service continuum for consumers
- Holistic consumer care from a biopsychosocial perspective to provide a one-stop service
- Well-planned evaluation component prior to initiation in order to collect relevant data in a prospective approach
- Successful completion of a descriptive evaluation to inform strengths and barriers to service
- Consumer advocacy and educational in-service cross-training to influence policy integration
- Team members' dedication to their work and helping the individual consumers
- Providing care where the consumer is most comfortable (where they eat and sleep)
- Consumer satisfaction (as rated by CSQ results)
- Daily Contact Log (DCL) data used for responsive re-alignment of services, tracking of utilization and providing accountable reporting to stakeholders such as funding agencies
- Flexibility of the model of care on a site-by-site basis to integrate appropriately into a pre-existing, unique organizational environment

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Limitations/challenges
- Acceptance into an established program
- Roles, responsibilities and shared tasks between shelter staff and shared care staff
- Clear objectives and consumer inclusion/exclusion criteria
- Hours of operation and inconsistent outreach/clinic hours
- Dedicated and appropriate space within host sites
- Confidentiality, information sharing and documentation acceptable to all stakeholder agencies
- High service demand which led to poor interagency communication and care co-ordination
- Insufficient training and orientation
- Consumer institutionalization into shelter life due to lack of affordable housing and lack of desire to leave social supports within the shelter system
- Transience of population as a barrier to continuity of care
- Barring hard-to-serve consumers from service
- Lack of identification to secure external health services, medication, bank accounts and social service funds
- Staff burn-out due to high service demand and unrealistic expectations of consumer outcomes
- Consumer tracking mechanism to avoid service overlap, duplication or gap in service
- Long wait lists for other community services

Community partners
- Centre for Addiction and Mental Health
- Toronto General Hospital
- St. Michael's Hospital
- Various host shelters
- Houselink Community Homes
- Good Shepherd Centre
- External community resources (complementary programs and services such as hospitals, community health centres, public health nurses, churches, case management programs, police services, universities and colleges)

Funders
- Centre for Addiction and Mental Health
- Partners' gifts-in-kind
- Ontario Ministry of Health and Long-term Care
- Government of Canada

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Capital District Shared Mental Health Care Program

Location

Various primary care sites in Halifax, Nova Scotia

Phase of implementation

Service began in 1997 at the North End Community Health Centre and at Cowie Hill Family Medicine; it was expanded to include a rural service centre. A summative evaluation was carried out in 1998 with funding from the Health Transition Fund. It continues to improve upon sustainability and enhancement of services.

Purpose

To improve the quality of mental health care provision across the lifespan in the Capital Health District community (Halifax)

Objectives

- To improve access to appropriate mental health services for people in the community
- To improve the mental health outcomes of people in the community
- To increase the knowledge base of care providers regarding the detection and management of mental health disorders
- To improve collaborative/consultative relationships between primary care and mental health providers

Introduction

The shared care model was implemented in the Halifax area when it was noted that community members suffering from mental illness were not gaining access to effective care, especially within the North End community, an area dominated by impoverished and socially isolated individuals and families that lack support on numerous levels of personal and social functioning. This followed in-depth collaboration with the local community stakeholders to identify gaps in service and community assets that could be leveraged to support such an endeavour.

Mental health workers and psychiatrists were hired to provide clinical support in direct care, consultation and education to the two primary care sites and later to the expanded rural site. Directive outreach was carried out with community agencies providing social services to settings such as shelters and drop-ins in order to gain buy-in, increase continuity of care, increase the reach of service to hard-to-serve clients, increase relevancy of service and avoid duplication of services. Equitable, reciprocal communication and education were ingrained for interagency collaboration to build capacity for a synergistic, holistic approach to consumer-centred care.

Two working groups, the evaluation working group and the sustainability working group, were struck to carry out key functions to promote the success of the initiative. The evaluation component was fundamental to demonstrate service improvement and

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stakeholder accountability. Many key successes and shortcomings were outlined and used as a blueprint for quality improvement and dissemination of the model to other interested professionals outside of Halifax.

Target population
- *Primary care consumers* experiencing difficulty in gaining access to mental health services through the traditional system
- *Primary care staff* lacking appropriate support and training to provide care to their consumers that suffer from mental illness
- *Individuals utilizing front-line social agencies* that tend to be in frequent crises without appropriate supports to improve health or life outcomes
- *Front-line agency staff* who tend to be the initial contact for unsupported, under-served individuals in crisis but lack the time, training and support necessary to aid these community members through their time of need.

Team composition
- General practitioners
- Psychiatrists
- Nurses
- Mental health workers
- Community agency staff

Model
All team members hold salaried positions allowing for compensation and flexibility with care co-ordination, educational sessions and other generally non-billable services required for effective collaboration and team functioning. The mental health worker (nurse, social worker, occupational therapist, etc. – depending on requirements of the primary care site as determined by consumer demographics) is the pivotal player in this care model. They act as a liaison between all stakeholders and as the first line of clinical care and referral. The mental health worker, though working out of an office in the primary care clinic, performs outreach on a regular basis to the community agencies. They maintain constant contact between agency staff, consumers at their place of residence, the shared care team and all other necessary community resources. After obtaining a referral from agency staff or another advocate (including self-referral), the mental health worker will decide when a referral to the GP is appropriate and when to involve other shared care team members. Referrals to the psychiatrist may follow, if appropriate.

Regular care co-ordination meetings are held, and there is constant communication on consumer matters. To augment the resources and capacity of the shared care team, numerous agreements have been established with Dalhousie University and their health professional programs to allow for undergraduate, residency and internship rotations within the shared care settings. This greatly increases the ability of the model to serve its

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intended populations, increases its community accountability and invests in a future resource pool from which to draw. Agency staff also functioned as key players in the model, given their intimate knowledge and often deep relationship with potential consumers, allowing access to a sub-population of consumers that may have never been served without their involvement.

Evaluation

Evaluation was built in as a key component of the initiative at the funding stage prior to completing the planning and implementation phases. Using a mixed-methods approach for triangulation (qualitative and quantitative research methodology), a summative report looking at impact assessment and process evaluation was tabled in 2001. The instruments used for data collection were:

- Shared mental health care referral data form
- Outpatient department referral/intake form
- Assessment and intervention
- Psychiatric contact form
- Treatment outcome
- Visit satisfaction questionnaire (VSQ)
- DUKE health questionnaire
- Weekly activity sheet
- Family physician knowledge assessment questionnaire
- Provider focus groups

Successes

- The model met the four program objectives; numerous statistically significant outcomes were described in the evaluation report that were anchored to the four key objectives.
- Consumer satisfaction was extremely high in all three sites.
- There was a better mix of providers in more appropriate settings in the community.
- There was a perceived increase in detection of mental illnesses.
- Wait times were decreased leading to fewer escalating health problems due to untreated conditions.
- Follow-up and continuity of care improved.
- The number of 'no-shows' decreased.
- Access was improved, especially for marginalized community members.
- Stigma surrounding mental illness and its treatment was reduced.
- There was improved provider satisfaction.

Limitations

- Transferability to fee-for-service environment
- Funding at an appropriate level

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- Access to professional staff especially GPs and psychiatrists
- Physical space for the initiative
- Interprofessional communication
- Apparent lack of validity of family physician knowledge assessment questionnaire
- Lack of involvement of community agencies in evaluation component
- Planning phase not adequately carried out prior to introduction of the model
- Enormous time delay for ethics approval for the evaluation components

Community partners
- Queen Elizabeth II Health Sciences Centre
- The Nova Scotia Hospital
- The IWK-Grace Health Sciences Centre
- Central Regional Health Board
- Nova Scotia Department of Health
- Dalhousie University
- Numerous community health and social service agencies
- Host community health centres

Funders
- Health Transition Fund
- Partners' gifts-in-kind

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Appendix D: Websites

Canadian sites

Centre for Addiction and Mental Health: http://www.camh.net
The Centre for Addiction and Mental Health (CAMH) is a provincial organization and teaching hospital located in Toronto, Ontario. It pursues a mandate to support and deliver consumer-centred work through its clinical programs, research, health promotion, public education, program planning and development, professional training and public policy development. Its resources and publications are indispensable for evidence-based program planning.

Canadian Mental Health Association: http://www.cmha.ca
The Canadian Mental Health Association (CMHA) is a national body responsible for promoting the mental health of all Canadians and supporting the recovery and resilience of people experiencing mental illness. It has branches across the country and is heavily involved in care of the homeless mentally ill through all its professional disciplines. The CMHA does this work through the programs and services they offer in communities with the involvement of professionals. CMHA's website contains a host of resources and publications from research reports to public policy statements that anchor treatment and health promotion efforts to best practices.

National Homelessness Initiative, Government of Canada:
http://www.homelessness.gc.ca/home/index_e.asp
The National Homelessness Initiative provides support for community-based responses to end homelessness. Through its numerous funding streams, it is a strategic investor of federal monies into community programs that utilize evidence-based approaches. On its website, there are case studies, program planning and evaluation tools, research publications and numerous other valuable resources.

Delivering healthcare to the homeless, University of Ottawa:
http://www.med.uottawa.ca/homeless/
This is an on-line curriculum from the University of Ottawa that provides a good overview of health care issues in working with homeless individuals from mental health and alcoholism to special sub-populations such as youth and women.

FASD Connections, Homeless: http://www.fasdconnections.ca/id83.htm and Homelessness Research Virtual Library, IHPR, UBC: http://www.hvl.ihpr.ubc.ca/
Both websites provide a wealth of current research documents concerning homelessness, searchable by subject and keyword. They also give links to other useful websites.

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B.C. Homelessness and Health Research Network: http://www.sharedlearnings.org/
This website is hosted by Raising the Roof and includes many informational tools related to homelessness. It contains case studies, initiatives and guidelines applicable to a diverse number of program-specific efforts.

U.S. sites
Health Care for the Homeless Clinicians' Network:
http://www.metrokc.gov/health/hchn/providers.htm
This is a provider network based in Seattle, Washington. Its mandate is to provide professional services including outreach to over 60 locations throughout the county in such agencies as shelters and drop-ins. The website has informational resources such as clinical guidelines, evidence-based publications, public policy papers and professional training modules.

National Health Care for the Homeless Council: http://www.nhchc.org/
This is a national organization that provides resources to communities, service providers, advocates and consumers to aid in the equitable care of homeless individuals in the US. Information is available concerning provision of care, policy and advocacy, training and education, respite care and publications.

Health Disparities Collaboratives: http://www.healthdisparities.net/hdc/html/home.aspx
The HDC is an innovative health initiative that seeks to: (1) generate and document improved health outcomes for underserved populations; (2) transform clinical practice through new evidence-based models of care; (3) develop infrastructure, expertise and multi-disciplinary leadership to improve health status; and (4) build strategic partnerships.

The HDC is currently moving from the chronic disease management model to the community-oriented primary health care (COPH) model. The website contains diverse informational resources. They are aimed at all levels of health care stakeholders from managers to service providers to consumers.

Substance Abuse and Mental Health Services Administration, United States Department of Health and Human Services: http://www.samhsa.gov/index.aspx
This US government website touches on a multitude of subjects from mental health service transformation to strategic prevention frameworks to concurrent disorders to homelessness. It provides links to evidence-based programming toolkits for health administrators and providers as well as important information on program planning for the reduction and stabilization of the mentally ill homeless population.

The National Association of Community Health Centers: http://www.nachc.com/
The NACHC is a national, non-profit agency that works to reduce disparity in health provision and enhance the quality of care for underserved populations. It represents a

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network of over 1000 qualified CHCs. According to its mission statement, it: " serves as the major source for information, data, research and advocacy on key issues affecting community-based health centers and the delivery of health care for the medically underserved and uninsured in America. Provides education, training, technical assistance and leadership development to health center staff, boards and others to promote excellence and cost-effectiveness in health delivery practice and community board governance. Builds partnerships and linkages that stimulate public and private sector investment in the delivery of quality health care services to medically underserved communities."

International sites

International Society for Urban Health: http://www.isuh.org/

This society is international in scope and promotes health care of people living in an urban environment. They publish the Journal of Urban Health, highlight numerous community research centres and publish online literature reviews of peer-reviewed articles dealing with urban health.

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Appendix E: Tools and resources

The following recommendations for providing health care for homeless individuals are from *Adapting Your Practice: General Recommendations for the Care of Homeless Patients* (Bonin, 2004):

Health Care for Homeless Patients: Summary of Recommendations

Diagnosis and evaluation
History

- *Living conditions* – Ask where patient is staying. Explore access to food, water, restrooms, place to store medications; exposure to toxins, allergens, infection; threats to health/safety. Be alert to possible homelessness.
- *Prior homelessness* – what precipitated it; whether first time, episodic, chronic; history of foster care
- *Acute/chronic illness* – Ask about individual/familial history of asthma, chronic otitis media, anemia, diabetes, CVD, TB, HIV/STIs, hospitalizations, medications.
- *Prior providers* – what worked well, does patient have regular source of primary care
- *Mental illness/cognitive deficit* – problems with stress, anxiety , appetite, sleep, concentration, mood, speech, memory, thought process and content, suicidal/homicidal ideation, judgment, impulse control, social interactions
- *Developmental/behavioral problems* – adaptive/maladaptive, underlying pathology
- *Alcohol/nicotine/other drug use* – Ask about use (amount, frequency, duration); look for signs of substance abuse/dependence.
- *Health insurance/prescription drug coverage* – entitlement assistance
- *Sexual* – gender identity, sexual orientation, behaviors, partners, pregnancies, hepatitis/ HIV/other STIs
- *History and current risk of abuse* – emotional, physical, sexual abuse; knowledge of crisis resources, patient safety
- *Legal/violence history* – legal problems, violence against persons or proper ty, domestic/interpersonal violence, history of arrest/incarceration, treatment while incarcerated
- *Regular/strenuous activities* – consistent routines (treatment feasibility); level of strenuous activity
- *Work history* – longest time held a job, occupational injuries; vocational skills and interests
- *Literacy* – If "trouble reading," offer help with intake form; assess ability to read English.
- *Nutrition/hydration* – diet, food resources, preparation skills, liquid intake, [might also include food allergies]

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- *Cultural heritage/affiliations/supports* – involvement with family, friends, faith community, other sources of support
- *Strengths* – coping skills, resourcefulness, abilities, interests

Physical examination
- *Comprehensive exam* – at first encounter if possible, following standard clinical guidelines
- *Serial, focused exams* – for patients uncomfortable with full-body, unclothed exam at first visit
- *Dental assessment* – age appropriate teeth, obvious caries, dental/referred pain, diabetes patients
- *Special populations* – Victims of abuse, sexual minorities

Diagnostic tests
- *Interpersonal violence* – Posttraumatic Diagnostic Scale for Use with Extremely Low-income Women
- *Mental health screenings* – Patient Health Questionnaire (PHQ-9, PHQ-2), MHS-III
- *Substance abuse screening* – SSI-AOD
- *Cognitive assessment* – Mini-Mental Status Examination (MMSE)
- *STI screening* – for chlamydia, gonorrhea, syphilis, HIV, HBV, trichomonas, bacterial vaginosis, monilia
- *Baseline labs* – including liver function tests
- *PPD* – for patients living in shelters and others at risk for tuberculosis
- *Health care maintenance* – cancer screening for adults, EPSDT for children
- *Developmental assessment* – Denver II or other standard screening tool
- *Forensic evaluation* – if strong evidence of child abuse

Plan and management
Plan of care
- *Basic needs* – Food, clothing, housing may be higher priorities than health care.
- *Patient goals & priorities* – immediate/long-term health needs, what patient wants to address first
- *Action plan* – simple language, portable pocket card
- *After hours* – extended clinic hours, how to contact medical provider when clinic is closed
- *Safety plan* – if interpersonal violence/sexual abuse suspected; mandatory reporting requirements
- *Emergency plan* – contacting PCP before going to ER, location of emergency facilities
- *Adherence plan* – clarification of care plan/patient feedback; use of interpreter, lay educator if LEP

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Education, self-management

- *Patient/parent instruction* – simple language/illustrations, confirm comprehension; pocket card listing immunizations, chronic illnesses, medications
- *Prevention/risk reduction* – protection from communicable diseases
- *Behavioral change* – individual/small group/community interventions, motivational interviewing
- *Nutrition counseling* – diet, dietary supplements, food choices, powdered formula for infants [might also include food preparation]
- *Peer support* – support groups, consumer advocates
- *Education of service providers (shelter/clinical staff)* – re: special problems/needs of homeless people

Medications

- *Simple regimen* – low pill count, once-daily dosing where possible; capsules/tablets for child less than 5 yrs
- *Dispensing* – on site; small amounts at a time to promote follow-up, decrease risk of loss/theft/misuse; avoid written prescriptions when possible.
- *Storage/access* – in clinic/shelters; if no access to refrigeration, do not prescribe meds that require it.
- *Patient assistance* – entitlement assistance, free/low-cost drugs if readily available for continued use
- *Aids to adherence* – harm reduction, outreach/case management, directly observed therapy
- *Potential for misuse* – inhalants, bronchodilators/spacers, pain medications, clonidine, needles
- *Side effects* – primary reason for non-adherence (diarrhea, frequent urination, nausea, disorientation)
- *Analgesia/symptomatic treatment* – patient contract, single provider for refills of pain medications
- *Immunizations* – per standard clinical guidelines; influenza, pneumococcus, HAV, HBV, Td for adults
- *Antibiotics* – standard liquid measurements, importance of completing regimen, RSV prophylaxis
- *Dietary supplements* – multivitamins with minerals, nutritional supplements with lower resale value [might also include individual vitamins and minerals]
- *Managed care* – Prescribe medications that don't require pre-authorization, assistance getting prescriptions filled

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Associated problems, complications

- *No place to heal* – efficacy of medical respite/recuperative care, supportive housing
- *Masked symptoms/misdiagnosis* – e.g., weight loss, dementia, edema, lactic acidosis
- *Developmental discrepancies* – focus on immediate concerns, not possible future consequences
- *Functional impairments* – documentation of disabilities, assistance with SSI applications
- *Dual diagnoses* – integrated treatment for concurrent mental illness/substance use disorders
- *Loss of child custody* – support for parent of child abused by others, and for abused parent

Follow-up

- *Contact information* – phone numbers, e-mail addresses for patient/friend/family/case manager
- *Medical home* – to coordinate/promote continuity of health care
- *Frequency* – more frequent follow-up, incentives, nonjudgmental care regardless of adherence
- *Drop-in system* – anticipate/accommodate unscheduled clinic visits
- *Transportation assistance* – provide carfare/tokens, help with social service coverage for transportation services
- *Outreach, case management* – connect with community outreach programs, HCH providers
- *Monitor school attendance* – address health/developmental problems with family/school.
- *Peer support* – client advocate to accompany patient to clinical appointments/ambulatory surgery
- *Referrals* – linkage with specialists, pro bono care, providers sensitive to underserved populations

Model of care

Service delivery design

- *Multiple points of service* – clinics, drop-in centers, outreach sites; electronic medical records, if feasible
- *Integrated, interdisciplinary* – coordinated medical and psychosocial services
- *Flexible service system* – walk-ins permitted, help with resolving systems barriers
- *Access to mainstream health system* – ready access to secondary/tertiary care

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Outreach and engagement

- *Outreach sites* – streets, soup kitchens, shelters, other homeless service sites [might also include community kitchens and community gardens]
- *Clinical team* – use of outreach workers/case managers and medical providers to promote engagement
- *Therapeutic relationship* – based on trust, nonjudgmental care, frequent encounters
- *Incentives* – to promote engagement: food, drink, vouchers, hygiene products, subway/bus fare (tokens)

Standard of care

- *Evidence-based medicine* – Make elimination of health disparities a clinical goal.

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The following description of a model of care for homeless individuals is from *Adapting Your Practice: General Recommendations for the Care of Homeless Patients* (Bonin, 2004):

Service delivery design

- *Multiple sites* Provide care where homeless people congregate, at multiple points of service (e.g., clinics, drop-in centers and outreach sites), as feasible. Consider using electronic medical records to promote continuity of care among multiple service sites.

- *Integrated, interdisciplinary services* Coordinate medical and psychosocial services across multiple disciplines and delivery systems, including the provision of food, housing, bathing facilities and transportation to service sites. Optimally, medical and psychosocial services should be easily accessible at the same location; fragmented service systems do not work well for homeless people. Resolution of the patient's homelessness is prerequisite to resolution of numerous health problems and should be a fundamental goal of the health care team.

- *Flexible service system* Access to care for initial evaluation or ongoing treatment depends on the existence of a flexible service system that homeless individuals can use on a walk-in basis or through outreach workers. Provide drop-in centers or designated slots for walk-in clients in every primary care clinic so that appointments are not necessary. Help to identify and resolve system barriers that impede access to care, recognizing that some barriers are not within the patient's capacity to control. Enlist the patient's assistance, and with his/her permission, utilize everyone in the community with whom s/he has contact to facilitate delivery of care.

- *Access to mainstream health system* Ensure that all homeless patients requiring referrals for secondary or tertiary care have access to the mainstream health care delivery system. Full collaboration between primary care providers and specialists is the only effective treatment and management strategy. Network with other community service providers who are sensitive to the needs of homeless patients to facilitate specialty referrals; assist with transportation and accompany patients to appointments. Frequently, the main problems for homeless clients are systems and access barriers rather than differences in intent or desire to adhere to a plan of care.

Outreach and engagement

- *Outreach sites:* Conduct outreach on the streets, in soup kitchens, in shelters and other places where homeless people receive services.

- *Clinical team:* Use outreach workers and case managers to promote initial engagement with the patient. Hire staff proficient in languages used by the populations served. Involvement of all members of the clinical team (outreach workers, case managers, medical providers, mental health professionals, substance abuse counselors and a dietitian) in care planning and co-ordination is important to

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facilitate engagement, diagnosis, treatment and follow-up of persons experiencing homelessness.

- *Therapeutic relationship:* Nonjudgmental and supportive patient interactions with members of the clinical team are essential for successful engagement in a therapeutic relationship. Recognize that caring for homeless patients is as much about building relationships as about clinical expertise.

- *Incentives:* Offer incentives to promote engagement – e.g., food and drink (or meal vouchers), hygiene products (toothpaste, brushes, socks), subway/bus cards or tokens.

Standard of care

Evidence-based medicine: Provide the same, evidence-based standard of care to patients who are homeless as to patients who have more resources. Elimination of health disparities between these patients and the general population should be a clinical goal.

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Appendix F: 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).

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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
BC	British Columbia
BCSS	British Columbia Schizophrenia Society
CAMH	Centre for Addiction and Mental Health
CCMHI	Canadian Collaborative Mental Health Initiative
CDM	Chronic Disease Management
CHC	Community Health Centre
CMHA	Canadian Mental Health Association
COPD	Chronic Obstructive Pulmonary Disease
COPH	Community Oriented Primary Health
CSQ	Client Satisfaction Questionnaire
CUPS	Calgary Urban Project Society

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CVD	Cardiovascular Disease
DCL	Daily Contact Log
EPSDT	Early and Periodic Screening, Diagnostic, and Treatment
ER	Emergency Room
GP	General Practitioner
HAV	Hepatitis A Virus
HBV	Hepatitis B Virus
HCH	Health Care for the Homeless
HDC	Health Disparities Collaboratives
HIV	Human Immunodeficiency Virus
LEP	Limited English Proficient
LOC	Loss of Consciousness
MHS-III	Mental Health Screening Form III
MMSE	Mini-Mental Status Examination
MOCAP	Medical On-Call Availability Program
NACHC	National Association of Community Health Centres
NH	Northern Health
NHA	Northern Health Authority
NPO	Non-Profit/Not-for-Profit Organization
ON	Ontario
PCP	Primary Care Physician
PHQ	Patient Health Questionnaire
PPD	Purified Protein Derivative; TB skin test
RFP	Request for Proposal
RSV	Respiratory Syncytial Virus
RSW	Registered Social Worker

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SCMH	Shared Care Mental Health
SSI	Supplemental Security Income (U.S.)
SSI-AOD	Simple Screening Instrument for Alcohol and Other Drug Abuse
STI	Sexually transmitted Infection
TB	Tuberculosis
Td	Tetanus and Diphtheria (immunization)
UBC	University of British Columbia
VSQ	Visit Satisfaction Questionnaire
WHO	World Health Organization

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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