



Canadian
Collaborative
Mental Health
Initiative

Initiative
canadienne de
collaboration en
santé mentale

Collaborative Mental Health Care in Primary Health Care: A Review of Canadian Initiatives

Volume II Resource Guide

5
vol.II

December 2005

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Acknowledgements

The authors would like to recognize the contributions of the CCMHI Steering Committee members for their assistance in identifying key informants, and express gratitude to the initiative contributors for their time and energy in completing the descriptions of their collaborative initiatives.

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Suggested Citation: Pauzé E., Gagné MA. Collaborative mental health care in primary health care: A review of Canadian initiatives. Volume II : Resource guide. Mississauga, ON: Canadian Collaborative Mental Health Initiative; December 2005. Available at: www.ccmhi.ca

Ce rapport est disponible en français.

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This document was commissioned by the CCMHI Secretariat. The opinions expressed herein do not necessarily reflect the official views of the Steering Committee member organizations or of Health Canada.

Funding for the CCMHI was provided by Health Canada's Primary Health Care Transition Fund.



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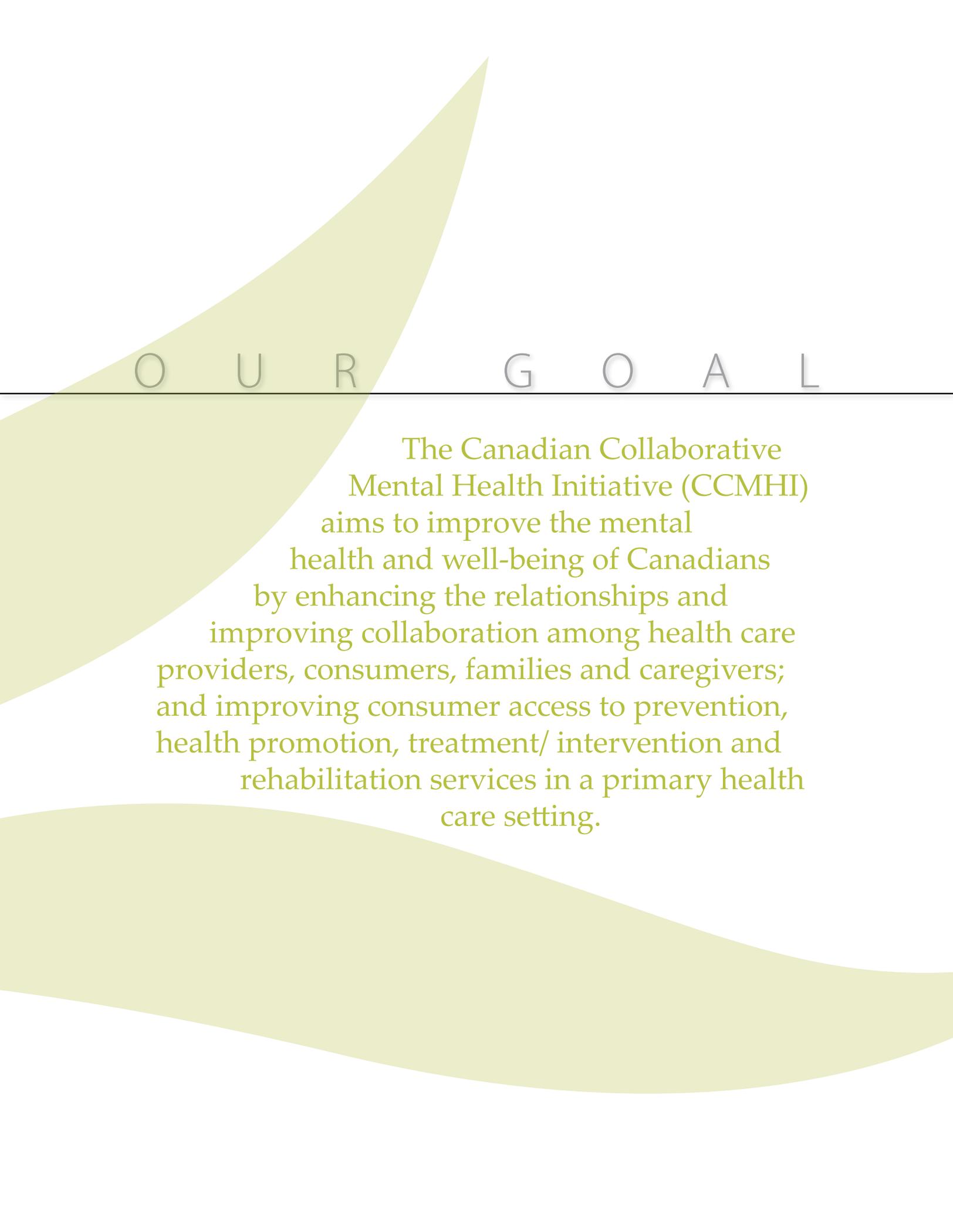
*A paper for the
Canadian Collaborative Mental Health Initiative
(Volume II of II)*

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December 2005



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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

The current document is **Volume II** of the report *Collaborative Mental Health Care in Primary Health Care: A Review of Canadian Initiatives*, which aims to describe as many self-identified collaborative mental health care initiatives as possible, to provide specific examples and trends of the current state of collaborative mental health care in Canada.¹

The objectives of the two-volume report are to:

- **Volume I: Analysis of Initiatives** - identify key themes and trends of collaborative mental health care according to the *Collaborative Mental Health Care Framework* (Gagné, 2005), in order to link these observations to previous research and best practices, and thus,
- **Volume II: Resource Guide** (this document) - create a resource that will support providers, planners, educators, and policy makers in the developing and enhancing collaborative mental health care activities in primary health care.

¹ This report builds upon and expands on the document created by The College of Family Physicians of Canada and the Canadian Psychiatric Association. Shared mental health care in Canada: a compendium of current projects, published in Spring 2002, (Kates and Ackerman, 2002). Available at: <http://www.shared-care.ca/pdf/compendium.pdf>

INTRODUCTION

Mental illness affects all Canadians: studies have estimated that nearly one in five adults will personally experience a mental illness during a one-year period (Offord et al., 1996; Bland et al., 1988). Even if a person does not have a mental illness, he or she is likely to know a family member, friend, or colleague who does (Health Canada, 2002). Considered a worldwide phenomenon (WHO, 2005), no one is immune to mental illness; it affects people of all ages, cultures, educational, and income levels (Health Canada, 2002). Mental or behavioural disorders represent four of the ten leading causes of disability around the globe (WHO, 2001). The economic costs of mental illness to the national economy are profound, with an estimated \$14.4 billion in lost productivity and health care costs (Stephens and Joubert, 2001).

Data from the Canadian Community Health Survey (CHS) Cycle 1.2, on Mental Health and Well-Being, which was conducted in 2002, revealed that, overall in Canada, only 61 per cent of individuals who had a self-reported mental disorder or dependency² in their lifetime had consulted a professional for their mental health during their lifetime. Analyses on whether individuals with mental health disorders or dependencies had consulted a professional were broken down into specific health care providers. Family physicians were consulted most frequently, with a Canadian average of 45 per cent. This data is consistent with the findings from other developed countries with modern mental health services that suggests that many people seek help first, and perhaps only, from primary health

2 Major depressive episode, manic episode, panic disorder, agoraphobia, social phobia, alcohol and drug dependence, gambling, suicide, distress, and eating trouble.

care providers for common mental disorders (Barrett et al., 1988; Blount, 1998); those with more serious mental illness are seen within mental health services.

The interest and support of collaborative care in primary health care are growing internationally. The World Health Organization (2003) promotes the treatment of common mental disorders such as depression in primary health care. Jenkins and Strathdee (2000), Saxena et al. (2002) and Thornicroft and Tansella (2004) note that primary health care is the logical site for meeting most or all mental health care needs, particularly in countries that have a low level of resources available. Even richly resourced countries like Canada that have a wider range of specialized mental health care programs demand treatment of common mental disorders through primary health care settings (Jenkins and Strathdee, 2000). Blount (1998) and Lester, Glasby and Tylee (2004) present convincing arguments that the integration of health and mental health care in primary health care settings is the best option because:

1. Primary health care settings are the predominant locus of treatment for problems that are clearly psychological or psychiatric in nature, such as depression and anxiety.
2. Consumers are more satisfied with their physical and mental health care being integrated in the primary health care setting.
3. Primary health care is a better fit with the typical way a majority of consumers present their undifferentiated mental health problems.

4. With this better fit, there is better adherence by consumers to treatment regimes and, ultimately, better health outcomes.
5. The range of mental health needs that appear in primary care settings exceeds the capacity and skills of even well-trained primary care physicians, and referral out is a poor alternative. A team approach is also the best way to improve the skills of primary care providers in dealing with the psychosocial aspects of care.
6. Job satisfaction is enhanced for primary care providers working in integrated settings.
7. Over the long term, collaborative care appears to be a break-even or cost-saving approach.

A reflection of this growing trend of collaborative mental health care in primary health care is the creation of the Canadian Collaborative Mental Health Initiative (CCMHI). CCMHI, funded through Health Canada's Primary Health Care Transition Fund, is comprised of twelve national organizations.

These organizations have come together for the first time in history to demonstrate their willingness and commitment to address the mental health needs of Canadians by:

- ∞ conducting an analysis of the current state of collaborative mental health care
- ∞ developing toolkits to aid in the implementation of collaborative initiatives
- ∞ creating a national charter for collaborative mental health care

Twelve reports have been commissioned to capture a snapshot of the current issues and trends in collaborative mental health care. The intent of the CCMHI Steering Committee was to provide an accurate baseline in order to develop clinical, education, and consumer, family, and caregiver toolkits; and to draft and sign a charter to promote the development of collaborative mental health care in the directions that are consistent with the view shared by the CCMHI Steering Committee members.³

The report, *Collaborative Mental Health Care in Primary Health Care: A Review of Canadian Initiatives*, was commissioned to provide a comprehensive analysis of current initiatives, which supported the development of implementation toolkits, and to create a resource that will be used to support the development of future initiatives. In addition to describing over 90 collaborative mental health care initiatives, this report provides an analysis of the findings and a rich discussion on the current collaborative mental health care initiatives in Canada. This report is divided into two volumes (**Volume I: Analysis of Initiatives** and **Volume II: Resource Guide**).

Making mental health care work:
New partners
New places
New hope!

3 The CCMHI developed a Charter for collaborative mental health care. This Charter has two vital components: a set of Principles that create the vision for collaborative care in Canada and a set of Commitments that are actions for all key health care partners working together to enact the Principles. For more information visit: <http://www.ccmhi.ca>

Volume I of the report:

(Pauzé, Gagné and Pautler, 2005)

- presents descriptive statistics based on the information collected from 89 collaborative initiatives from across Canada;
- offers a discussion of the key trends in collaborative care based on the fundamentals and key elements of the Collaborative Mental Health Care Framework (Gagné, 2005);
- illustrates some of the barriers and solutions that have been used to overcome obstacles to collaborative mental health care in primary health care;
- provides specific examples and quotations to support the discussion;
- identifies key messages for the fundamentals and key elements of collaborative mental health care;
- relates key findings to previous research and best practices;
- informs the development of implementation toolkits, which will be an asset to health care partners looking to develop and enhance collaborative activities.

This Report

Volume II is a resource that will help connect health

care partners who want to implement or enhance collaborative initiatives. Volume II provides the following:

- summary of the key descriptive statistics and findings presented in Volume I;

- index arranged according to each of Canada's five regions, to help readers quickly identify collaborative initiatives by specific characteristics, including: funding, location/setting, resources, collaborative disciplines, knowledge exchange, special populations, and evaluation (see Appendix D);
- two-page description for 91 Canadian collaborative mental health care initiatives (see Appendix C). Each initiative description in Volume II includes information about: funding, sponsoring organization(s), purpose, goals/objectives, collaborative disciplines/resources, unique characteristics to the local community, barriers, strategies, and contact information. This resource will give readers concrete examples of the inner workings of collaborative initiatives in primary health care, and provide them with creative ideas about how to participate in the future of collaborative mental health care in Canada.
- complete contact information for individuals who are involved in collaborative mental health care initiatives, including individuals who may or may not have submitted an initiative description for Volume II (see Appendix E).

METHODOLOGY

The goal of the data collection was to identify a broad cross-section of the current collaborative mental health care initiatives in primary health care in each of Canada's provinces and territories. **Participants** in the study were the contacts (e.g., managers, directors, coordinators, or other contacts) for collaborative mental health care initiatives from across Canada. The data (initiative descriptions) were gathered between July 2004 and July 2005 and included three major steps.

Procedure:

The qualitative research technique of 'snowball' sampling was used to gather the data. This procedure has been used to reach populations that are difficult to access, using non-random data collection whereby an initial group of participants is asked to make referrals in order to generate additional participants (Henry, 1990).

During *step one*, selected key informants were requested via e-mail, phone, and/or mail (in both English and French) to identify key contacts for Canadian collaborative mental health initiatives. Key informants included known experts in collaborative mental health care, experts in mental and primary health care, government representatives and associate members of the 12 CCMHI steering committee organizations. Approximately 850 key informants were initially contacted.

During *step two*, a survey was used to gather the data (i.e., initiative descriptions). This survey was emailed and/or mailed to contacts listed in the document, *Shared Mental Health Care in Canada: A Compendium of Current Projects* (Kates and Ackerman, 2002) and new

Measures

The following documents were used to collect the data (copies of the documents are included in Appendix A):

1. Key informant letter
2. Contact letter
3. Survey
4. Revised information request letter
5. Phone interview guide
6. Consent form

contacts identified by the key informants.⁴ This survey was available in English and French. Due to an initial low response rate and feedback from participants suggesting that the survey was too lengthy, the survey was condensed into a letter requesting the same information (revised information request letter). The revised letter was re-sent to the key contacts that had not yet responded to the initial surveys. Phone interviews and emails were also used to collect the missing pieces of information. A total of 57 initiative contacts completed phone interviews.

During *step three*, a screening process separated the initiatives that would and would not be included in the data analysis for Volume I. All collaborative initiatives that involved both primary and mental health

⁴ This report was created by The College of Family Physicians of Canada and the Canadian Psychiatric Association. Shared mental health care in Canada: a compendium of current projects (Kates and Ackerman, 2002), published in Spring 2002. Available at: <http://www.shared-care.ca/pdf/compendium.pdf>

care providers and that offered mental health care services to consumers in a primary care setting were included. Those that did not directly provide mental health services to consumers (e.g., educational initiatives, guides, and manuals) were excluded.⁵ In addition, completed programs/projects and international collaborative mental health care initiatives were not included in the analysis. Of the total 147 potential collaborative initiatives identified during the data analysis period, 37 initiatives did not meet the inclusion criteria.

A total of 110 collaborative initiatives met the inclusion criteria, but only 89 completed a survey or phone interview prior to the deadline for submissions and were included in the data analyses.

A total of 91 initiatives provided consent to include their descriptions in Volume II.

A total of 91 participants provided written consent to include their completed initiative descriptions in Volume II. An additional five individuals representing collaborative initiatives gave consent by e-mail to include their contact information, but did not provide a completed description for Volume II. Reasons that these individuals were unable to provide a completed description and signed consent included the following:

- ∞ lack of time to complete the description
- ∞ the initiative was in a very early planning stage

5 For a more detailed discussion of educational initiatives and interprofessional education issues, refer to Interprofessional education initiatives in collaborative mental health care (McVicar et al., 2005), a report prepared for the CCMHI.

- ∞ contacts were unable to get signed consent from board/committee members or directors
- ∞ the contact did not feel comfortable providing a description at the current time

A comprehensive list, including contact information for individuals who submitted initiative descriptions, or those individuals who were unable to submit a completed description (but who wanted their contact information to be incorporated), is included in Appendix E.

Editing of the descriptions:

Participants submitted descriptions of their initiatives in writing or by phone. Consent for publication of the initiative descriptions was sought from the participants. Each initiative description was edited to fit a 'description template' used in Volume II of this report. This required some text to be cut in order to meet the maximum word count allowance. However, the content of each description was not altered with regard to the use of language that was originally provided by each initiative contact. No attempt was made to qualify the successfulness of the initiatives. The opinions expressed in the text in Appendix C are those of the participants who submitted and approved their descriptions.

Limitations:

The methodology used to collect the data had a few limitations. First, although the 'snowball' technique is a widely used and acceptable method for qualitative data collection, its non-randomized nature makes it difficult to generalize the results to the greater population. In addition, the success of this technique is also dependent upon how representative the initial key informants are.

Although an attempt was made to identify appropriate key informants, the collaborative initiatives that were ultimately identified during the data collection may not be completely representative of all of the existing collaborative initiatives from across Canada.

Second, due to an initial low response rate and feedback from participants who suggested that the survey used to collect the data was too long, the survey was condensed into a letter requesting the same information. The revised letter was re-sent to the key contacts that had not yet responded to the initial surveys. This change in methodology resulted in the initiative contacts failing to report all of the required information. Ultimately, the change made it challenging to compare each initiative across all variables that were initially requested. As a result, the analysis of the trends of collaborative mental health care is based only on information that was consistently provided by the majority of initiatives. The analysis is not as comprehensive as was initially intended prior to the change in methodology.

Finally, the initiative contacts were allowed to self-identify their collaborative activities. A select few of the initiatives included in Volume II do not offer the majority of their collaborative services within a primary health care context. For example, some of the initiatives provide the majority of their services at the secondary or tertiary care levels, although they may connect with or offer some services at the primary health care level. In addition, the degree to which collaboration between mental and primary health care providers occurs appears to exist on a continuum whereby some initiatives provide collaborative services to a great extent and on a consistent basis, while others do not.

Blount (2003) developed a method of categorizing and describing primary health care programs. Blount identified two dimensions — initiatives exist along these two continuums:

- ∞ *types of care*: coordinating, co-located, integrated; and,
- ∞ *relationships of services provided to populations served*: targeted versus untargeted, specific versus unspecified care, small versus large scope of implementation.⁶

The initiatives described in this report, were not categorized along any continuum. Contacts were allowed to self-identify and define their work as collaborative. The range of approaches described therein, is indicative of the growth in this field, the lack of consistent terminology, and of a fragmented system — where many will define collaboration as any interdisciplinary interactions.

6 For more detailed discussion on Blount model, refer to Blount (2003) or Pautler K, Gagné MA. Annotated bibliography of collaborative mental health care. Report prepared for the Canadian Collaborative Mental Health Initiative, Mississauga, Ontario, Canada; September 2005. Available at: www.ccmhi.ca

Analysis:

The analysis of the data was guided by 15 questions. For some of the questions, the Collaborative Mental Health Care Framework (Gagné, 2005) was used as a guide to code the data. Simple descriptive statistics were calculated from the quantitative and qualitative data.

Based on the information collected from the initiative descriptions, the following questions guided the analysis:

1. How many initiatives were identified in each province and territory?
2. From where do collaborative initiatives receive their funding?
3. Where are the services provided?
4. What are the service volumes?
5. What approach is used by the initiatives to deliver their services?
6. Who are the non-health care professionals that support the collaborative team?
7. Who are the health care professionals that support the collaborative team?
8. Which provider(s) assume(s) responsibility or liability for consumer care?
9. What special populations are served by the collaborative initiatives?
10. What are the common methods used for knowledge exchange?
11. How many collaborative initiatives are conducting evaluations?
12. How many of the collaborative initiatives report using information technologies to support their activities?
13. How many short-term and long-term collaborative initiatives have been identified?
14. What are the common barriers or challenges reported by the collaborative initiatives?
15. What are the common strategies or solutions that the collaborative initiatives use to address the challenges they face?

DESCRIPTIVE STATISTICS

This section presents a summary of the descriptive statistics gathered from the 89 collaborative mental health initiatives. An in-depth discussion of the collaborative mental health care trends, which emerged from these data, can be found in Volume I of this report.

1. How many initiatives were identified in each province and territory?

Every attempt was made to identify a broad cross-section of the current collaborative initiatives in each of Canada's provinces and territories within the data collection period. It is important to note that the initiatives in this report are not exhaustive. Collaborative initiatives are constantly emerging from new forged relationships. Figure 1 provides a map of Canada, indicating the representation of the initiatives; this information is summarized in Table 1.

Figure 1: Geographical Representation of the 89 Canadian Initiatives included in the Analysis

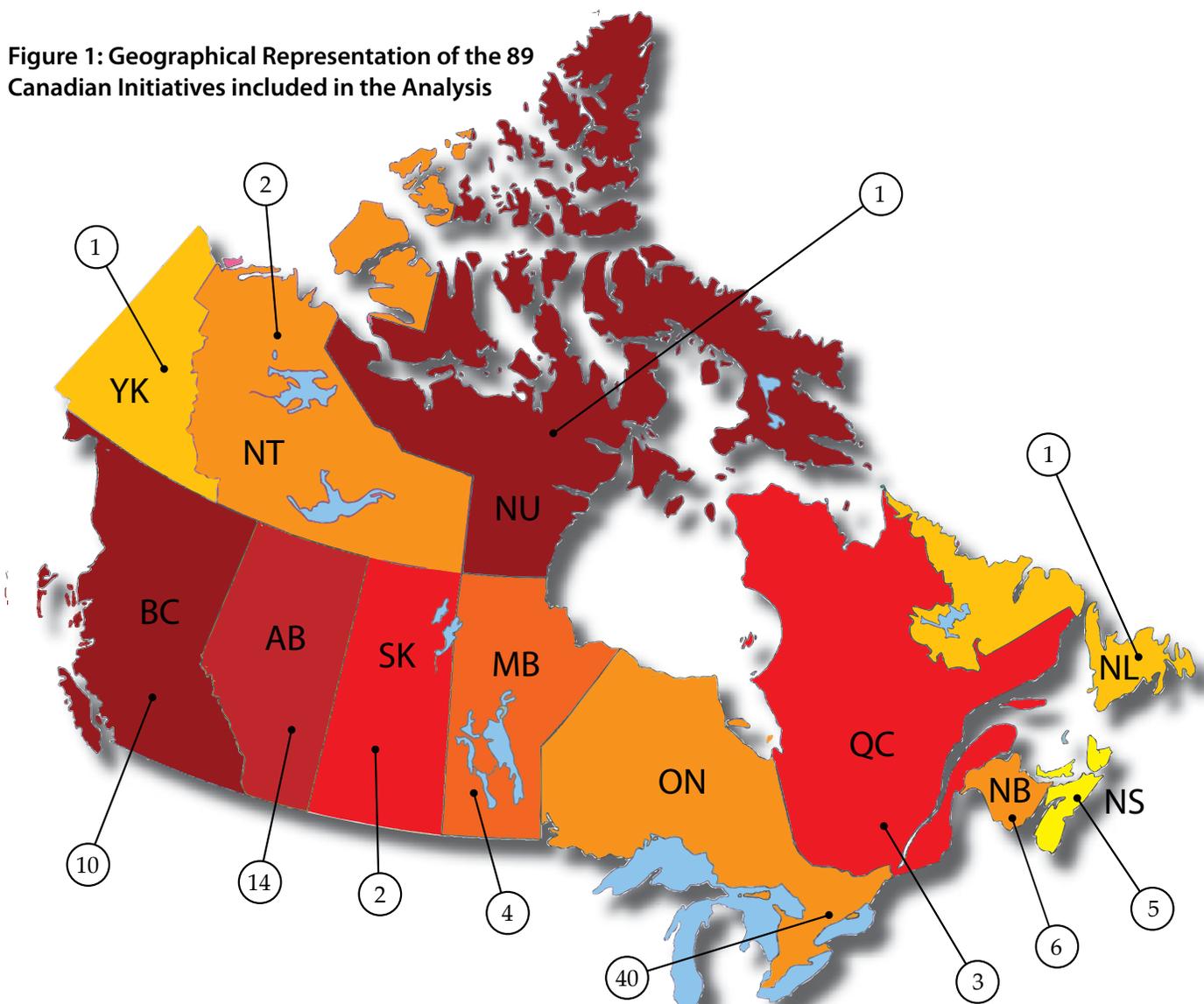


table 1

Summary of the Regional Representation of Canadian Initiatives

Region of Canada	Province/ Territory	Number of Initiatives Identified that Met the Inclusion Criteria	Number of Initiatives Included in the Analysis
Pacific	British Columbia (BC)	12	10**
Western	Alberta (AB)	18	14
	Saskatchewan (SK)	2	2
	Manitoba (MB)*	3	4**
Central	Ontario (ON)*	49	40
	Quebec (QC)	4	3
Eastern	New Brunswick (NB)	6	6
	Prince Edward Island (PE)	1	0
	Nova Scotia (NS)	5	5
	Newfoundland and Labrador (NL)	1	1
Northern	Yukon (YT)	2	1
	Northwest Territories (NT)	2	2
	Nunavut (NU)	5	1
Total		110	89

* Note: Two initiatives (one in MB and another in ON) only provided consent to include their data in the overall analysis and not in Appendix C: Inventory of Canadian Initiatives

** Note: There are two initiatives that provide services to more than one province or territory. One initiative provides services to parts of BC and the YT; the initiative is listed under BC. In the second initiative, services are provided by clinicians from MB to parts of NU; the initiative is listed under MB.

2. From where do collaborative initiatives receive their funding?

A majority of the initiatives received funding from a government source (Table 2). Of the initiatives, 19.1 per cent received funding from more than one type of source. Some initiatives received funding from multiple sources within the same funding category. For example, it was possible for an initiative to receive funding from a provincial and federal government source.

table 2

Sources of Funding in Per cent

Source of Funding	N (89)	Per cent
Educational institution	3	3.4
Government	57	64.0
Health Organization	29	32.6
Internal/ Did not specify	14	15.7
Multiple Types	17	19.1

3. Where are the services provided?

Participants were requested to indicate the service delivery site(s) (location or setting) where their mental health services are provided (Table 3). They were asked to note the number of and the type of site(s). The locations/settings were coded according to: group practice/health centre, hospital/outpatient, physician office, or type of outreach. Some examples of the outreach sites included the following: school, home, workplace, shelter, long-term care facility, and church. Of the initiatives, 48.3 per cent provided services in more than one type of setting. The majority of participants reported providing services in either group practice/health centre (56.2 per cent) or physician office (42.7 per cent). Due to incomplete information, the number of sites could not be analyzed for each type of location/setting.

table 3

Location/Setting of Services in Per cent

Location/Setting	N (89)	Per cent
Group practice/health centre	50	56.2
Hospital/outpatient	25	28.1
Physician office	38	42.7
Outreach	35	39.3
More than one location/setting	43	48.3

4. What are the service volumes?

Participants were requested to report their service volumes according to the number of patient or client-visits per month. Due to the inconsistencies in the way this information was reported, it was too difficult to analyze the service volumes for the initiatives in a meaningful way. That is, initiatives record service volumes differently. For example, information was reported on a monthly, biannual and/or annual basis. Some of the data came from completed program evaluations; however, some of the data were only rough estimations or 'best guesses'.

Participants reported service volumes for the number of referrals received, and/or the number of patients/clients/consumers seen, and/or the number of follow-up visits that were given. These inconsistencies made it impossible to describe general trends regarding initiative sizes or the range of service volumes.

5. What approach is used by the initiatives to deliver their services?

This information was coded according to the key element 'accessibility' as defined in the Collaborative Mental Health Care Framework (Gagné, 2005) (Table 4). Initiatives were coded as using:

- ∞ *a direct approach* - mental health specialists offer their services to consumers in primary health care settings;
- ∞ *an indirect approach* - a primary health care provider delivers mental health services to consumers while receiving consultative support from a mental health specialist (i.e. the mental health specialist provides indirect mental health care);
- ∞ *a combination of indirect and direct approaches* - the majority of initiatives use a combination of direct and indirect approaches to providing their services (68.5 per cent).

table 4

Approaches Used by the Collaborative Initiatives in Per cent

Approach	N (89)	Per cent
Direct	18	20.2
Indirect	10	11.2
Combination of direct and indirect	61	68.5

6. Who are the non-health care professionals that support the collaborative team?

Non-health care professionals that support the collaborative team were grouped into the following categories (based on how the information was reported by the participants): administrative, coordinator, manager/director, research associate/assistant, or other (Table 5).

table 5

Non-Health Care Professionals that Support the Collaborative Team in Per cent

Human Resource	N (89)	Per cent
Administrative	30	33.7
Coordinator	22	24.7
Manager/director	50	56.2
Research associate/assistant	7	7.9
Other	9	10.1

Other human resources included: health promoter, educator, project evaluator, information technology specialist, and policy analyst.

7. Who are the health care professionals that support the collaborative team?

Participants were asked to specify the type of service providers that are involved in their collaborative initiative (Table 6a), which included: Aboriginal Elders, peer supports/volunteers, dietitians, family physicians, nurses (see Table 6b for a complete list), occupational therapists, social workers, pharmacists, psychiatrists, psychologists, or others. The list of providers for each initiative included those who were and were not directly employed by the initiative. The categories for the providers were developed based upon the responses that were received. For example, several categories of nurses were developed to represent the range of responses. Examples of 'other professional' included: chiroprapist, occupational health physician, psychometrist, psychotherapist, neuropsychologist, physiotherapist, speech language pathologist, recreation therapist and rehabilitation therapist.

table 6a Health Care Professionals that Support the Collaborative Team in Per cent

figure 4 Percentage breakdown of self-identified group description, Phase II (English)

Human Resource	N (89)	Per cent
Aboriginal Elder	3	3.4
Addictions specialist	9	10.1
Case manager/worker	44	49.4
Dietitian/nutritionist	16	18.0
Family physician	84	94.4
Nurse	56*	62.9
Nurse – Registered psychiatric nurse or mental health nurse	24	27.0
Occupational therapist	19	21.3
Peer support/volunteer	21	23.6
Pharmacist	5	5.6
Psychiatrist	75	84.3
Psychologist	34	38.2
Social worker	56	62.9
Undergraduate/graduate resident	12	13.5
Other professional	26	29.2

* Note: This number represents all categories of nurses combined, with the exception of psychiatric and mental health nurses. Refer to Table 6b for a complete breakdown of the nursing categories reported by the participants.

In order to accurately summarize the different types of nurses reported by the participants, several categories were developed, including: nurse, primary care nurse, registered psychiatric nurse or mental health nurse, public health nurse, registered nurse, nurse practitioner, licensed practical nurse, regional outreach nurse, and registered practical nurse. These categories are representative of the type of nurse that was indicated by the participants (see Table 6b).

The most common providers listed included: family physicians, psychiatrists, nurses, and social workers. Although the participants were requested to indicate FTEs (full-time equivalents) where possible, this information was inconsistently reported and was not included in the analyses.

table 6b

Reported Nursing Categories in Per cent

Nursing Category	N (89)	Per cent
Licensed practical nurse	3	3.4
Nurse	36	40.4
Nurse practitioner	13	14.6
Primary care nurse	3	3.4
Public health nurse	6	6.7
Regional outreach nurse	1	1.1
Registered nurse	12	13.5
Registered practical nurse	1	1.1
Registered psychiatric nurse or mental health nurse	24	27.0

8. Which provider(s) assume(s) responsibility or liability for consumer care?

Participants were requested to indicate who was most responsible or liable for the care being provided to the consumers. Only 37 of the 89 participants provided this information. The participants indicated that responsibility/liability was either shared (22.5 per cent) or not shared (19.1 per cent). When responsibility/liability was not shared, it was held by one of the following: family physician, primary care provider, psychiatrist, general practitioner, health centre or another unspecified clinician.

9. What special populations are served by the collaborative initiatives?

Participants were requested to identify all of the special populations that they primarily serve. The following populations were identified: Aboriginal, addictions/concurrent disorders, children/youth, disorder specific, ethno-cultural, homeless/transient, northern/isolated, rural, seniors/geriatrics, serious mental illness, urban, and other (Table 7). The most common special population served was urban (44.9 per cent) and 71.9 per cent of the initiatives serve more than one special population. Examples of 'other' populations included: pregnant women, families, people in crisis, and persons with chronic illnesses.

table 7

Per cent of Initiatives Serving Special Populations

Special Population	N (89)	Per cent
Aboriginal	22	24.7
Addictions/concurrent disorders	30	33.7
Children/youth	30	33.7
Disorder specific	30	33.7
Ethno-cultural	15	16.9
Homeless/transient	15	16.9
Northern/isolated	12	13.5
Rural	27	30.3
Seniors/geriatrics	31	34.8
Serious mental illness	20	22.5
Urban	40	44.9
Other	14	15.7
More than one special population	64	71.9
Did not indicate/none	8	9.0

10. What are the common methods used for knowledge exchange?

The methods commonly used to facilitate knowledge exchange fell into one of three broad groups: dissemination of materials, interactive sessions, or joint consultations (Table 8). It should be noted that the participants were not requested to specifically provide this information. Therefore, it is possible that initiatives use a broader range of methods more often than was reported. The most common method involved interactive sessions, including: weekly/monthly meetings, informal case

table 8

Strategies Used for Knowledge Exchange

Method of Knowledge Exchange	N (89)	Per cent
Dissemination of materials	14	15.7
Interactive sessions	73	82.0
Joint consultations	11	12.4
Did not say	16	18.0
More than one method	24	27.0

discussions, educational workshops, conferences, teleconferences, or other; 18.0 per cent of the initiatives did not clearly report using any method.

11. How many collaborative initiatives are conducting evaluations?

Participants were requested to identify if they: had completed a program or service evaluation, had not completed an evaluation, or were currently conducting an evaluation (Table 9). Although the initiatives that had completed an evaluation were asked to identify what their top three key findings were, this information was not used in the current data analysis because it was inconsistently reported.

In addition, participants were asked to submit any proposed evaluation strategies or completed evaluation results for analysis. These data were then forwarded to researchers of the Continuous Enhancement of Quality Measurement (CEQM) primary care mental health project for further analysis. The CEQM project is a sister project of the CCMHI initiative, from which the present research has sought advice. Key findings from this analysis are included in Volume I of this report.

table 9

Per cent of Initiatives Conducting Service or Program Evaluations

Evaluation	N (89)	Per cent
Yes, completed	7	7.9
Yes, ongoing	61	68.5
Yes, completed and ongoing	13	14.6
No	3	3.4
Did not say	5	5.6

12. How many of the collaborative initiatives report using information technologies to support their activities?

Participants were asked to indicate all of the technologies that were used to support the work of the initiative, including: telehealth, electronic health records, e-mail, or other. See Table 10 for information related to the use of electronic health records/databases and telehealth/videoconferencing technology.

table 10

Use of Information Technologies to Support Communication in Per cent

Method	N (89)	Per cent
Electronic health record/database	24	27.0
Telehealth/videoconferencing technology	12	13.5
Both an electronic health record/database and telehealth/videoconferencing technology	5	5.6
Did not say	56	62.9

13. How many short-term and long-term collaborative initiatives have been identified?

This information was coded according to the start and end dates reported by the initiatives. Based on this information, a total of 18 initiatives reported a specific end date for their activities. Many of these programs are hoping to secure long-term/ongoing funding to sustain their activities. Ongoing initiatives were coded according to those that existed prior to the year 2000 (when the Primary Health Care Transition Fund was implemented); those that were created between the years 2000 and 2004; and those that were created after January 2004 (Table 11).

table 11

Per cent of Long-Term Initiatives

Long-Term Initiatives	N (89)	Per cent
Existing prior to 2000	31	34.8
Created between 2000 and 2004	30	33.7
Starting on or after January 2004	25	28.1
Did not report a start date	3	3.4

14. What are the common barriers or challenges reported by the collaborative initiatives?

Participants were asked to describe briefly the difficulties they encountered in establishing and sustaining their initiative. This information was coded according to the fundamentals (macro-level) and key elements (micro-level) of the Collaborative Mental Health Care Framework (Gagné, 2005). Several categories emerged including: buy-in, evaluation, funding, geography, policy and legislation, remuneration, human resources, skill, structures/systems, team development, and technology. Only 7.9 per cent of the initiatives reported that they did not experience any barriers. This information is summarized in Table 12. Please refer to Appendix B for examples of each of the barriers that were identified.

table 12

Barriers Encountered by the Collaborative Initiatives in Per cent

Barriers	Macro- and Micro-Level Barriers	N (89)	Per cent
Funding/remuneration	Macro	38*	42.7
Structures/systems	Micro	37*	41.6
Buy-in	Micro	32*	36.0
Human Resources	Macro	25*	28.1
Skill	Micro	18	20.2
Team Development	Micro	16	18.0
Geography	Micro	12	13.5
Technology	Micro	8	9.0
Evaluation	Micro	7	7.9
Policy and legislation	Macro	7	7.9
None		7	7.9

* Note: indicates the most prominent barriers reported

15. What are the common strategies or solutions that the collaborative initiatives use to address the challenges they face?

Participants were asked to describe briefly the strategies they used to overcome the difficulties (barriers) they had experienced. This information was coded according to the fundamentals (macro-level) and key elements (micro-level) of the *Collaborative Mental Health Care Framework* (Gagné, 2005). Several categories emerged including: advocacy, buy-in, evaluation, funding, geography, policy and legislation, remuneration, human resources, skill, structures/systems, team development, and technology. Only 11.2 per cent of the participants reported that they did not use any strategies. This information is summarized in Table 13. Please refer to Appendix B for examples of each of the strategies that were identified.

table 13

Strategies Used by the Collaborative Initiative to Overcome Barriers in Per cent

Strategies	Macro- and Micro-Level Strategies	N (89)	Per cent
Structures/systems	Micro	38*	42.7
Team development	Micro	33*	37.1
Skill	Micro	21*	23.6
Advocacy	Macro	21*	23.6
Human Resources	Macro	19	21.3
Funding/remuneration	Macro	15	16.9
Policy and legislation	Macro	14	15.7
Evaluation	Micro	11	12.4
Technology	Micro	9	10.1
Buy-in	Micro	8	9.0
Geography	Micro	4	4.5
None		10	11.2

* Note: indicates the most prominent strategies reported.

SUMMARY

The following is a brief summary of the emerging themes from current Canadian collaborative mental health care initiatives.

There are many exciting ways in which health care partners from across Canada are working to improve the delivery of mental health care in primary health care. The evidence suggests that collaborative activities are gaining momentum, but these efforts must be supported through congruent policies, legislation, and funding regulations in order for collaborative mental health care initiatives to continue to grow successfully in primary health care settings. In addition, coordinated research, and process and outcome evaluations are vital to identifying and implementing better practices. Collaborative initiatives must also continue to support and enhance the involvement of consumers, families, and caregivers in the development, implementation and evaluation these programs. If these factors can be achieved and implemented collaboratively, the integration of mental health care into primary health care settings will be more successful in meeting the needs of each unique community and, ultimately, in improving the mental health and well-being of all Canadians.

Key Findings

Based on the responses from the initiatives, several key findings are discerned.

- ∞ Macro-level issues related to policy, legislation, resources, funding regulations, and funds are vital to enhancing collaborative mental health care practices. There must be continued effort to ensure that
 - these fundamentals are supportive of collaborative activities.
- ∞ The most prominent barrier reported by the initiatives was a lack of adequate and/or sustainable funding and remuneration. The second most prominent barrier was related to structures/systems.
- ∞ Creating ‘buy-in’ of providers (especially primary health care providers) and/or consumers, families and caregivers was also a prominent barrier to collaboration.
- ∞ The most prominent solution to overcoming challenges reported by the initiatives was related to collaborative structures/systems. For example, strategies included:
 - developing key partnerships with community resources;
 - having flexible structures that accommodate the needs of the community;
 - having designated planning days or team meetings;
 - implementing strong orientations for new team members;
 - working closely with key stakeholders to ensure that the initiative goals are achieved;
 - developing formal communication strategies;
 - designating a coordinator who has clearly defined roles and responsibilities; and

- reviewing the partnership agreement and recommitting to the purpose, objectives, and service delivery methodologies with all of the key stakeholders.
- ∞ Ninety-one per cent of initiatives are conducting or have completed some form of service or program evaluation of their collaborative activities. Evaluations often included measures of: provider/consumer satisfaction, quality of life, and various consumer outcomes.
- ∞ Most initiatives use a combination of direct and indirect approaches to providing their services.⁷ Many initiatives are looking for strategies to increase consumer access to mental health care specialists. In addition, many initiatives aim to enhance the capacity of primary health care providers to manage confidently complex mental health illnesses.
- ∞ The most common providers who are part of the collaborative team include family physicians, psychiatrists, nurses and/or social workers. However, there is a trend towards including a broader range of primary and mental health care providers, consumers, families, and caregivers.
- ∞ Involving consumers in all aspects of their care is an important trend that is increasingly recognized and supported by collaborative initiatives. The knowledge and expertise of consumers should not go overlooked during the development, implementation or evaluation of collaborative activities.

For a comprehensive discussion of the themes and trends as they relate to previous research and best practices, refer to Volume I of the report *Collaborative Mental Health Care in Primary Health Care: A Review of Canadian Initiatives*. (Pauzé, Gagné and Pautler, 2005).

7 In a *direct approach* to collaborative mental health care in primary health care, mental health specialists offer their services to consumers in primary health care settings. In an *indirect approach*, a primary health care provider delivers mental health services to consumers, while receiving consultative support from a mental health specialist (i.e., the mental health specialist provides indirect mental health care).

REFERENCES

- Barrett JE, Barrett JA, Oxman TE, Gerber PD. The prevalence of psychiatric disorders in a primary care practice. *Arch Gen Psychiatry*. 1988 Dec;45(12):1100-6. <PubMed>
- Bland RC, Newman SC, Orn H. Period prevalence of psychiatric disorders in Edmonton. *Acta Psychiatr Scand Suppl*. 1988;338:33-42. <PubMed>
- Blount A. Integrated primary care: organizing the evidence. *Families, Systems & Health*. 2003 Summer; 21(2):121-33.
- Blount A. Introduction to integrated primary care. In: Blount A, editor. *Integrated primary care: the future of medical and mental health collaboration*. New York: Norton; 1998. p. 1-43.
- Canadian Medical Association; Canadian Nurses Association. Working together: a joint CNA/CMA collaborative practice project. HIV/AIDS example [background paper]. Ottawa: CMA; 1996. 24p. Available through the CMA's Member Service Centre 1867 prom. Alta Vista Dr., Ottawa ON K1G 3Y6; tel.: 800 663-7336 ext. 2307, fax: 613 731-9102, e-mail: cmamsc@cma.ca
- Gagné MA. What is collaborative mental health care? An introduction to the Collaborative Mental Health Care Framework. Mississauga, ON: Canadian Collaborative Mental Health Initiative; June 2005. Available at: <http://www.ccmhi.ca>
- Health Canada. A report on mental illnesses in Canada. Ottawa: Health Canada Editorial Board Mental Illness in Canada; October 2002. Available at: <http://www.phac-aspc.gc.ca/publicat/miic-mmhc/> OR http://www.phac-aspc.gc.ca/publicat/miic-mmhc/pdf/men_ill_e.pdf
- Henry GT. *Practical Sampling*. Newbury Park: Sage Publications; 1990.
- Institute of Medicine (U.S.). Committee on Quality of Health Care in America. *Crossing the quality chasm: a new health system for the 21st century*. Washington, DC: National Academy Press; 2001. Available at: <http://www.nap.edu/catalog/10027.html>
- Jenkins R, Strathdee G. The integration of mental health care with primary care. *Int J Law Psychiatry*. 2000 May-Aug;23(3-4):277-91. <PubMed>
- Kasman N, Carley H. Prevalence of mental illnesses and related service utilization in Canada: an analysis of the Canadian Community Health Survey [working draft]. Mississauga, ON: Canadian Collaborative Mental Health Initiative; May 2005.
- Kates N, Ackerman S. Shared mental health care in Canada: a compendium of current projects. The College of Family Physicians of Canada and the Canadian Psychiatric Association; 2002. Available at: <http://www.shared-care.ca/pdf/compendium.pdf> (accessed July 2004)
- Klaiman D. Increasing access to occupational therapy in primary health care. *Occupational Therapy Now Online*. 2004 Jan-Feb;6(1): [about 7p.]. Available at: <http://www.caot.ca/default.asp?pageid=1031>
- Lester H, Glasby J, Tylee A. Integrated primary mental health care: threat or opportunity in the new NHS? *Br J Gen Pract*. 2004 Apr;54(501):285-91. <PubMed>
- Mable AL, Marriott J. *Sharing the learning: the Health Transition Fund synthesis series: primary health care health*. Ottawa: Health Canada; 2002. Available at: http://www.hc-sc.gc.ca/hhf-fass/english/primary_en.pdf
- McVicar J, Deacon D, Curran V, Cornish P. Interprofessional education initiatives in collaborative mental health care. Mississauga, ON: Canadian Collaborative Mental Health Initiative; July 2005. Available at: <http://www.ccmhi.ca>

- Nova Scotia Advisory Committee on Primary Health Care Renewal. Primary health care renewal action for healthier Nova Scotians, May 2003. Halifax, NS: NS Department of Health; 2003. Available at: http://www.gov.ns.ca/health/primaryhealthcare/acphcr_report.htm OR <http://www.gov.ns.ca/health/primaryhealthcare/pubs/PHCISP%20FAQ.pdf>
- Oandasan I. Interdisciplinary education for collaborative patient-centred practice: research and findings report. February 20, 2004. Ottawa: Health Canada; 2004. Available at: http://www.medfam.umontreal.ca/chaire_sadok_besrouer/ressource/PDF/IECPCP_Final_Report.pdf
- Offord DR, Boyle MH, Campbell D, Goering P, Lin E, Wong M, Racine YA. One-year prevalence of psychiatric disorder in Ontarians 15 to 64 years of age. *Can J Psychiatry*. 1996 Nov;41(9):559-63. <PubMed>
- Pautler K, Gagné MA. Annotated bibliography of collaborative mental health care. Mississauga, ON: Canadian Collaborative Mental Health; September 2005. Available at: <http://www.ccmhi.ca>
- Paupé E, Gagné MA, Pautler K. Collaborative Mental Health care in primary health care: a review of Canadian Initiatives. Volume I: analysis of initiatives. Mississauga, ON: Canadian Collaborative Mental Health Initiative; November 2005. Available at: <http://www.ccmhi.ca>
- Saxena S, Maulik PK, O'Connell K, Saraceno B. Mental health care in primary and community settings: results from WHO's Project Atlas [editorial]. *Int J Soc Psychiatry*. 2002 Jun;48(2):83-5. <PubMed>
- Stephens T, Joubert N. The economic burden of mental health problems in Canada. *Chronic Dis Can*. 2001;22(1):18-23. <PubMed>
- Thornicroft G, Tansella M. Components of a modern mental health service: a pragmatic balance of community and hospital care: overview of systematic evidence. *Br J Psychiatry*. 2004 Oct;185:283-90. Erratum in: *Br J Psychiatry*. 2004 Nov;185:440. <PubMed>
- Way DO, Busing N, Jones L. Implementation strategies: "Collaboration in primary care — family doctors & nurse practitioners delivering shared care". Toronto: Ontario College of Family Physicians; May 18, 2000. Available at: <http://www.ocfp.on.ca/English/OCFP/Communications/Publications/default.asp?s=1>
- World Health Organization. Mental health: new understanding, new hope. Geneva, Switzerland: World Health Organization; 2001. Available at: <http://www.who.int/whr/2001/en/index.html>
- World Health Organization. Investing in mental health. Geneva, Switzerland: World Health Organization; 2003. Available at: http://www.who.int/mental_health/media/en/investing_mnh.pdf
- World Health Organization. Mental Health Atlas — 2005 [database]. Geneva: WHO; 2005. Available at: http://www.who.int/mental_health/evidence/atlas/index.htm

appendixA

DATA COLLECTION TOOLS

- A1. Key informant letter**
- A2. Contact letter**
- A3. Survey**
- A4. Revised information request letter**
- A5. Phone interview guide**
- A6. Consent form**

appendixA

DATA COLLECTION TOOLS

A1. Key informant letter



Canadian
Collaborative
Mental Health
Initiative

Initiative
canadienne de
collaboration en
santé mentale

Dear Colleagues –

We are looking for your assistance in creating a very important resource intended to assist in strengthening collaborative, inter-disciplinary mental health care in Canada.

Funded through the Primary Health Care Transition Fund Project (Health Canada), the Canadian Consortium on Collaborative Mental Health Care is comprised of twelve national organizations, representing community services, consumers, family and self-help groups, dietitians, family physicians, nurses, occupational therapists, pharmacists, psychiatrists, psychologists and social workers from across Canada. The Consortium is working together to improve the mental health and well-being of Canadians by strengthening the relationships and improving collaboration among health care providers, consumers and their families and communities. For more information, please see <http://www.shared-care.ca/consortium.shtml>.

Our shared vision is of a country where consumers receive the most appropriate service, from the most appropriate provider, when they need it, in a location that is accessible and with the fewest obstacles. Together, the partners will develop a charter to define their inter-relationship(s) and develop strategies to support collaboration among individual health care providers, consumers and community/social services.

One of the **key activities is the development of a *Review of Collaborative Mental Health Care Initiatives in Primary Health Care*** (working title) that demonstrates successful interdisciplinary, collaborative mental health care in primary care. This resource is intended to document the ‘state-of-the-art’ in collaborative mental health care and to provide a resource tool to assist others in developing their own initiatives. The Review will build upon and broaden the Compendium compiled in 2002 by the Collaborative Working Group on Shared Mental Health Care (to see a copy, go to <http://www.shared-care.ca/pdf/compendium.pdf>). In this Review, we will include the full range of health professionals, consumers, and providers involved in mental health care.

We are requesting your assistance in identifying the contact person for *Canadian or international initiatives*, that should be included in the 2005 *Review of Collaborative Mental Health Care Initiatives in Primary Health Care* (working title). Please forward the contact name, a telephone number and/or email and the location of the initiative(s) to Marie-Anik Gagné, Project Manager, on or before Friday, September 24, 2004: fax (905) 629-0893 or e-mail mag@cfpc.ca. Please forward this request to any interested parties.

If you have any questions or comments regarding this initiative, or the Canadian Consortium, please email or call Marie-Anik Gagné, Project Manager, mag@cfpc.ca or (905) 629-0900 ext. 209.

With great appreciation, and thanks in advance for your assistance with this important work, I remain

Sincerely yours,

Scott Dudgeon
Executive Director
Canadian Collaborative Mental Health Initiative

The College of Family Physicians of Canada
2630 Skymark Avenue
Mississauga, ON
L4W 5A4
tel: (905) 629-0900 fax: (905) 629-0893

appendixA

DATA COLLECTION TOOLS **A2. Contact letter**



Dear Colleagues –

We are looking for your assistance in creating a very important resource intended to assist in strengthening collaborative, inter-disciplinary mental health care in Canada.

Funded through the Primary Health Care Transition Fund Project (Health Canada), the Canadian Consortium on Collaborative Mental Health Care is comprised of twelve national organizations, representing community services, consumers, family and self-help groups, dietitians, family physicians, nurses, occupational therapists, pharmacists, psychiatrists, psychologists and social workers from across Canada. The Consortium is working together to improve the mental health and well-being of Canadians by strengthening the relationships and improving collaboration among health care providers, consumers and their families and communities. For more information please see <http://www.shared-care.ca/consortium.shtml>.

Our shared vision is of a country where consumers receive the most appropriate service, from the most appropriate provider, when they need it, in a location that is accessible and with the fewest obstacles. Together, the partners will develop a charter to define their inter-relationship(s) and develop strategies to support collaboration among individual health care providers, consumers and community/social services.

One of the **key activities is the development of a *Review of Collaborative Mental Health Care Initiatives in Primary Health Care*** (working title) that demonstrates successful interdisciplinary, collaborative care in mental health. This resource is intended to document the ‘state-of-the-art’ in collaborative mental health care and to provide a resource tool to assist others in developing their own initiatives. The Review will build upon and broaden the Compendium compiled in 2002 by the Collaborative Working Group on Shared Mental Health Care, and will include: consumers, family and self-help groups, dietitians, family physicians, nurses, occupational therapists, pharmacists, psychiatrists, psychologists and social workers (to see a copy, go to <http://www.shared-care.ca/pdf/compendium.pdf>).

Below, please find a **brief survey** that will ensure that your initiative is included in the *Review of Collaborative Mental Health Care Initiatives in Primary Health Care*, to be released in 2005. It can be filled out in one of two ways:

1. as an email (ie, completed in the body of the email itself and returned via email) or
2. as a word document, which can be downloaded, completed by word processing and returned via email or fax to (905) 629-0893.

If you have any questions or comments regarding the survey, please email or call Marie-Anik Gagné, Project Manager, mag@cfpc.ca or (905) 629-0900 ext. 209.

We greatly appreciate your assistance in completing this survey and returning it on or before October 22, 2004. The *Review of Collaborative Mental Health Care Initiatives in Primary Health Care* will be not only an important record of the state of interdisciplinary mental health care, but an invaluable resource to others hoping to improve mental health care in Canada through enhanced collaboration.

Sincerely,

Marie-Anik Gagné, PhD
Project Manager
Canadian Collaborative Mental Health Initiative

The College of Family Physicians of Canada
2630 Skymark Avenue, Mississauga, ON L4W 5A4
tel: (905) 629-0900 ext. 209, fax: (905) 629-0893

appendixA

DATA COLLECTION TOOLS **A3. Survey**



Canadian
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Initiative
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collaboration en
santé mentale

2005 REVIEW OF COLLABORATIVE MENTAL HEALTH CARE INITIATIVES IN PRIMARY HEALTH CARE SURVEY QUESTIONS

Program / Project Title:

Sponsoring organization(s):

Other participating organizations or individuals:

Current Status: ongoing, completed, abandoned
(starting date, finish date)

Funding - Source and duration:

Identify the individual or organization responsible for the regulation of funds:

Rationale:

Goals:

Description:

Which of the following populations do you primarily serve? Please check all that apply.

- | | |
|---|---|
| <input type="checkbox"/> Homeless/Transient | <input type="checkbox"/> Northern/Isolated |
| <input type="checkbox"/> Concurrent Disorders | <input type="checkbox"/> Rural |
| <input type="checkbox"/> Children & Youth | <input type="checkbox"/> Urban |
| <input type="checkbox"/> Seniors/Geriatrics | <input type="checkbox"/> Disorder Specific (e.g., depression) |
| <input type="checkbox"/> Aboriginal | <input type="checkbox"/> Serious Mental Illness |
| <input type="checkbox"/> Ethno-Cultural | <input type="checkbox"/> Other, please describe: |

Identify service delivery site(s) (if applicable). Please note the number of sites, and the type of site (e.g., hospital, community health clinic, private practice, university, others).

Which health care provider assumes liability for patients/clients involved in the collaborative initiative?

Service Volumes:

How many client visits per month? _____

How many patients per month? _____

<p>Resources: Type and FTEs of service providers involved, including dietitians, family physicians, nurses, occupational therapists, social workers, pharmacists, psychiatrists, psychologists, self-help or advocacy groups, others.</p> <p>Please include:</p> <ul style="list-style-type: none"> ⊙ Collaborative or indirect/external relationships with other service providers, including any of the list immediately above ⊙ Relationship with any primary medical care setting – (if not covered above) ⊙ Relationship with any community-based agency or service – (if not covered above)
<p>Is there something unique to your local setting that played a role in implementing your initiative?</p>
<p>Briefly describe the difficulties encountered in setting up and sustaining this initiative.</p>
<p>Briefly describe the strategies used to overcome difficulties identified above:</p>
<p>Program or Service Evaluation:</p> <p style="padding-left: 40px;">Did you evaluate your collaborative mental health care initiative?</p> <ul style="list-style-type: none"> ⊙ No ⊙ Yes – Ongoing ⊙ Yes - Completed <p>What were the top 3 key findings?</p> <p>Where can the evaluation be accessed? (i.e., website, request a hard copy, etc)</p>
<p>Identify planned future developments of your project:</p> <p>Identify desirable future developments (assuming resources available):</p>
<p>Use of internet-based technology:</p> <p>What technology is used to support the work of the initiative? Check all that apply:</p> <ul style="list-style-type: none"> ⊙ Telehealth ⊙ Electronic health record ⊙ Email ⊙ Other, please specify _____
<p>Identify any other significant aspects of the project, or comments:</p>
<p>Contact(s): Including name, organization, address, telephone, fax and email</p>
<p>Were you aware of the publication “Shared Mental Health Care in Canada: A Compendium of Current Projects” (2002) prior to receiving this survey?</p> <p>___Yes ___No</p> <p>If yes, was it useful to you in the development of your initiative? ___Yes ___No</p>
<p>Do you have any recommendations or suggestions on ways in which this <i>Review of Collaborative Mental Health Care Initiatives in Primary care</i> could be made more useful?</p>

Thank you for completing this survey!
Please complete and return the survey on or before [Insert date] to Enette Pauzé
e-mail: ep@cfpc.ca fax: (905) 629-0893

appendixA

DATA COLLECTION TOOLS

A4. Revised information request letter



Canadian
Collaborative
Mental Health
Initiative

Initiative
canadienne de
collaboration en
santé mentale

**IMPORTANT
REQUEST!!**

Please respond to Enette Pauzé, ep@cfpc.ca fax: (905) 629-0893 as soon as possible.

Dear Colleagues:

A representative from your association/college is a member of the Canadian Collaborative Mental Health Initiative (CCMHI). This Initiative is conducting a national *Review of Collaborative Mental Health Initiatives in Primary Health Care* (working title). We do not wish to miss any key collaborative activities.

Thank you to all of you who responded to our previous requests!

This Review is intended to represent the range of collaborative mental health initiatives in Canada, and to provide a resource tool to assist others in developing their own initiatives. This Review will build upon and broaden the Compendium of Current Projects on Shared Mental Health Care in Canada compiled in 2002 by the Collaborative Working Group on Shared Mental Health Care. The new Review will include initiatives involving consumers, family and self-help groups, community-based services, dietitians, family physicians, nurses, occupational therapists, pharmacists, psychiatrists, psychologists and social workers (to see a copy, go to <http://www.shared-care.ca/pdf/compendium.pdf>).

Over the past several months, we have been working very hard to contact individuals involved in various collaborative mental health initiatives, in order to collect valuable information about the current state of collaboration.

If you are involved in or are aware of a *collaborative* approach to providing mental health services in a primary care setting (an approach whose purpose is to enhance mental wellbeing and/or to improve the mental health of individuals and their families and involves your discipline and at least one other discipline), we need to hear from you. *If one of your colleagues is better suited to respond, please forward this request to them.*

Please tell us more about your initiative by providing details related to the following:

- ∞ **Program / Project Title**
- ∞ **Sponsoring organization(s)**
- ∞ **Funding** - Source and duration (please also identify the individual or organization responsible for the regulation of funds). Is the funding part of a funding or policy framework encouraging collaborative initiatives, or is it for a more local, *ad hoc* or demonstration initiative?
- ∞ **Current Status:** ongoing, completed, abandoned (starting date, finish date)
- ∞ **Rationale**
- ∞ **Goals**
- ∞ **Description**, For example:
 - Identify service delivery site(s) (if applicable). Please note the number of sites and the type of site (e.g., community group or agency, hospital, community health clinic, private practice, university, others).
 - Which service provider(s) assume legal liability for clients/patients involved in the collaborative initiative?
 - Service Volumes: How many client visits per month? How many individual patients per month?
 - Resources: Type and FTEs of service providers directly involved, including self-help or advocacy services, dietitians, family physicians, nurses, occupational therapists, social workers, pharmacists, psychiatrists, psychologists, others. Please include:
 - Collaborative or indirect/external relationships with other service providers, including any of the list immediately above
 - Relationship with any primary medical care setting – (if not covered above)
 - Relationship with any community-based agency or service – (if not covered above)
 - Is there something unique to your local setting that played a role in implementing your initiative?
 - Briefly describe the difficulties encountered in setting up and sustaining this initiative, and any strategies used to overcome these difficulties. Include lessons learned.

∞ **Special Populations:** Please identify any specific populations that you primarily serve.

- Homeless/Transient
- Disorder Specific (e.g., depression)
- Concurrent Disorders
- Children & Youth
- Seniors/Geriatrics
- Aboriginal
- Ethno-Cultural
- Self-help (e.g., group setting)
- Northern/Isolated
- Rural
- Urban
- Other, please describe:

∞ **Program or Service Evaluation** (yes, no, ongoing - What were the top 3 key findings?)

∞ **Planned future developments**

∞ **Desirable future developments (assuming resources available)**

∞ **Use of information/communication technology** (e.g., telehealth, electronic health record, email)

∞ **Any other significant aspects of the project, or comments**

∞ **Project Contact(s)** (name, address, E-mail, phone and fax numbers)

If you would like to learn more about our national initiative, the CCMHI, please refer to the attached brochure, or visit www.ccmhi.ca.

We thank you for taking the time to share your collaborative mental health activities. The information you provide is vital to the success of this national initiative and improving the state of mental health services in Canada.

Sincerely yours,

Scott Dudgeon
Executive Director
Canadian Collaborative Mental Health Initiative

The College of Family Physicians of Canada
2630 Skymark Avenue
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appendixA

DATA COLLECTION TOOLS **A5. Phone interview guide**



Phone Interview Guide

Steps:

1. Book phone calls.
2. ½ hour needed to prep before each phone call.
3. 1 hour needed per phone call. (1.5 hours average needed for each call)

Suggested phone script:

Hello, my name is _____ and I am calling on behalf of the Canadian Collaborative Mental Health Initiative.

A few weeks ago, we emailed you a survey to collect information about the collaborative mental health initiative you are working on. We have extended our response deadline so we can ensure that important initiatives, such as yours, are not missed.

The information you provide us with will be published in our report, *Collaborative Mental Health Care in Primary Health Care: A Review of Canadian Initiatives*. From this resource, others will be able to create more collaborative initiatives.

Can we send you another copy of the survey?

We greatly appreciate your assistance in completing this survey and returning it on or before (**insert appropriate date**). The information you provide will be not only an important record of the state of interdisciplinary mental health care, but an invaluable resource to others hoping to improve mental health care in Canada through enhanced collaboration.

If you have any questions or comments regarding the survey, please email or call Marie-Anik Gagné, Project Manager, mag@cfpc.ca or (905) 629-0900 ext. 209.

Thank you for your time - we look forward to receiving information about your initiative.

General Project Information:

One of our key activities is the development of the report *Collaborative Mental Health Care in Primary Health Care: A Review of Canadian Initiatives* to demonstrate successful interdisciplinary, collaborative care in mental health. This resource is intended to document the ‘state-of-the-art’ in collaborative mental health

care and to provide a resource tool to assist others in developing their own initiatives. The Review will build upon and broaden the Compendium compiled in 2002 by the Collaborative Working Group on Shared Mental Health Care.

The survey can be filled out in one of two ways:

1. as an email (ie, completed in the body of the email itself and returned via email) or
2. as a word document, which can be downloaded, completed by word processing and returned via email or fax to (905) 629-0893.

Suggested questions:

1. Briefly explain why we are gathering this information (to produce a Review).
2. Explain the direction of the phone call (to gather more information about activities).
3. Ask contact to describe their program in 2-3 minutes or less.
4. Ask specific questions that get at the finer details of how the program works. For example:
 - a. Who sees the patient/client first?
 - b. Who assumes the role of the primary care provider?
 - c. How do members of the team (or various providers involved) communicate patient information? (e.g., how often, using what methods, and where is the information recorded)
 - d. Where are services provided?
 - e. Are all providers located in the same building?
 - f. Do the primary health care providers have access to the mental health specialists on an ongoing basis if needed?
 - g. What are the service volumes?
 - h. How are patients/clients involved in the program? Do you have consumer representation on your committee or board? Were consumers/families/caregivers involved in the development or evaluation of the program?
 - i. What information technologies support the program?
 - j. Is there opportunity for ongoing professional development?
5. Gather missing information using the Evaluation form as a guide.
6. Emphasize gathering information about consumer centredness.
7. Ask contacts to send evaluation information, or ask where it can be accessed.
8. Ask contacts about other initiatives they are aware of (title, location, contact).
9. Does the contact have any questions?
10. Remind the contact that a consent form will be sent to them, along with their description.

appendixA

DATA COLLECTION TOOLS **A6. Consent form**



Canadian
Collaborative
Mental Health
Initiative

Initiative
canadienne de
collaboration en
santé mentale

Dear [INSERT initiative contact(s)],

Thank you for taking the time to share your collaborative mental health care activities. As discussed, a description of your initiative has been formatted to be included in the *Review of Collaborative Mental Health Care Initiatives in Primary Health Care* (2005, working title). For our next step we need:

- 1) Confirmation that your initiative information (see attached) is accurate (missing information is highlighted in yellow); and,
- 2) Your consent to include this information in this Review, being compiled by the Canadian Collaborative Mental Health Initiative (www.ccmhi.ca).

Please note any inaccuracies or required changes to the attached document and forward to Enette Pauzé (ep@cfpc.ca). We are restricted to 2-pages per initiative. Your description has been formatted to be concise (*approximately 300 words*) while trying to maintain the integrity of your initiative. ***Please provide your comments and/or consent on or before [INSERT date].***

To save time, if you will be making changes to the attached initiative description, please sign the consent form based on your revisions.

We thank you for your time and attention. Your information and experience will be an invaluable resource to helping others improve mental health care through collaboration! Please do not hesitate to contact me with any questions.

Kind regards,

Enette Pauzé
Research Coordinator
Canadian Collaborative Mental Health Initiative
ep@cfpc.ca
tel: (905) 629-0900 ext. 250
fax: (905) 629-0893

Consent Form

I hereby give the Canadian Collaborative Mental Health Initiative (CCMHI) consent to include the information presented in the attached initiative description: “[INSERT Initiative title]” in the Review of Collaborative Mental Health Initiatives in Primary Health Care (2005, working title) being compiled by the CCMHI.

Name: _____ Position: _____
(please print)

Signature: _____ Date: _____

Please complete and return the form by either:
Inserting you electronic signature and E-mail to Enette Pauzé (ep@cfpc.ca) or
Signing the form and faxing to Enette Pauzé (905) 629-0893

appendixB

EXAMPLES OF BARRIERS AND STRATEGIES

Examples of barriers experienced by the initiatives

Barriers	Examples
Buy-in	<ul style="list-style-type: none"> ➤ Lack of buy-in ➤ Misconceptions about the concept of collaborative care ➤ Fear of job loss ➤ Feeling threatened by other providers on the collaborative team ➤ Reluctance of providers to embrace new and unfamiliar work arrangements
Evaluation	<ul style="list-style-type: none"> ➤ Lack of evaluations published by comparable programs ➤ Lack of effective assessment tools and systems ➤ Little time for evaluation ➤ Lack of resources for evaluation
Funding/ remuneration	<ul style="list-style-type: none"> ➤ Lack of funding for meetings and other necessary collaborative activities ➤ Lack of funding for providers to participate in collaborative activities ➤ Lack of sustained funding ➤ Inadequate funding ➤ Difficulty obtaining funding for the start-up of the initiative ➤ Obtaining payment for providers to take part in educational initiatives ➤ Challenges with fee-for-services sites ➤ Inflexible remuneration strategies
Geography	<ul style="list-style-type: none"> ➤ Isolation of collaborative team members ➤ Geographic challenge of the province size ➤ Large distribution of patients, providers and specialized facilities
Human resources	<ul style="list-style-type: none"> ➤ Unavailability of targeted expertise ➤ Shortage of required resources ➤ Challenges with finding the appropriate ratio of providers per clinic based on required services ➤ Inadequate resources based on need ➤ Staff turn-over

Barriers	Examples
Policy and legislation	<ul style="list-style-type: none"> ✎ Legal issues related to recording visits when using an electronic medical record ✎ Challenges with sharing information between organizations ✎ Lack of a developed protocol to inform the patient/client of necessary information
Skill	<ul style="list-style-type: none"> ✎ Discomfort with providing mental health services ✎ Lack of skill to provide specific services ✎ Lack of providers with required skill sets
Structures/systems	<ul style="list-style-type: none"> ✎ Challenges with developing a model for collaborative care ✎ Lack of a designated coordinator ✎ Difficulty with sufficiently involving regional partners in the planning process ✎ Challenges with referrals ✎ High referral volumes ✎ Difficulty with meeting goals related to wait times ✎ Lack of space ✎ Lack of time ✎ Difficult to schedule providers who are very busy ✎ Required renovations to physical space
Team development	<ul style="list-style-type: none"> ✎ Difficulty building relationships with community partners, families, consumers, and caregivers ✎ Growing pains associated with team development ✎ Role diffusion ✎ Difficulty maintaining a common goal ✎ Each professional discipline has a unique perspective to providing care to consumers
Technology	<ul style="list-style-type: none"> ✎ Lack of database to analyze the information being collected in the program ✎ Lack of skills related to the technology used to provide services ✎ Lack of technical support ✎ Discomfort with using the technology, including video conferencing equipment

EXAMPLES OF BARRIERS AND STRATEGIES

Examples of strategies used to overcome barriers experienced by the initiatives

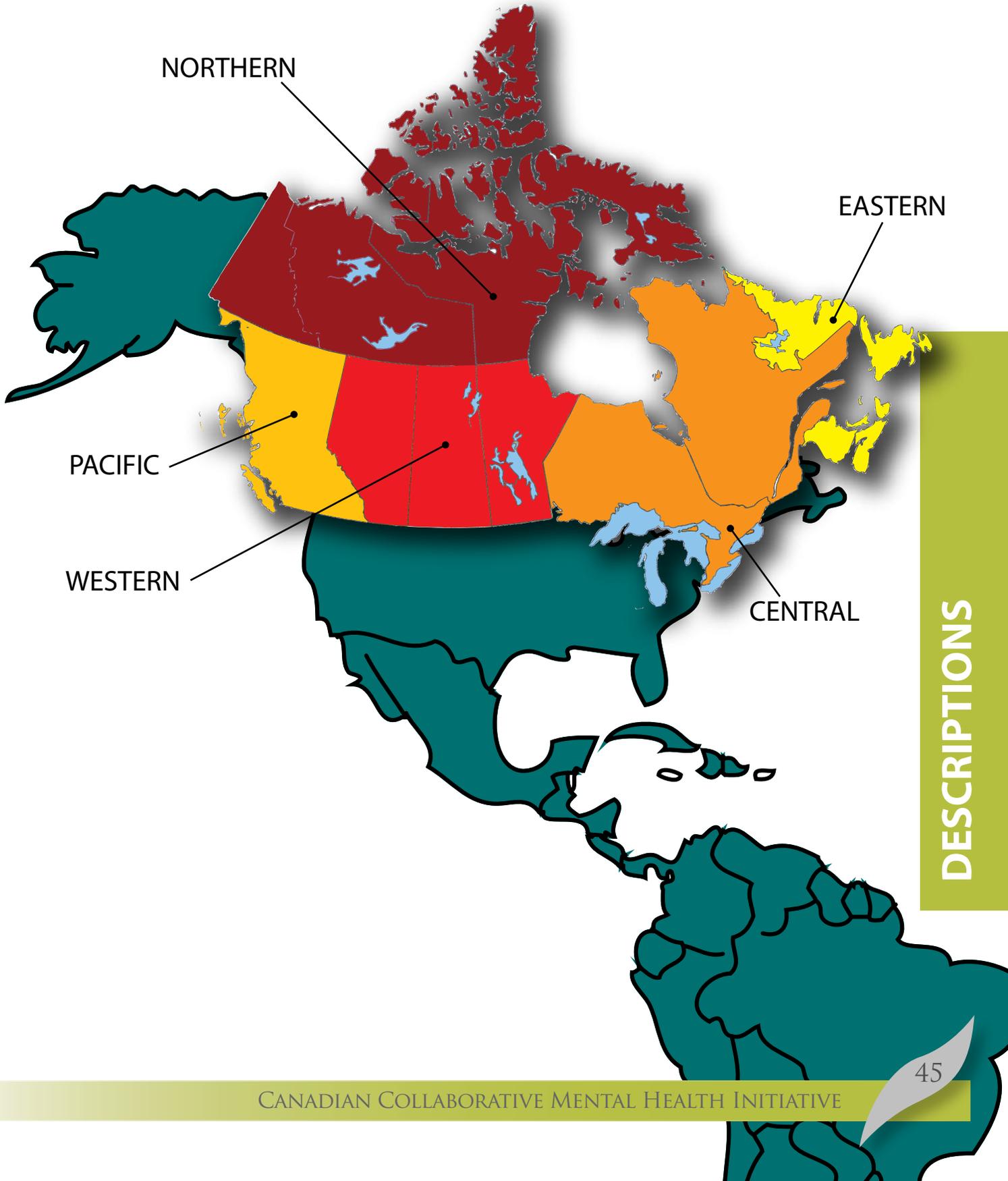
Strategies	Examples
Advocacy	<ul style="list-style-type: none"> ➤ Developed key partnerships with community resources ➤ Encouraged 'word-of-mouth' advertising ➤ Lobbied for the services and benefits of collaborative care ➤ Promoted a healthier lifestyle and/or increased quality of life to patients/clients
Buy-in	<ul style="list-style-type: none"> ➤ Received support from leaders/champions in the field ➤ Administrative/management personnel saw value in the collaborative activities ➤ Providers saw value in the collaborative activities
Evaluation	<ul style="list-style-type: none"> ➤ Used evaluations to dispel myths and support the benefits of collaborative initiatives ➤ Used an ongoing review of monthly statistics to ensure adequate resources were allotted to each collaborative initiative location ➤ Results of evaluation led to a refined service delivery model ➤ Regular performance reviews showed enhanced satisfaction of providers and patients/clients
Funding/ remuneration	<ul style="list-style-type: none"> ➤ Obtained adequate funding ➤ Obtained sustained funding ➤ Worked collaboratively with stakeholders to apply for funding ➤ Found creative funding sources ➤ Obtained additional funding to supplement fee-for-service arrangements ➤ Used salaried positions rather than fee-for-service arrangements ➤ Used creative funding sources to remunerate providers who were not funded by capitation
Geography	<ul style="list-style-type: none"> ➤ Staff visited mental health clinics outside of their region ➤ Isolation of providers was reduced through participation in monthly meetings, continuing education events, and professional development groups ➤ Used various information technologies to enhance communication with isolated sites

Strategies	Examples
Human resources	<ul style="list-style-type: none"> ➤ Received resources from internal sources ➤ Pooled resources with partner organizations ➤ Recruited providers that were willing to work in a collaborative initiative
Policy and legislation	<ul style="list-style-type: none"> ➤ A new mental health plan was developed and implemented in the region ➤ Worked closely with governments during the project development and its implementation to ensure the focus and expected outcomes were in line with the government framework ➤ Government incorporated mental health care into primary health care reform models ➤ Developed and implemented protocols regarding legal and health information to comply with statutes ➤ Developed a medical directive to allow providers to independently assess patients and share patient records
Skill	<ul style="list-style-type: none"> ➤ Funded additional skills training for providers ➤ Offered continued education opportunities ➤ Focused on capacity building of local providers and community members
Structures/ systems	<ul style="list-style-type: none"> ➤ Formed a working group composed of representatives of the various stakeholders so that the project reflected the input of those most involved in it ➤ Developed flexible structures to accommodate the needs of the community ➤ Created designated planning days for team meetings ➤ Implemented strong orientations for new team members ➤ Worked closely with key stakeholders to ensure that the initiative goals were achieved ➤ Implemented a coordinator who had clearly defined roles and responsibilities ➤ Reviewed partnership agreements and recommitted to the purpose, objectives, and service delivery methodologies with all of the key stakeholders ➤ Developed guidelines for appropriate referral strategies ➤ Developed strong links between primary-, secondary- and tertiary-level service facilities ➤ Developed communication strategies ➤ Obtained adequate space for necessary meetings ➤ Obtained additional funding for required space ➤ Obtained funding for renovations of physical space required ➤ Created more flexible work hours to accommodate staffing ➤ Offered flexible meeting times to accommodate busy work schedules

Strategies	Examples
Team development	<ul style="list-style-type: none"> ➤ Held meetings with all team members where they could share their concerns and success stories ➤ Developed respectful relationships with team members and members of the community ➤ Held regular planning days ➤ Encouraged regular, candid, and clear communication among staff members ➤ Involved both senior management and clinical leaders in the planning and implementation of the initiative
Technology	<ul style="list-style-type: none"> ➤ Used telehealth technologies to bridge the distance between isolated communities ➤ Used distance-based technologies to decrease costs ➤ Used electronic health records to enhance communication between providers

appendixC

INVENTORY OF CANADIAN INITIATIVES



NORTHERN

EASTERN

PACIFIC

WESTERN

CENTRAL

DESCRIPTIONS

appendixC

INVENTORY GUIDE

START DATE

Reports when the initiative came into existence. This may include the development period of the initiative, prior to providing mental health care services to consumers.

END DATE

Reports when the initiative is to be completed, if this is applicable.

SPECIAL POPULATIONS

Identifies all the consumer populations that initiatives target or offer their services to.

HUMAN RESOURCES

Identifies the human resources, including both non-health care and health care professionals, which support the collaborative initiative.

LOCATION(S)/SETTINGS(S)

Lists the location(s) or setting(s) where consumers receive or access mental health services.

EVALUATION

Specifies if an evaluation of an initiative has or has not been completed, or if an evaluation is currently ongoing.

INITIATIVE SHORT TITLE

Indicates the condensed or 'short title' for the initiative.

PURPOSE

Provides the underlying principles, fundamentals or justifications for developing and/or sustaining the initiative.

Chronic Disease Collaborative Initiative	
<p>Start Date September 2003</p> <p>End Date 2006</p> <p>Special Populations Concurrent disorders Disorder-specific Rural Urban</p> <p>Human Resources Family physician Master's of social work therapist Medical director Psychiatric nurse Psychiatrist Therapist</p> <p>Location(s)/ Setting(s) Physicians' offices</p> <p>Evaluation Yes, ongoing.</p> <p>Initiative Short Title Chronic Disease Collaborative</p>	<p>Purpose</p> <p>The initiative extends the services of mental health therapists and psychiatrist(s) to primary care through on-site enhanced skills training. By the initiative's completion, 20 family physicians in the Greater Victoria and Sooke areas will be involved.</p> <p>Goals/objectives</p> <ul style="list-style-type: none"> To develop a model of education and a manual for the family physician's office To enhance the family physician's ability to treat depression, not only with medications, but also with self-management and patient empowerment strategies (taken from a one-page handout in the manual) <p>Description</p> <p>Two teams of psychiatrists/therapists provide outreach services to family physicians. Four 20-minute interviews are allowed to family physicians in British Columbia. One session is provided for proper diagnosis, another session addresses triage for what type of treatment is required (e.g., medication, therapy, self-management), and two sessions are allowed for self-management. The staff has developed an easy-to-use manual that family physicians can learn from and use in designing treatment for their patients. It is based on cognitive behavioural therapy and methods for patient self-management and empowerment. The manual is available on request.</p>

GOALS/OBJECTIVES

Suggests the desired or expected outcomes of the initiative.

DESCRIPTION

This section describes how mental health care is delivered to consumers.

Information regarding: who provides care, what type of care is provided, where care is provided, and how the various collaborating health care partners (i.e., a broad range of primary and mental health care providers, consumers and caregivers) work interdependently to meet the needs of consumers (including methods of communication and supporting information technology) is summarized.

In addition, methods for knowledge exchange between health care providers are noted where appropriate (e.g., joint consultations, formal and informal meetings, case discussions and formal educational activities).

The primary or mental health care provider who assumes liability or responsibility for consumer care is also noted where possible.

UNIQUE CHARACTERISTIC(S) TO LOCAL COMMUNITY

Highlights distinctive features of the initiative's local community that were important during the development and/or implementation of collaborative mental health care services in primary health care to consumers.

Unique characteristic(s) to local community

- Our initiative runs in smaller suburban communities with an easy-to-target, identifiable general practitioner population.

Barriers

- Operational issues related to how to structure intake and referral processes, paperwork and scheduling office visits with physicians

Strategies

- Getting the word out about the initiative, and getting physicians to take the time to become better oriented about the service
- Integrating the service with the established mental health services (i.e., separating this service from other mental health services, where all therapists are expected to liaise with general practitioners)

Funding

- Funds are provided and regulated by the Regional Mental Health Program (Capital Health)

Sponsoring organization(s)

- Capital Health, Regional Mental Health Program.

Other participant(s) or organization(s)

- Capital Health Primary Care Division
- Private practice physicians

Contact(s)

Anita Murphy
Tel: (780) 467-6562
E-mail: AnitaMurphy@cha.ab.ca

June Clark
Tel: (780) 429-7840
E-mail: JuneClark@cha.ab.ca

BARRIERS

Draws attention to various types of barriers to collaboration and provides descriptions of these challenges as experienced by participants during the development and/or implementation of their collaborative activities.

FUNDING

Lists the source and/or duration of the initiative's main financial support, including the organization(s) or individual(s) responsible for regulating these funds.

SPONSORING ORGANIZATION(S)

Recognizes the organization(s) that provide additional financial support, human resources or other forms of support (e.g., office space) for the initiative.

OTHER PARTICIPANT(S) OR ORGANIZATION(S)

Recognizes any other individual(s) and/or organization(s) that support the success of the initiative in meeting the needs of consumers.

CONTACT(S)

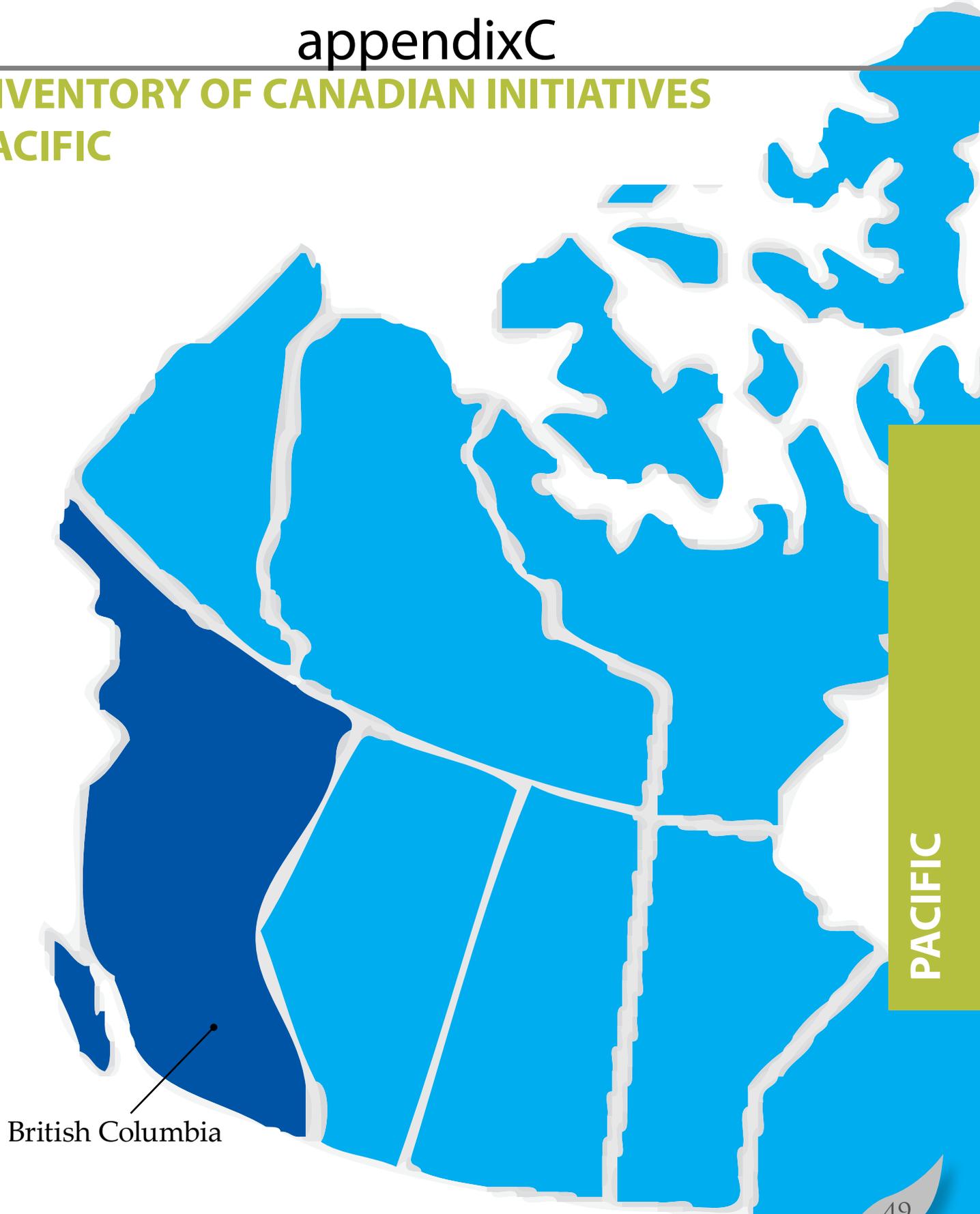
Provides brief contact information for the individual(s) who are in the best position to provide more information about the initiative. Full contact information is provided in Appendix G.

STRATEGIES

Brings to light the various strategies used by initiatives to overcome the challenges they experienced regarding their collaborative efforts and methods used to improve their ability to meet the mental health needs of consumers. Solutions may or may not correspond to the barriers identified..

appendixC

INVENTORY OF CANADIAN INITIATIVES PACIFIC



British Columbia

PACIFIC

Chronic Disease Collaborative Initiative

Start Date

2003

End Date

2006

Special Populations

Concurrent disorders
Disorder-specific
Rural
Urban

Human Resources

Family physician
Master's of social work therapist
Medical director
Psychiatric nurse
Psychiatrist
Therapist

Location(s)/Setting(s)

Physicians' offices

Evaluation

Yes, ongoing.

Initiative Short Title

Chronic Disease Collaborative

Purpose

The initiative extends the services of mental health therapists and psychiatrist(s) to primary care through on-site enhanced skills training. By the initiative's completion, 20 family physicians in the Greater Victoria and Sooke areas will be involved.

Goals/objectives

- To develop a model of education and a manual for the family physician's office
- To enhance the family physician's ability to treat depression, not only with medications, but also with self-management and patient empowerment strategies (taken from a one-page handout in the manual)

Description

Two teams of psychiatrists/therapists provide outreach services to family physicians. Four 20-minute interviews are allowed to family physicians in British Columbia. One session is provided for proper diagnosis, another session addresses triage for what type of treatment is required (e.g., medication, therapy, self-management), and two sessions are allowed for self-management. The staff has developed an easy-to-use manual that family physicians can learn from and use in designing treatment for their patients. It is based on cognitive behavioural therapy and methods for patient self-management and empowerment. The manual is available on request.

Unique characteristic(s) to local community

- The initiative is being implemented on an island

Barriers

- Trying to get payment for family doctors to take part in the education initiative when we worked in their offices
- Developing relationships with the particular doctors or communities we were working with took different forms and required a different approach with each area
- Getting the idea of what we would be doing across
- Clarifying the roles in each initiative; the most difficult clarification was with the education initiative, in which we had to make it clear to ourselves and to the family doctors that we were not providing a service, and that they, and not their patients, were the objects of the initiative. Doctors had to adapt to more of a student role in the education initiative

Strategies

- We were able to get funding for family doctors to take part in the education initiatives through the Mental Health Evaluation Clinical Care Unit in British Columbia
- For the depression education initiative, several solutions were found: we put on a workshop to role-play the initiative and we met for a half day orientation with each family doctor and his or her medical office assistant to clarify objectives, roles and scheduling
- The medical office assistant played a key role in overcoming some of the challenges experienced

Funding

- Vancouver Island Health Authority (VIHA)
- Federal Health Transition Fund
- Funds are regulated by VIHA

Sponsoring organization(s)

- Urgent Short Term Assessment and Treatment Unit (USTAT)
- VIHA
- The Federal Health Transition Fund's Chronic Disease Collaborative (Depression)

Other participant(s) or organization(s)

- Family doctors and their medical office assistants

Contact(s)

Dr. Rivian Wienerman
 Tel: (250) 213-4400
 E-mail: rweinerman@caphealth.org

Collaborative Care: Integrating Primary Care with the Multi-disciplinary Team Collaborative Care for Substance Use and Concurrent Disorders

Start Date

July 1 2003

End Date

March 31 2006

Special Populations

Aboriginal
Children and youth
Concurrent disorders
Northern/isolated

Human Resources

Director
Family physician
Mental health and addictions clinician
Nurse
Project manager
Psychiatrist

Location(s)/Setting(s)

Physician group practice setting

Evaluation

Yes, ongoing.

Initiative Short Title

Collaborative Care

Purpose

Research indicates that Canadians with substance use disorders are under-identified and under-treated. A large proportion of Canadians with substance use disorders also have psychological problems, particularly mood and anxiety disorders. It is estimated that mental health and substance-related problems account for at least 30 per cent of the health concerns presenting in primary care. The primary care setting presents important opportunities to identify and introduce treatment for such patients, as well as to minimize relapse.

Goals/objectives

- To enhance the effectiveness, efficiency and accessibility of primary health services for individuals with substance abuse problems, with or without additional mental illness (concurrent disorders), within select regions of British Columbia (B.C.) and the Yukon Territory
- To improve the prevention, identification and treatment of substance-using and co-morbid individuals, and to integrate community and regional resources within a collaborative, multi-disciplinary framework

Description

This multi-jurisdictional project involves three different locations: the Yukon, the Central Okanagan area of the Interior Health Region (B.C.) and the north shore area of the Vancouver Coastal Health Region (B.C.). Clinical working groups in each of the three locations have been working actively over the past year to develop a collaborative care model and plan for implementation of the active phase of the project. In February 2005, clinical staff from Mental Health and Addictions Services began working collaboratively with selected physicians and other primary health-care providers (primarily practice nurses). Services are organized somewhat differently in each of the three participating regions, in order to better address local requirements.

In Kelowna, mental health and addictions clinicians work one-half day per week in each of four physician group practice settings. They provide a range of services including secondary screening and assessment, brief interventions and referral to other services. Psychiatrists work in these group practice settings one-half day per month to provide enhanced consultation and assessment services.

In the Yukon, collaborative multi-disciplinary teams are organized around clusters of clients to better support high-need clients with concurrent disorders. For those in very remote locations, this involves the use of video-conferencing to link community practice nurses and community agency clinicians to specialized resources in Whitehorse and in the Lower Mainland of B.C. In Whitehorse, addictions and (possibly) mental health clinicians will work from selected private practice sites on a regular schedule.

On the North Shore of Vancouver, mental health and addictions staff attend physicians' offices, and physicians also do rotations through various mental health and addictions programs. Psychiatrists provide enhanced consultation and supervise physician rotations. An electronic health record links physicians with community mental health and addictions programs, so that all care providers receive timely information about the client's ongoing care and changing health status.

Unique characteristic(s) to local community

- The three regions are separated from each other by distance and, in the Yukon, the different collaborative disciplines may also be separated by distance

Barriers

- A major challenge has been to sufficiently involve regional partners in the planning process and to support them in developing project deliverables
- Timelines for developing a shared-care model and best-practice initiatives in each region have been very tight, and the clinical leaders entrusted with this task have had many demands on their time

Strategies

- Establishing a temporary project management position in each region to support the work of the clinical working groups
- Convening a two-day "think tank" to support planning and implementation of a concurrent disorders collaborative care system in each region

Funding

- The Centre for Tele-health at the Mental Health Evaluation and Community Consultation Unit (MHECCU) of the Department of Psychiatry, Faculty of Medicine, University of British Columbia administers this project on behalf of the governments of British Columbia and the Yukon Territory
- Health Canada, through the Primary Health Care Transition Fund, for the duration of 33 months

Sponsoring organization(s)

- Government of British Columbia
- Government of Yukon
- Health Canada

Other participant(s) or organization(s)

- None

Contact(s)

Dr. Julian Somers

Tel: (604) 822-1642

E-mail: julian.somers@ubc.ca

Ms. Sherry Masters

Tel: (604) 885-0286

E-mail: sherrymasters@dccnet.com

Provincial Eating Disorders Network

Start Date

2005

Special Populations

Disorder-specific

Human Resources

Dietitian
 Director
 Family physician
 Intern
 Nurse
 Nutritionist
 Psychiatrist
 Social worker

Location(s)/Setting(s)

Hospital
 Mental health centres
 Outreach (i.e., community)
 Private practices
 Specialized mental health support teams

Evaluation

Yes, ongoing.

Initiative Short Title

Eating Disorders Network

Purpose

Recommendations from a provincial specialized eating disorder program were aimed at improving access to specialized services and working with other service providers to build capacity in local communities across British Columbia. As part of the recent review of provincial specialized services, providers across the province identified many common issues and supported the concept of a network as a vehicle for collaborative planning and problem-solving.

Goals/objectives

- To coordinate specialized eating disorder services across the province through: identifying and addressing common service, policy and planning issues; addressing effective patient transition between service components; and creating a forum to discuss and prioritize cross-organization and cross-health authority initiatives
- To support the delivery of consistent, high-quality care in all parts of the province by: encouraging best practices, developing and sharing clinical guidelines; providing consultation support on complex cases; sharing specialized expertise; linking provincial eating disorder services and research to practice in health authorities, and supporting the transfer of knowledge into practice

Description

The Eating Disorders Network attempts to increase collaboration and coordination among service components across British Columbia. Included in this recommendation is the development of a clear mandate to: improve integration among primary, secondary and tertiary or specialized care, conduct collaborative research, support more equitable access to eating disorder services across the province, and make optimal use of highly specialized services.

The second main component of the network focuses on capacity-building in primary and secondary care, as well as collaboration. This includes support, training and consultation to community providers (including family physicians), focusing on providing appropriate and effective treatment in local communities. There is an emphasis on building the capacity of family physicians to manage patients with eating disorders. The network is designed to enable provincial eating disorder specialists to offer consultative and direct mental health services in primary health-care settings. The network uses a virtual team model, including tele-health. There is

potential for expanded Share Point Community of Practice (software) technologies to support the services and the expansion of face-to-face consultation support. Education opportunities include: grand rounds, discussion topics, network meetings and the dissemination of relevant materials.

It is expected that mechanisms to interface with advocacy and family groups and other stakeholders may also be accommodated using the Community of Practice Web site, but further work is required to design and support this role.

In addition to primary care practitioners and private psychiatrists, the province's specialized resources link to adult programs of the regional adult mental health services, where they provide eating disorder services, regional health authority hospital-based eating disorder services, and community child and youth mental health services (operated by a separate ministry and regional organizations that provide eating disorder services to the adolescent population).

Unique characteristic(s) to local community

- The Provincial Health Services Authority's mandate is to provide specialized provincial eating disorder services and to provide provincial leadership in making high-quality, accessible, specialized health services available

Barriers

- Geographic challenge of the province's size and the distribution of patients, providers and specialized facilities
- Complex service component across the continuum of care

Strategies

- Funded face-to-face planning/start-up meetings in 2004, and continuing dedicated funding for network infrastructure and operations
- Involvement of both senior management and clinical leaders in the planning and activation stages
- Establishment of an Internet-based Community of Practice using Share Point software to support communication and collaboration; current participants are staff and physicians of the separately managed provincial adolescent and adult eating disorder programs

Funding

- Operating budget component aimed at strengthening coordination and capacity of provincial and regional eating disorder services

Sponsoring organization(s)

- British Columbia Mental Health and Addiction Services, an agency of Provincial Health Services Authority (PHSA)

Other participant(s) or organization(s)

- Interior Health Authority
- Fraser Health Authority
- Northern Health Authority
- Vancouver Coastal Health Authority
- Vancouver Island Health Authority

Contact(s)

Ms. Val Embree

Tel: (604) 524-7676

E-mail: vembree@bcmhs.bc.ca

Geriatric Psychiatry Outreach Team (GPOT) Shared Care Initiative

Start Date

Fall 2003

Special Populations

Seniors/geriatrics
Urban

Human Resources

Clerical staff
Coordinator
Family physician
Neuropsychologist
Nurse
Nutritionist
Occupational therapist
Physical therapist
Psychiatrist
Registered nurse
Rehabilitation therapist
Social worker
Speech language therapist

Location(s)/Setting(s)

Health centre
Patient home
Private office

Evaluation

Yes, ongoing.

Initiative Short Title

GPOT

Purpose

The initiative seeks to improve communication with a primary health-care clinic, as well as two family practice clinics in the city, and the Geriatric Psychiatry Outreach Team (GPOT) at the Vancouver Hospital.

Goals/objectives

- To enter into a shared-care experience with primary care providers
- To increase access to psychogeriatric consultation for specific clinic patients and to enhance patient care
- To educate primary care staff in order to avoid some consultations in the future
- To begin work on health promotion and prevention for psychogeriatric issues

Description

The Geriatric Psychiatry Outreach Team (GPOT) provides consultation services to two family practice clinics in Vancouver and one community health centre, visiting each site once a month.

One psychiatrist and one case manager (e.g., a nurse or social worker) are attached to each primary health clinic, using their allotted GPOT time to do this; this amounts to either a half-day or two half-days of work for each GPOT dyad per month. The outreach team offers on-site consultation and assessment and ongoing follow-up. For patients of the family practice clinic, the outreach team travels to the patient's home (e.g., long-term care facility) to conduct assessments.

Funding was initially provided for management start-up, the development of a Cognitive Behavioural Therapy Group, six educational pamphlets and an early identification system, as well as project evaluation. Family practice clinicians were not being paid to sit in collaborative educational rounds. Previously, each primary health-care clinic was to be visited once a month for an hour's discussion, and patients were to be seen in between those times or during formal educational sessions.

All GPOT team members and physicians involved in seeing or discussing patients take their own responsibility for liability. The primary health clinicians continue to be responsible for primary health care. The team consults and only does ongoing follow-up on an “as required” basis. A team database is used to keep track of patients. One or two new patients are seen by the team every month. On average, one formal educational session per quarter is offered at the Raven Song Clinic. During each visit, several patients are discussed and recommendations may be given for between one and three new patients who will not be seen by the team.

Unique characteristic(s) to local community

- Mental health care has traditionally been separate from continuing care and family practice; this was a good opportunity to connect the geriatric psychiatry team to the primary care clinics for better overall integrative care

Barriers

- Funding was initially a challenge
- Set-up has been more difficult within the family practice settings because family physicians are so busy and there is no funded time for meetings to occur
- One clinic was undergoing renovations and changes because they were part of a much larger primary care initiative, making it even more difficult to implement change

Strategies

- Received start-up funding from the Primary Care Transitional Fund
- Project workers from the GPOT have been very flexible in their approach (by meeting the needs of the primary health clinics, but not imposing an unhelpful structure)

Funding

- Vancouver Coastal Health Authority, Primary Health Care Transition Fund for over three years (intended to be self-sustaining afterwards)
- Funds are regulated by the Vancouver Coastal Health Authority

Sponsoring organization(s)

- Vancouver Coastal Health Authority
- The Geriatric Psychiatry Outreach Team (GPOT) Shared Care Initiative

Other participant(s) or organization(s)

- Family Practice Centre of British Columbia Women’s Hospital
- Mid-Main Clinic, Vancouver
- Raven Song Health Centre, Vancouver

Contact(s)

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Independent Vancouver Island Health Authority (VIHA) Program

Start Date

2003

Special Populations

Aboriginal
Concurrent disorders
Rural
Urban

Human Resources

Aboriginal crisis worker
Aboriginal Elder
Aboriginal nurse
Band member
Community worker
Director
Faith community
Family
Family physician
Psychiatrist
Public health nurse

Location(s)/Setting(s)

Downtown churches
Family physicians' building boardroom
Hospital doctors' lounge
NATIVE Friendship Centre
Salt Spring Island Urgent Community
Clinic

Evaluation

Yes, ongoing.

Initiative Short Title

Independent VIHA program

Purpose

The program aims to extend the arm of mental health therapists and psychiatrist to various communities through on-site, one-time consultations in family physicians' offices; on-site demonstration and education; education conferences; and consultation and follow-up.

The areas involved in the program include these outlying South Vancouver Island communities: Langford, Saanich and Salt Spring Island, Pender Island; faith communities; and Aboriginal communities.

Goals/objectives

- To provide direct or indirect psychiatric consultation in areas where this is not readily available
- To develop relationships, and to provide educational and consultation services to communities that do not have a consistent link to psychiatric services (e.g., Aboriginal communities)
- To increase psychiatric consultations and services to patients with more severe mental illness in areas of Salt Spring Island, thus completing a circle of service in local communities

Description

This is an independent VIHA program that serves five unique sites, by providing the services of psychiatrists and mental health therapists. In the case of the first site, one-time consultations are provided weekly in a clinic that includes 30 family physicians.

At Saan Pen Hospital, a psychiatrist is available weekly (when possible) to discuss specific patient issues and answer general questions, as well as to provide information about referral options to the family physicians. However, the psychiatrist does not provide direct patient care.

At the third site, outreach services are made available to First Nations communities, including presentations and education by elders (by invitation). Referrals for one-time consultations come from the public health nurses of four Saanich bands, crisis workers, relatives and family physicians, in addition to self-referrals. No patient is refused.

On Salt Spring Island, outreach services have been provided to the community. Consistent patient forms have been introduced, information and educational materials are made available, and educational sessions for family physicians are offered. Direct and indirect consultations to family physicians and community mental health workers are also provided. Community service workers receive weekly supervision.

The program offers visits by a mental health therapist and a psychiatrist to 12 faith communities. Services that are provided by the 12 faith communities (that serve patients in their communities who do not reach the VIHA system) are documented. Difficult cases and options are discussed and an education conference is offered.

Unique characteristic(s) to local community

- The program takes place in an island setting

Barriers

- Funding resources for family doctors to spend time with the mental health therapists and the psychiatrists
- Travelling to Salt Spring Island
- Building respectful relationships with the Aboriginal community (involving elders, public health nurses, four bands, crisis workers and families)
- Bringing together family doctors, hospital administrators, community workers and psychiatrists on Salt Spring Island

Strategies

- In the case of Aboriginal communities, the approach was to be respectful (i.e., wait to be invited, be available and genuinely interested, enter when invited and do not to refuse patients)
- Meetings were held with all of the players in order to listen to and hear each other's needs; the program tried to find solutions that fit these needs, given limited resources

Funding

- Vancouver Island Health Authority (VIHA)

Sponsoring organization(s)

- Urgent Short-Term Assessment and Treatment Unit (USTAT)
- VIHA
- Family doctors from the St. Anthony Clinic

Other participant(s) or organization(s)

- Band members
- Counsellors
- Faith communities
- Family doctors
- First Nations elders

Contact(s)

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Provincial Neuro-psychiatry Network

Start Date

2005

Special Populations

Disorder-specific

Human Resources

Director
 Family physician
 Neuro-psychiatrist
 Nurse
 Occupational therapist
 Psychologist
 Physiotherapist
 Regional representative/liaison
 Social worker

Location(s)/Setting(s)

Hospital
 Mental health centres
 Outreach
 Private practices
 Specialized mental health support teams

Evaluation

Yes, ongoing.

Initiative Short Title

Neuro-Psychiatry Network

Purpose

This network will improve service coordination across the continuum of care, improve access to provincial specialized services, and build capacity to deliver consistent, high-quality, specialized mental health in neuro-psychiatry services across the province.

Goals/objectives

- To coordinate specialized mental health services across the province through: identifying and addressing common service, policy and planning issues; addressing effective patient transition between service components; and, creating a forum to discuss and prioritize cross-organization and cross-health authority initiatives
- To support the delivery of consistent high-quality care in all parts of the province by: encouraging best practices, developing and sharing clinical guidelines; providing consultation support on complex cases; sharing specialized expertise; and linking provincial neuro-psychiatry services and research to practice in health authorities, and supporting the transfer of knowledge into practice

Description

Provincial neuro-psychiatry services are currently located at University of British Columbia Hospital and Riverview Hospital. These services are being redeveloped as part of a province-wide redevelopment of specialized mental health services, creating an opportunity to redesign neuropsychiatry network services to be more effective and efficient, and to make them more accessible to residents throughout British Columbia. The program has two main components: service coordination and direct patient services.

The provincial neuropsychiatry network links the multiple service providers across health authorities, in order to create a seamless continuum of care that connects with the province's few clinicians specializing in this area and enables collaboration with them. In addition, it provides a mechanism to support standardization of protocols, as appropriate.

The network is designed to enable provincial neuro-psychiatric specialists to offer consultative and direct mental health services in primary health-care settings. These specialists provide consults to patients who are on a waiting list, in addition to offering joint consultations and ongoing follow-up and support to family physicians, based on their areas of expertise. The network uses a virtual team model, including current tele-health and planned Share Point Community of Practice (software) technologies to support the services. There is also an opportunity for face-to-face meetings. There is an emphasis on building the capacity of family physicians to manage patients with neuro-psychiatric illnesses and disorders.

Unique characteristic(s) to local community

- The Provincial Health Services Authority's mandate is to coordinate the redevelopment of provincial tertiary psychiatry services, and to provide leadership provincially to make high-quality, accessible specialized health services available

Barriers

- Coordinating network start-up with acute service redesign and regionalization timetable for specialized rehabilitation and residential services
- The geographic challenge of the province's size and the distribution of patients, providers and specialized facilities
- Ensuring identification/designation of regional clinical leads for network liaison

Strategies

- Funded face-to-face planning/start-up meetings in 2004 and also anticipate doing so for 2005
- Involvement of both senior management and clinical leaders in the planning and activation stage
- Establishment of an Internet-based "Community of Practice" using Share Point software to support communication and collaboration

Funding

- Operating budget component aimed at strengthening coordination and capacity of provincial and regional neuro-psychiatric resources

Sponsoring organization(s)

- British Columbia Mental Health and Addiction Services, an Agency of the Provincial Health Services Authority

Other participant(s) or organization(s)

- All five of British Columbia's regional health authorities: Fraser Health Authority; Interior Health Authority; Northern Health Authority; Vancouver Coastal Health Authority; Vancouver Island Health Authority

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Shared Care Program

Start Date

1999

Special Populations

Children and youth
Seniors/geriatrics
Other

Human Resources

Administrative staff
Clinical counsellor
Clinical psychologist
Coordinator
Family physician
Psychiatric nurse
Psychiatrist
Social worker

Location(s)/Setting(s)

General practitioners' offices
Hospital outpatient clinics
Pediatricians' offices
Primary Care Obstetrical Clinic

Evaluation

Yes, completed and ongoing.

Initiative Short Title

Shared Care Program

Purpose

The project seeks to make collaborative mental health care available through family physicians to those clients living in Fraser Health; this program is modelled on the Hamilton–Wentworth Program.

Goals/objectives

- To improve the mental health outcomes of clients in the primary care setting (client-focused)
- To increase the skills and confidence of family physicians to identify and manage mental health problems (physician-focused)
- To enhance the system and the continuum-of-care for mental health clients in the region (system-focused)

Description

The Shared-Care Program of the Fraser Health Authority links mental health clinicians with family physicians. The clinicians include psychiatrists, psychiatric nurses and/or counsellors (i.e., clinical psychologists, clinical counsellors, or social workers). Services are delivered by the shared-care team, which is co-located in family physicians' offices, a primary care obstetrics clinic, a pediatrician's office and hospital outpatient clinics. The shared-care team spends, on average, a half-day per week at each site.

Family physicians are responsible for sending forms initiating a referral to the psychiatrist or counsellor, who then conducts the initial assessment. Depending on the client's condition, the psychiatrist or counsellor may do any of a combination of the following: provide short-term care; provide referral to community supports or agencies; or, provide collaborative care with family physicians, who have direct or indirect consultative support, when needed. Notes from the initial assessment or other notes regarding client information are documented in a common file in the family physician's office. The average number of referrals per month is 36 for the five service sites in Fraser North.

The program liaises with local Mental Health Centres and the Ministry of Children and Family Development in Fraser Health. Clients are referred to the mental health teams for more comprehensive follow-up or to specific programs (e.g., cognitive behavioural therapy groups). The program is currently seeking annualized funding for child and youth shared care and the adult shared-care program has expanded to other areas in Fraser Health.

In the fall of 2004, the Shared-Care Program expanded to four sites in Fraser East and four sites in Fraser South. An evaluation framework is being developed for the program. The child/youth project was first funded through a grant provided by the Ministry of Children and Family Development to the University of British Columbia's Mental Health Evaluation and Community Consultation Unit (MHECCU) in January 2003.

Unique characteristic(s) to local community

- We have been fortunate that the administration for the Health Authority has been supportive of this program from the start

Barriers

- Funding challenges
- Coordination of the expanded program
- Recruitment of staff

Strategies

- We are currently looking into funding options for family physicians
- We created a steering committee and working groups for program coordination
- We are conducting ongoing evaluations that will help to improve the overall effectiveness of the program
- We are advocating for funding

Funding

- Fraser Health Authority

Sponsoring organization(s)

- Fraser Health Authority

Other participant(s) or organization(s)

- Ministry of Children and Family Development

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Discharge Group at South Mental Health Team

Start Date

April 2005

Special Populations

Serious mental illness

Human Resources

Case manager
 Director
 Family physician
 Occupational therapist
 Psychiatric nurse
 Team physician

Location(s)/Setting(s)

Community resources (consumers' drop-in centre, clubhouse)
 South Mental Health Team (community mental health site)

Evaluation

Yes, ongoing.

Initiative Short Title

South MH Team

Purpose

The purpose of the Discharge Group is to prepare clients for their eventual discharge from the South Mental Health Team to the care of their general practitioners.

Goals/objectives

- Clients who attend the Discharge Group receive the following: support and medications; opportunity to learn more about mental illness, its symptoms and management; community resources; and peer support

Description

Clients of the South Mental Health Team who have been receiving one-to-one service (i.e., seeing a case manager and physician) and whose mental illness/psychiatric condition is stable can receive treatment in a group model, to prepare them for discharge. Team members include stable clients of the South Mental Health Team. Clients are referred to the program by their case managers and/or treating physicians.

Clients attend the group once a week for approximately one-and-a-half hours. At the group meetings, clients receive information about mental illness and how to manage their symptoms. Medication renewal is also part of the group process. The group also provides support for family members or other close personal contacts who are involved in the clients' treatment. The group facilitator meets with the clients' family or loved ones, as needed, and the team makes sure that the family or loved ones and the clients' family doctors receive support when the clients are discharged.

Psycho-educational modules have been used in the group, including: Introduction of Group Members and the Purpose of the Group, Wellness Plan, Understanding of the Individuals Diagnosis, Medication—It's Importance, and Side Effects, Psychosocial Health, Stress Management, Problem-Solving, Community Support, Talking to Your General Practitioner, and Group Closure. The timeframe for the group is ten weeks (one session per week, with each session lasting two hours). The group consists of ten to 12 people.

Once clients are in the Discharge Group, the group facilitator (one of the team's therapists) connects with the clients' family doctors to prepare for transfer to their care. Once this transfer is complete, if clients feel their psychiatric symptoms reoccurring, they may still attend the team for a short time, in order to have their medications adjusted and to have time to re-stabilize; the team can also make recommendations to their family doctors.

Unique characteristic(s) to local community

- The need to use existing resources to treat new clients in the community
- The need to further establish use of the group as a treatment modality

Barriers

- Some stable clients who are using minimal team services are reluctant to participate in the Discharge Group because they know they will be discharged from the South Mental Health Team

Strategies

- Provide support to discharged clients, family members of discharged clients and family physicians who take over care of the clients

Funding

- No additional funding is provided; funds come from within the South Mental Health Team's Adult Program budget

Sponsoring organization(s)

- South Mental Health Team
- Vancouver Community Mental Health Services of Vancouver Coastal Health Authority

Other participant(s) or organization(s)

- None

Contact(s)

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The Navigator Project

Start Date

April 2005

Special Populations

Aboriginal
 Children and youth
 Concurrent disorders
 Ethno-cultural
 Homeless/transient
 Northern/isolated
 Rural
 Seniors/geriatrics

Human Resources

Addictions clinician
 Ambulance personnel
 Community mental health clinician
 Community nurse
 Employment counsellor
 Family physician
 Royal Canadian Mounted Police (RCMP)
 School counsellor
 Self-help and advocacy group
 Social worker

Location(s)/Setting(s)

Ambulance station
 Employment agency
 Local family physicians' offices
 Port Renfrew community office
 RCMP/Victim Services office
 Sooke Family Resource Centre
 Sooke Seniors centre
 Transition house
 T'Souke Band office

Evaluation

Yes, ongoing.

Initiative Short Title

The Navigator Project

Purpose

The purpose of the Navigator Project is to make an innovative contribution to the shared-care model within mental health and addictions, by introducing a role intended to link various community providers into an effectively functioning network of care.

Goals/objectives

- Systematically document levels of unmet local mental health and addictions service need, and characterize the types of clients whose needs challenge local capacity
- Optimize the function of this new navigator role within the local context by evaluating (in real time) the effectiveness and appropriateness of the services provided by the navigator
- Identify and manage the impact of geographic challenges and other barriers to providing essential services for mental health and addictions
- Acquire abstract knowledge that will support the most effective and appropriate use of a shared-care service delivery model in other locations
- Together, the key partners will develop a charter to define the nature of their service partnerships and develop strategies to support collaboration with the primary health care system

Description

The Navigator Project is designed to gain a better understanding of access to appropriate help with mental health and addictions for individuals living in the Sooke catchment area. A "Navigator" acts as a broker for health services in the Sooke, East Sooke, Otter Point, Shirley, Jordan River or Port Renfrew communities for any individual who has concerns about mental illness and/or substance abuse or addiction.

The Navigators are available to provide Navigation to other service providers (i.e., provide information about available services and their requirements), and also meet with clients to perform a strength-based assessment, which is used as a basis for coordinating and facilitating access to both the formal service system and the informal community sector. In urgent situations, the Navigators remain involved until appropriate service access can be confirmed. At the same time, the individual seeking help is offered the opportunity to have his or her assessment data be used as part of the research component of the project.

Service access issues addressed by the Navigator include: identifying service barriers, real-time problem solving relating to specific service access issues, referring more enduring problems on to service managers/administrators, cataloguing and tracking progress on critical unresolved issues, and evaluating access outcomes at an individual case level.

The Navigators also provide family physicians and other providers with appropriate feedback on client follow-up, and help to identify barriers with service access. Other duties include: referrals, standardized screening assessment (strength-based), guidance until service contact is made, and outreach (by telephone and/or in person) to individuals of all ages who have agreed to Navigation service. Referrals are unrestricted.

Unique characteristic(s) to local community

- Sooke is a rural, West Coast community of approximately 17,000 people, located one to three hours from most of the mental health and addiction services and programs in Victoria, B.C.; there is no local hospital, nursing home or community health centre; the number of family physicians has decreased to six; current and projected population increase is more than four per cent annually

Barriers

- Among the most difficult challenges has been securing adequate funding, interest and involvement from the local health authority
- Assessment and care for individuals with mental health and addiction problems usually requires frequent long trips outside the local community (preventing access to care)

Strategies

- The participants in the project development live and work in the community, and so, have been able to generate widespread community support
- A strong, community-based steering committee has helped gain the interest of the health authority and various funding sources
- We continuously write grant applications and lobby local, provincial and federal politicians for support

Funding

- The British Columbia Ministry of Children and Family Development
- Vancouver Foundation
- Vancouver Island Health Authority (VIHA)
- Victoria Foundation

Sponsoring organization(s)

- Sooke Family Resource Society

Other participant(s) or organization(s)

- Community of Sooke
- Edward Milne Community School
- Jordan River and East Sooke
- Mental Health Evaluation and Community Consultation Unit (MHECCU) at University of British Columbia
- Ministry of Children and Families
- Pacific Centre for the Family
- Provincial Ambulance Service
- Regional district encompassing Port Renfrew
- Royal Canadian Mounted Police (RCMP)
- Sooke Crisis Centre, Sooke Seniors Centre
- Sooke-works
- T'Sooke Band
- University of Victoria
- VIHA

Contact(s)

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Three Bridges Community Health Centre

Start Date

1995

Special Populations

Aboriginal
Children and youth
Concurrent disorders
Homeless/transient
Seniors/geriatrics
Urban

Human Resources

Addiction counsellor
Dietitian
Family physician
Licensed practical nurse
Nurse
Psychiatrist
Receptionist
Self-help/advocacy group
Social worker

Location(s)/Setting(s)

Community Health Centre

Evaluation

Yes, ongoing.

Initiative Short Title

Three Bridges CHC

Purpose

Due to the significant lack of mental health resources, especially for marginalized populations, a shared care program was established at Three Bridges Community Health Centre in general psychiatry, dual diagnosis and crystal methamphetamine psychosis.

Goals/objectives

- To enhance mental health care to marginalized patients in the inner city areas of Vancouver and in particular, the Downtown South community

Description

As part of the health centre, patients are connected to the collaborative mental health program on a drop-in or appointment basis. Patients are triaged by a receptionist, who refers them to an appropriate family physician. The family physician is responsible for conducting patient assessments, diagnosis and treatment, and is supported by three psychiatrists who work on a part-time basis; the psychiatrists also provide consultation and educational services. Addiction counsellors, an addiction nurse and four peer support groups offer support to patients. Approximately 30 patients, many of whom suffer from concurrent disorders and/or do not have regular access to a family physician, are seen each month.

Direct communication between the psychiatrists and family physicians occurs regularly during informal face-to-face contact and formally, through referral sheets. A family physician may refer a patient to a psychiatrist for an independent assessment, after which the results are shared with the patient's physician. When appropriate, a psychiatrist and a family physician may conduct joint consultations.

In the near future, family physicians will be leading case presentations for the team every second month. This will be an opportunity for the team to discuss unique or challenging cases.

Unique characteristic(s) to local community

- We are situated in the middle of the Downtown South inner city and are very close to the West end. It is an urban core community comprised of a significant number of gay, lesbian, bisexual and transgendered individuals, as well as large immigrant, refugee and elderly populations

Barriers

- It took a four-year search to find psychiatrists who had time and interest in taking part in this program
- It was difficult to find funding
- The service is currently looking for a mental health counsellor

Strategies

- Funding for additional training for our general psychiatrists through the Department of Family Practice was provided
- Funding has become available, as the region has developed a new mental health plan

Funding

- University of British Columbia (UBC), Department of Family Practice
- Vancouver Coastal Health

Sponsoring organization(s)

- Vancouver Coastal Health

Other participant(s) or organization(s)

- None

Contact(s)

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appendixC

INVENTORY OF CANADIAN INITIATIVES WESTERN



Alberta

Saskatchewan

Manitoba

WESTERN

Boyle McCauley Health Centre On-site Mental Health Services

Start Date

1994

Special Populations

Aboriginal
Concurrent disorders
Ethno-cultural
Homeless/transient
Urban

Human Resources

Inner-city agency worker
Mental health therapist
Nurse
Nurse-practitioner
Peer support
Physician
Program manager
Psychiatrist
Social worker

Location(s)/Setting(s)

Health centre
Mental health clinic

Evaluation

Yes, ongoing.

Initiative Short Title

Boyle McCauley Health Centre

Purpose

This position is funded by Regional Mental Health as a way of ensuring consistent and efficient services for a transient, inner-city population and for clients who do not feel comfortable, or are unable to attend the mental health clinic.

Goals/objectives

- To provide readily accessible mental health assessment and follow-up to a transient, inner-city population
- To provide on-site consultation to other health professionals, as needed, in order to help them with care planning and service delivery
- To increase consistency in the consulting service by having one therapist assigned to the partner organization

Description

The mental health therapist is co-located at the Boyle McCauley Health Centre. This is an inner-city agency offering a comprehensive range of services, including physicians, nurse-practitioners, dental services, laboratory, safe needle exchange, addictions counselling and client advocacy. The therapist provides on-site mental health assessment, consultation and follow-up, primarily to clients who are registered with the Boyle McCauley Health Centre, or who may be connected with other inner-city agencies. This is primarily a collaborative role, in that the therapist takes on clinical responsibility for the psychiatric care of many of the clients who are referred to her. While she is primarily based at the Boyle McCauley Health Centre, she reports administratively and clinically to one of the treatment teams at the Edmonton Mental Health Clinic. New cases are, therefore, discussed in case conferences with her mental health team colleagues. Approximately 60–100 contacts are made with 45–60 clients each month.

In situations where clients need to be seen by a psychiatrist, appointments are scheduled for the client to attend the mental health clinic; psychiatrists do not travel to the Boyle McCauley Health Centre. The therapist attends staff meetings at Boyle McCauley Health Centre when the topic is relevant to her role. In addition, her on-site location makes her readily available for case discussions with staff and physicians.

Liability is shared with the treating physician. Not all clients seen at the health centre are clients of the family physicians at that health centre, and some do not have a doctor. However, experience has shown that it is necessary to have physician involvement, since this is a collaborative arrangement. If the client has been seen by, and is receiving prescriptions from, a treating mental health psychiatrist, the psychiatrist is liable. Otherwise, liability rests with the family physician who is working with the client.

Unique characteristic(s) to local community

- For many years, Mental Health Services has had a practice of assigning each staff member to an agency that serves people with psychiatric disorders in a psychiatric consultation–liaison arrangement; the request from Boyle McCauley Health Centre to expand this arrangement to a full-time assignment evolved from the relationship that was already in place

Barriers

- Finding documentation processes to meet the needs of both systems, including the Mental Health Information System
- Differences in culture associated with the type of clientele
- Trying to provide psychiatric care to clients who do not have a family physician in the catchment area
- There is a high no-show and treatment dropout rate with this client group

Strategies

- The new therapist is discouraging drop-ins by having the receptionist take client information and arranging bookings, having a designated open afternoon, and establishing a referral program to be used by other inner-city agencies who are wanting to have clients seen

Funding

- Capital Health, Regional Mental Health Program
- Regional Mental Health Program
- Funds are regulated by the Regional Mental Health Program

Sponsoring organization(s)

- Boyle McCauley Health Centre
- Capital Health
- Capital Health, Regional Mental Health Program, Edmonton Clinic

Other participant(s) or organization(s)

- None

Contact(s)

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Calgary Diversion Service (CDS)

Start Date

2001

Special Populations

Aboriginal
 Children and youth
 Concurrent disorders
 Disorder-specific
 Ethno-cultural
 Homeless/transient
 Rural
 Seniors/geriatrics
 Urban

Human Resources

Administrative support
 Community agency
 Community support worker
 Consultant psychiatrist manager
 Family physician
 Registered psychiatric nurse
 Research assistant
 Social worker

Location(s)/Setting(s)

Community service sites
 Hospital
 Outreach
 Remand centre
 Salvation Army building

Evaluation

Yes, ongoing.

Initiative Short Title

Calgary Diversion Service

Purpose

The Calgary Diversion Service was conceptualized by a group of influential visionaries who believed that mentally ill individuals who commit minor criminal offences would be more appropriately served through appropriate community mental health services. The program was planned, developed and implemented by a multi-stakeholder partnership that included three provincial ministries. The project was initially a response to the government's encouragement of innovation and partnerships as a means to deliver appropriate and needed health services, while demonstrating collaboration and efficiency.

Goals/objectives

- To reduce contacts with the justice system for individuals who are mentally ill and commit minor low-risk offences, through timely and appropriate intervention and follow-up, via links to a continuum of community-based treatment and support services
- To implement effective and efficient strategies to link the mental health and justice systems, as a way to appropriately meet the needs and improve the outcomes for individuals who, due to mental illness, come into minor conflict with the law
- To serve the community appropriately and safely

Description

The Calgary Diversion Service (CDS) team has developed a protocol with a health-care centre for mental health consultations (provided by a psychiatrist). A great number of the service's clients do not have regular physicians, and attempts have been made to link them to this service. When a client enters the service, the team (e.g., social workers, a registered psychiatric nurse, a community support worker) conducts a needs assessment and, based on case merit, links with other appropriate services. All cases are reviewed by the team at weekly case conference/triage reviews.

The team routinely connects with agencies/services (e.g., community mental health services) to ensure access for the client, and strives to provide effective and lasting linkages to appropriate services during the three-month adjournment. The team is encouraged to develop and maintain professional

links to front-line workers from other services. Referrals received from hospitals, community agencies and families, are followed up by the team in its discussions with the Crown and/or defence.

The team also offers outreach services to three diversion points: the Arrest Processing Unit, the Provincial Court (Crown's office) and the Calgary Remand Centre. Referrals initiated by hospitals will be responded to by outreach services (one of the three clinicians from diversion will do a triage assessment while the individual is in the hospital). There is also a protocol for tele-health.

The transition and/or access to education and advocacy have improved through teaching and identifying needs with the client. There is also secondary reporting to the Director of Primary Care. Representatives from consumer groups, community-based mental health agencies, addictions organizations and the legal system sit on the operations committee, as well as the steering committee.

Unique characteristic(s) to local community

- The commitment and ongoing support from organizations in the legal and health systems was exceptional
- In addition, although the service is located in Calgary, it serves clients as far away as Manitoba, Saskatchewan and British Columbia

Barriers

- Challenges with the information-sharing between organizations
- The police had concerns about identifying individuals for the service and wanted to ensure that an assessment to determine appropriateness will be conducted and followed up on

Strategies

- Protocols regarding legal information, as well as health information, were developed and implemented to comply with statutes
- Educational opportunities were offered by staff to stakeholders

Funding

- Alberta Health and Wellness, Health Innovation Fund
- Calgary Health Region and the Alberta Mental Health Board
- Funds are regulated by the Alberta Mental Health Board and the Calgary Health Region, and implemented through the Southern Alberta Forensic Psychiatry Services

Sponsoring organization(s)

- Alberta Mental Health Board
- Calgary Health Region

Other participant(s) or organization(s)

- Alberta Alcohol and Drug Abuse Commission (AADAC), Addictions
- Calgary Police Services
- Calgary Remand Centre, Solicitor-General
- Central Care Pharmacy
- City of Calgary
- Human Resources and Development Canada
- Probation, Solicitor-General
- Provincial Court, Justice
- Royal Canadian Mounted Police (RCMP)
- Schizophrenia Society
- The Salvation Army

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Child and Adolescent Shared Mental Health Care (CASMHC)

Start Date

February 2004

Special Populations

Children and youth
Urban

Human Resources

Family physician
Manager
Psychiatrist
Psychologist

Location(s)/Setting(s)

Private office

Evaluation

Yes, ongoing.

Initiative Short Title

CASMHC

Purpose

More than 80 per cent of Canadians visit their family physicians each year (Decima Research, 1993). Of the mental health problems that present in a family physician's office, almost half go undetected (Goldberg and Bridges, 1987). A position paper jointly developed by The College of Family Physicians of Canada and the Canadian Psychiatric Association (1997) recommends a shared care approach to treating mental health problems in the primary care setting.

Goals/objectives

- To increase primary health care providers (e.g., 'family physicians') capacity to identify, assess, treat and/or refer children and adolescents with mental health concerns

Description

The Child and Adolescent Shared Mental Health Care (CASMHC) program delivers mental health services (i.e., consultation, brief therapy and education) in collaboration with primary health care providers in south Calgary. The program serves patients in the primary health care providers' offices. The primary health care provider is supported by an interdisciplinary team, but remains the primary caregiver. The program serves 30 primary health care providers altogether.

The CASMHC program is an extension of the Adult Shared Mental Health Program for the Calgary Health Region. These two programs work closely to ensure comprehensive support to primary health care providers.

Primary health care providers who wish to access the program enter into a formal agreement with the CASMHC program for one year. The service aims to enhance their capacity to identify, assess and treat children and adolescents with mental health concerns. Clinicians schedule regular visits (up to four hours per month) to the primary health care provider's office. The clinician and the provider jointly assess patients and plan the approach to treatment. Clinicians also strive to increase the providers' knowledge of clinical and social resources in the community, as well as relevant professional resources.

Primary care physicians enroll in an alternative payment plan, which provides remuneration for the time (up to six hours per month) they spend doing shared care. This includes direct care, consulting with another provider and continuing education.

Unique characteristic(s) to local community

- In Alberta, there is a provincial trend to supporting primary care programs
- The Local Primary Care Initiative (an existing funding mechanism) supported this program; it provides adequate compensation to physicians and psychiatrists enrolled in the program
- A health region consultant report (by Dr. P. Steinhauer) promoted the use of a “multiplier effect” to build capacity in other health care providers through consultation and teaching

Barriers

- Because targeted expertise was unavailable, recruiting clinicians to work for the program was difficult, and there was reluctance on the part of clinicians to embrace new, unfamiliar working arrangements
- Generating buy-in from family physicians was a challenge
- Since many physicians believe it reduces their overall volume capacity, there were misconceptions about the efficiency of the model
- Recruiting psychiatrists has also been difficult because of a local shortage

Strategies

- Encouraging word-of-mouth advertising of the service has proven more effective in engaging primary health care providers than more formal advertising methods, such as cold calls or brochures
- The program is planning to actively dispel the belief held by physicians that “collaboration will reduce capacity,” through sharing evaluations and anecdotal evidence

Funding

- Provincial Funding, Calgary Health Region

Sponsoring organization(s)

- Calgary Health Region

Other participant(s) or organization(s)

- None

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Collaborative Mental Health Care (0-5 years)

Start Date

June 2000

Special Populations

Children and youth
Urban

Human Resources

Child psychiatrist
Family physician
Nurses
Program manager
Psychologist
Social worker

Location(s)/Setting(s)

Non-clinical (i.e., child care centre, day care)
Private office (physician's office)

Evaluation

Yes, ongoing.

Initiative Short Title

CMHC

Purpose

The service was developed in response to the Calgary Health Region's Children's Mental Health Working Group's recommendation that mental health support be provided in primary care settings. Providing mental health education, intervention and referral support to primary health and child-care providers will improve their ability to identify and treat mental health problems; this will benefit high-risk infants and children, and their families.

Goals/objectives

- To respond to identified needs and promote the mental well-being of infants, toddlers and preschool children (aged 0 to 5) identified as being at significant risk of developing mental health problems and their families, through provision of consultation and education for primary care providers

Description

The Collaborative Mental Health Care program offers consultation, brief therapy and education in collaboration with primary care providers (e.g., family physicians, child care centres and day cares) in the northeast quadrant of Calgary, to patients in a variety of settings. The service was developed in collaboration with the Alberta Child Health Initiative, Alberta Mental Health Board and the Calgary Health Region, and is run in conjunction with the Adult Shared Mental Health Program and the Child and Adolescent Shared Mental Health Care (CASMHC) program in Calgary Health Region, to ensure a comprehensive continuum of support to primary health-care providers.

The program's clinicians travel to the primary care provider's office to meet with the provider and determine his or her concerns and expectations from consultation. Consent from families is required for the assessment, if this is determined to be appropriate. In some cases, the child and family may receive brief time-limited intervention or therapy from the program. The primary health-care provider is supported by an interdisciplinary team, but remains the primary caregiver.

In addition to consultation and assessment, program clinicians work with providers to expand the competencies of caregivers and service providers by enhancing their knowledge of other clinical and social resources in the community and relevant professional resources.

Unique characteristic(s) to local community

- It is the first program in this area that targets this age group
- The program is limited to one quadrant of Calgary; this quadrant was chosen because it has a higher population of young children and families experiencing difficulties related to the socio-economic determinants of health

Barriers

- Involvement of physicians has been challenging; this may be due, in part, to a view held by many physicians that mental health issues are not relevant for such young children
- Convincing parents/guardians that current intervention efforts will have a positive impact further along in the child's development; eliminating the notion that "child welfare" will be brought in (a common fear)

Strategies

- By using a health promotion approach to a child's care, and by bringing physicians and families together, we facilitate the likelihood of being able to have access to a shared mental health-care service
- Imposing a rigid structure on primary health-care providers is not beneficial; offering a service that is flexible and accommodating ensures that primary health-care providers are more likely to have their needs met in a responsive and realistic fashion

Funding

- Calgary Health Region

Sponsoring organization(s)

- Calgary Health Region

Other participant(s) or organization(s)

- None

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Community Geriatric Psychiatry

Start Date

1990

Special Populations

Seniors/geriatrics
Serious mental illness

Human Resources

Clinical psychologist
Community psychiatric nurse
Community nurse
Community support worker
Family physician
Program manager
Psychology intern
Recreation therapist
Social worker
Therapy assistant

Location(s)/Setting(s)

Acute care hospitals
Community agencies
Educational outreach
Geriatric community clinic
Group homes
Homes
Lodges
Nursing homes
Outpatient clinic
Seniors' residences

Evaluation

Yes, completed.

Initiative Short Title

Community Geriatric Psychiatry

Purpose

The purpose of the program is to provide prompt, accessible and effective treatment, consultation and support services for individuals 65 years and older who require specialist psychiatric services.

Goals/objectives

- To prevent or minimize disability caused by severe mental illness and to prevent unnecessary hospitalization
- To demonstrate a set of key values that provide: prompt response to referrals; assertive community treatment and support when needed; seamless service delivery between Alberta Hospital, Edmonton, and Community Geriatric Psychiatry; a key worker assigned for service coordination and continuity of treatment; support for and enablement of the patient, family, primary health care workers and other caregivers; and pragmatic partnerships and links with other health-care providers

Description

Our program consists of a core team of social workers, psychiatrists, family physicians and psychiatric nurses who provide mental health services to individuals who are 65 years of age and over and who have severe mental illnesses. These individuals require initial assessment, treatment or crisis intervention in the community, and short-term, intensive follow-up after discharge from hospital. Some require long-term follow-up and support, including access to a specialized day program, in order to live successfully in the community. The team accepts referrals from a range of sources. The program assumes legal liability for patients who receive treatment and have a file opened. In other situations, the program provides recommendations on a consulting basis and the primary care provider chooses to accept or reject these recommendations.

The team provides: in-home assessment, diagnosis, treatment and follow-up; outpatient clinic assessment, treatment and follow-up; home-care consultation and support; post-hospital monitoring and treatment for patients discharged from Alberta Hospital, Edmonton, as well as from other acute care hospitals, upon request; crisis support and stabilization; a day program, situated in the Community Geriatric Community clinic; educational outreach; and liaison with and referral to other community agencies.

Patients who do not require ongoing care are referred back to their family physicians. The team provides ongoing consultative support to the family physician over the phone or face-to-face.

On average, the team receives 50–60 referrals per month: 875 direct or face-to-face patient contacts and 1,800 indirect contacts, which include phone calls to family, caregivers, supports and family physicians. These do not include education or administrative contacts. On average, 450 patients per month are registered and are receiving services.

Our program uses daily teleconferencing to review referrals to all Seniors' Mental Health Programs in the region. Capital Health uses an electronic health record called Netcare. Tele-psychiatry has been provided in the past.

Unique characteristic(s) to local community

- Our current program was developed in response to the reduction/closure of inpatient beds in geriatric psychiatry, as a result of funding cutbacks in the early 1990s; if inpatient beds were not going to be available, it was necessary to provide proactive assertive treatment in the community to reduce the demand for inpatient beds

Barriers

- Initially, the program experienced difficulties related to the lack of policies and protocols; with the expansion in 1994, the program experienced difficulties related to becoming known in the community, struggling to make people aware of this resource

Strategies

- Policies and protocols developed over time
- As the program became better known, the demand increased and the program has expanded; in some cases, for example, a direct link between the program's services and home care helped to overcome difficulties

Funding

- Capital Health Region, Alberta Hospital, Edmonton Site

Sponsoring organization(s)

- Capital Health

Other participant(s) or organization(s)

- Mental Health Clinic (Edmonton Geriatric Psychiatry Services)
- Northern Alberta Regional Geriatric Psychiatry (Glenrose Hospital, Edmonton)
- Long-Term Care Psychiatric Consultation Services
- Mobile Mental Health Crisis Response Team
- Home Care
- The Elder Abuse Intervention Team

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Calgary Urban Project Society (CUPS)

Start Date

2000

Special Populations

Aboriginal
 Concurrent disorders
 Homeless/transient
 Urban
 Other

Human Resources

Mental health nurse
 Mental health social worker
 Nurse
 Physician
 Psychiatrist

Location(s)/Setting(s)

Community Health Centre

Evaluation

Yes, completed and ongoing.

Initiative Short Title

CUPS

Purpose

The initiative seeks to improve access to comprehensive mental health and primary health care services to individuals living in Calgary who are affected by homelessness and poverty. In addition, the program increases the coordination of service delivery and systems integration, which is a necessary part of the transition of mental health care services to community care. This includes the creation of partnerships in community and inter-agency coalitions through service advocacy for the individuals that the Shared Care Mental Health Program serves.

Goals/objectives

- To address access issues for individuals with concurrent diagnoses through the provision of comprehensive mental health and primary health-care services
- To increase the knowledge, skills and competencies of health-care professionals in the area of mental health through a shared learning environment and continued professional development
- To create of an interdisciplinary health-care team that addresses the determinants of health (medical, emotional, social and spiritual)

Description

The Calgary Urban Project Society (CUPS) Community Health Centre is a non-profit, faith-based organization dedicated to serving the health, social and spiritual needs of individuals and families who lack adequate income, shelter, nutrition and social support. Services are not dependent on health-care coverage. The health centre houses numerous programs that benefit those living with poverty, as well as partners of the One World Child Development Centre.

The Shared Care Mental Health Program is based on the idea of integrating primary health care and mental health services and sharing care; clientele are seen by the health-care professional who best suits their needs. The interdisciplinary team is composed of physicians, a psychiatrist, nurse-practitioners, nurses, a mental health nurse and mental health social worker. The premise is to work with the client through a holistic approach that incorporates a variety of disciplines/perspectives to address the medical, emotional, social and spiritual realms of health care. The program takes into account the determinants of health, which often compound mental health issues.

The clientele (approximately 90 per month) are shared among the team of professionals. However, the model is flexible and the key person may change over time. If there are complications with client care, then consultation and collaboration ensures collective liability and accountability. The goal of care is that any staff member will be able to understand and follow up with the treatment plan, so that the client does not have to be reassessed and repeat his or her story again and again. This is achieved through effective communication and collaboration, both formal and informal, among staff members.

Unique characteristic(s) to local community

- Proximity and flexibility, guided by our mission statement, decreases the exclusion criteria for clientele. The number of specialty programs we have encourages wellness across the lifespan of patients. Often, clientele will overlap into other programs at the health centre, which is unique because the shared-care program has expanded to include all internally available support and therefore, makes the best use of the community-based services that are appropriate to the clientele's needs

Barriers

- Issues that occur when numerous disciplines are involved in a shared learning environment include: role diffusion; maintaining a common goal; staff turnover; challenges with effective assessment and evaluation tools and systems; and the challenges of working within multiple professional disciplines with their own perspectives on client care

Strategies

- The continuation of professional development and education has been essential in overcoming issues related to interdisciplinary care and increasing knowledge of mental health issues and their impact on overall health

Funding

- Calgary Health Region (potential source)
- Fee-for-service (psychiatrist)
- Health Innovation Fund (three years, completed)
- The United Way of Calgary and area (three years, completed)

Sponsoring organization(s)

- Calgary Urban Project Society (CUPS) Community Health Centre

Other participant(s) or organization(s)

- Numerous community services, agencies and organizations, including local outreach programs, shelters, hospitals and care facilities, community health-care centres, counselling services, crisis supports, and addiction treatment centres and programs

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Healthy Minds/Healthy Children

Start Date

April 2003

End Date

April 2006

Special Populations

Aboriginal
Children and youth
Rural
Urban

Human Resources

Clinical consultant
Nurse
Primary care physician
Project manager
Psychiatrist
Psychologist
Social worker

Location(s)/Setting(s)

Primary care physician's office

Evaluation

Yes, ongoing.

Initiative Short Title

Healthy Minds/Healthy Children

Purpose

Most children and youth in need of mental health services do not receive them, and those individuals with mental health needs who do, usually receive services from their family health-care provider. Most family/general practice physicians have indicated in surveys that they do not feel especially trained or comfortable dealing with children's mental health issues. This project works to increase family/general practice physicians' capacity to do so by providing them with consultation, continuing education, information resources to give to their patients and support with accessing specialized services.

Goals/objectives

- To increase the capacity of primary health-care providers in selected communities to meet the mental health needs of children and youth among their patients
- To facilitate links between primary health-care providers and specialized regional and tertiary care services
- To improve access, by helping to provide children's mental health services "closer to home"

Description

This project is a partnership of the Southern Alberta Health Regions and the Treaty 7 First Nations. The goal is to provide physicians with mental health consultation, access to psychiatric consultation, lay information that can be given to patients and families, continuing education and support in referring patients who need more specialized treatment services. The consultation is provided by licensed mental health clinicians and also includes access to psychiatric consultation. It supports access to specialized and tertiary care programs. The primary-care physician retains responsibility for services to patients. The project also makes use of tele-health conferencing. Currently, the project serves a total of 40 physicians, including family practitioners and pediatricians.

Parents and youth are involved in the steering committee of the project's source network—the Southern Alberta Child and Youth Health Network (SACYHN). They participate in planning and decision-making (including the overall direction and advocacy) for this network. The steering committee establishes and facilitates implementation of priorities, determines network infrastructure

and identifies resource needs. It also ensures the involvement of stakeholders, including families, provides the accountability mechanism for the network, and oversees process and outcome evaluation.

The project also provides an office resource kit containing a mix of online and desktop professional materials and information for parents. The online resource is a continuing medical education program offered to physicians and allied health professionals in partnership with the University of Calgary's Faculty of Social Work and the regional departments/divisions of Pediatrics, Psychiatry and Family Medicine. The continuing medical education consists of five separate modules. Each module involves an audio-visual presentation, an exchange of questions and answers between registrants and presenters, and an online live dialogue between presenters and practitioners.

Unique characteristic(s) to local community

- The catchment area of this project is large and includes diverse cities, small communities and First Nations communities. Specialized services are often not easily accessible and similarly, many primary health-care providers are isolated

Barriers

- The vastness of the catchment area and the need to involve many jurisdictions as partners necessitated a more carefully planned collaboration process
- Primary care physicians are very busy, and strategic selection was critical in recruiting physicians

Strategies

- A working group made up of representatives of various stakeholder groups was formed to make sure that the project reflected the input of those most affected
- Tele-health technology was used to help bridge the distance
- Time was taken to build relationships with the various regions covered by the project's mandate

Funding

- Primary Health Care Transition Fund through Alberta Health and Wellness (over three years)

Sponsoring organization(s)

- Southern Alberta Child and Youth Health Network

Other participant(s) or organization(s)

- Calgary Health Region
- Chinook Health Region
- David Thompson Health Region
- Palliser Health Region
- Treaty 7 First Nations

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Mental Health Consultation to Home Care (for both adult and senior populations)

Start Date

1994

Special Populations

Seniors/geriatrics
Urban

Human Resources

Nurse
Occupational therapist
Physician
Psychiatric nurse
Psychiatrist
Psychologist
Social worker

Location(s)/Setting(s)

Clients' homes
Clinics

Evaluation

Yes, ongoing.

Initiative Short Title

MH Consultation to Home Care

Purpose

The initial purpose was to fast-track home-care referrals to community-based seniors' mental health services. This was needed because of the high volume of elderly clients they were working with, and the immediacy of the presenting mental health problems, which required mental health assessment and intervention within three to five working days. This service has expanded to include all populations.

Goals/objectives

- To support the screening, detection and early intervention of mental health concerns by home-care providers
- To provide timely access to mental health and psychiatric consultation for home-care clients and the home-care staff who work with/support them
- To facilitate the appropriate and timely transfer of care to secondary and tertiary services, when necessary

Description

Community Mental Health Services are "stand-alone" (no hospital affiliation) clinics that are a proven model of success in providing psychiatric treatment and support for clients living in the community. Home-care services were started 30 years ago to provide in-home, medically required services. This initiative provides mental health therapists (nurses, social workers or occupational therapists) from the adult and seniors' community mental health clinics programs to provide consultation, support, education and service facilitation to regional home-care staff and clients.

Two therapists are attached to each of the Edmonton home-care offices from the seniors' mental health program and the home-care offices from the adult mental health program. Specific site allocations are based on the volume of referrals. Similar services are provided on an as-requested basis from the Community Mental Health Clinics in suburban communities to the home-care staff and clients in those areas. Home-care mental health consultants for seniors and for adults each saw 165 clients in the last calendar year.

These consultants spend part of their week at their assigned home-care office, for liaison purposes, attend some home-care meetings, provide education and orientation to/about mental health, etc. They are primarily housed at the Edmonton Mental Health Clinic, where they have access to consulting psychiatrists and mental health colleagues for consultation and support purposes.

The primary focus is to provide consultation on clients referred by the home-care case managers because of evident or suspected mental health problems. In most circumstances, clients are assessed and recommendations are made to home care and/or the client's family physician, with the case being closed within one to three visits. Liability for client care is usually with the primary care physician. When indicated, longer-term mental health intervention and support is provided via transfer to one of the community mental health therapists or programs. On occasion, hospitalization is facilitated.

Unique characteristic(s) to local community

- The impetus for more partnerships among these initiatives was enhanced by the first round of planning for regionalization in 1995–96 and the development of the first Regional Mental Health Service Delivery Plan in 1996; the focus on partnership, collaboration and integration was re-confirmed in service delivery planning in late 2003–early 2004

Barriers

- Finding/reallocating funding and finding resources for the evaluation
- Overcoming the “we/them” distinctions that guide respective program processes, in order to come up with blended or new approaches to match the joint initiative
- Lack of physical space in many community-based settings to house staff

Strategies

- Positive and respective inter-agency and inter-sectoral collaboration with a shared, client-focused approach
- Cultivating a culture of regional partnering and innovation by building on consultation and liaison relationships
- The consultants are assigned to home care, but are not home-care staff/service, which provides the advantage of being perceived as an external and therefore, expert source with credibility

Funding

- Capital Health, Regional Mental Health Program
- Capital Health, Home Care
- Funds are regulated by the Capital Health, Regional Mental Health Program in collaboration with Capital Health, Home Care

Sponsoring organization(s)

- Capital Health, Regional Mental Health Program

Other participant(s) or organization(s)

- Capital Health, Home Care

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Northeast Community Health Centre, Mental Health and Addictions Shared Care

Start Date

January 1999

Special Populations

Urban

Human Resources

Addiction counsellor
 Family physician
 Mental health therapist
 Psychiatrist
 Registered nurse
 Registered psychiatric nurse
 Social worker

Location(s)/Setting(s)

Northeast Community Health Centre
 Physicians' offices in Northeast
 Edmonton

Evaluation

Yes, ongoing.

Initiative Short Title

Northeast CHC

Purpose

The Northeast Community Health Centre is a key primary health care initiative in the Capital Health Region's Primary Care Division. The centre bases its approach on the World Health Organization (WHO) definition of primary health care, and is also guided by a key WHO recommendation to deliver mental health treatment as part of primary care.

Goals/objectives

- To integrate mental health and addiction services with the other primary health care services offered at the Northeast Community Health Centre
- To support the role of primary health care providers in delivering mental health and addictions care
- To extend the integration of mental health and addiction services within community primary health care, particularly with family physicians

Description

The model of integrated or shared care is a fundamental premise for the overall operation of the Northeast Community Health Centre. The centre opened its doors in January 1999, and much of the first two years has focused on developing this model among primary health care services. An interdisciplinary team comprised of nurses and social workers provides mental health and addiction services to the centre and the community. A consulting psychiatrist supports the program one day a week. Liability for patient care is shared by the health professionals involved, and is based on professional standards of practice and codes of ethics.

In 2001, mental health shared care expanded to include local family physicians interested in this approach to patient care. In April 2004, the service was renamed Mental Health and Addictions, to more clearly reflect the service being provided to the centre and the community. At the request of family physicians, a therapist will travel to the physician's office to conduct an on-site assessment of a patient. While the physician remains the primary caregiver, the physician may negotiate with the therapist to ensure care of the patient for a limited period of time. The consulting psychiatrist can be accessed as indicated by the physician. Therapists also provide support to physicians via telephone (e.g., consultation and information-sharing about community resources).

Unique characteristic(s) to local community

- The Northeast Community Health Centre was one of the first primary health care initiatives developed in Alberta (1999)
- The centre included mental health as one of the primary health care services offered to the community
- Now past its fifth year of operation, the centre continues to offer and develop innovative primary health care

Barriers

- The centre was part of the Umbrella Alberta Primary Health Care Project, funded in part through the federal Health Transition Fund; when project funding for an enhanced team of health care providers finished, the centre secured continued funding for some, but not all, providers
- Participating physicians do not receive additional remuneration beyond what is currently provided in their fee schedule
- A consultation model offered in physicians' offices is often subject to space constraints

Strategies

- Developing key partnerships with other health and social services in the community enables better care coordination
- Scheduling consultations where family physicians are present can reduce the need for an extra interview room
- In 2001, mental health shared care was extended to community-based family physicians; the centre also received an additional therapist position from the Regional Mental Health Program
- The program has continued to attract interested family physicians, despite the lack of any additional budget

Funding

- Capital Health Region
- Partner, Capital Health Community Care, Rehabilitation and Mental Health (Regional Mental Health Program)
- Partner, Alberta Alcohol and Drug Abuse Commission (AADAC)

Sponsoring organization(s)

- Capital Health Region, Primary Care Division

Other participant(s) or organization(s)

- None

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Post-Partum Depression Consultation

Start Date

1997

Special Populations

Disorder-specific
Urban

Human Resources

Nurse
Physician
Program manager
Psychologist
Public health nurse
Social worker

Location(s)/Setting(s)

Mental health clinics
Outreach: community social agencies
Public health centres

Evaluation

Yes, ongoing.

Initiative Short Title

PP Depression Consultation

Purpose

The impact of maternal post-partum depression on infant development has been clearly documented. Therefore, as a preventative health measure, it is important that post-partum depressions be identified and successfully treated as quickly as possible, to ensure healthy outcomes for the mother, the child and the family unit.

Goals/objectives

- To support the screening, detection and early intervention of mental health concerns in the post-partum period by a broad range of primary care providers
- To facilitate the appropriate and timely transfer of care to secondary and tertiary services, when necessary

Description

Mental health consultants from the Adult Assessment and Treatment Program visit seven public health centres in Edmonton for a half-day per week. Service arrangements in the seven suburban communities and to the travelling clinic locations vary in frequency from weekly to once every second week. Post-partum women are screened (i.e., using the Edinburgh Post-Partum Depression Scale) during “well-baby visits” at the public health centre. Based on the scores and the woman’s own account, she may be referred to the mental health therapist for an interview at one of the public health centres (or at the local Mental Health Clinic, if the woman prefers). If the woman is reluctant to see a mental health professional, alternate resources (including referral to the family doctor) are outlined by the public health nurse.

Mental health therapists from the community mental health clinics work collaboratively with public health nurses, who have conducted the post-partum depression screening to provide early intervention with women at risk of developing, or who have developed, a post-partum depression. The service provider assigned to a post-partum consultation is based on the availability of the therapist and interest, rather than professional discipline. Much of the work done is based on the skill set of the generic “mental health therapist” (e.g., nurse, psychiatric nurse, social worker or psychologist). In addition, the mental health consultants are available for indirect consultation with the public health nurses

and for education on mental health topics (including risk assessment and management) for public health staff and the general public. New moms' support groups are run by public health staff, often in partnership with community agencies, in various locations throughout the region.

At screening, the public health nurse assumes liability for client care, until care is transferred to the client or another care provider. After engagement, the mental health therapist assumes liability, until care is transferred to the client or another care provider. Approximately one in three women recommended for mental health consultation follows through with self-referral. In 2004, there were approximately 150 referrals to the Edmonton-based mental health consultants. Of those who are seen, the majority are seen for three or fewer sessions. From 25 to 40 per cent are seen in a single session.

Unique characteristic(s) to local community

- The impetus for more partnerships was enhanced by the first round of planning for regionalization in 1995–96 and the development of the first Regional Mental Health Service Delivery Plan in 1996; another round of regional planning occurred in 2003–04, with a new regional service delivery plan about to be released

Barriers

- Finding/reallocating funding and finding resources for the evaluation
- Overcoming the “we/them” distinctions that guide respective program processes, in order to come up with blended or new approaches to match the joint initiative

Strategies

- Fostering positive and respectful inter-agency and inter-sectoral collaboration through a shared, client-focused approach
- Cultivating a culture of regional partnering and innovation by building on consultation and liaison relationships

Funding

- Capital Health, Regional Mental Health Program

Sponsoring organization(s)

- Capital Health, Regional Mental Health Program

Other participant(s) or organization(s)

- Capital Health, Public Health
- Private practice physicians

Contact(s)

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Student Health Initiative Partnership (SHIP)

Start Date

September 1999

Special Populations

Children and youth

Human Resources

Child psychiatrist
 Children's mental health therapist
 Nurse
 Psychiatric nurse
 Social worker
 Psychologist
 Family/school liaison worker
 Occupational therapist
 Special education counsellor
 Speech therapist
 Teacher

Location(s)/Setting(s)

Clinics
 Home
 School

Evaluation

Yes, ongoing.

Initiative Short Title

SHIP

Purpose

The Student Health Initiative Partnership (SHIP) provides integrated health and educational services to students to support their academic achievements and success.

Goals/objectives

- To ensure students receive the health services they require, so that they are able to achieve academic success

Description

Local partnerships of mental health, child health, education and children's services deliver integrated, school-based health services. The service mix varies according to the local community's needs and priorities.

Services for the Student Health Initiative are directed by local community partnerships consisting of education, health, mental health and children's services (child welfare). Each service model is tailored to local priorities and the model that best fits the community's needs.

In most locations, the mental health therapist primarily provides clinic-based services aimed at assessing, treating and providing family therapy for children who are referred by the school system and/or their parents. Therapists make recommendations to the teacher as to how the child can be helped to function better in school. Services are also often combined with those of family/school liaison workers and behavioural consultants, who focus on behavioural interventions relevant to the school environment. Children being followed by children's mental health therapists are given priority access to child psychiatry.

Unique characteristic(s) to local community

- The Student Health Initiative was spearheaded by an inter-ministry initiative aimed at improving working relationships among departments that serve children; the partnership annually submits a service plan and an annual report and must have the agreement of all partners in all aspects of the service model; school boards act as bankers for funds, but decisions about service delivery are made by partnerships

Barriers

- Sustained funding from government in keeping with wage settlements is crucial to ongoing service delivery

Strategies

- Flexible hiring arrangements
- Creative use of surplus funds
- Working better as partners to collaborate
- Making the most of scarce funding

Funding

- The Student Health Initiative Partnership (SHIP) is funded with provincial dollars through the department of education
- Funds are regulated by the local partnership committee and the local education authority

Sponsoring organization(s)

- Capital Health, Regional Mental Health Program

Other participant(s) or organization(s)

- Capital Health and other local/ community-specific service agencies
- Regional public, separate and private school authorities
- Regional Children's Services

Contact(s)

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Shared Mental Health Network for Southern Alberta

Start Date

April 2003

Special Populations

Children and youth
Rural
Seniors/geriatrics

Human Resources

Administrative personnel
Family physician
Nurse
Psychiatrist
Psychologist
Social worker

Location(s)/Setting(s)

Family physicians' offices

Evaluation

Yes, ongoing.

Initiative Short Title

SMH Network

Purpose

Previous surveys suggested that overall, mental health services in Calgary were regarded as needing to be more community-based, in order to be more accessible to those in need. Family physicians indicated that their role in delivering mental health care could be enhanced if psychiatric services were more accessible, and if support or advice was more readily available.

Goals/objectives

- To improve the identification, assessment, treatment and referral of individuals with mental health concerns who present themselves to their family physicians
- To increase capacity for family physicians and the health-care system to deal with patients with mental health concerns
- To reduce referrals from physicians' offices to secondary or tertiary hospital mental health/psychiatric programs, to hospital emergency departments, and/or to community mental health clinics and crisis services
- To foster positive satisfaction ratings of community mental health therapists and psychiatrists on the shared-care teams, and other primary care providers engaged with the teams

Description

This program functions as a network, and represents two participating health regions: Chinook and Calgary Rural (currently providing service to 13 rural sites). A consultation model is used when mental health professionals (i.e., a psychiatrist, psychologist, social worker, nurse or psychiatric nurse) meet regularly with family physicians in their offices. Family physicians decide whether to schedule a patient for joint review, to discuss cases, or to use the time for education. If a patient is seen, the family physician maintains responsibility for the patient's care; the patient is not transferred to the mental health professional. The family physician and the health region both assume liability for patient care.

The outcome of joint sessions can include a mental health diagnosis, referral to an agency, short-term joint psychotherapy, and/or a change in the treatment plan. There is a priority placed on increasing the capacity of the family physician to deal with mental health concerns. In addition to direct service to family physicians, there are plans to provide information sessions, for which continuing medical education credits will be available. Family physicians and psychiatrists are compensated for their time through project funds. Communication is supported through the use of tele-health, e-mail and electronic health records.

The physicians participating in the project (family physicians and psychiatrists) are paid using a sessional format comparable to an alternate payment plan. The project will consider the role that this form of payment will play in sustaining this primary care innovation.

Unique characteristic(s) to local community

- The initiative involves the collaboration of two health regions
- There is some variability among rural communities, in terms of mental health resources and specific needs

Barriers

- Recruitment of skilled, trained staff was more difficult, due to their unfamiliarity with working formally with family physicians and the extensive travel this entails
- Family physicians were initially skeptical about the amount of time that they would need to invest in a shared-care relationship
- Working relationships between psychiatrists, physicians and mental health clinicians require specific attention
- The initiative requires a funding arrangement for physicians that supports and recognizes the twin benefits of this model (i.e., more economical and better outcomes for patients)

Strategies

- Providers with experience in shared care meet with potential participants to review their concerns and address some of the myths about shared care, by relating their own experiences
- The consistent partnership of the mental health administration in Chinook Health Region was a key factor in facilitating staff members' and physicians' interest in and acceptance of, the initiative

Funding

- This is a three-year project funded by Alberta Health and Wellness Primary Care Capacity-Building Fund

Sponsoring organization(s)

- Calgary Health Region
- Chinook Health Region
- Southern Alberta Mental Health Network

Other participant(s) or organization(s)

- Alberta Mental Health Board
- Palliser Health Region

Contact(s)

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Shared Mental Health Care

Start Date

November 1998

Special Populations

Children and youth
 Concurrent disorders
 Disorder-specific
 Ethno-cultural
 Rural
 Urban

Human Resources

Family physician
 Manager
 Mental health clinician
 Nurse
 Psychiatrist
 Psychologist
 Social worker

Location(s)/Setting(s)

Family physicians' offices

Evaluation

Yes, completed.

Initiative Short Title

SMHC

Purpose

Surveys of health-care consumers and service providers indicated that existing mental health services in the Calgary region were difficult to access, had long wait times and referrals were often inappropriate. Family physicians had concerns about the lack of availability of psychiatrists. Family physicians had to deal with a large number of patients with mental health needs, many of which were of a complex nature.

Goals/objectives

- To provide professional mental health consultation and related support services to family physicians in the community
- To increase the mental health-care capability of primary care providers by improving their ability to identify, manage and treat their mental health patients
- To educate family physicians on mental health issues/topics, and help them become more knowledgeable in treatment and assessment techniques
- Improve patient outcomes, with decreased reliance on secondary and tertiary care

Description

Nine mental health clinicians (i.e., social workers, nurses and psychologists) and five psychiatrists provide consultative services to 95 family physicians. Each clinician is attached to a family physician (roughly 16 family physicians per full-time clinician). They visit each family physician weekly for consultation about the treatment/management of patients experiencing primary mental health problems, or those whose health is compromised by psychological or psycho-social problems. Consultant psychiatrists are available to the family physician, by telephone or personal visit, approximately one to two hours a month. Educational sessions are held quarterly to address mental health related topics chosen by the physicians. A Shared Mental Health Care Steering Committee, comprised of senior administrators from family medicine, mental health and psychiatry, oversees the program and meets on a monthly basis.

An evaluation of the program was completed in 2002. Successful negotiations with Alberta Health and Wellness resulted in a three-year alternative payment plan for family physicians and psychiatrists to ensure that consultation and administrative time spent on the program are considered billable procedures and are included in the physicians' fee schedule.

In 2003–04, family physicians and mental health clinicians co-facilitated six anxiety groups in family physicians’ offices. Outcomes indicate that the patients involved reduced their visits to family physicians’ offices and other formal health settings (i.e., hospital) significantly, after attending the group. Family physicians report new learning and an ability to transfer this learning to individual patient situations. We are working with Child and Adolescent Shared Mental Health Care, Pre-school Collaborative Care, and Geriatric Services to offer family physicians a menu of Shared Mental Health Care services, spanning the life cycle. We are also incorporating recommendations included in the evaluation, namely: identify learning objectives with family physicians and develop ongoing evaluative processes to measure change in the family physician (learning and skill development) and the patient (outcomes).

Unique characteristic(s) to local community

- An opportunity for innovative collaboration was identified by the Alberta Mental Health Board and the Calgary Health Region

Barriers

- At times, encouraging the system to think “outside the box” has been difficult
- Knowing how busy family physicians are, it is natural for them to question the ability of the program to build capacity in their practice
- At times, moving from a hierarchical mental health system to collaborative partnership has been challenging for the professionals involved
- Finding funding for the continued involvement of family physicians and psychiatrists in the program can be challenging

Strategies

- A strong orientation process for family physicians, clinicians and psychiatrists is important to stressing how collaborative working relationships in the program have reduced frustration for participants

Funding

- Alberta Health and Wellness provides an Alternative Relationship Plan (ARP), which funds family physicians’ and psychiatrists’ involvement in the initiative
- Calgary Health Region funds administrative costs, clinical staff and operations

Sponsoring organization(s)

- Alberta Health and Wellness
- Calgary Health Region

Other participant(s) or organization(s)

- None

Contact(s)

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Shared Mental Health Care Team

Start Date

September 2003

Special Populations

Concurrent disorders
Disorder-specific
Seniors/geriatrics
Rural

Human Resources

Family physician
Mental health therapist
Psychiatric nurse
Psychiatrist

Location(s)/Setting(s)

Two health clinics

Evaluation

Yes, ongoing.

Initiative Short Title

SMHC Team

Purpose

The Shared Mental Health Care Team provides mental health consultation and support to primary care providers in their delivery of primary health services to individuals with a mental illness or those at risk of developing a mental illness.

Goals/objectives

- To provide joint assessment and treatment for patients with concurrent medical and mental health concerns
- To increase capacity of general practitioners to address mental health concerns of their patients
- To provide more comprehensive and integrated mental/physical health services, and better address the mind/body connection
- To support the screening, detection and early intervention of mental health concerns by a broad range of primary care providers
- To facilitate the appropriate and timely transfer of care to secondary and tertiary services, when necessary

Description

Services are provided in the St. Albert Mental Health Clinic and the Sherwood Park Mental Health Clinic. In each clinic, a mental health therapist is dedicated to providing support, consultation, information, education and service facilitation to primary care providers (e.g., family physicians) who are providing care to individuals who have or are at risk of developing a mental health concern. Both therapists are psychiatric nurses. Both are integrated into the working of the mental health clinic and are supervised with other therapists. They use consulting psychiatrists from the clinic and case conference their cases with the clinics. These therapists are on staff with the local community mental health clinic's interdisciplinary team. They have direct access to secondary and tertiary mental health and psychiatric services. Both the mental health therapist and the physician assume liability for the services they provide.

The clinics see approximately 180 individuals per month. Planned future developments include linking with new initiatives funded by Alberta Health and Wellness related to primary care enhancement (i.e., local primary care initiatives). Desirable future developments include implementing positions in all eight suburban clinics in Edmonton.

Unique characteristic(s) to local community

- Our initiative runs in smaller suburban communities with an easy-to-target, identifiable general practitioner population

Barriers

- Operational issues related to how to structure intake and referral processes, paperwork and scheduling office visits with physicians

Strategies

- Getting the word out about the initiative, and getting physicians to take the time to become better oriented about the service
- Integrating the service with the established mental health services (i.e., separating this service from other mental health services, where all therapists are expected to liaise with general practitioners)

Funding

- Funds are provided and regulated by the Regional Mental Health Program (Capital Health)

Sponsoring organization(s)

- Capital Health, Regional Mental Health Program

Other participant(s) or organization(s)

- Capital Health Primary Care Division
- Private practice physicians

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Hudson Bay Provider Team

Start Date

2000

Special Populations

Rural

Human Resources

Addictions counsellor
 Diabetic educator
 Dietitian
 Family physician
 Internist
 Mental health nurse
 Nurse-practitioner
 Occupational therapist
 Pharmacist
 Physiotherapist
 Psychiatrist
 Public health nurse
 Social worker

Location(s)/Setting(s)

Clinic and health facility

Evaluation

Yes, completed and ongoing.

Initiative Short Title

Hudson Bay Provider Team

Purpose

This is a primary care initiative that supports a collaborative community-centred approach to health care.

Goals/objectives

- None

Description

The Hudson Bay Provider Team serves a small community in Northern Saskatchewan and is comprised of both primary and mental health-care providers. We service an area with a population of about 2,500 people, and a surrounding area with approximately 25 more people.

The providers are located at the Hudson Bay Health Care Facility and the adjacent primary care clinic (Hudson Bay Medical Group). Between the two sites, patients have access to a range of providers including: primary care nurses, physicians, an addiction worker, a mental health nurse and a public health nurse. In addition, there are several providers who support the team by traveling to the clinic or health-care facility including: social workers, dietitians, a diabetic educator, an occupational therapist, a physiotherapist and a psychiatrist. The provider who initially sees the patient on his/her first visit is generally responsible for the patient and ensures that the patient is getting the care he/she needs (i.e., the provider acts as the patient's case manager). The team also connects with several community services, depending on what patients' needs are.

A patient may present to anyone on the team by self-referral or from an internal or external referral source. Based on an initial assessment and depending on the needs of the patient, the provider and patient identify treatment goals and discuss whether or not the patient should be referred to another provider on the team. Team members communicate informally when possible, and may do so either face-to-face or over the phone. In addition, there is a common referral form that is available electronically for all the providers on the team, designed to support communication and sharing of patient information. In future, the team hopes to integrate an electronic health record.

Once a month, the provider team meets to discuss progress or common issues. All members of the team, including the visiting providers, are encouraged to participate. It is at these meetings that the group makes collective decisions about the way services are provided and how to enhance the program. Since the group is self-governed, all members of the team are viewed as equal members, avoiding a hierarchical or top-down governance approach. The team finds this to be very effective in enhancing collaboration and communication among team members.

Unique characteristic(s) to local community

- A physician shortage was the initial reason for primary care

Barriers

- Increasing public awareness of the relationship between the Hudson Bay Health Care Facility and the Hudson Bay Medical Group, as well as the services available
- Working through the initial processes with government

Strategies

- We worked together, had regular meetings with all involved, and worked through each issue, as it came up (teamwork and respect are vital)

Funding

- Funding was provided by our own agencies

Sponsoring organization(s)

- Kelsey Trail Health Region

Other participant(s) or organization(s)

- None

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Kelsey Trail Health Region

Start Date

August 2003

Special Populations

Aboriginal

Human Resources

Addictions worker
 Community educator
 Director
 Exercise therapist
 Family physician
 Mental health nurse
 Mental health therapist
 Nurse-practitioner
 Nutritionist
 Physiotherapist
 Psychiatrist
 Psychologist
 Registered nurse
 Social worker

Location(s)/Setting(s)

Five primary health-care sites
 Itinerant and satellite sites

Evaluation

Yes, ongoing.

Initiative Short Title

Kelsey Trail Health Region

Purpose

We want to provide services that will support our vision for “healthy people in healthy communities.” Our mission is: “Working together to improve the health of people.”

Goals/objectives

- To provide effective health promotion and disease prevention
- To retain, recruit and train health providers
- To provide improved access to quality health-care services
- To provide a sustainable, efficient, accountable and quality health system

Description

The Kelsey Trail Health Region serves three health districts: the former North Central, North-East and Pasquia. The region encompasses an area of 47,397 sq. km. and has an estimated population of 45,700. The region includes approximately 33 towns and villages and five First Nation communities. The region also includes a remote northern community, Cumberland House, which is Saskatchewan’s oldest settlement. There are three district hospitals providing comprehensive acute care services 24-hours-a-day, seven days a week, as do three community hospitals that provide basic medical and emergency services. In addition, five health centres provide various services, unique to each.

The Kelsey Trail Health Region has made significant efforts to coordinate and integrate primary and mental health-care services in the region; however, there is no formalized process. The mental health staff members in the region are primarily located in the three community hospitals (including mental health nurses, addictions workers, psychologists, mental health therapists and social workers). The mental health staff has access to and communicates with a number of other providers, including family physicians, physiotherapists, nutritionists, exercise therapists and other community resources, as necessary. Physicians also have access to the mental health staff for one-time or ongoing consultative support; communication is usually informal and may be written or by phone. In addition, the physicians also have access to a psychiatrist, when needed. The physician remains liable for patient care.

There is a dedicated role of “community educator” in the region; this person is responsible for increasing awareness of mental health issues. In addition, the mental health staff provides “in-services” to other providers (e.g., primary care teams) in the region. Past educational topics have included: mental health, the emotional impact of disease and suicide response. The mental health staff also provides consultative support to educational psychologists, teachers and principals in the education system.

There are five primary health-care sites in this area; each has a nurse-practitioner who works with a medical group and an interdisciplinary team. The handling of many psychological patient issues is part of the team’s role. The registered nurses or nurse-practitioners handle many common medical conditions, including some mental health issues. In addition to the sites listed above, patients receive care in several itinerant sites in the health region. Efforts are made to provide satellite services in larger towns or by trading areas, to minimize travel for patients who are unable to do so.

Unique characteristic(s) to local community

- Some of the teams use a referral form that is common to all disciplines and can be initiated by any party (i.e. home care to doctor, or doctor to addictions worker); we are hoping to expand this format to the entire region, to simplify the process and eliminate 1,000 forms

Barriers

- There is a lack of understanding about what primary care is
- There is not enough training to support a sufficient understanding of the value or meaning of integration or working in teams
- Fee-for-service arrangements hinder incentives for providers to work collaboratively

Strategies

- Team development workshops were planned

Funding

- Internal funding

Sponsoring organization(s)

- Community support
- Volunteers

Other participant(s) or organization(s)

- None

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**J.A. Hildes Northern Medical Unit, Inuit Health Program
(University of Manitoba)**

Start Date

1999

Special Populations

Aboriginal
Northern/isolated

Human Resources

Administrative
Family physician
Inuit Elder
Mental health consultant
Nurse
Occupational therapist
Physiotherapist
Psychiatrist
Social worker
Speech language pathologist

Location(s)/Setting(s)

Community health-care centres
Community settings
Tertiary care sites in Manitoba

Evaluation

Yes, completed and ongoing.

Initiative Short Title

NMU Inuit Health Program

Purpose

The Northern Medical Unit coordinates and implements the delivery of a variety of health-related services in the Kivalliq region of Nunavut and the hamlet of Sanikiluaq, which complement the existing primary health-care system. Its guiding principles are service, education, research, advocacy and community development.

Goals/objectives

- To be an effective resource for the people of Nunavut and the Nunavut health-care system in providing quality health care
- To help achieve the best possible health outcomes for the people of Nunavut

Description

Northern Medical Unit staff (e.g., family physicians, psychiatrists, pediatricians, occupational therapists and library staff) work together with government of Nunavut employees (e.g., nurse-practitioners, mental health workers, social workers, medical interpreters and health administrators) to provide interdisciplinary mental health services in primary health-care settings.

Services are provided to seven Kivalliq communities plus the hamlet of Sanikiluaq (about 9,000 people, mostly Inuit); psychiatric consultant services are also provided for three communities in the Kitikmeot region. Access to each of these communities is by air only. Each community has a health centre, where nurse-practitioners provide the majority of the primary health-care services. The nurse-practitioners are able to refer patients to a family physician, if needed. Family physicians reside in Rankin Inlet, and visit the other centres once or twice a month.

The nurse-practitioners may address the mental health issues of patients on their own or in consultation with other mental health specialists (they may refer patients to see a mental health specialist). Patients may also self-refer to a community mental health consultant, or be referred by social services, the RCMP (Royal Canadian Mounted Police), their families or the health centre. These mental health consultants are Government of Nunavut employees and may be psychiatric nurses or social workers. In addition, mental health consultants consult with members of the community, including Inuit Elders.

Northern Medical Unit psychiatrists visit each community for one to two or three to six visits per year, depending on the size of the community (about 90 days per annum). Referrals are accepted from family physicians, mental health workers, or directly from community nurses. The psychiatrists are accessible by phone for consultative services and/or case conferences via telephone. In addition, the unit's family physicians and visiting psychiatrists in Churchill, Manitoba are available for consultation on Kivalliq patients. The unit's psychiatrists also provide formal and informal educational sessions (via teleconference or video-conference) to the full spectrum of Nunavut health-care workers, and act as a doorway to Winnipeg-based acute care services for patients who are in crisis.

Unique characteristic(s) to local community

- The communities are far apart and geographically isolated from tertiary care centres
- The population served (primarily Inuit) is culturally, historically and socially distinct
- In some parts, the suicide rate is about five times higher than the rest of Canada and there is a tremendous need for services related to depression, addictions and social issues

Barriers

- Language and cultural differences
- Geographical isolation of program area
- Difficulty recruiting and retaining family physicians in these isolated Northern areas
- High turnover and short staffing among Northern health workers

Strategies

- Use medical interpreters to overcome language barriers
- Emphasis on enhancing the capacity of Inuit mental health workers in the community
- Maintain frequent and open communication among multiple stakeholders
- There is strong emphasis on using a holistic view when addressing the needs of patients in these communities

Funding

- Department of Health and Social Services, Government of Nunavut

Sponsoring organization(s)

- Department of Community Health Sciences, Faculty of Medicine, University of Manitoba

Other participant(s) or organization(s)

- Northern Medical Unit staff and contractors work closely with Government of Nunavut nurses, social workers, mental health workers and health administrators

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St. Boniface Health Centre—Shared Mental Health Care Services

Start Date

July 2001

Special Populations

Concurrent disorders
 Children and youth
 Disorder-specific
 Ethno-cultural
 Seniors/geriatrics
 Urban
 Other

Human Resources

Community development professional
 Community nurse
 Director
 Family medicine intern
 Family medicine resident
 Family physician
 Mental health counsellor
 Nutritionist
 Primary health nurse
 Psychiatrist
 Social worker

Location(s)/Setting(s)

Health centre

Evaluation

Yes, completed and ongoing.

Initiative Short Title

St. Boniface Health Centre

Purpose

Approximately one-third of all family practice clients have identifiable mental health problems and 25 per cent of all clients who visit their family physicians will have a diagnosable mental disorder (Canadian Psychiatric Association, 1997). Family physicians are in a good position to treat the medical problems of individuals with a psychiatric disorder (who have a higher risk of not being treated), to recognize co-morbid drug or alcohol dependency, and to initiate treatment or referral at an early stage of an episode of illness.

Goals/objectives

- To establish collaborative working relationships that would strengthen the role of the family physician and enhance the consultative role of the psychiatrist
- To enhance key roles of other primary health professionals in delivering mental health services
- To improve access and quality of care to clients
- To provide access to bilingual psychiatric services/consultation

Description

In this situation, the psychiatrist comes to the health centre one afternoon a week. The services provided by the psychiatrist include: consultations to physicians (both in-house and physicians in the community, if clients meet the admission criteria for the health centre); consultations to other health professionals in the clinic; psychiatric assessments, follow-up of clients already seen, review of clients or problems the family physician is managing; focused educational sessions; and contact with family medicine interns and residents who are doing a practicum in the centre.

When a consult request comes in from a community psychiatrist (i.e., not one of the in-house family physicians) and the person is already a client of the centre (i.e., seeing one of the counsellors or nurses), this request is usually received by fax. If this individual is not a client of the centre but does meet the criteria, the client is seen by one of the counsellors. The counsellor completes a baseline assessment of the client, so that a consult to the psychiatrist can be facilitated. When the client has been seen, a copy of the assessment is faxed out to the treating family physician; this usually happens

within one or two weeks. If the situation is more urgent, the psychiatrist will call the treating family physician and discuss results over the phone. The family physician assumes most responsibility and liability for the client.

When the individual is a client of one of the centre's physicians, the consult can be requested directly. After the psychiatrist has seen the client, an informal conversation with the physician about the findings and recommendations ensues. The program uses an electronic health record to communicate client information. The psychiatrist also communicates informally about his or her findings in person or by phone, as often as needed (often weekly) with other providers.

Educational sessions have been conducted formally, but on an infrequent basis. Other educational sessions are usually very informal and respond to a particular issue, problem or diagnosis. The psychiatrist provides articles and written information on recent research findings and new drugs. Case-by-case discussions are "on-the-fly" on an "as-needed" basis, since this is a very small centre, and we work in close proximity to each other.

Unique characteristic(s) to local community

- This is the first bilingual primary health-care centre in Winnipeg; access to bilingual health/psychiatric services was very limited prior to implementation of this shared-care approach

Barriers

- Very few; everyone involved was very enthusiastic about this initiative and quickly got on board

Strategies

- None

Funding

- Medical remuneration dollars from the Province of Manitoba
- Using physician dollars not allocated, due to lack of a full physician complement

Sponsoring organization(s)

- Centre de Santé St. Boniface—St. Boniface Health Centre

Other participant(s) or organization(s)

- Health Sciences Centre, Psychiatric Department (consulting psychiatrist)

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Winnipeg Regional Health Authority Shared Mental Health Care Program

Start Date

November 2003

Special Populations

Aboriginal
 Children and youth
 Concurrent disorders
 Disorder-specific
 Ethno-cultural
 Seniors/geriatric
 Urban

Human Resources

Counsellor
 Director
 Family physician
 Nurse practitioner
 Primary care nurse
 Psychiatrist

Location(s)/Setting(s)

Access River East (access centre)
 Aikins Health Centre
 Health Action Centre
 Henderson Medical Centre
 Kingsford Medical Group (private practice)
 Northwest Community Health Centre
 Plessis Medical Group (private practice)
 River Avenue Clinic
 St. James Street Medical Clinic
 Transcona Medical Centre

Evaluation

Yes, ongoing.

Initiative Short Title

WRHA SMHC Program

Purpose

The Shared-Care Program has been introduced to assist family physicians working with clients with mental health issues. The shared-care counsellor and psychiatrist are available to help the family physician with diagnosis, treatment and education related to working effectively with mental health issues.

Goals/objectives

- To improve access to mental health services for both the family physician and the client, to achieve good mental health and emotional well-being in the population and to maintain it

Description

The program services ten different sites: five private practice clinics and five alternate payment clinics (i.e., access centre programs). The program is accessed via a referral from the family physician (i.e., to the shared-care psychiatrist, shared-care counsellor, or both). The physician, counsellor and/or psychiatrist will then work with the client to identify what support and assistance the client needs to achieve his or her health goals. Counsellors come from a variety of educational backgrounds, including clinical psychology, social work, marital and family therapy, and educational psychology. Typically, a mental health counsellor provides individual, family or group counselling, depending on the needs of the individual. A psychiatrist provides assessment and consultation to the family physician about treatment for those clients who need specialized mental health care. Services are short-term and time-limited, as clients are generally referred back to their physicians after one to six sessions. The family physician assumes liability for client care. On average, the program receives 80 new referrals per month and about a thousand per year.

The family physician, the counsellor and the psychiatrist collaborate on client care in a variety of ways. The psychosocial assessment, psychiatric consultation summary and shared-care closure form are placed in the client's chart for review by the family physician. In addition, the team also discusses the case and treatment issues either in informal or formal scheduled meetings. The counsellor and the psychiatrist also meet and consult about cases.

To further education about treatment issues and client care, both the shared-care counsellors and the psychiatrists can provide educational training for primary care sites. Presentation topics have included treatment of borderline personality disorder, cognitive behavioural therapy, stress management, depression and medication issues.

Unique characteristic(s) to local community

- Shared care is available in many community health clinics in Winnipeg. In addition, the program has been implemented in a number of diverse communities in Winnipeg

Barriers

- Lack of a database to analyze information that is being collected in the program
- Finding the proper counsellor-to-psychiatrist ratio per clinic
- Reducing referrals to those appropriate to the program

Strategies

- The program is searching for an adequate database to support the data being gathered for the program
- Monthly statistics are reviewed and communicated to the shared-care counsellor, psychiatrist and health care team at each site to ensure that adequate time is allocated to each shared-care site
- Collaboration, education and guidelines are being developed to identify appropriate referrals for the shared-care program

Funding

- Primary Health Care Transition Fund
- Manitoba Health
- Funds are regulated by the Winnipeg Regional Health Authority (WRHA)

Sponsoring organization(s)

- WRHA

Other participant(s) or organization(s)

- Henderson Medical Centre
- Kingsford Medical Centre
- North East Winnipeg Primary Care Project
- Plessis Medical Centre
- St. James Street Medical Clinic
- Transcona Medical Centre

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appendixC

INVENTORY OF CANADIAN INITIATIVES CENTRAL



CENTRAL

Ontario

Quebec

A Care Navigator Program for Family Medicine Practices: A Demonstration Project

Start Date

November 2004

End Date

March 2006

Special Populations

Disorder-specific
Seniors/geriatrics
Urban
Other

Human Resources

Family physician
Nurse
Program manager
Psychiatrist
Psychologist
Social worker

Location(s)/Setting(s)

Family physicians' offices

Evaluation

Yes, ongoing.

Initiative Short Title

A Care Navigator Program

Purpose

While recognizing complex care needs, family physicians often work in a context where they are rushed and could benefit from additional resources to help navigate their patients' trajectories through acute and community care, and to meet complex needs that are related to health, welfare, justice, employment and education.

Goals/objectives

- To improve the quality of life of patients with complex chronic illnesses who are in crises, by providing support and rehabilitation in physical, social, emotional and spiritual domains
- To demonstrate and evaluate the feasibility of a social worker acting as "care-navigator" for people with complex chronic illness being treated in family practice
- To identify both the type of care needs and caseload for the Care Navigator Program, as a basis for establishing the program
- To collect baseline data to be used in the design of a future full-scale effectiveness evaluation

Description

"Navigation" is a term used to denote a system of professional roles primarily intended to expedite a patient's access to services and resources, and to improving continuity and co-ordination of care throughout the disease continuum. The role of the navigator is multifaceted and is intended to address patient needs from the time of diagnosis through treatment, rehabilitation, follow-up and palliative care, as appropriate. The major focus of the role is coordinating, educating, liaising and undertaking advocacy, facilitating access, transitioning and integrating patients to supportive and palliative care, supporting activities of daily living, and informing them about the services of community volunteer organizations.

The care-navigator is a social worker with additional training/experience in case management and psycho-social rehabilitation. The program will focus on all patients with complex care needs, while they are in crisis. One care-navigator will be placed in each of two large family medicine practices (with between five and nine family physicians in each practice). Care-navigators will go through an extensive training process, using the training model of the Cancer Care Nova Scotia (CCNS) program. The care-navigator is a resource to the whole practice. This program is for patients of the

practice who are in crisis and need support and care coordination for their serious chronic illness. Any health professional in the practice (e.g., family physician or nurse) can refer a patient to the care-navigator. For this demonstration project, patient or family self-referrals are not accepted.

The application of the navigator role involves the following tasks: initial service needs assessment, in order to understand the needs of the patients; access for chronically ill patients to an important support system through a single point of referral by their family physicians; uniform assessment and care planning protocols for chronic care patients; use of evidence-based best practices; post-hospitalization review; crisis intervention and social support; links with community organizations (e.g., Cancer Care Ontario and peer self-help groups); links with social work and rehabilitation programs; links with mental health and psychology services; and links with hospital information and decision-making support.

Unique characteristic(s) to local community

- None

Barriers

- None

Strategies

- None

Funding

- Ontario Ministry of Health and Long-term Care, Primary Care Transition Fund
- Funds are distributed by the Ottawa Hospital

Sponsoring organization(s)

- Ottawa Health Research Institute
- Ontario Ministry of Health and Long-term Care, Primary Care Transition Fund

Other participant(s) or organization(s)

- None

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Brockville Psychiatric Hospital Shared Care Program

Start Date

September 2004

Special Populations

Concurrent disorders
 Disorder specific
 Rural
 Urban

Human Resources

Case manager
 Family physician
 Psychiatrist
 Registered nurse
 Research coordinator
 Social worker
 Unit director

Location(s)/Setting(s)

Hospital-based
 Five satellite clinics

Evaluation

Yes, completed and ongoing.

Initiative Short Title

Brockville Psychiatric Hospital

Purpose

This program was developed in response to an assessment of needs in this community. Shared care emphasizes partnerships between patients, families (natural support systems), family physicians and service providers. By supporting and educating family doctors and other care and service providers, shared care will assist the system in caring for patients with greater mental health needs at the primary care level. Services are tailored to the individual needs of the patient and family, using the evidence-based practice model.

Goals/objectives

- To improve access to mental health care
- To provide more effective use of scarce psychiatric resources
- To improve knowledge of mental health and its treatment among family physicians
- To optimize patient outcomes
- To create high levels of patient, family and family physician satisfaction

Description

This program coordinates and integrates primary mental health care with psychiatric consultation and mental health continuing education. It offers interdisciplinary assessment with initial stabilization; liaison with family physicians, including telephone access and indirect/direct consultation; continuing medical education for family physicians and other mental health clinicians; and, a thorough evaluation of the above. In partnership with affiliated programs, integrated and accessible adult mental health services are being offered to a mixed urban and rural population. In addition, an outpatient service, a 24/7 crisis response service and a 24-bed inpatient service are available. An interdisciplinary team, comprised of a nurse (clinical coordinator), a social worker (clinician), a case manager and a psychiatrist, provides clinical care, consultation and education. To facilitate patient and family access, services are provided in five satellite clinics, which are collaboratively organized and co-located with hospital and community partners.

The shared-care clinical coordinator and/or the shared-care clinician liaise with the patient and the family physician prior to assessment. The goal of pre-assessment is to conduct adequate triage to facilitate a timely and effective assessment. Then, the team is available to support and educate the patient, also liaising with the patient's family, his/her support network, and his/her family physician, as needed. The goal in the post-assessment phase is to facilitate recommendations being put into practice, and to ensure optimal communication and follow-through. The team also becomes a patient's first line of re-entry to the system. The team's ability to respond with flexibility to changing clinical needs reflects the fact that many of the most seriously ill patients have chronic illnesses with symptoms that wax and wane, even with the best possible treatment. The team uses both an electronic health record and an electronic database to collect outcome measures.

A working group and a program of continuing medical education complement the clinical project. The working group meets annually and membership (both hospital and community-based partners) is drawn from volunteers identified in the needs assessment. Working group subcommittees meet periodically; this gives them an opportunity to discuss issues relevant to shared care, review work in-progress and have input into systems change. These meetings are followed by continuing medical education events on topics identified in the needs assessment as areas of need (events are also open to non-physician partners).

Unique characteristic(s) to local community

- Collaborative community and hospital networks have developed over the years in the area

Barriers

- In the initial phase, gaining access to the skills for developing data collection tools

Strategies

- Pooling resources with partners

Funding

- Brockville Psychiatric Hospital: in-kind resources from Brockville Psychiatric Hospital, and Leeds and Grenville Rehabilitation and Counselling Service (for two years)

Sponsoring organization(s)

- Brockville Psychiatric Hospital, a division of the Royal Ottawa Health Care Group

Other participant(s) or organization(s)

- Family physicians
- Leeds and Grenville Rehabilitation and Counselling Service

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Clinical Case Collaborative Mental Health Network (CCM)

Start Date

September 2004

End Date

January 2006

Special Populations

Concurrent disorders
Disorder specific
Homeless/transient
Rural
Serious mental illness
Urban

Human Resources

Chiropracist
Clerical support
Clinic social worker
Clinical case manager
Counsellor
Dietitian
Family physician
Management
Nurse-practitioner
Psychiatrist

Location(s)/Setting(s)

Family practice site

Evaluation

Yes, ongoing.

Initiative Short Title

CCM

Purpose

In the context of scarce physician and provider resources, and the unique health care needs of the severely and persistently mentally ill (SMI) population and their families, innovative service delivery models are needed. The approach used in this project reflects current research findings from the domains of clinical case management, advanced nursing practice, primary care reform, mental health care reform, evidence-based medicine, collaborative integrated health teams, shared care and outcomes evaluation.

Goals/objectives

- To improve access to primary health care/primary mental health care for the SMI population within the family health network
- To improve continuity of care
- To improve the overall health status of the SMI population

Description

The target population is severely and persistently mentally ill patients who are age 16 and older; there are approximately 300 such patients in total in the practice. This demonstration project uses a nurse-practitioner, who functions as primary care provider as well as clinical case manager. The nurse-practitioner collaborates closely with each patient's family physician and a consultant psychiatrist. This core team is physically integrated into the family practice setting and also uses the skills and expertise of the clinic's social worker/counsellor, dietitian, chiropracist, nursing staff and administrative staff. The core team has the capacity to provide care in the community, as needed (e.g., home visits), and to work in partnership with community-based resources. All team members have access to patient information via an electronic database. Each professional (e.g., family physician, nurse-practitioner, psychiatrist) assumes liability for patients in his or her own practice. Approximately three to ten new cases per month are seen for ongoing care.

Unique characteristic(s) to local community

- This region is under-resourced for both family physicians and psychiatrists
- There is a significant number of SMI patients in the practice (approximately 300)

Barriers

- A delay in project funding shortened the lifespan of the project from the initially proposed three years to 18 months

Strategies

- Revised evaluation methodology to allow for briefer duration of project (i.e., less rigorous design, fewer instruments/measures/variables)

Funding

- Ontario Ministry of Health and Long-Term Care, Primary Health Care Transition Fund (PHCTF)

Sponsoring organization(s)

- Dr. Mel Krass, Niagara Health Services, Niagara Medical Group

Other participant(s) or organization(s)

- Mark Wakefield and Dr. Sarah Danials

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Children's Mental Health Collaborative Care Clinic: A Shared Care Model of Youth Mental Health Consultation in a Family Practice Training Centre

Start Date

January 2002

Special Populations

Children and youth
Serious mental illness

Human Resources

Child and adolescent psychiatrist
Family practice resident
Psychiatric resident
Research associate
Social worker

Location(s)/Setting(s)

Family practice clinic

Evaluation

Yes, completed and ongoing.

Initiative Short Title

Children's MHCC Clinic

Purpose

Up to 40 per cent of adolescents suffer from psychiatric disorders or psychological distress. However, only one in ten children in need of treatment is receiving it. Due to the shortage of child and adolescent psychiatrists in Ontario, family physicians do not always have timely access to consultations. Less than five per cent of graduating family physicians (Spenser, 2000 unpublished survey) report feeling prepared to diagnose and treat common mental health problems in children and youth. Family physicians felt especially unprepared to deal with youth presenting with behavioural problems that involved aggression towards others, and to identify which of these children suffered from a treatable mental illness

Goals/objectives

- To assist family physicians in feeling more prepared at graduation to diagnose and treat commonly presenting mental illnesses in children and youth, such as depression, Attention Deficit Hyperactivity Disorder and school phobia
- To reduce waiting time to get in to see specialists for children with severe and persistent mental illnesses
- To model a relationship between child psychiatry specialists and family practitioners that will, ultimately, create increased confidence and skill for primary care physicians, when identifying and managing common mental health problems in children and adolescents

Description

The clinic takes place every two weeks in a family practice training centre. Residents book children and adolescents about whom they query mental health problems. Community physicians refer children to the clinic. Ideally, the youth are seen by the trainee who will continue to be his or her family physician. The consultant psychiatrist observes the interview and is available part-way through and following the consultation to provide guidance and teaching about the differential diagnosis and suggested course of treatment for the child and his or her family. The team's social worker is located in the clinic to provide ongoing teaching support for the family medicine residents, as well as patients and their families. In addition, a six-week follow-up appointment is made with the social worker and the family medicine resident. Patients remain the responsibility of their referring family physician; however, the

attending psychiatrist is responsible specifically for treatment rendered. The clinic provides an average of six consultations per month, and offers teaching and supervisory services to approximately six to eight family practice residents per month.

Learning needs assessment questionnaires were completed and a focus group held to obtain information about the impact of the clinics on residents and their perceived confidence and skill levels in child and adolescent psychiatry. Overall, residents elected to continue the program and steps have been taken to ensure a steadier supply of children. In addition, there has been the valuable addition of the clinic's social worker, to reinforce and supplement teaching provided in Children's Mental Health.

Unique characteristic(s) to local community

- This program takes place in the training setting of future family physicians

Barriers

- Because of the structure of family practice training, we had trouble obtaining completed questionnaires for the pre- and post-assessments, and thus planned a post-clinic focus group instead
- The patient population at the Bruyere training site is biased towards the upper end of the age spectrum, making it difficult to find enough children for the clinics

Strategies

- We will continue to examine new incentives to assist in obtaining pre and post questionnaire data
- Family physicians in the community have been solicited to send children from their practice with mental health concerns for the residents to assess

Funding

- The Janus Scholarship from The College of Family Physicians (for the research evaluation component)
- The clinical program is supported by the Children's Hospital of Eastern Ontario, Psychiatry Associates Alternate Funding Plan (i.e., two collaborative psychiatric assessments and one hour of teaching to family practice residents every two weeks)

Sponsoring organization(s)

- Children's Hospital of Eastern Ontario
- Psychiatry associates
- University of Ottawa, Department of Family Medicine (Bruyere Site)

Other participant(s) or organization(s)

- Clinical services provided by child and adolescent psychiatrists from the Children's Hospital of Eastern Ontario (Ottawa, Ontario) and a MSW (Master's of Social Work) social worker from the Bruyere Family Practice Centre

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Collaborative Mental Health Care Network (CMHCN)

Start Date

March 2001

Special Populations

None

Human Resources

Director
 Family physician
 General practitioner psychotherapist
 Psychiatrist
 Social worker

Location(s)/Setting(s)

Private physicians' offices

Evaluation

Yes, completed and ongoing.

Initiative Short Title

CMHC Network

Purpose

Family physicians report a lack of access to psychiatric services leading to a lack of satisfaction and subsequent sub-optimal support for treating serious and persistent mental illness. The Ontario College of Family Physicians' (OCFP) Collaborative Mental Health Care Network (CMHCN) wanted to determine whether a mentoring program would increase physicians' knowledge of, access to, and satisfaction with mental health consultations.

Goals/objectives

- To improve family physician/psychiatrist collaboration and exchange of knowledge
- To support primary care physicians in the provision of mental health-care services
- To provide continuing medical education as defined by the needs assessment
- To improve physician satisfaction with collegial relationships in mental health care
- To improve patient adherence to intervention
- To reduce time for consultation

Description

The OCFP has developed a mentoring program, the Collaborative Mental Health Care Network (CMHCN), that links psychiatrist and general practitioner (GP) psychotherapists as mentors with family physicians in a collaborative relationship intended to enhance provincial mental health care. Adjunct mentors (three social workers) have been added to the program to provide clinical support in high need, lower frequency areas of clinical practice. There are currently 17 groups involved in the network, although the family physicians have access to support from all 32 mentors. Advice in the areas of diagnosis, psychotherapy and pharmacotherapy is provided to them by e-mail, fax, telephone or face to face, as needed. Two mentors work with a group of family physicians providing clinical case-based support on an as-needed basis. Mentors commit one hour per week, for which they are paid. The family physician continues to assume liability for patients.

Family physicians are matched with mentors according to clinical interests and/or geographic location, where possible. Family physicians consult with their psychiatrist mentor an average of 3.8 times and with their GP psychotherapist mentor an average of 1.7 times per year. The program includes case-based continuing medical education activities among mentor/family physician groups and includes an annual day-and-a-half-long educational conference. In addition, four educational modules were developed based on the CMHCN needs assessment. These modules have been disseminated across the province on the following topics: working with the difficult patient; practical office management of co-morbid alcohol and anxiety disorders; managing change: a solution development workshop for stress reduction; and cognitive behavioural therapy on the fly. Two modules currently being developed are: using atypical antipsychotics; and dealing with eating disorders in family medicine. There are a total of 268 family physicians and 39 mentors (including adjunct mentors) involved in the network.

Unique characteristic(s) to local community

- Implementation of Community Treatment Orders allowed for the development of this provincial program, with multiple participants from family medicine and psychiatry

Barriers

- Lack of funding
- Provincial at-a-distance program
- Technology skill level differences among participants

Strategies

- Sought funds from alternate funding sources
- Implemented face-to-face session to increase group cohesion and increase contact between mentors and family physicians; administration continues to send reminders to participants to use mentors; mentors are required to contact family physicians
- Mentors and family physicians were grouped based on their preferred mode of communication (e-mail versus telephone); participants were encouraged to use e-mail (a demonstration was provided at an annual conference on the benefits of technology)

Funding

- Ontario Ministry of Health and Long-Term Care: yearly for the last four years (four-year base funding), as of the 2004–2005 fiscal year
- Pharmaceutical funding provided one-time educational grants
- Funds are regulated by the Ontario College of Family Physicians (OCFP)

Sponsoring organization(s)

- OCFP

Other participant(s) or organization(s)

- None

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Community Mental Health Services

Start Date

1987

Special Populations

Concurrent disorders
Homeless/transient
Rural
Seniors/geriatrics
Serious mental illness
Urban

Human Resources

Caregivers' Group
Clerical support
Clinical social worker
Consumer volunteer
Coordinator
Intensive case manager
Internist
Masters of Education
Masters of Social Work
Medical student
Occupational therapist
Physician
Psychiatrist
Psycho-geriatric resource consultant
Registered nurse

Location(s)/Setting(s)

Community agency
Community mental health services offices
Emergency room
Patient homes
Physicians' offices

Evaluation

Yes, ongoing.

Initiative Short Title

Community MH Services

Purpose

Mental health is an essential element in the provision of comprehensive health care. By providing community-based psychiatric and interdisciplinary staff services, the patient is able to remain in the community under the continuing care of the referring physician. Two programs were developed in response to a rise in the number of patients with concurrent disorders and those with complex psycho-geriatric presentations.

Goals/objectives

- To provide accessible, geriatric assessment expediting treatment and appropriate placement of patients with physical and neuro-degenerative conditions
- To deliver services in a way that allows the person to continue living in the community, respects the dignity and right of the seriously mentally ill to take part in mainstream community life, and their responsibilities to the extent of their individual capacities, regardless of fluctuations

Description

The Geriatric Assessment Clinic provides consultation to the family doctor on pharmacological management and offers the necessary clinical supports indicated. Physicians and elderly patients involved in the program have access to crisis and scheduled assessments, as well as follow-up support and consultation for the most fragile or vulnerable patients. Access to a high-priority follow-up is consistent with outpatient treatment of seriously mentally ill people. Telephone consultation effectively increases the flow of information to the patient and his or her physician. Although psycho-geriatric patients require an extensive commitment of office time, the physician experiences an increased capacity to see patients when he or she is able to refer them with confidence and receive support from the clinic.

This intervention enables the physician to monitor medication and symptoms with dispatch. Physicians participating in an ongoing dialogue with a consulting psychiatrist naturally increase their expertise about psychotropic medications and diseases of the elderly. Therefore, family doctors are able to manage seriously ill patients who, otherwise, would be treated in the mental health system. Medical/legal responsibilities are assumed by the most responsible physician in each case and the Collingwood General

and Marine Hospital Board of Trustees. We offer approximately 600 client visits per month, and see 400 individual patients per month. We have expanded the shared-care model via video-conferencing and use of Smart System for Health and NET-MED software.

Our intensive case manager has a selected caseload of the most vulnerable patients, who are seen individually and in social groups. The assistance of Consumer Survivors' Project in Collingwood's mental health advocate and support program enables the intensive case manager to design group therapy specifically for chronically ill women. Our staff works with the Alzheimer's Society, providing caregivers' education and a support group for family members dealing with the neuro-degenerative illness of a relative.

Unique characteristic(s) to local community

- Community Mental Health Services is an adaptation of Collingwood General and Marine Hospital, which is family-physician-based; there is an underlying assumption that the family physician is competent to be a provider of care for seriously mentally ill patients

Barriers

- Physicians moving into the area on locum, or who have limited experience with rural centres, must adjust to an expectation that they will maintain an ongoing relationship with the patient. The physician and patient will be discouraged from splitting off mental health care from the routine care provided by any family physician
- Stigma and age-ism

Strategies

- To overcome this reticence, the physicians learn that, if deterioration occurs, they have access to immediate consultation and, if needed, their patients will be seen immediately
- We meet with new physicians to explain the features of Community Mental Health Services Shared Care

Funding

- Ontario Ministry of Health and Long-Term Care
- Funds are regulated by the Collingwood General and Marine Hospital

Sponsoring organization(s)

- Collingwood General and Marine Hospital

Other participant(s) or organization(s)

- None

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Consultation to Community Health Centres

Start Date

March 1993

Special Populations

None

Human Resources

Community developer
Counsellor
Executive Director
Family physician
Family worker
Housing worker
Mental health worker
Nurse-practitioner
Psychiatrist
Youth worker

Location(s)/Setting(s)

Health care centres

Evaluation

Yes, completed and ongoing.

Initiative Short Title

Consultation to CHCs

Purpose

The program developed to address the needs of clients with multiple problems who were using many health centre services, which were sub-optimally coordinated. The program addresses the fragmentation and divisiveness among disciplines, especially medical (primary health care) and non-medical. It attempts to provide clinical guidance and build skills in managing a sizeable caseload of clients suffering from psychiatric disorders. The goal is to add clinical input to community initiatives or prevention programs (secondary or tertiary), targeting specific high-risk populations.

Goals/objectives

- To provide client-focused consultation to front-line workers in primary care, counselling, prevention and community development programs
- To provide direction and education concerning the management of clients with mental health difficulties and complex psycho-social problems, as this clientele forms a large portion of the population served by community health centres
- To facilitate and improve shared care across disciplines and programs within the centre
- To increase cohesion and consistency of practice, and implementation of the values outlined in the centre's mission
- To initiate and facilitate the process of systemic planning, as programs are altered to meet the community's needs

Description

The psychiatrist visits each centre every two to four weeks and holds regular 90-minute meetings with representatives of all service provider groups in each centre. Discussions are often about shared cases (e.g., of clients that are connected to more than one provider or service). Anyone may ask questions about clients with whom they are having difficulty. Direct consultations to clients are not provided. Telephone consultation is available between meetings, although this is rarely used. Occasionally, there have also been longer, pre-arranged education sessions.

Unique characteristic(s) to local community

- Implementation came about because the Executive Director valued and sought to implement the service

Barriers

- The biggest challenge has been combining the medical and non-medical teams: In one of the health centres, the primary health-care team split off from the main group; in another, the doctors and nurse-practitioners have been somewhat frustrated by the lack of direct consultation to clients; in some centres, this has been addressed by very occasional consultation; yet another centre has chosen to hire someone who does more direct consultation
- Front-line workers (health services) feel lots of time pressure to show up for meetings; it is also difficult to coordinate part-time staff to attend meetings

Strategies

- Telephone availability between consultations on specific clinical cases has helped clinicians feel more supported; difficulties have also been encountered in convincing certain teams (often medical) that the time required is worthwhile, when they feel very pressed by clinical demands; this challenge is being addressed with sustained endorsement and support from management
- Worked on creating an environment where staff members feel they can be open and honest about their concerns about collaborative efforts
- Work on consultation skills, to bridge audiences; encourage shared knowledge; explain each clinical group's issues, mandate and limitations; focus on the importance of shared information for the benefit of the client

Funding

- Each participating health centre uses funding from its internal budget

Sponsoring organization(s)

- None

Other participant(s) or organization(s)

- Carlington Community and Health Services
- Centretown Community Health Centre
- Pincrest-Queensway Community Health Centre
- Southeast Ottawa Community Health Centre

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Diabetes Screening, Risk-Management and Disease Management in a High-risk Mental Health Population

Start Date

September 2004

End Date

March 2006

Special Populations

Disorder-specific
Serious mental illness

Human Resources

Case manager
Community case worker
Diabetes nurse educator
Dietitian
Family physician
Foot-care specialist
Nurse-practitioner
Project coordinator
Psychiatrist
Registered nurse
Research assistant
Social worker
WOTCH nursing staff

Location(s)/Setting(s)

Clients' private residences (for some screening purposes)
London Intercommunity Health Centre
Western Ontario Therapeutic Community Hostel (WOTCH) headquarters

Evaluation

Yes, ongoing.

Initiative Short Title

Diabetes in a MH Population

Purpose

Historically, the medical care of persons with severe and persistent mental illness has been difficult. The disorder of schizophrenia has been repeatedly associated with a higher than normal incidence of medical illness—specifically, diabetes. In addition, the first line of treatment of schizophrenia (i.e., novel anti-psychotics) has been associated with increased risk for diabetes.

Goals/objectives

- To evaluate the implementation of a multidisciplinary model of care, consistent with current guidelines for diabetes management, within this high-risk population

Description

Collectively, the Western Ontario Therapeutic Community Hostel (WOTCH) and the Canadian Mental Health Association (CMHA) maintain a common client record, which facilitates recruitment for the current project. Participants (clients) in the project are drawn from the active hostel and association database (currently holding information on 736 clients). Family physicians linked to either program provide consent to the research team to review client charts. Participants are randomly selected from the database, using a three-tier organization of the data. Records are screened by the nurse-practitioner and case manager for one of two risk factors: diagnosis of schizophrenia or psychoses and/or current use of novel anti-psychotic medication. Then, the client records are checked to see if the client has been screened for diabetes in the last year, and whether or not he or she is adhering to the guidelines. When clients need to be screened, their case manager contacts them, and both the nurse-practitioner and the case manager meet with the client in the location where they will be screened and receive treatment.

In consultation with their community workers, participants are contacted and invited to take part in a multidisciplinary program for diabetes management. The program is run monthly at WOTCH or CMHA service locations. The participants meet individually with the nurse-practitioner, who works through the Diabetes Care Flow Sheet with them, and assesses glycemic control, hypertension, medications, weight and foot care at each monthly session. The nurse-practitioner works closely with the multidisciplinary diabetes health-care team (i.e., foot-care specialist, dietitian, social worker, diabetes education nurse and a family physician), and makes referrals when necessary. Documentation is sent to the client's family physician after every screening or clinic appointment.

Unique characteristic(s) to local community

- One key factor is that the case manager and nurse-practitioner see the client through all steps of the program, which provides a sense of consistency and comfort
- The Labrador Inuit Health Commission's piloting of this interdisciplinary model, screening for diabetes among clients with mental illness, provided the confidence to extend this service to the community

Barriers

- Physician consent has proven difficult, with an initial response rate of approximately ten per cent

Strategies

- Actively using the hostel staff to remind physicians of the project, when attending health-care appointments with clients
- Continuing medical education credit dinner, organized and advertised as an information night for the project

Funding

- Primary Health Care Transition Fund (until March 2006)

Sponsoring organization(s)

- Canadian Mental Health Association (CMHA)
- London Intercommunity Health Centre
- Regional Mental Health, London
- Western Ontario Therapeutic Community Hostel (WOTCH)

Other participant(s) or organization(s)

- University of Western Ontario, Centre for Studies in Family Medicine

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Downtown Community Health Centre

Start Date

October 2000

Special Populations

Seniors/geriatrics
 Serious mental illness
 Urban

Human Resources

Family physician
 Manager
 Nurse practitioner
 Psychiatrist
 Psychologist

Location(s)/ Setting(s)

Canadian Mental Health Association,
 Windsor-Essex County Branch

Evaluation

Yes, completed and ongoing.

Initiative Short Title

Downtown CHC

Purpose

The project developed from a community task force initiated by the Windsor-Essex County Branch of the Canadian Mental Health Association to examine a concern about access to primary care for people having a mental illness. The positive response from patients and providers encouraged the branch to open a satellite centre in the community, with a specialization in mental health.

Goals/objectives

- To provide access to primary care for people having a serious mental illness (SMI) and to improve continuity of care with mental health services and community programs
- To improve accessibility to primary care for individuals in the downtown catchment area
- To promote an increased awareness which will increase individual and community responsibility for health
- To integrate complementary/alternative therapeutic interventions in an expanded interdisciplinary team approach
- To provide an increased emphasis and focus on health promotion, disease prevention and monitoring of chronic stable disease

Description

A community mental health agency provides a broad range of mental health services, which are targeted for adults having a SMI. Currently the nurse practitioner sees patients four days a week, once a day until 8 P.M. Two physicians see patients one-day per week each, and consult with the nurse practitioner on an on-call basis. Two psychiatrists are on site for a total of three days a week, providing diagnoses, treatment and consultation to the primary care practitioners and mental health workers. In 2004, there were 1479 clients rostered in, 281 new intakes, 967 unique patients seen by all providers, 6457 appointments, seven average appointments per client and 26 average number of patients/day.

The community health centre concept includes increased access to primary care services. The Downtown Community Health Centre will have the ability to provide daily clinical services and extended hours two nights a week. On-call services for registered clients will be provided 24/7.

An outreach team will offer multidisciplinary consultation, medical assessment and treatment planning as well as nutrition, chiropody and health promotion services. Convenient pharmacy

and blood laboratory services will also be available. Home visits will be determined by practitioners in conjunction with the Program Manager and Director of Operations. The capacity will be increased to serve 5,000 registered patients. The project is currently in the process of hiring the following: family physicians, nurse practitioners, a nurse, therapists, a dietitian, a health promotion educator, a chiropodist, medical secretaries and a receptionist.

Placements for nursing students and nurse practitioner students are also provided by the clinic through the University of Windsor, School of Nursing. The community health services received a three-year accreditation as did other branch services by the Canadian Council on Health Services Accreditation for the first time in August, 2005.

Unique characteristic(s) to local community

- The branch is a community mental health agency providing primary care rather than a primary care setting providing mental health services

Barriers

- Filling nurse practitioner positions: one has been vacant since the incumbent moved out of the community
- Having different salaries for the same positions, funded by the same Ministry of Health and Long term Care, but by different ministry branches
- Competing for health care professionals, hospitals, new family health teams and recruitment, especially with a stronger U.S. dollar
- Developing support for a community mental health agency to provide primary care

Strategies

- Striving for community collaboration, and providing a solution to a concern that over 50 per cent of psychiatric patients were being discharged without access to primary care
- Working collaboratively with the University of Windsor, School of Nursing and a few interested physicians
- Demonstrating effectiveness by providing primary care on a limited basis with funding for a nurse practitioner

Funding

Ministry of Health and Long Term Care:

- Mental Health Branch (for psychiatrist and psychologist positions)
- Nurse Practitioner Project (for two positions)
- Community Health Centre Branch (for remaining positions)
- Funds are provided and regulated by the Regional Mental Health Program (Capital Health)

Sponsoring organization(s)

- Canadian Mental Health Association, Windsor-Essex County Branch

Other participant(s) or organization(s)

- Teen Health Centre

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Hamilton Health Service Organization (HSO) Mental Health and Nutrition Program

Start Date

1994

Special Populations

Children and youth
Concurrent disorders
Disorder-specific (e.g., depression)
Seniors/geriatrics
Urban

Human Resources

Administrative staff
Counselling position
Evaluation staff
Program director
Program manager
Project manager
Psychiatrist
Registered dietitian
Research staff

Location(s)/Setting(s)

Family physicians' offices

Evaluation

Yes, completed and ongoing.

Initiative Short Title

Hamilton HSO

Purpose

The development of the program was based upon an acknowledgement of the following: the family physician plays a key role in delivering mental health care; primary care is an important setting for identifying and treating individuals who have mental health problems and would not otherwise receive mental health care and the role of the family physician can be supported and strengthened through collaboration with mental health-care providers.

Goals/objectives

- To integrate mental health services into the offices of 87 family physicians in 51 practices in Hamilton
- To increase access to mental health care for primary care patients
- To expand the range of mental health services available in primary care
- To strengthen links between mental health and primary care services
- To support the role of primary care providers in delivering mental health care

Description

The program currently integrates mental health counsellors and psychiatrists into the offices of 80 family physicians at 50 practice sites in Hamilton, Ontario. As part of the primary care team, each practice has a counsellor permanently attached. The amount of time varies, but the ratio is approximately one full-time equivalent counsellor for every 8,000–10,000 patients. Counsellors see a broad range of mental health problems and provide assessment, treatment/management and follow-up recommendations. They also facilitate a number of psycho-educational groups, on such topics as stress management/self-esteem, depression education, couples communication, and generalized anxiety disorder.

A consulting psychiatrist visits each practice every one to four weeks; the ratio is approximately one half-day per month per family physician. The psychiatrist sees new cases in consultation, often with the counsellor present, as well as cases in follow-up. The psychiatrist meets with the family physician to discuss the specific reasons for the consultation before the person is seen, and to review the proposed management plan before the person leaves. The psychiatrist is also available by telephone between visits to offer advice or support. Child psychiatrists and geriatric psychiatrists are available on a limited basis for telephone advice and periodic

meetings to discuss cases.

Counsellors and psychiatrists will see any case referred by the family physician, regardless of age or presenting problem. The emphasis is on short-term care, although in each practice, a number of individuals are seen on an ongoing basis. Services are provided to individuals, couples and families.

The counsellor and psychiatrist spend a significant amount of time discussing cases with the family physician. These are usually informal, case-based discussions ranging from one to five minutes in duration. Psychiatrists have also organized regular educational sessions for groups of family physicians on topics relevant to primary care.

The program is administered by a central management team, which is responsible for: allocating resources; recruiting and orienting counsellors and psychiatrists; establishing and maintaining program standards; linking with the funding source; and advocating for the program. The central management team also organizes educational events for counsellors, psychiatrists and family physicians, and circulates pertinent educational materials.

Unique characteristic(s) to local community

- When the program began, Hamilton was the site of 50 per cent of Ontario's health service organizations
- The rostered population and funding mechanism enabled these organizations to more easily integrate a variety of additional services into their practices

Barriers

- Some individuals may require specific treatments or a comprehensive range of mental health services which primary care cannot support
- Logistical problems, such as lack of available space and time constraints
- Isolation of counsellors working in primary care

Strategies

- Developing strong links between primary care, and secondary and tertiary services facilitates smoother and more appropriate flow between sectors
- Logistical issues are identified and addressed as they arise, by the central management team, in collaboration with clinicians and other practice staff
- Counsellor isolation is reduced through participation in monthly counsellors' meetings, continuing education events and professional development groups

Funding

- Ontario Ministry of Health and Long-Term Care, Primary Care Delivery Models Unit, Primary Health Care and Physician Policy Branch

Sponsoring organization(s)

- Ontario Ministry of Health and Long-Term Care
- St. Joseph's Health Care, Hamilton

Other participant(s) or organization(s)

- None

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Hospitalist: An Integrated Physician/Nurse-Practitioner Model

Start Date

April 1998

Special Populations

Serious mental illness

Human Resources

Family physician
Mental health nurse
Nurse-practitioner
Occupational therapist
Psychiatrist
Recreation therapist
Registered nurse
Social worker

Location(s)/Setting(s)

Mental health centre

Evaluation

Yes, ongoing.

Initiative Short Title

Hospitalist Model

Purpose

The initiative provides for the medical needs of 325 inpatients in a psychiatric hospital and is being adapted to provide services to outpatients referred to the program (currently part of a pilot project).

Goals/objectives

- To provide medical assessment of all inpatients on admission
- To provide screening for common disorders
- To ensure that immunization meets provincial standards
- To create or support health promotion/illness prevention programs

Description

A centralized medical service has been phased in to the Whitby Mental Health Centre (WMHC). Supported by the centre's staff, an external service provider (Med-Emerg Inc.) provides services to the patient care units through a central medical clinic and scheduled visits to patient care units. The central clinic has expanded its mandate to provide medical services to 11 of the 13 units. The centre partners with Med-Emerg Inc. to provide an integrated "hospitalist" model, using a family physician and two primary care nurse-practitioners, who are supported by two registered nurses. Physicians provide medical services to inpatients (of a psychiatric hospital) referred by a mental health nurse or attending psychiatrist. A pilot project has recently expanded services to approximately 20 outpatients referred to the program. The service also acted as a major resource during the SARS outbreak and a recent influenza outbreak.

The physician and nurse-practitioners attend team meetings at the WMHC. All primary and mental health-care providers have access to patient charts. The physician is cross-appointed to a local general hospital and are therefore able to get access to clinical records. The program has links with community mental health agencies and outreach programs. On an annual basis, there has been an average of 4,500 contacts for treatment of a minor nature, 3,200 contacts for treatment of an intermediate nature, and 2,300 contacts for general treatment, for a total of approximately 10,000 annual contacts.

Unique characteristic(s) to local community

- The initiative replaced a traditional family practitioner approach with one that uses advanced practice nurses to screen and provide routine health care and health promotion, and which uses a family practitioner for complex care

Barriers

- Concerns about knowledge and skills of advanced practice nurses

Strategies

- Gradual introduction with regular review process

Funding

- Ontario Ministry of Health and Long-Term Care

Sponsoring organization(s)

- Whitby Mental Health Centre (WMHC)

Other participant(s) or organization(s)

- Med-Emerg International Inc.

Contact(s)

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Rural General Community Mental Health Services and Specialized Regional Geriatric Psychiatry Services, Joint Enhancement Project

Start Date

April 2003

Special Populations

Rural
Seniors/geriatrics

Human Resources

Administrative staff
Family physician
Geriatric psychiatrist
Nurse
Occupational therapist
Recreation therapist
Social worker
Specialty geriatric case manager

Location(s)/Setting(s)

Rural Community Mental Health Clinic

Evaluation

Yes, completed and ongoing.

Initiative Short Title

Joint Enhancement Project

Purpose

In an effort to enhance the capacity, integration and accessibility of Geriatric Mental Health Services, the Regional Geriatric Psychiatry Services of Providence Continuing Care Centre launched a number of shared care and educational projects throughout the region. The Support and Education for Primary Care, Focusing on the Elderly with Disorders in Mental Health (SEED) and a Shared-Care Development Initiative in a Rural Community with a Community Health Organization in Geriatric Mental Health (TWEED) projects target primary-care settings. The current project involves a collaborative, shared-care initiative between a specialized geriatric psychiatry service and the general community mental health services, which provide services across the age span to a targeted rural community.

Goals/objectives

- To enhance the knowledge and skills of Lennox and Addington Community Mental Health Services in order to improve their capacity to provide assessment and intervention services for older people with severe mental illness
- To improve the service links between Lennox and Addington Community Mental Health Services and Geriatric Psychiatry Services
- To act as a guide for future development of Specialty Geriatric Mental Health Services in Lennox and Addington
- To discover new knowledge regarding the delivery of specialty geriatric mental health services in small urban and rural settings, by working collaboratively with local mental health services
- To assist in clarifying and defining the respective roles, functions and activities of specialty and intensive community-level services in Ontario

Description

This project involves application of a knowledge exchange model between a community mental health agency and a specialty service collaboration. The goal is to enhance a response by rural mental health services and specialty services, in support of the primary care system. The Knowledge Exchange Model (developed by Berta, Sullivan and Le Clair) was used.

Recently published Ontario Guidelines and Accountability Framework for Outreach Services in Ontario places increased emphasis on shared care, education, and program and systems development for specialty geriatric mental health outreach services. In light of these requirements, the major service activities associated with the Lennox and Addington project focus on indirect consultation and targeted, case-based educational sessions. The model of consultation adopted for this project uses a multi-level approach (Caplan, 1970) which permits shared care, education and systems development. The significant elements of this non-hierarchical model are that there is both an interactive engagement and a bilateral exchange of knowledge between consultants and recipients of the service.

In addition, this initiative complemented traditional, direct-referral specialty outreach services. The framework used to integrate these activities is based on a knowledge exchange paradigm that identifies four key elements: the need for awareness of knowledge; accessibility of knowledge; action or use of knowledge; and accumulation of new knowledge (i.e., lessons learned from the exchange), according to Berta, Sullivan and Le Clair.

Unique characteristic(s) to local community

- The initiative takes place in a rural setting and already has established links with the regional centre

Barriers

- None

Strategies

- Learning from the challenges and barriers identified in SEED, including: ensuring the commitment of the administration of both organizations; understanding of participant team development responses that would occur (i.e., norm, storm, form, perform); and identifying a coordinator in each participant agency

Funding

- In-kind support from sponsoring agency
- One-time funding from Ontario Ministry of Health and Long-Term Care

Sponsoring organization(s)

- Lennox and Addington Community Mental Health Services
- Providence Continuing Care Centre, Specialty Geriatric Psychiatry Services, Mental Health Services
- Queen's University

Other participant(s) or organization(s)

- None

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Kingston Street Health Clinic Shared Care Initiative

Start Date

October 2001

Special Populations

Concurrent disorders
Homeless/transient

Human Resources

Addictions counsellor
Administrative staff
Family medicine resident
Family physician
Mental health counsellor
Nurse practitioner
Practical registered nurse
Psychiatrist
Psychiatry resident
Psychologist
Social worker

Location(s)/ Setting(s)

Street Health Centre

Evaluation

Yes, completed and ongoing.

Initiative Short Title

Kingston Street Health Clinic

Purpose

The initiative provides integrated mental health care in a multidisciplinary medical centre for addicted and homeless patients in the Kingston area.

Goals/objectives

- To improve access to psychiatric care and generic mental health care services for the clinic
- To improve communication between family physicians and other health care workers and psychiatry
- To improve case detection and knowledge about mental illness, concurrent mental illness and addiction
- To offer case by case mental health education to family physicians, other health care workers and their patients
- To improve mental health outcomes for these patients

Description

This community clinic for addicted and homeless patients, many of whom receive methadone, is located in a downtown location in Kingston. Eight local family physicians provide methadone prescriptions and general medical care and support to patients in the community who suffer from drug addiction, and often homelessness and poverty.

The clinic is linked to an urban community health centre that also provides addictions workers, nurse practitioners, practical registered nurses, social workers, a psychologist and a psychiatrist who visit weekly. The psychiatrist sees new consults and follow-ups and, in some cases, provides psychotherapy. The psychologist provides supervision and psychotherapy training for staff.

Notes regarding patient care are shared in the same chart and, when possible, the psychiatrist is available to the family physicians for face-to-face consultation and education. Often, a mental health counsellor will sit in for the psychiatry consults and follow-up visits if concurrent mental health or addictions counselling is required. Family medicine and psychiatry residents have their own caseloads and are supervised by the visiting psychiatrist.

Unique characteristic(s) to local community

- None

Barriers

- An alternate payment scheme would be preferable for the psychiatrist
- There are no resources for a formal evaluation
- There is an absence of a formal addictions service, specialty addictions psychiatrists, and a concurrent/dual-diagnosis team in the city
- There is a lack of integration between the local detox centre and the Street Health Clinic

Strategies

- Providence Continuing Care Centre has offered limited funding and travel support for the psychiatrist
- Two practices have been approved as family health teams, and are applying for funding for psychiatric resources and community mental health care workers
- Other practices are applying for family health team status

Funding

- None

Sponsoring organization(s)

- North Kingston Community Health Centre

Other participant(s) or organization(s)

- Queen's University Department of Family Medicine and Department of Psychiatry

Contact(s)

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Lakehead Shared Care Mental Health Program

Start Date

July 2001

Special Populations

Disorder specific
Northern/isolated
Serious mental illness
Urban

Human Resources

Family physician
Medical director
Psychiatrist
Registered nurse
Social worker

Location(s)/Setting(s)

Family practice clinic

Evaluation

Yes, completed and ongoing.

Initiative Short Title

Lakehead SCMH Program

Purpose

Access to specialized mental health care was very limited and accounted for about 20 per cent of more traditional outpatient services. This program was created to provide mental health services as close as possible to those patients/clients who want to use these health services.

Goals/objectives

- To make psychiatric services available to a family practice clinic in Thunder Bay.
- To increase access to prompt psychiatric consultation and counselling services
- To support the role of primary care physicians in providing mental health services
- To assist in providing care to people with serious mental illnesses in the area

Description

The primary care clinic is staffed by 13 independent family physicians. This core team receives consultative support from two mental health counsellors (social workers) and a psychiatrist for one half-day every two weeks in the clinic. Referrals are made from the family physicians to the mental health support staff, although the family physician is most responsible for the care of patients. The model of care used in the clinic is to provide brief counselling, targeting six to eight sessions. Each counsellor may see between 90 and 100 clients per month, and 60 and 80 patients per month. The clinic also assists in providing care to those individuals with serious mental illness.

Cases are discussed on bi-weekly rounds. Information about patient progress is recorded on clinic charts. Most communication between health care providers occurs face to face, although consultative support is available by e-mail and phone if needed.

Outcome measures and symptom scales are similar to those of the Hamilton Health Services Organization Mental Health and Nutrition Program. These include the Personal Health Questionnaire for symptom assessment and WHO's Disability Assessment Schedule (WHO_DAS) for a functional measure. This program is integrated with a second program, Transition into Primary Care Psychiatry (TIPP), on site, to provide care to those individuals with serious mental illnesses. Ongoing program evaluation of all providers and patients/clients permits changes to the program to be specific and meaningful.

Unique characteristic(s) to local community

- The program is the first of its kind in the region
- The program provides detailed intake and post-treatment data on patient status regarding symptoms and function, as well as satisfaction
- Ongoing evaluation helps to maintain effectiveness

Barriers

- Unstable funding for research support
- Withdrawal of funding for education needs
- Some family physicians' reluctance to engage

Strategies

- Some research support from provincial hospital
- Effective communication with physicians has overcome their reluctance to engage

Funding

- Ontario Ministry of Health and Long-Term Care
- The funds are regulated by the Thunder Bay Regional Health Science Centre (TBRHSC)

Sponsoring organization(s)

- TBRHSC

Other participant(s) or organization(s)

- Lakehead Psychiatric Hospital, St. Joseph's Care Group

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McMaster University Psychiatric Outreach Program

Start Date

1992

Special Populations

Northern/isolated

Human Resources

Family physician
Mental health worker
Psychiatrist
Psychiatric resident

Location(s)/Setting(s)

Physicians' offices

Evaluation

Yes, completed and ongoing.

Initiative Short Title

McMaster Psychiatric Outreach

Purpose

Northern communities are under-serviced in psychiatry. Providing scheduled occasional psychiatric coverage was one way to alleviate these shortages.

Goals/objectives

- To provide psychiatric services to rural, remote and under-serviced communities
- To allow residents to experience psychiatry as it functions in a variety of rural, remote or under-serviced areas

Description

Psychiatrists from McMaster University provide fly-in psychiatric services to communities in James Bay (since 1992) and Sault Ste. Marie (since 1995). Services include consultations to family physicians, as well as working closely with community and mental health workers. Emphasis is on family physicians' education and treatment/management. The McMaster University Psychiatric Outreach Program is open to psychiatric residents as an elective opportunity. There are currently six physicians involved in the program. A tele-psychiatry (video-conferencing) option is available.

Unique characteristic(s) to local community

- None

Barriers

- Retention of staff in the absence of resources has been difficult

Strategies

- None

Funding

- None

Sponsoring organization(s)

- McMaster University
- St. Joseph's Healthcare, Hamilton

Other participant(s) or organization(s)

- None

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Mental Health Consultation and Evaluation in Primary Care Psychiatry (MHCEP)

Start Date

November 2003

Special Populations

Aboriginal
 Children and youth
 Concurrent disorders
 Ethno-cultural
 Homeless/transient
 Rural
 Seniors/geriatrics
 Urban

Human Resources

Coordinator
 Family physician
 Nurse
 Psychiatrist
 Research assistant
 Secretary
 Director

Location(s)/Setting(s)

Byron Family Medical Centre
 London Intercommunity Health Centre
 Southwest Middlesex Health Centre
 St. Joseph's Family Medical and Dental Centre
 Victoria Family Medical Centre

Evaluation

Yes, ongoing.

Initiative Short Title

MHCEP

Purpose

Up to 30 per cent or more of a family physician's practice involves people experiencing emotional problems. Less than three per cent of patients are referred for psychiatric care or counselling. In the field of medicine, in many parts of the world sharing clinical care has been common practice for decades. This is especially true in psychiatry in the United Kingdom. In the past five to ten years, specialists have been working more frequently within family physicians' offices. Primary care reform and recent best practices documents support such bridging. The concept of mental health providers working in the same location as family physicians is now increasingly supported by research evidence suggesting greater efficiency with limited mental health resources; very high patient satisfaction; decreasing service need for inpatient and outpatient services; encouraging the use of time-limited and evidence-based therapies; providing standards to evaluate the impact of such services on symptom change; and, functional improvement.

Goals/objectives

- To evaluate the measures of change in symptomatology, functional status, severity of illness and perceived need for care in Mental Health Consultation and Evaluation in Primary Care (MHCEP) patients, and patient satisfaction with the service in such patients, the primary-care providers and the staff

Description

The Mental Health Consultation and Evaluation in Primary-Care Psychiatry (MHCEP) program provides consultative services (assessment, treatment and counselling) to both individual patients and their families as part of family practice. An on-site nurse with specialized training in psychiatry and a psychiatrist support family physicians in their role as the primary care providers at five different sites. Formal (weekly team meetings) and informal contact frequently occurs between providers. In addition, electronic health records support communication about patient progress.

Patients of the program receive comprehensive, holistic care in a familiar environment. Using standardized instruments, evaluation of patients' symptoms, function and satisfaction with the MHCEP service is an integral part of this shared care program. This information is shared between providers through the use of an electronic health record. The primary care provider assumes liability for patient care. Approximately four patients are seen per month.

Unique characteristic(s) to local community

- The University of Western Ontario, Department of Psychiatry and Family Medicine, was interested in developing a shared-care initiative
- Dr. Haslam, who had a shared-care program in North Bay, was interested in establishing a shared-care program in an academic setting

Barriers

- Historical discontent with mental health service in the area
- The program was the "face" of a system which was perceived to be inadequate
- Allied sites were initially threatened by the use of a psychiatric nurse
- Patients not showing up for appointments has presented a challenge

Strategies

- Work hard to form relationships with patients
- Conduct primary-care provider satisfaction surveys to learn about responses from team members at the co-location sites; this was followed by brief focus groups to find mutually agreed upon actions to improve the service
- Foster ongoing pro-active communication with co-location teams

Funding

- St. Joseph's Health Care, London
- Funds are regulated by the Specialized Adult Services of the Regional Mental Health Care in London

Sponsoring organization(s)

- Mental Health Consultation and Evaluation in Primary-Care Psychiatry (MHCEP)
- Specialized Adult Services, London
- St. Joseph's Health Care, London

Other participant(s) or organization(s)

- None

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Kingston Area Multi-Practice Shared Care Initiative

Start Date

October 2001

Special Populations

Rural
Urban

Human Resources

Family physician
Geriatric case manager
Mental health worker
Mobile social worker
Psychiatrist

Location(s)/ Setting(s)

Four rural practices (including:
Tamworth; Sharbot Lake; Verona;
and Northbrook, Ontario)
Three urban practices in Kingston,
Ontario

Evaluation

Yes, completed and ongoing.

Initiative Short Title

Multi-Practice Shared Care

Purpose

The initiative provides on-site mental health care and education to seven different groups of family physicians in the Kingston area.

Goals/objectives

- To improve access to psychiatric care for generic mental health care services in the region
- To improve communication between family physicians and other health care workers and psychiatrists
- To improve case detection and knowledge about mental illness in the involved family practices
- To offer case by case mental health education to family physicians and their patients
- To improve mental health outcomes for primary care patients in the practices involved

Description

A private psychiatrist visits seven different family practice clinics on a weekly basis. There are a total of 31 family physicians and approximately 30,000 patients in these practices. The psychiatrist offers consultations and follow-up care to patients referred by their family physicians. Notes are shared with family physicians by typed copies of the psychiatrists' consultations and follow-up notes in the chart. Care is provided in a collaborative fashion between family physicians and the psychiatrist. As much as possible, local mental health care agencies and services are involved in the care of patients by inviting agency representatives to appointments with the patients.

Two practices have weekly meetings to discuss cases and new referrals. The waiting time for new referrals is about four to six weeks in most cases. The psychiatrist sees between six and ten new referrals per week, and 50 to 60 patient visits per week. As much as possible, the psychiatrist offers hallway consultations to the general practitioners. The psychiatrist acts as a referral source and access point to generic psychiatric services (i.e., emergency, inpatients, subspecialty clinics) in the area. The psychiatrist works on a fee-for-service basis in four of the cases, and is supported by sessional money in three of the clinics. The psychiatrist teaches second year family medicine residents from the Queen's University Department of Family Medicine, as well as electives for psychiatry residents from the Queen's University Department of Psychiatry.

Unique characteristic(s) to local community

- Rural communities have close ties with their local mental health agencies, as they know the workers personally. These agencies (specializing in addictions, women's health care, child and family services, etc.) have been welcoming and very cooperative and collaborative with the visiting psychiatrist

Barriers

- An alternate payment scheme would be preferable for the psychiatrist
- There are no resources for a formal evaluation
- There is limited administrative support for the psychiatrist
- There is an absence of community mental health workers in the urban practices

Strategies

- Providence Continuing Care Centre has offered limited funding and travel support for the psychiatrist
- Two practices have been approved as family health teams, and are applying for funding for psychiatric resources and community mental health care workers
- Other practices are applying for family health team status

Funding

- None

Sponsoring organization(s)

- The psychiatrist is paid fee-for-service by the Ontario Ministry of Health and Long-Term Care

Other participant(s) or organization(s)

- Providence Continuing Mental Health Care

Contact(s)

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Northern Ontario Francophone Psychiatric Program (NOFPP)

Start Date

February 1983

Special Populations

Concurrent disorders
 Disorder-specific (e.g., depression)
 Ethno-cultural
 Northern/isolated
 Rural
 Seniors/geriatrics

Human Resources

Administrative assistant
 Director
 Medical administrator
 Psychiatrist
 Physician
 Secretary

Location(s)/Setting(s)

Hospitals
 Nursing home
 Community mental health centres

Evaluation

Yes, completed and ongoing

Initiative Short Title

NOFPP

Purpose

The program provides Francophone psychiatric services to under-served communities in Northern Ontario.

Goals/objectives

- To provide psychiatric services in French to the various communities in Northern Ontario that require these services

Description

The Northern Ontario Francophone Psychiatric Program (NOFPP) operates within the Department of Psychiatry of the University of Ottawa; it provides coordination of French-language psychiatric services in Northern Ontario. The program currently maintains a pool of 12 Francophone psychiatrists who travel to Northern Ontario and provide a variety of psychiatric, clinical and educational services to multidisciplinary teams and/or physicians, ranging from in-service consultation to individual therapy, in the communities mentioned above.

Patients are initially referred and assessed by the Community Mental Health program served by the itinerant psychiatrist. If required, they are then directed to the psychiatrist for consultation and developing a treatment plan. In community hospitals, patients are referred by their general practitioner. Consultations are dictated and further discussed with Community Mental Health team members. The responsibility for patient care is assumed by the referrer or another team member, following case discussion.

In 2004–05, 12 psychiatrists traveled to eight community mental health centres and five hospitals for a total of 432 days. During these visits, they provided 530 consultations and 1,617 follow-ups. Their visits are frequently linked to an educational component.

Since 2002, televideo psychiatry has been added to the program in certain communities where connectivity was possible, increasing the number of services available to these communities. The results of a 2002 study comparing the cost and satisfaction of tele-psychiatry versus face-to-face contact with a psychiatrist showed benefits for both. It also confirmed the program's premise that televideo psychiatry should not be used in isolation, but is better used when combined with the ongoing activities of visiting psychiatrists.

Unique characteristic(s) to local community

- Locating the program within the Department of Psychiatry of the University of Ottawa has given it access to a larger pool of qualified psychiatrists who were willing to leave their urban practices for a few days each month; their absence does not appear to have had too negative an impact on their practices; this has worked so well for our program that the Ontario Psychiatry Outreach Program, an extension of the Ontario Underserved Area Program, is trying to offer similar programs through all Ontario Faculties of Medicine

Barriers

- As the program continues to offer consulting services to the current points-of-service, supplementary funding is often needed to support increasing demands for psychiatric services in French to under-served areas of Northern Ontario

Strategies

- Through annual budget submissions, the program continues its efforts to request additional funding in order to provide increased services, as requested by the communities served, or to expand its services to other communities in Northern Ontario in need of Francophone psychiatric services

Funding

- Ontario Psychiatric Outreach Program (OPOP)

Sponsoring organization(s)

- Ontario Ministry of Health and Long-Term Care
- OPOP
- Under-served Area Program
- University of Ottawa

Other participant(s) or organization(s)

- *Northern Ontario Community Mental Health Programs*, including: Timiskaming Health Unit (Kirkland Lake and New Liskeard); Hearst/Kapuskasing/Smooth Rock Falls Counselling Services; Minto Counselling Services (Cochrane, Matheson, Iroquois Falls); East Algoma Mental Health Clinic (Elliot Lake); Algonquin Nursing Home (Mattawa); Alliance Centre (Sturgeon Falls); Turning Point (Chapleau); North Algoma Counselling Services (Wawa)
- *Northern Ontario Community Hospitals*, including: Timmins and District Hospital; St. Joseph's General Hospital (Elliot Lake); Mattawa General Hospital; Kirkland and District Hospital; and Englehart and District Hospital

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The North Simcoe Community Mental Health System (NSCMHS)

Start Date

July 2003

End Date

2006

Special Populations

Aboriginal
Rural
Serious mental illness

Human Resources

Administrative support
Evaluation staff
Family physician
Mental health registered nurse-clinician
Project coordinator
Psychiatrist

Location(s)/Setting(s)

Christian Island First Nations Reserve
Private physicians' practices

Evaluation

Yes, ongoing.

Initiative Short Title

The NSCMHS

Purpose

There is a substantial demand for formal mental health services for persons with serious mental illnesses within North Simcoe County. This area has the second highest density of persons with serious mental illness in Ontario (as measured by the rates of disability pensions issued for mental illness reasons) and a significant shortage of community mental health resources. This region receives the lowest level of community mental health funding per capita in the province. Any measures that can be put in place to alleviate demand and facilitate streaming into the most appropriate services will be of benefit.

Goals/objectives

- To improve access and quality of mental health services in North Simcoe County through the collaboration between mental health services and comprehensive primary care, and by enhancing links to crisis (and other related) community and institutional programs
- To support and increase the knowledge primary care physicians have of the management of mental health issues, including management of the seriously mentally ill, through collegial contact and educational events

Description

The North Simcoe Community Mental Health System (NSCMHS) is a collaborative venture. Together with its partners, the service provides a seamless, coordinated approach to care for persons in need of mental health services. As a system, we identify gaps in service availability and attempt to provide a holistic, easily accessible service for all individuals with mental health needs living in the communities of North Simcoe County.

The addition of Shared Mental Health Care improves access to the most appropriate service for clients of primary care physicians. Those who have been reluctant to seek service through the formal mental health system are provided with timely assessment and treatment recommendations through the collaboration of a psychiatrist, a mental health clinician and primary care physicians. Most clients are managed collaboratively within the primary care setting. Those who could be better served by other community resources are streamed directly to those resources, rather than into the formal mental health system. This enables the vitally needed services of the formal mental health system (i.e. the outpatient

services program) to focus on management of persons with a chronic mental illness. Our hope is to expand service delivery to general practitioners who practice in outlying areas.

Primary care physicians at the Huronia Medical Centre meet jointly on a scheduled basis; the shared-care staff team (i.e., psychiatrist and/or mental health clinician) are regular participants (this is the formal means for ongoing communications between the two groups). Informally, the shared-care staff team has daily contact with the primary care physicians, due to co-location in the same medical centre. Service partners of the NSCMHS (other community resources used in this project) meet on a bi-monthly basis. Once a year, the shared-care project team calls a meeting with major stakeholders to formally review the project, examine milestones and make adjustments/recommendations for the coming year.

Unique characteristic(s) to local community

- North Simcoe is a rural and under-served area, in terms of medical resources; there is a diverse population, including a First Nations Reserve, located on Christian Island
- The proximity to the Mental Health Centre in Penetanguishene and the move towards deinstitutionalization has meant that there is a significant population with serious mental illness who require service

Barriers

- Initially, the service provided appointments directly within the primary care physicians' practices; this was cumbersome to coordinate, because of the high demand for space

Strategies

- The NSCMHS worked collaboratively to apply for funding through the Primary Health Care Transition Fund; this has enabled the project to rent office space in the medical centre

Funding

- Mental Health Centre Penetanguishene: in-kind resources
- Primary Health Care Transition Fund: has provided funding on a one-time basis

Sponsoring organization(s)

- North Simcoe Catholic Family Life Centre
- Outpatient Services Program of the Mental Health Centre, Penetanguishene
- Vocational and Educational Services of the Mental Health Centre, Penetanguishene
- Wendat Community Psychiatric Support Programs

Other participant(s) or organization(s)

- None

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Primary Care Community Outreach Program

Start Date

July 1996

Special Populations

Urban

Human Resources

Family physician
Psychiatrist

Location(s)/Setting(s)

Private office

Evaluation

No

Initiative Short Title

PC Community Outreach

Purpose

In 1996, family physicians at North York General Hospital expressed dissatisfaction and frustration with a poor, non-collaborative relationship and a lack of access to psychiatry. In response, the hospital's department of psychiatry implemented this program.

Goals/objectives

- To better meet the clinical needs of patients in the North York General Hospital community
- To provide better access to mental health-care services for patients in the primary care physician's office
- To educate family physicians, in order to improve their delivery of mental health care
- To provide better quality clinical consultation, involving not only a written consultation note, but disclosure and dialogue between the consultant and the professional asking for a consultation

Description

Contextually-based educational and clinical consultations are provided by psychiatrists in the offices of participating family physicians. If requested by a general practitioner, the consulting psychiatrist(s) will travel to the physician's office to conduct an on-site assessment of the patient. Most often, advice regarding assessment, care and treatment is provided to family physicians over the telephone. A great deal of patient-related information can be obtained by the participating psychiatrist, which improves the quality of the consultation, with respect to the patient's diagnosis and appropriate interventions.

The service is available to all the family physicians on staff at the North York General Hospital. However, despite having 381 general practitioners on staff, the service is rarely used. A portion of the family physicians use the outpatient clinic as their psychiatric referral source and many family physicians have other outpatient community psychiatrists to whom they refer. On average, the program receives one or two requests per month from the same few physicians.

Unique characteristic(s) to local community

- None

Barriers

- Since its implementation, the Primary Care Psychiatric Outreach Program has been infrequently used
- Funding for the psychiatrists
- Travel to the various outpatient offices can be complicated
- Missed appointments can be problematic

Strategies

- Under-utilization of the program may be explained by the hospital's outpatient clinic; it has proven to be responsive to patients' mental health and primary health care needs in a collaborative, shared-care fashion, despite not being advertised as such
- Better use of the psychiatrists' time, by booking several appointments for the same visit
- The Chief of Psychiatry, who has been supportive and encouraging of the program, has provided some sessional funds

Funding

- North York General Hospital

Sponsoring organization(s)

- North York General Hospital, Department of Psychiatry and Department of Family Medicine

Other participant(s) or organization(s)

- None

Contact(s)

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Primary Care Pilot Project

Start Date

March 2004

End Date

March 2006

Special Populations

Northern/isolated
Rural
Serious mental illness
Urban

Human Resources

Director
Evaluation consultant
General practitioner
Psychiatric nurse
Psychiatrist
Social worker

Location(s)/Setting(s)

Community health centre

Evaluation

Yes, ongoing.

Initiative Short Title

PC Pilot Project

Purpose

There is a shortage of primary care providers and psychiatrists in Northern Ontario. Many people with serious and persistent mental illness (SMI) have difficulty accessing primary care services. In addition, individuals who initially experience mental health difficulties often visit their family physician first. It is important that these doctors be connected to and supported by the local mental health system, and that they have opportunities to explore continuing education in mental health.

Goals/objectives

- To increase opportunities for people with SMI to address their primary health care needs
- To introduce local primary care providers to the shared care concept and a holistic, recovery-oriented approach to treating patients with mental health difficulties
- To create and enhance connections between local primary care providers and the local mental health system
- To engage local primary care providers and invite them to participate in a process of identifying sustainable shared-care models for Northern Ontario
- To evaluate the effectiveness of the project

Description

The project has two major parts. In the first part, a nurse-practitioner working in the Canadian Mental Health Association (CMHA) office addresses the primary health care needs of CMHA patients in the Kirkland Lake area (services may potentially expand to include the Timmins area). Patients are referred internally to see the nurse, once they have received their diagnosis from a psychiatrist. The nurse tends to the physical health needs of the patients (e.g., medication changes, injections) and offers health prevention and promotion education to the patients. The project's general practitioner, who also assumes liability for the patients involved in the project, supervises the nurse. At this time, our nurse is seeing 48 patients per month, including repeat visits for follow-up.

In the second part, a series of four education sessions will be held in 2005 in both the Timmins and Temiskaming Shores area. These case-based, interactive education sessions will feature modules on recovery, skill development for assessment, diagnosis, treatment, referral protocols and common mental health issues that a general practitioner might encounter. Interested physicians from the education sessions will be invited to participate in a working group to develop a sustainable shared-care model for Northern Ontario.

Unique characteristic(s) to local community

- The shortage of both primary care providers and psychiatric services have made it necessary to increase communication and support between the primary health care system and the mental health care system in order to improve overall patient care and increase opportunities for recovery

Barriers

- The project is still in the process of being set up
- Recruiting a nurse-practitioner

Strategies

- Incentives were offered and the position was posted in a wider area (as far east as Nova Scotia)

Funding

- Ontario Ministry of Health and Long-Term Care (March 2004 to March 2006)
- Funds are regulated by the Mental Health and Rehabilitation Reform Branch

Sponsoring organization(s)

- Canadian Mental Health Association (CMHA), Cochrane-Timiskaming Branch

Other participant(s) or organization(s)

- Addictions Ontario
- North Bay Psychiatric Hospital
- North East Ontario Consumer Survivors' Network (NEON)
- The Ontario College of Family Physicians, Collaborative Mental Health Care Network

Contact(s)

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Region of Peel Outreach Program

Start Date

July 2000

Special Populations

Concurrent disorders
 Disorder-specific
 Homeless/transient
 Urban

Human Resources

Administrative assistant
 Family transitional support worker
 Housing support worker
 Mental health outreach worker
 Ontario Works case worker
 Policy analyst
 Program coordinator
 Program manager
 Public health nurse
 Substance abuse outreach worker

Location(s)/Setting(s)

Shelter health clinics
 Community

Evaluation

Yes, ongoing.

Initiative Short Title

Peel Outreach Program

Purpose

The number of individuals and families who are homeless or transient, and the lack of mobile outreach services were identified as a gap in service delivery to this particular client group

Goals/objectives

- To provide mobile case management, health care, basic needs, addictions, mental health and housing support to those who are homeless or at risk of being homeless in the Region of Peel

Description

The program serves those in the Peel community who are homeless or at risk of being homeless. Community agencies, service providers and faith groups are determined to reintegrate homeless individuals and families into the community, and to act collaboratively to educate society about the reality of homelessness. This program works with regional staff, along with community agencies, to provide outreach, counselling and case-management services that complement the needs of the service users. Community-based client-focused service is delivered via a mobile outreach van, foot patrol or within health clinics located in two of Peel's homeless shelters during daytime and evening hours. Focus is given to five basic types of service: primary health care, basic needs, referral/advocacy, mental health/addictions counselling and transitional support.

Clients may self-refer into the program, or be referred by another community member (e.g., health-care professional, employer, family member). The program serves approximately 20 clients per month. Services are provided seven days a week by the following methods: a mobile outreach van provides services in the days and evenings; the outreach office is used for administration purposes, team meetings and client follow-up. Street Help Line Peel is a toll-free help-line that provides callers with general and referral information, and connects them to the outreach program. Street health clinics are located in two emergency shelters in Peel. The street outreach program includes a foot patrol service and drop-in sites.

The Needle Exchange is open on Monday, Wednesday and Friday evenings, and during Saturday and Sunday daytime hours. Mental health specialists, addictions support workers, Ontario Works caseworkers and housing support workers also provide services. The Canadian Mental Health Association and Region of Peel's Health Department assume liability for clients involved in the program.

Unique characteristic(s) to local community

- In Peel, there is a lack of affordable housing

Barriers

- Consistent and additional funding to meet the needs of the growing homeless population

Strategies

- Continuously advocating for additional funding

Funding

- National Child Benefit Supplement (NCBS) Redirect
- Off-the-Street, Into Shelter Fund (OSIS)
- Provincial Homeless Initiative Fund (PHIF)
- Regional Municipality of Peel
- Supporting Communities Partnership Initiative (SCPI)
- Funds are regulated by Ontario Works in Peel (OWIP)

Sponsoring organization(s)

- Program Coordinator, Ontario Works in Peel
- Region of Peel Outreach Program

Other participant(s) or organization(s)

- Canadian Mental Health Association
- Catholic Cross-Cultural Services
- Peel Addiction Assessment and Referral Centre
- Region of Peel Health Department
- Region of Peel Housing and Property
- St. Leonard's House

Contact(s)

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Portuguese Mental Health and Addictions Services

Start Date

Fall 1998

Special Populations

Ethno-cultural
Serious mental illness

Human Resources

Case manager
Director
Family physician
Psychiatrist

Location(s)/Setting(s)

Private clinic

Evaluation

No.

Initiative Short Title

Portuguese MH and Addictions

Purpose

The Portuguese-speaking population of Ontario is not well-represented, with respect to mental health providers. The clinic provides a much-needed service for a population, which is under-served.

Goals/objectives

- To meet the mental health and addiction needs of approximately 150,000 Portuguese-speaking Ontarians
- To be accessible to family physicians and other health-care providers, families, school boards, service agencies, community organizations and others wishing to refer patients with serious mental health and addiction needs

Description

The Portuguese Mental Health and Addictions Services clinic provides both consultation and ongoing treatment to patients with severe mental illness and substance-related disorders. If the family physician is also Portuguese-speaking, care is shared, with ongoing follow-up by the family physician. Portuguese-speaking family physicians are not plentiful, however, so the clinic also provides ongoing care to patients with English-speaking family physicians. The clinic has developed strong connections with community providers in contact with the Portuguese-speaking community and shares patient care with them.

Unique characteristic(s) to local community

- None

Barriers

- Community resources for Portuguese-speaking patients are limited; when the program needs to refer a patient to a consultant or other ancillary resource not available in the Portuguese language, it becomes quite burdensome

Strategies

- One of the solutions has been a successful funding proposal to the Ministry of Health and Long-Term Care to fund an additional four intensive case managers to work with the program, thus increasing the complement of clinicians working with Portuguese-speaking patients

Funding

- None

Sponsoring organization(s)

- Toronto Western Hospital

Other participant(s) or organization(s)

- None

Contact(s)

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Psychiatric Outpatient Clinic, Sault Area Hospital

Start Date

January 1996

Special Populations

Other

Human Resources

Clerical staff
 Family physician
 Nurse
 Program director
 Psychiatrist
 Social worker

Location(s)/Setting(s)

Hospital/community care

Evaluation

Yes, ongoing.

Initiative Short Title

Psychiatric Outpatient Clinic

Purpose

Sault Ste. Marie is under-serviced with regard to psychiatrists, resulting in waiting times of more than six months for consultative care. Before this clinic opened, the majority of patients with mental health needs went to the emergency rooms of local hospitals, where they were admitted and assessed by psychiatrists. The outpatient clinic was established to provide patients with urgent mental health needs with timely consultations, and to alleviate overuse of hospital beds for that purpose.

Goals/objectives

- To provide timely psychiatric consultation to local family physicians and limited follow-up with adults who have urgent mental health needs
- To reduce unnecessary admissions through emergency departments
- To reduce workload pressures on local psychiatrists

Description

Through the Ontario Psychiatric Outreach Program, visiting psychiatrists travel to Sault Ste. Marie to provide consultative services to family physicians two days per week. Family physicians refer patients with urgent mental health needs for consultation with the visiting psychiatrists during those days. Referrals are triaged and screened by the clinic's nurse. After seeing a patient, the psychiatrist contacts the referring physician by telephone to discuss his or her findings, make recommendations and answer any questions. A detailed written report is sent to the referring physician within one week.

Complex cases or those requiring close monitoring are referred to the clinic's registered nurse and/or social worker for follow-up care for a period of up to four months. Written progress reports are provided to the family physician and telephone support from the clinic's nurse is available to physicians. The adoption of the recommendations made by the visiting psychiatrist, however, remains the responsibility of the family physician. On average, visiting psychiatrists see approximately 150 patients per month.

Unique characteristic(s) to local community

- Sault Ste. Marie area is designated by the Ontario government as under-serviced
- The area is geographically distant from alternative services

Barriers

- Recruitment and retention of psychiatrists

Strategies

- Shifting the way the program is marketed to potential/new psychiatrists to promote the lifestyle/quality of life benefits they would receive, in addition to those offered by the program and related work
- Involving clinicians with advanced training (e.g., clinical nurse specialist) in an outreach model that uses visiting psychiatrists provides a previously unavailable local resource to family physicians (due to the shortage of local psychiatrists)

Funding

- Ontario Ministry of Health and Long-Term Care, Under-Serviced Area Program
- Sault Ste. Marie area hospitals' global budgets

Sponsoring organization(s)

- Ontario Psychiatric Outreach Program, Ontario Ministry of Health and Long-Term Care

Other participant(s) or organization(s)

- None

Contact(s)

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Psychiatric Outreach to the Homeless

Start Date

July 2004

Special Populations

Aboriginal
 Children and youth
 Concurrent disorders
 Disorder-specific
 Ethno-cultural
 Homeless/transient
 Seniors/geriatrics
 Urban

Human Resources

Coordinator
 International medical graduate
 Outreach worker
 Physician
 Psychiatrist
 Shelter worker

Location(s)/Setting(s)

Cambridge Shelter Corporation
 House of Friendship
 Mary's Place
 Reaching Our Outdoor Friends
 St. John's Community Kitchen

Evaluation

Yes, ongoing.

Initiative Short Title

Psychiatric Outreach

Purpose

The Regional Municipality of Waterloo Social Services Department began conducting sustainability interviews with organizations that work with homeless individuals. During these interviews, Reaching Our Outdoor Friends (ROOF) found that traditional hospital- or clinic-based psychiatric services do not work for the homeless population.

Goals/objectives

- To reduce crisis and increase the mental health of individuals who are homeless
- To increase the access individuals who are homeless have to psychiatric care and basic needs by conducting Ontario Disability Support Program (ODSP) assessments, thereby increasing the capacity of individuals to receive more appropriate supports

Description

The psychiatric outreach program offers services to five different sites. Clients are referred to the psychiatrist and/or physician, who provide(s) medical and mental health-care services. The psychiatrist and physician are supported by outreach and shelter workers, and an international medical graduate, who provides medical clerical and record-keeping support. In addition, the community helps to provide support when individuals need to obtain identification and temporary OHIP cards.

There is a close collaboration between the identification programs, shelters, community kitchens, physicians and Ontario Works. The psychiatrist provides support to the Kitchener Downtown Community Health Centre, enhancing the centre's ability to support individuals with mental health problems. The psychiatrist and physicians assume legal liability for issues associated with the practice of psychiatry. This service operates two days per week and has approximately 70 clients, who have been seen up to seven times each.

The Region of Waterloo Supporting Community Partnership Coordinator works closely with the program to identify and resolve system problems by facilitating a community healing approach (rather than just an individual's perspective). It takes relationship-building and helping people with basic needs, in order to establish the necessary trust to discuss further means of support.

Unique characteristic(s) to local community

- The Waterloo region has a respectable history of service development through cooperation, and this process is an example of being able to adapt rapidly to potential innovation

Barriers

- Initially, the program had to develop systems for mobile record-keeping and clerical support for the psychiatrist at shelters, community kitchens and the street; the need for such systems varies, depending on the psychiatrist and the amount of support and type of practice to which they are accustomed
- As of yet, there is no stable funding, and all funding is currently provided through one-time initiatives
- Coordinating partners is time-consuming, and was possible only because the Region of Waterloo provided the program coordinator of the National Homelessness Initiative (NHI) with the time to do so

Strategies

- Mobile clerical support was resolved by hiring an international medical graduate, who assisted the doctor, as part of her Canadian training
- The planning committee is currently identifying local resources and strategically aligning them to provide a fuller level of support to homeless individuals who are ready to move into housing, receive services or engage in work
- Because the psychiatrist was open to getting the program established by doing the work and being present, the momentum was created to fill in the rest of the program's development
- The psychiatrist was willing to present himself in a low-key way, with a backpack as his only tool; this humble approach was well-received, and he immediately gained respect from all sectors

Funding

- Regional Municipality of Waterloo Employment and Income Support Program

Sponsoring organization(s)

- Community Mental Health Services
- Community Kitchens
- Homeless Shelters
- Housing providers
- Kitchener Downtown Business Association
- Kitchener Downtown Community Health Centre
- Regional Municipality of Waterloo Ontario
- Schedule One hospital
- The Working Centre
- Works and Employment and Income Supports

Other participant(s) or organization(s)

- Regional Municipality of Waterloo Supporting Communities Partnership Initiative for the National Homelessness Initiative (NHI)

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Psychiatric Referral Service (PRS)

Start Date

April 2002

Special Populations

None

Human Resources

Physician
Program coordinator
Psychiatrist

Location(s)/Setting(s)

Community psychiatrists' offices

Evaluation

Yes, completed and ongoing.

Initiative Short Title

Psychiatric Referral Service

Purpose

The Academy of Medicine Ottawa launched its Psychiatric Referral Service in response to the growing difficulty primary care physicians were experiencing in gaining access to community psychiatric resources for their patients.

Goals/objectives

- To provide primary care physicians with a resource to assist them in gaining access to community-based psychiatrists for their patients

Description

The Psychiatric Referral Service (PRS) has one primary coordinator, who is responsible for connecting family physicians (whose patients need mental health services) with psychiatrists.

Family physicians contact the Academy of Medicine Ottawa and are given the names of two to three appropriate psychiatrists who are available to provide consultation and follow-up. More than 50 community-based psychiatrists participate in the Psychiatric Referral Service. They each see at least one new referral from the service per month.

The type of care provided to the patient depends upon his or her needs. For example, psychiatrists might offer one-time consultations, the physician and psychiatrist might share ongoing care, or the psychiatrist might assume a more long-term role in providing care for the patient. Once the referrals coordinator has provided the primary care physician with the names of appropriate psychiatrists, the primary care physician contacts the psychiatrist, arranges an appointment and determines how best to communicate appropriate information.

In three years of operation (April 1, 2002 to March 31, 2005), the Psychiatric Referral Service has assisted more than 500 primary care physicians by providing an average of 71 referrals per month. The Psychiatric Referral Service is not involved in patient care; its focus is only to facilitate the process of connecting physicians with psychiatrists.

Unique characteristic(s) to local community

- The Psychiatric Referral Service was established because family physicians, who provide the bulk of primary mental health care to the citizens of Eastern Ontario, found it very difficult to gain access to psychiatrists
- At the time the program was started, Ottawa's psychiatric hospital, The Royal Ottawa, had closed its emergency service and no longer provided consultations in general psychiatry. As well, both psychiatric outpatient departments of the Ottawa Hospital were closed to consultations from the community

Barriers

- The greatest barrier to establishing and sustaining this service has been securing funding

Strategies

- Through the effort and persistence of the Academy of Medicine Ottawa's Executive Committee, funding has been achieved each year for a one-year period; permanent funding will be in place as of April 1, 2005

Funding

- Ontario Ministry of Health and Long-Term Care

Sponsoring organization(s)

- Academy of Medicine Ottawa

Other participant(s) or organization(s)

- None

Contact(s)

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Psychotic Disorders Clinic at McMaster University

Start Date

1992

Special Populations

Children and youth
Disorder specific
Serious mental illness
Urban

Human Resources

Dietitian
Family practitioner
Occupational therapist
Pharmacist
Psychiatrist
Psychometrist
Registered nurse care coordinator
Registered nurse family educator

Location(s)/Setting(s)

Hospital

Evaluation

Yes, completed.

Initiative Short Title

Psychotic Disorders Clinic

Purpose

The population of persons with severe mental illness is very diverse, with a consequent need for a range and a variety of approaches to community care, tailored to the specific needs of individual clients. As well, there are not enough case management placements in the region for all persons with a severe psychiatric disorder. Since not all persons with severe mental illness need assertive community treatment, the psychotic disorders team felt that certain clients could learn excellent self-care, and do well in shared care provided by a partnership of family practice with the specialized psychiatric team. For these clients, the Alumni Program at the Psychotic Disorders Clinic can provide the right treatment at the right time in the right place and at the right cost.

Goals/objectives

- To provide continuity of support to clients and their families over the entire course of their illness
- To support clients in attaining their health maintenance goals
- To share care effectively with general practitioners, providing specialist psychiatric services, when appropriate
- To reduce the propensity for client dependence on the system
- To provide continuous support to general practitioners and certain case management services
- To support a large number of clients

Description

The Alumni Program has been incorporated into the regular clinical functioning of the Psychotic Disorders Clinic. It is situated in a hospital outpatient department and staffed by hospital employees. The Alumni Program is a model of continuing care, involving shared care between family practitioners and the clinic, and early intervention. Participants in the program (“alumni”) have completed a period of active treatment with the clinic, and have attained a level of self-care competency. Participants remain in treatment with their family practice physician, with “backup” from the psychotic disorders team (including a psychiatrist, registered nurses, occupational therapist, a dietitian and a pharmacist).

Participants attend the clinic for regular six- to 12-month visits, and are welcome to re-enter the clinic for renewed active treatment, as indicated and negotiated. A few may also receive concurrent support from case management services. Participation by family, friends and community workers is welcome, if the client wishes. There is quick access to the clinic by the participants and the family practitioners.

For family practitioners, the clinic provides same-day return of phone calls, offering telephone advice, urgent appointments to participants (on the same day or within a week), timely written reports/letters after each participant visit and collaboration, if clients develop a physical condition which affects their psychiatric care. Responsibility for clients is shared. Approximately 135 participants currently participate in the program, and data have been collected on their marital status, employment status, living situation, diagnosis and other factors.

Unique characteristic(s) to local community

- Hamilton has pioneered the Health Services Organization program and is recognized for its innovative shared-care approach

Barriers

- Some physicians are initially uncomfortable with assuming their role in maintenance care of clients with psychotic disorders

Strategies

- After experiencing how the Alumni Program works, including receiving a letter from the clinic any time there is client contact, physicians usually are quite accepting of this shared-care approach
- Communication between the physicians and the clinic team helps to ease concerns

Funding

- Psychotic Disorders Clinic at McMaster University

Sponsoring organization(s)

- Psychotic Disorders Clinic: Hamilton Health Sciences, McMaster Site

Other participant(s) or organization(s)

- None

Contact(s)

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Specialized Adult St. Thomas (SAS)

Start Date

1999

Special Populations

Ethno-cultural
Rural
Serious mental illness

Human Resources

Case manager
Chiropracist
Counsellor
Dietitian
Nurse
Nurse-practitioner
Physician
Psychiatric nurse
Psychiatrist
Psychologist
Social worker

Location(s)/Setting(s)

Health clinic
Medical centre
Physicians' offices

Evaluation

Yes, ongoing.

Initiative Short Title

SAS

Purpose

The Specialized Adult St. Thomas (SAS) program strives to offer a continuum of seamless service delivery among inpatient, ambulatory and community-based care, in order to enable recovery of people with moderate and serious mental illnesses. Through collaborative relationships between patients, their family physicians, mental health clinicians and psychiatrists, shared care is felt to be an essential component of this continuum—one that allows for delivery of service as close to home as possible.

Goals/objectives

- To allow for earlier intervention for both mental and physical problems, continuity of care, service as close to home as possible, and services that are responsive to the needs of different patient populations

Description

The Specialized Adult St. Thomas (SAS) program offers many services within Elgin County. At the Aylmer Clinic, shared care (i.e., consultation, education and brief follow-up) is provided to the six family physicians, the nurse-practitioner and a number of other rural family physicians, as well as offering service to the “low”-German-speaking Mennonites in the region. The clinic is co-located with the other family physician offices, and is staffed by a psychiatric nurse five half-days per week, in addition to a psychiatrist who consults two half-days per month. Services are primarily based at the clinic, with frequent phone contact with the family physicians, although the nurse also visits their respective offices about once a month.

At the West Elgin Community Health Centre, a psychiatric nurse joins the Inter-Community Mental Health Team two days a week, providing shared care in conjunction with a psychiatrist who visits one half-day per month. The team includes a social worker with primary interest in adolescents and children, child and youth workers who work directly in the area schools whenever possible, a Canadian Mental Health Association (CMHA) counsellor, two case managers for long-term mental health support and a physician for short-term (10–16 sessions or less), mental health issues. The centre is also staffed by a primary physician and four nurse-practitioners. A dietitian and chiropracist are co-located with the team.

The crisis and relapse prevention service (at the Regional Mental Health Care in St. Thomas) offers shared-care liaison with interested family physicians in St. Thomas and Port Stanley. Mental health professionals from the crisis service (i.e., nurses, psychologists, social workers) are teamed with family physicians/practices, and visit on a monthly basis to review shared cases and provide educational materials. They are also the contact for any questions or concerns that the family physicians might have.

We are developing a long-term care clinic for our tertiary patients with serious mental illness, who require long-term follow-up. This will operate as part of the Community Mental Health Centre. A subset of these patients will be followed by the clinic's team (including a nurse, nurse-practitioner and psychiatrist), in conjunction with the patient's family physician, operating in a shared-care model. This will allow patients to be gradually transitioned back to their family physicians, with backup support and consultation from the nurse-practitioner and psychiatrist.

Unique characteristic(s) to local community

- The Aylmer Clinic serves a large "low"-German-speaking Mennonite population. The psychiatrist visits the clinic on market day

Barriers

- There is some reluctance for family physicians to get involved
- The program takes place in a long, narrow county; it is predominantly rural, so transportation is a major barrier for patients who need service
- We have experienced a shortage of physicians, so we have relied heavily on non-physician resources

Strategies

- By starting with some champions, word gradually spreads about the program

Funding

- The program is funded as part of the Crisis and Relapse Prevention Program, Specialized Adult St. Thomas (SAS), Regional Mental Health Care, St. Thomas
- Funds are regulated by the SAS program director

Sponsoring organization(s)

- Regional Mental Health Care (RMHC), St. Thomas (St. Joseph's Health Centre, London)

Other participant(s) or organization(s)

- West Elgin Community Health Centre
- A number of family physicians in Elgin County, including the Aylmer physicians

Contact(s)

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Shared Care Clinical Outreach Service

Start Date

1995

Special Populations

Homeless/transient
 Serious mental illness
 Urban

Human Resources

Clinical housing worker
 General practitioner
 Manager
 Outreach worker
 Psychiatrist
 Psychology
 Recreation therapist
 Registered nurse
 Social worker
 Student

Location(s)/Setting(s)

Adelaide Women's Resource Centre
 Fred Victor Community Centre
 Good Sheppard Centre
 Houselink
 Metro United Out of the Cold
 Salvation Army Hope Shelter
 Salvation Army Maxwell Meighan
 Seaton House

Evaluation

Yes, ongoing.

Initiative Short Title

SC Clinical Outreach Service

Purpose

The Shared-Care Clinical Outreach Service seeks to provide psychiatric care, based on a Shared-Care Model, to the homeless population of Toronto with mental illness.

Goals/objectives

- To provide continuous medical and psychiatric services to people who are homeless and have a mental illness
- To increase the number of people receiving both mental and physical health care through primary care services
- To work collaboratively with service providers to improve client access to enhanced services, thereby reducing reliance on inappropriate or fragmented services
- To promote personal safety
- To reduce hospitalization but, when necessary, to provide access to beds
- To optimize people's potential for independent community living

Description

The Shared-Care Clinical Outreach Service provides medical and mental health care for homeless men and women visiting shelters and drop-in centres in the downtown Toronto area in a comprehensive, accessible and respectful manner. Services are provided in partnership with emergency hostels and shelter programs, community agencies and neighbouring hospitals. There are currently five Shared-Care Teams based at nine different sites/locations.

As a teaching hospital, student placements are actively supported within the shared-care teams. Operating on a primary care support model, shared-care teams work collaboratively with clients and staff at each site, addressing clients' mental health, physical health and psycho-social needs. The service is free, and lack of identification (i.e., health card) is not a barrier to treatment.

As an on-site service, a nurse and an outreach worker have an office located within a hostel or drop-in centre. In preparation for visits from a general practitioner, they engage with and assess clients who may need health-care services, and begin treatment. Each team's predictable hours of operation, visible location and familiar faces strengthen communication among clients and service providers. Duplication of services is minimized, while continuity and consistency of care are ensured. A general practitioner makes routine visits to the site each week. Because the physician is on salary, lack of identification is not a barrier to treatment. The physician may also spend as much time as required providing care to a client. A salaried psychiatrist makes regular visits as a staff consultant. The psychiatrist predominantly works indirectly with clients through consultation, education, case conferences and program development.

The shared-care office is often the initial point of contact for clients and other agency staff. Clients see the shared-care team for treatment of acute physical health problems, as well as diagnosis and treatment of serious mental health problems. On average, shared care provides active treatment to 2,200 individuals per year, who are homeless and experience serious and persistent mental health problems.

On-site care in a familiar environment helps clients avoid the stigma of entering a psychiatric treatment facility, allows them to be seen on a regular basis, and builds a basis of trust that facilitates treatment and enhances clients' quality of life.

Unique characteristic(s) to local community

- The number of homeless individuals with a mental illness who are untreated in Toronto was a unique characteristic of the service

Barriers

- None

Strategies

- None

Funding

- Centre for Addiction and Mental Health (CAMH)
- City of Toronto
- Ontario Ministry of Health and Long-Term Care

Sponsoring organization(s)

- CAMH, Schizophrenia Division
- University Health Network, St. Michael's Hospital

Other participant(s) or organization(s)

- Same as location/setting

Contact(s)

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**Shared-Care Treatment for Adolescent Girls with Depression:
Evaluation of a Cognitive Behavioural Therapy (CBT) Training
Program for Family Physicians**

Start Date

January 2004

End Date

December 2005

Special Populations

Children and youth
Other

Human Resources

Family physician
Psychiatrist
Psychologist
Researcher

Location(s)/Setting(s)

Hospital clinic

Evaluation

Yes, ongoing.

Initiative Short Title

SC for Girls with Depression

Purpose

Females are particularly at risk for developing depression, with mood disorders being five times more prevalent among adolescent girls than boys (Nolen-Hoeksema and Girgus, 1994). With regard to treating adolescents with depression, a shared-care model of Cognitive Behavioural Therapy (CBT) represents an important and viable strategy for improving access to effective treatment, as well as the quality of life for individual sufferers. The purpose of the current project is to increase access and dissemination of CBT to adolescent girls with depression through a shared-care training program.

Goals/objectives

- To increase access and dissemination of CBT to adolescent girls with depression
- To implement a shared-care treatment program for teaching family physicians to provide CBT to adolescent girls with depression
- To evaluate the efficacy of this pilot shared-care intervention, including physicians' satisfaction with training, knowledge and skill level in CBT, use of CBT post-training and patient treatment outcomes

Description

Treatment is jointly delivered by a psychologist and a family physician in a hospital clinic. Physicians are recruited from the community by mailing out information letters about the project that includes a contact person. CBT training involves a three-hour commitment per week by physicians (for a total of ten to 12 weeks), in which they complete psycho-educational readings on depression and CBT, engage in co-therapy sessions with an adolescent with depression, and receive supervision from a psychologist.

Pre- and post-therapy consultation occurs between the psychologist and physician to set the agenda for each treatment session and to assign responsibilities. Patient participants are recruited from a prevention study entitled the "Resourceful Adolescent Program," in which adolescent girls (grades 9 to 11) are screened for depression at their high schools. Consent for treatment is obtained from both the patients (adolescent girls) and their parents; the psychologist assumes legal liability for patients. To date, seven patients have received treatment through the program, and it is anticipated that a total of 12 will take part.

Participating physicians receive monetary compensation for their training time, consistent with the Ontario Health Insurance Plan (OHIP) rates. To date, three physicians have participated in the program and it is expected that a total of six will complete the training. Survey methodology is used to assess physician satisfaction with training; preliminary results indicate both high levels of satisfaction and increased knowledge of CBT through the program.

Unique characteristic(s) to local community

- Members of the project experienced positive working relationships with community physicians; these physicians demonstrated interest in providing treatment to adolescent girls with depression

Barriers

- The time commitment required from participating physicians (they have difficulty arranging this time because of their practice demands)
- Scheduling: therapy sessions must be coordinated with the psychologist, the physician and the adolescent patient

Strategies

- To date, participating physicians have had some flexibility in their practice (i.e., employed part-time); scheduling efforts begin at the initial recruitment point, identifying a regular appointment time and day of the week

Funding

- Ontario Ministry of Health and Long-Term Care, 2002–2006
- The London Health Sciences Centre regulates funds through the institution; the funding was provided as an ad hoc to a prevention initiative for women's mental health

Sponsoring organization(s)

- London Health Sciences Centre

Other participant(s) or organization(s)

- Family physicians

Contact(s)

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Shared Care in a University's Student Health Service

Start Date

April 2004

Special Populations

None

Human Resources

Counsellor
Family physician
Psychiatrist

Location(s)/Setting(s)

Student health centre

Evaluation

Yes, ongoing.

Initiative Short Title

SC in a Student Health Service

Purpose

Many students experience difficulties with mental health problems. However, despite the presence of counselling services on most university campuses, there is often a lengthy wait for referrals to see a psychiatrist. For a student struggling with depression, for example, a six-to-eight-week wait for a referral can mean the loss of an academic semester, and possibly a year.

In an attempt to improve this situation, McMaster University Student Health Services and the Hamilton Health Service Organization (HSO) Mental Health and Nutrition Program have established a shared-care model with psychiatrists consulting to family physicians who are working in a university health services and also to the student services counselling team.

Goals/objectives

- To improve access to psychiatric consultation for students with mental health problems
- To be available to discuss mental health problems and issues with staff of student health and counselling services
- To provide other support to staff of student health and counselling services

Description

A psychiatrist visits student health services every two weeks for half a day. In that time, the psychiatrist will see any case referred by occupational health services or by student council services, with access being coordinated through student health services. The psychiatrist will also be available to discuss cases with counsellors or family physicians working with either of those two services. On average, two to three new cases are seen every half-day. The psychiatrist will also meet periodically with the student health physicians as a group, to discuss issues of general interest or concern and to provide brief, focused educational presentations.

Unique characteristic(s) to local community

- None

Barriers

- None

Strategies

- None

Funding

- McMaster University Student Health Services

Sponsoring organization(s)

- McMaster University Student Health Services

Other participant(s) or organization(s)

- Hamilton Health Service Organization (HSO) Mental Health and Nutrition Program

Contact(s)

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Seniors' Mental Health Program, Community Service

Start Date

1993

Special Populations

Seniors/geriatrics

Human Resources

Director
 Family physician
 Geriatric psychiatrist
 Mental health-care worker
 Nurse clinician
 Outreach manager
 Regional outreach nurse
 Secretary
 Social worker
 Statistics clerk

Location(s)/Setting(s)

Hospitals
 Long-term care facilities
 Private homes

Evaluation

No.

Initiative Short Title

Seniors' MH Program

Purpose

None.

Goals/objectives

- To provide mental health assessment, diagnosis, treatment recommendations, limited follow-up and/or referral, on an outreach basis, for people with age-related mental health problems
- To collaborate with health-care agencies and caregivers (formal or informal) to ensure that the mental health needs of the elderly are met
- To provide consultation and education to community agencies, as well as to other health professionals concerned with geriatric psychiatry issues
- To provide advocacy for clients and their families in their relationship with the community
- To prevent hospitalization when possible (and when necessary), to reduce the trauma and enhance the effectiveness of the overall treatment program by preparing the client and his or her family
- To facilitate rehabilitation and reintegration of hospitalized clients into the community

Description

The team functions as an interdisciplinary team, using a shared-care model, when possible. This reflects the large catchment area served: it is not possible to deliver primary psychiatric care throughout such a region, especially in the absence of well-developed tele-medicine resources. For outreach areas which do not have access to a visiting psychiatrist, the use of video consultation via NORTH Network has been requested.

Clients referred by their family physicians are visited by the team in private homes, long-term care facilities and sometimes, general hospitals. The team endeavours to provide peer education, with nurses acting as teaching resources to the nursing staff of long-term care facilities, using both didactic and informal teaching methods. To varying degrees, the physicians try to collaboratively support family physicians in their care of the elderly, with regard to mental health needs, through didactic lectures, informal discussion and primarily, teaching consultations; these are consult reports that outline how a given diagnosis was determined and the reasoning

behind interventions and medications recommended, as well as detailed information on how to use and monitor them. The approach varies with the consultant (individual preference), as well as the family physician who is consulting, as not all are equally enthusiastic about a shared care/teaching model.

The program serves a vast area of northeastern Ontario. Referrals within the Nipissing District are assigned weekly by a rotating intake clinician to team members. The referrals are seen, in turn, except when a more urgent assessment is clinically indicated (though the program does not offer itself as an emergency service). Based on the initial assessment, the clinician determines the need to involve other disciplines (family physician or a psychiatrist) to assist. At this time, clients are not seen in family physicians' offices, although this was considered when the program still had more psychiatry resources.

Unique characteristic(s) to local community

- None

Barriers

- The possibility of seeing clients in family physicians' offices has been broached a couple of times, but the main concern of these physicians has been the loss of time and financial reimbursement in their fee-for-service practices
- Limited psychiatry resources and the large geographic area limit on-site psychiatric consultations

Strategies

- Creative funding sources must be developed for family physicians not funded by capitation; perhaps the move toward Family Health Networks in the province will help to address such issues as these
- Video-conferencing technology is currently under-utilized and may help to overcome some of the barriers

Funding

- Ontario Ministry of Health and Long-Term Care

Sponsoring organization(s)

- North Bay Psychiatric Hospital
- Ontario Ministry of Health and Long-Term Care

Other participant(s) or organization(s)

- None

Contact(s)

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“SHARE”: Shared Mental Health Accessibility Research and Evaluation

Start Date

April 2004

End Date

March 2006

Special Populations

Serious mental illness
Other

Human Resources

Advance practice psychiatric nurse
Family medicine resident
Family physician
Psychiatrist
Psychology
Social worker

Location(s)/Setting(s)

Family practice clinics

Evaluation

Yes, ongoing.

Initiative Short Title

SHARE

Purpose

The Shared Mental Health Accessibility Research and Evaluation program is evaluating whether a multidisciplinary mental health team results in improved access to and better quality psychiatric and physical care for patients with mental health problems, who are seen first within either the primary care system or the mental health system. The program links a psychiatric emergency service and mental health urgent consultation clinics with two comprehensive family medicine practices.

Goals/objectives

- To pilot a shared mental health care approach to family medicine in Ottawa and to determine whether this makes a difference, from the patients’ and family practitioners’ perspectives, with respect to access to and satisfaction with mental health services
- To determine the educational needs of family physicians and meet these needs through a format that is useful to them

Description

This program provides mental health services to two family practice clinics involving 19 family physicians and 24 residents. Currently, the clinic receives referrals from both sites, and they are reviewed and triaged through the Shared Mental Health Accessibility Research and Evaluation (SHARE) office. Clinical support is provided to the family physicians and residents through a shared mental health team consisting of social workers, psychology staff, psychiatrists and advanced practice psychiatric nurses. Each professional is available for at least one half-day per site each week for clinical services, plus an additional half-day per week for chart review, education, evaluation activities and indirect patient care. Members of the program see all referred patients on site in the family physician’s office and document observations directly on their patients’ charts.

Education strategies to enhance resident training are being developed with the University of Ottawa’s Department of Family Medicine. The program staff is accessible to the physicians in their practices through e-mail, face-to-face meetings or brief, unplanned discussions when we are on site. Where appropriate, the clinical team may link patients to community services. The family physician and family medicine resident assume primary responsibility for care and follow-up. This program receives five to ten referrals per week, and we book approximately 20 visits per week.

This program also aims to demonstrate how patients using the hospital's mental health system who do not have a family physician, are more easily referred to family practices in the presence of a shared mental health team.

A program logic model and an evaluation strategy to assess the functions of the program have been developed. For example, how the model is organized and operates as a whole, patient outcomes, patient satisfaction and quality of life, the links established between various components of the shared-care model, and changes in service user health status are being tracked. Measurement of access to mental health and primary care services will be one of the main outcome measures, with an attempt made to find natural comparison groups of patients with a serious mental illness who do not have access to a shared-care program.

Unique characteristic(s) to local community

- There are long waiting lists for community psychiatrists and limited access to acute mental health care for patients treated by family physicians

Barriers

- Sustaining the program will be difficult without additional funding, once the demonstration project ends
- Patients who use the mental health system and do not have family physicians experience difficulty in accessing the primary health care system

Strategies

- Incorporation of mental health care into primary care reform models, which the Ontario Government is currently implementing
- Applications have been made to the Ontario Ministry of Health and Long-Term Care to establish two family health teams that incorporate a shared mental health care team, based on the SHARE demonstration project

Funding

- Ontario Ministry of Health and Long-Term Care, Primary Transition Funding
- Funds are regulated by the principal investigator; funding is transferred to the Ottawa Health Research Institute

Sponsoring organization(s)

- Central Ottawa Family Medicine Associates
- Ottawa Hospital and the University of Ottawa Family Medicine Centre

Other participant(s) or organization(s)

- Ottawa Health Research Institute

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Sharbot Lake Medical Centre Shared Care Initiative

Start Date

October 2001

Special Populations

Rural
Urban

Human Resources

Addictions worker
Child and family worker
Community mental health worker
Developmental disability counsellor
Family medicine resident
Family physician
Geriatric case manager
Mobile community mental health worker
Nurse practitioner
Psychiatrist
Social worker
Women’s counsellor

Location(s)/ Setting(s)

Sharbot Lake Medical Centre

Evaluation

Yes, completed and ongoing.

Initiative Short Title

Sharbot Lake Medical Centre

Purpose

This initiative offers accessible mental health care to this rostered rural family health team.

Goals/objectives

- To improve access to psychiatric care to generic mental health care services in the region
- To improve communication between family physicians and other health care workers and psychiatrists
- To improve case detection and knowledge about mental illness in the family practice
- To offer case by case mental health education to family physicians and their patients
- To improve mental health outcomes for the practice’s patients

Description

Sharbot Lake Medical Centre is a rural family practice with two family physicians and a nurse practitioner. There is a family medicine resident from the Department of Family medicine at Queen’s University. The practice services 2,700 rostered patients as well as many other patients who are not rostered.

On a weekly basis, the practice is visited for a half-day session by a general psychiatrist, two mobile community mental health workers from different local mental health agencies, and a geriatric case manager. New referrals and ongoing care are discussed at a team meeting. The meeting offers the primary care staff the opportunity to ask for help with cases not seen by the mental health workers and for learning about mental illness and care in their patients. It also offers the mental health care staff the opportunity to learn about their patients and their co-morbid medical illnesses.

Patients are seen on site by the psychiatrist and other mental health care workers. Often, the mental health care worker will sit in on the psychiatric consultations. The clinic is well connected to a multi-service community agency and these workers (social workers, child and family workers, developmental disability counsellors, women’s counsellors, addictions workers) often attend meetings and consultations with their patients. A monthly multi-agency meeting is held at the medical centre with all of these agencies, the clinic staff and the mental health team staff. There is also a monthly multidisciplinary mental health education meeting for case-based learning about mental illness and community mental health.

Unique characteristic(s) to local community

- This is a very well-functioning community and the medical centre has been an important force in the community development and interdisciplinary activities
- Sharbot Lake Medical Centre has been approved for family health team status and is applying for funding to enlarge and consolidate the mental health team

Barriers

- An alternate payment scheme would be preferable for the psychiatrist
- There are no resources for a formal evaluation
- There is limited administrative support for the psychiatrist

Strategies

- Providence Continuing Care Centre has offered limited funding and travel support for the psychiatrist
- The family health team is applying for funding for a formal evaluation of the mental health service as well as for program development

Funding

- None

Sponsoring organization(s)

- The psychiatrist is paid fee-for-service by the Ontario Ministry of Health and Long-Term Care

Other participant(s) or organization(s)

- Providence Continuing Mental Health Care
- Frontenac Community Mental Health Association

Contact(s)

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Integrating Shared Mental Health Care in Primary Health-Care Practice

Start Date

March 2004

End Date

March 2006

Special Populations

Aboriginal
 Children and youth
 Disorder-specific
 Homeless/transient
 Seniors/geriatrics
 Urban

Human Resources

Administrative Assistant
 Nurse
 Project coordinator
 Project evaluator
 Physician
 Social worker

Location(s)/Setting(s)

Community health centre

Evaluation

Yes, ongoing.

Initiative Short Title

SMHC in Primary Health Care

Purpose

This demonstration project grew out of the need for health professionals and clients to have greater access to mental health professionals; this was identified as a critical area for the Hamilton Urban Core Community Health Centre. This project is intended to facilitate the integration of mental health services with our primary health-care practice, as part of a comprehensive approach to overall health and well-being, particularly for people who belong to homeless, refugee, immigrant and isolated populations. This will be accomplished through an expanded multidisciplinary team, using a holistic and integrated approach to mental health and primary health care. This project improves access to primary care for clients, which will result in a reduction in inappropriate hospital visits and will streamline referrals to external experts.

Goals/objectives

- To increase mental health-care services at the primary care level at Hamilton Urban Core Community Health Centre
- To increase access to primary health care through the integration of primary mental health services and primary health care
- To increase health providers' access to mental health professionals at Hamilton Urban Core Community Health Centre
- To decrease reliance on hospital-based mental health services
- To increase knowledge among health providers

Description

Hamilton Urban Core Community Health Centre is a community-based agency, serving individuals from marginalized groups, whose likelihood of experiencing mental health issues is even greater than that of the general population. Clients who present at the centre go through an intake process and see the community health or outreach worker, who then decides which of the other interdisciplinary team members the client should see next. Since staff is co-located, communication regarding client care occurs frequently via case conference meetings, a paging system, phone, e-mail, an internal referral form or through hallway conversations. Enhancing the capacity of the primary health-care staff to manage clients with mental illness is also accomplished through in-services. Currently, the family physicians on staff are managing clients with mental illness through the ongoing support of staff mental health professionals.

The centre also provides case management for its clients, linking them to other community agencies and services, when required. If necessary, attempts are also made to link individuals to available family physicians in the community.

The centre has legal liability for its clients. The numbers of case files is growing rapidly. Project staff has shared access to computers, and e-mail use is limited. Excel and Access are used for database for evaluation. Electronic data capture the system for scheduling and “encountering” client information.

Unique characteristic(s) to local community

- The uniqueness of the local setting is connected mainly to the population served by the centre (i.e., inner city, marginalized groups)

Barriers

- There is a limited number of mental health professionals and there has been a lack of response to postings for nurse-practitioner and psychiatrist positions; contract and part-time positions make it difficult to attract and retain staff
- Limited funds are available for the capital needs of the project (i.e., office space, clinic space, consult space, computers)
- Educating other health-care providers that this project is not intended to be set up as an additional or parallel service, but rather is about integrating services provided to existing clients of the community health clinic—the challenge is to deal with external referrals appropriately

Strategies

- Advocate for additional funding for capital costs such as computers, as well as for staffing, psychiatric consultations, and research; desirable future developments include an extension of funding beyond March 2006

Funding

- Agreement with the Ontario Ministry of Health and Long-Term Care, with funding from the Primary Health Care Transition Fund

Sponsoring organization(s)

- Hamilton Urban Core Community Health Centre

Other participant(s) or organization(s)

- None

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Shared Mental Health-Care Program, College of Family Physicians of Canada, Ontario Chapter

Start Date

June 2004

Special Populations

Children and youth
 Concurrent disorders
 Disorder-specific
 Ethno-cultural
 Seniors/geriatrics
 Urban

Human Resources

Administrative support
 Family physician
 Primary care manager
 Psychiatrist
 Psychologist
 Social worker

Location(s)/Setting(s)

Family practice offices
 Health centre
 Hospital

Evaluation

Yes, completed and ongoing.

Initiative Short Title

SMHC Program

Purpose

There is evidence to support the idea that shared-care models can provide patients with better access to appropriate mental health services, including increased referrals, reduced waiting times for treatment and care within their own communities. Patients and providers have indicated satisfaction with shared-care models.

Goals/objectives

- To increase accessibility to mental health assessment and treatment for primary care patients
- To enhance the role of the family physician as a provider of mental health care
- To increase knowledge and comfort of the family physician in handling mental health problems
- To strengthen links between mental health and primary care services
- To provide mental health consultation services to community health centre staff

Description

This program includes several family physicians and a clinical team; it is supported by Trillium's Mental Health System and the Primary Care and Community Health Initiative. Family physicians are able to refer patients to a team consisting of a psychiatrist, social worker and a psychologist for rapid consultation. Recommendations made by the team are provided to the family physician. The mental health team and the physician work together to link patients to appropriate treatment. While patients remain in the care of their family physicians, the mental health team is available to advise and assist with implementation of the recommendations. Family physicians assume liability for their work and decisions, and psychiatrists for their consultation and recommendations. Physicians meet once a month with the mental health team to discuss cases and learn about advances in mental health, such as new medications.

Project components include: rapid consultation service in a psychiatrist's office in hospital (for patients referred by family physicians); telephone advice provided to family physicians (for non-referred cases) and/or follow-up support for family physicians implementing recommendations; in-hospital meetings for one hour per month; and consultation to patients and staff at the community health centre. Some patients are also referred to local supportive programs such as a Community Mental Health Clinic. In some cases, the service uses a Meditech/MOX system to communicate questions and answers between the psychiatrist and the family physicians.

Another aspect of the program includes an annual weekend conference (Friday to Sunday) sponsored by The College of Family Physicians of Canada (Ontario chapter). It brings together the participants from across Ontario for education sessions. Planned future developments include expansion to shared care with child and adolescent psychiatrists. Desirable future developments include successfully covering the costs of family physicians' time and offering morning meetings.

Unique characteristic(s) to local community

- Having a primary care manager to facilitate the program and initiate the process was instrumental in the start-up phase and for ongoing support
- The College of Family Physicians (Ontario chapter) has played a role in maintaining the pilot project

Barriers

- Difficulties include the family physicians' unremunerated time spent traveling to meetings at the hospital, and discussing problems and strategies to improve individuals' patient care
- The timing of the meetings is mid-day (12 a.m.–1 p.m.), meaning that the period between 11:30 a.m. and 1:30 p.m. is lost to office work for family physicians

Strategies

- Ensure that the needs of all participants are met
- Ensure that sessions are seen as valuable and contribute positively to the care of patients

Funding

- Costs for staff are provided from within the organization's operating budgets
- Space is provided in-kind
- Psychiatrists are given a stipend through the College of Physicians and Surgeons, for meetings and phone calls with family physicians
- Family physicians bill OHIP (Ontario Health Insurance Plan) for patients seen—no further payment is made to general practitioners for their participation

Sponsoring organization(s)

- Lakeshore Area Multiservice Project (LAMP) Community Health Centre
- Trillium Health Centre

Other participant(s) or organization(s)

- None

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Introduction of Shared Mental Health Care Services to Family Medicine

Start Date

June 2004

Special Populations

Concurrent disorders
Seniors/geriatrics
Urban

Human Resources

Psychiatrist
Family physician
Family medicine resident

Location(s)/Setting(s)

University teaching hospital

Evaluation

Yes, ongoing.

Initiative Short Title

SMHC Services

Purpose

The purpose of the program is to introduce Shared Mental Health Care Services to Family Medicine.

Goals/objectives

- To enhance patient care
- To enhance education for professional staff

Description

This program follows a shared mental health care model, with a designated psychiatrist to provide a variety of clinical and educational services in two university-affiliated family practice units: Sunnybrook and Women’s College. A consulting psychiatrist provides services for half a day per week to physicians and family medicine residents. Acting as a resource, the psychiatrist also provides educational services about community resources. Patient information is recorded on a chart that is shared between the psychiatrist and the family physician; they also share liability for patient care. Approximately ten patients are seen per month.

Unique characteristic(s) to local community

- A need for services was identified

Barriers

- Lack of funding (sessional fee is limited)
- Promotion of shared care is time-consuming
- Resistance to change from physicians
- Patients want ongoing service
- Family medicine residents struggle because they see challenges to shared care, and lack direction

Strategies

- Lobbying (maintaining visibility within the primary care setting)
- Developing formal communication strategies (e.g., attending key administrative meetings)
- Creating a buy-in by physicians

Funding

- Funding is internal and is regulated by the department of psychiatry, Sunnybrook and Women's College Health Sciences Centre

Sponsoring organization(s)

- Sunnybrook and Women's College Health Sciences Centre

Other participant(s) or organization(s)

- None

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Shared Mental Health Care in the Workplace: The Dofasco Project

Start Date

March 2004

Special Populations

Concurrent disorders

Human Resources

Family physician
Occupational health physician
Psychiatrist
Social worker

Location(s)/Setting(s)

Occupational health clinic in the workplace

Evaluation

Yes, ongoing.

Initiative Short Title

The Dofasco Project

Purpose

Many individuals with mental health problems are treated through their workplace, either through an employee assistance program or occupational health services. These services often experience problems (and frustration) in trying to link mental health services, especially psychiatric consultation, with workers. Often, care delivered in the workplace may be poorly coordinated with the care delivered by the workers' family physicians.

To address workplace-related health problems effectively, the clinician requires an understanding of the workplace and its demands. This can lead to the development of programs that can prevent or mitigate the impact of workplace stress, and facilitate an employee's rapid return to work.

To address these issues, the Hamilton Health Service Organization (HSO) Mental Health and Nutrition Program and Dofasco Inc., one of Hamilton's largest employers, have developed a project based on a shared-care model, whereby psychiatric consultation to occupational health physicians is provided within the workplace.

Goals/objectives

- To improve access to mental health services for Dofasco Inc. workers being seen by occupational mental health services
- In conjunction with occupational health services and other workplace resources, to address issues that may be contributing to mental health problems in the workplace
- To look at the adaptability of this project to other work settings

Description

A psychiatrist visits Dofasco for half a day every two weeks. The psychiatrist works closely with occupational health services and consults to the family physicians working in the program. Individuals are seen predominately in consultation, although some follow-up can be provided and they can be referred on to the social worker in occupational health services for ongoing counselling, if required. The psychiatrist is also able to review cases with occupational health staff, to determine those that may not need to be seen or who have been seen on a previous visit.

The psychiatrist also makes every effort to work closely with the individual's family physician to ensure that care is coordinated. As the relationship proceeds, it is envisaged that there will be opportunities to address broader issues related to the workplace, in addition to treating the problems of individual workers.

It is anticipated that the evaluation of this model will also include a cost-benefit analysis, looking at reduction in workdays lost, if effective treatment can be initiated at an earlier stage of an episode.

Unique characteristic(s) to local community

- This project is seen as an extension of the Hamilton HSO Mental Health and Nutrition Program, but the key factor in its establishment has been the interest of Dofasco in improving the mental health care available to its employees, and the company's willingness to invest in this project

Barriers

- None

Strategies

- None

Funding

- Dofasco Occupational Health Services

Sponsoring organization(s)

- Hamilton Health Service Organization (HSO) Mental Health and Nutrition Program

Other participant(s) or organization(s)

- Dofasco Inc.

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The SEED Project (Support and Education for Primary Care Focusing on the Elderly with Disorders in Mental Health)

Start Date

November 2002

End Date

March 2006

Special Populations

Rural
Seniors/geriatrics
Urban

Human Resources

Coordinator
Family physician
Health service researcher
Psychiatrist
Secretarial support

Location(s)/Setting(s)

Family practice offices

Evaluation

Yes, completed and ongoing.

Initiative Short Title

The SEED Project

Purpose

Innovative models of shared mental health care can facilitate the exchange of knowledge between primary care and geriatric mental health networks. This is required to ensure the meaningful application of best practices and knowledge in geriatric mental health to a growing number of older adults and their caregivers in the community.

Goals/objectives

- To enhance the knowledge and skills in geriatric mental health of family physicians
- To provide accessible and useful support to primary practitioners from Specialty Geriatric Psychiatry Services
- To improve access, knowledge and skills of specialty services and specialists so that they may better support family doctors (e.g., action-based needs analysis and skill development of specialists)
- To develop an ongoing shared-care primary care network

Description

The SEED project (Support and Education for Primary Care Focusing on the Elderly with Disorders in Mental Health) includes two components: SEED I and SEED II. In SEED I (2002–03), we identified which family doctors were opinion leaders in the field of geriatric mental health in southeastern Ontario. We held a large group session for family physicians to promote their understanding of the project and to identify the priority needs of family physicians. SEED I had three components: mentorship; TIPS (Timely Information Physician Service); and educational sessions.

The mentorship program involved linking primary care clinicians to expert mentors in geriatric mental health, providing indirect advice, and identifying resources to assist the family doctors in their practices. The mentors were gero-psychiatrists who already provided clinical consultation in the area; therefore, there was familiarity and the match between mentors and physicians was aligned with more traditional clinical links to outreach services.

In TIPS, family doctors were able to fax or e-mail relevant clinical and educational questions from the field, using a web-based support service. An expert advisor provided advice and information (via fax or e-mail), and responses were shared with other members of the family physician network.

Specific educational, interactive, case-based or topic-specific sessions relevant to practice were provided. The first educational session focused on needs assessment. A follow-up session was offered at the conclusion of the project, which allowed focus-group evaluation to be completed.

The SEED II project has now been launched through similar partnerships, integrating these activities with the service and development initiatives of the Providence Continuing Care Centre's Mental Health Services. The lessons learned from the first project have been incorporated into this follow-up development.

Unique characteristic(s) to local community

- This knowledge transfer and exchange initiative was complementary to the traditional learning already occurring through existing outreach services to these areas

Barriers

- Physicians in individual practices (versus those in group practices) identified the need for interactive exchange with other family physicians to take the core content knowledge and look at ways of translating the information into changes in their practices
- Participants found the TIPS strategy to be the least helpful
- Physicians preferred an approach using mentorship or colleague-to-colleague connection, either through the mentorship program or through other colleagues in the office
- Some participants had limited access to a computer; therefore, filling out the TIPS form was seen as time-consuming

Strategies

- Increased structure and active mentorship was identified as critical for continued and effective use of the mentorship program
- Some participants said that integrating opportunities for dialogue among family physicians (e.g., face-to-face lounge sessions) and between family physicians and psychiatrists were critical; complex questions often required discussion, before specific patient issues could be identified by the family physicians

Funding

- Ontario Ministry of Health and Long-Term Care

Sponsoring organization(s)

- Division of Geriatric Psychiatry and Specialty Geriatric Psychiatry Services, Providence Continuing Care Centre, Mental Health Services, Kingston, Ontario

Other participant(s) or organization(s)

- None

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Transition Into Primary Care Psychiatry (TIPP)

Start Date

July 2004

Special Populations

Northern/isolated
Serious mental illness
Other

Human Resources

Administrative
Family physician
Medical director
Psychiatric nurse
Psychiatrist
Registered nurse

Location(s)/Setting(s)

Family Health Network of seven to ten family physicians

Evaluation

Yes, ongoing.

Initiative Short Title

TIPP

Purpose

Mental health-care reform directives throughout Canada have led to clients' care being transferred from relatively intensive mental health services to their family physicians. However, published descriptions of these services lack an adequate evaluative component. The Transition into Primary Care Psychiatry (TIPP) project uses an evaluation framework and outcome measures of importance to patients, their careers and the health care system, as well as rigorous evaluation methodology. If successful, this feasibility project will provide the basis for a large-scale trial with the potential to guide future shared-care services.

Goals/objectives

- To determine if clients transferred from an outpatient mental health service to their family physician through the TIPP intervention (compared to clients in the group receiving the usual care from their family physicians) experience less change or significant improvement in health-related quality of life, symptomatology, client-perceived need for care and service satisfaction
- To determine if TIPP is more cost-effective with respect to the above outcomes

Description

TIPP is an intervention that facilitates the transfer of patients from an outpatient mental health service to their family physicians. Mental health services staff include a psychiatric nurse and a psychiatrist, who visit the family physician's office at one and three-month intervals, respectively. During these visits they review and document the client's progress, which empowers the family physician as a clinical manager. At times of greater need and/or impending crisis, contact between team members may increase to every 14 days, with weekly or more frequent calls from the family physician. Contact with all providers is adjusted to accommodate client needs. Through links with area mental health services, the psychiatric nurse assists the family physician to coordinate access.

The TIPP nurse selects, prepares and facilitates transfers for appropriate clients from the outpatient department to family physicians. The initial transfer process includes a face-to-face meeting with the client, TIPP nurse and family physician in the family physician's office. A project psychiatrist and/or psychiatric nurse provide telephone back-up for the family physicians whose

clients are involved in the project. Client monitoring is maintained through administrative staff support procedures targeted at ensuring a high level of retention and effective client follow-up. Standardized CLIPP (Consultation and Liaison in Primary Care Psychiatry)-based contact and data sheets promote efficient and effective communication between clinical care providers. The primary care provider assumes liability for patient care. Currently, there are 32 clients in the program and approximately ten clients are seen per month.

This project has been funded in conjunction with the TIPP site in Regional Mental Health Care in London, Ontario. In addition, this program is integrated with the Lakehead Shared-Care Mental Health Program, which is already in place to provide counselling. The Shared-Care Mental Health Program sees approximately ten to 20 clients per month, and two to eight patients per month. The family physician is most responsible for the care of patients. An electronic health record facilitates the collection of evaluation data.

Unique characteristic(s) to local community

- The project is the first of its kind in the region
- The project provides detailed intake and post-treatment data on patient status regarding symptoms and function, and patient satisfaction
- Ongoing evaluation helps to maintain effectiveness

Barriers

- Early in start-up phase
- Patient reluctance to move to the sole care of the primary care physician
- Some reluctance on the part of the mental health program to engage
- Fear of job loss or shifting services to the community
- Initially, funding for office space

Strategies

- Frequent and clear communication of expectations
- Clarifying roles and responsibilities
- Ensuring funding for space in private offices from mental health providers was important early in the dialogue process

Funding

- Ontario Ministry of Health and Long-Term Care

Sponsoring organization(s)

- Lakehead Psychiatric Hospital, St. Joseph's Care Group

Other participant(s) or organization(s)

- Thunder Bay Regional Health Science Centre

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Transition into Primary Care Psychiatry (TIPP) Clinical

Start Date

July 2004

Special Populations

Aboriginal
Children and youth
Concurrent disorders
Ethno-cultural
Seniors/geriatrics
Serious mental illness
Urban

Human Resources

Administrator
Director
Family physician
Nurse
Psychiatrist

Location(s)/Setting(s)

Private practice

Evaluation

Yes, ongoing.

Initiative Short Title

TIPP Clinical

Purpose

Mental health care reform directives in Ontario call for more efficient use of resources as well as better co-ordination of resources. They stipulate that care for those with mental illness should be provided in the least intensive setting that is also the most appropriate one for the client. To respond to these demands, it has become imperative to respond to the need for an effective and efficient shared mental health care model that addresses collaboration and demonstrates coordinated provision of care for the serious mentally ill. The Transition into Primary Care Psychiatry (TIPP) program will systematically include use and outcome indicators consistent with the Canadian Institute for Health Information and the Advisory Network on Mental Health framework, as part of ongoing program evaluation. The TIPP project will use a modification of Consultation Liaison in Primary Care Psychiatry (CLIPP), an internationally recognized shared mental health care model that has been successfully implemented in Australia. See: <<http://www.health.vic.gov.au/mentalhealth/publications/clipp/>>.

Goals/objectives

- To implement and evaluate (on an ongoing basis) a new primary-care focused program of mental health care delivery for people with chronic mental illness
- To evaluate the measures of change in health-related quality of life; symptomatology; functional status; severity of illness and perceived need for care in TIPP clients; and, satisfaction with the service by clients, family physicians and staff

Description

TIPP is an intervention that facilitates the transfer of the client from an outpatient mental health service to the care of his or her family physician. Co-location of mental health services staff include a psychiatric nurse and a psychiatrist, who visit the family physician's office at one- and three-month intervals, respectively. During these visits, they review and document the client's progress, which empowers the family physician as a clinical manager. At times of greater need and/or impending crisis, contact between team members may increase to every 14 days (with weekly or more frequent calls from the family physician), and contacts with all providers adjusted to accommodate client needs. Through links with area mental health services, the psychiatric nurse assists the family physician to coordinate access.

The TIPP nurse selects, prepares and facilitates appropriate clients from the outpatient department for transfer to family physicians. The initial transfer process includes a face-to-face meeting with the client, TIPP nurse and family physician in the family physician's office. A project psychiatrist and/or psychiatric nurse provide telephone back-up for the family physician whose clients are involved in the project. Client monitoring is maintained through administrative staff support procedures targeted at ensuring a high level of retention and effective client follow-up. Standardized CLIPP-based contact and data sheets promote efficient and effective communication among clinical care providers. The primary-care provider assumes liability for patient care. Currently, there are 32 clients in the program and approximately ten clients are seen per month.

Unique characteristic(s) to local community

- The Mental Health Consultation and Evaluation in Primary Care program (MHCEP) was already in place at the time the initiative was implemented
- Through the course of the initiative's implementation, local area mental health services (Regional Mental Health Care, London and London Health Sciences Centre) have been seeking to help appropriate clients make the transition from their programs to non-institutional, community-based mental health care

Barriers

- The biggest has been accessing family doctors; although they have not necessarily refused clients, a number of family doctors working on the project have either taken retirement, closed their practices because they were relocating, or discharged clients from care because they had not seen their family doctor for several years

Strategies

- None

Funding

- St. Joseph's Health Care, London
- Funds are regulated by the Specialized Adult Services of the Regional Mental Health Care in London

Sponsoring organization(s)

- Mental Health Consultation and Evaluation in Primary Care Psychiatry (MHCEP), Specialized Adult Services, London
- St. Joseph's Health Care, London

Other participant(s) or organization(s)

- University of Western Ontario, Department of Psychiatry

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Toronto Urban Health Alliance

Start Date

1994

Special Populations

Aboriginal
 Children and youth
 Concurrent disorders
 Disorder-specific
 Ethno-cultural
 Homeless/transient
 Seniors/geriatrics
 Urban

Human Resources

Clinician
 Coordinator
 Dietitian
 Director of clinical service
 Family physician
 Health promoter
 Nurse-practitioner
 Nurse
 Psychiatrist
 Registered practical nurse
 Secretarial support
 Social worker

Location(s)/Setting(s)

Six community health centres

Evaluation

Yes, ongoing.

Initiative Short Title

Toronto Urban Health Alliance

Purpose

We seek to improve the mental health of clients in community health centres by providing a shared-care model, which enhances communication; builds new linkages between physicians, psychiatrists and psychiatric services; and integrates psychiatrists and psychiatric services, through the provision of direct and indirect care within the community health centre primary care setting.

Goals/objectives

- To improve access to mental health services and strengthen each community health centre's capacity to meet the mental health needs of its clients
- To ensure that clients are comfortable with mental health services provided
- To ensure that clients have improved or have stable levels of general functioning
- To increase the skill and knowledge of community health centre generalists about mental health service delivery, and mental health specialists about clients and community contexts
- To help community health centre providers identify, assess and manage greater numbers of clients with mental health issues

Description

Funding is provided for a psychiatrist and secretarial support for on-site mental health consultation to six community health centres. The University Health Network (UHN) provides mental health clinicians to the community health centres (where resources permit). The mental health clinicians provide short-term treatment for a variety of mental health problems. The mental health specialists are available for telephone support and consultation when they are not on site. All staff members are legally liable for any professional activity provided to the client. The community health centres have multidisciplinary teams of family physicians, nurse-practitioners, social workers, dietitians and health promoters. The mental health resources vary between centres, as well. Four of the community health centres receive services every week and two receive services every other week. The program uses the community health centre database (York Med system) as a data-gathering tool.

Previously, clinicians saw an average of 38 clients per month among all sites, and psychiatrists saw an average of 23 clients per month. Overall, an average of 34 indirect consultations was conducted per month. These statistics from 2003–2004 may not be reflective, due to the SARS (severe acute respiratory syndrome) outbreak and its impact on service delivery in that period. Planned development includes joint educational sessions for all community health care providers. Developments may also include increasing psychiatrist services in each of the centres, especially bringing the two community health centres that receive services bi-weekly to up to weekly frequency.

Unique characteristic(s) to local community

- The initiative takes place in a multicultural community and in a marginalized population with low levels of engagement in formal mental health systems
- It services clients who experience barriers to accessing health care services (e.g., no health coverage, homeless, low levels of trust) and who have developed primary care relationships within the community health centre model, but who are reluctant or unable to access care elsewhere

Barriers

- Interpretation and application of shared-care model of service delivery varied among different centres, as well as within them
- The practice patterns of the psychiatrists have an impact on the quantitative data of each community health centre and comparing data among centres

Strategies

- To address the interpretation/application issues, a manual and orientation to the program was designed and delivered to all centres and mental health specialists; as well, reviewing the partnership agreement and recommitting to the purpose, objectives and service delivery methodologies with all the partners assisted this process
- The ethno-cultural needs of clients have led to recruitment of mental health service providers who possess language skills reflective of the client base
- Coordination of program activities among various centres, which has been facilitated more recently by the hiring of an evaluator with some co-ordination responsibilities

Funding

- Ontario Ministry of Health and Long-Term Care, Community Health Branch

Sponsoring organization(s)

- Six community health centres: Access Alliance (multicultural), Parkdale, Regent Park, South Riverdale, Queen West and Davenport-Perth
- University Health Network (UHN), Toronto Western Division

Other participant(s) or organization(s)

- None

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Urgent Consultation Clinics (UCC)

Start Date

July 2000

End Date

December 2005

Special Populations

Urban
Other

Human Resources

Case manager
Community treatment order coordinator
Director
Occupational therapist
Psychiatric nurse
Psychiatrist
Psychologist
Regional mobile crisis team
Social worker

Location(s)/Setting(s)

Family physicians' group practices
Hospital outpatient mental health clinics

Evaluation

Yes, ongoing.

Initiative Short Title

UCC

Purpose

Patients discharged from the emergency room or discharged from the inpatient psychiatric unit often require outpatient follow-up within a matter of days, to ensure patient safety and continuity of care.

Goals/objectives

- To improve access to urgent psychiatric consultation and short-term follow-up for patients
- To provide an outpatient psychiatric assessment within one week of referral and multi-disciplinary short-term follow-up by a psychiatrist, along with a psychiatric nurse, social worker or psychologist

Description

A close liaison exists between the Urgent Consultation Clinics (UCC) and our acute day hospital programs, which also operate at each campus of The Ottawa Hospital (General and Civic campuses). Patients who are seen and discharged from the psychiatric emergency service and psychiatric inpatient services of the hospital are given priority for follow-up at the clinics. All patients are initially seen by a psychiatric nurse, social worker or psychologist, and then seen by a psychiatrist within two weeks. Individual follow-up (including short-term, cognitive behavioural therapy) is provided by one of these providers for six to eight sessions, usually over four to six weeks.

Patients seen in the UCC may be referred to the acute day hospital after their initial assessment, if intensive daily outpatient follow-up is indicated. During the time the patient is seen at the clinics, contact with the patient's family physician is established and arrangements are made for follow-up. If the patient does not have a family physician, then the referral is made and, if possible, an appointment is secured. Psychiatric backup to the family physician after discharge from the clinic is made on an informal basis with the psychiatrist or psychiatric nurse. We have recently established a liaison with the shared mental health care team, which provides mental health service to two large family practices. We hope this will facilitate access to primary medical care for mental health system outpatients who lack family physicians.

Regarding patient care, psychiatrists are covered through their own liability coverage; social workers, nurses and psychologists are covered by the hospital. Hospital staff members are given specific guidelines for provision of collaborative mental health care according to a medical directive developed specifically for the clinics. Approximately 10 to 15 new patients (in total) are seen each week in the clinic at each campus, with 150 new patients seen per month at both campuses, and about 1,500 patient visits each month at both campuses.

Unique characteristic(s) to local community

- The psychiatric emergency services account for about 75 per cent of mental health patient visits to emergency rooms within the urban area; there is also a severe limitation on the number of available inpatient beds in the region for acute mental health care, so the majority of patients seen by this service must be discharged (and not admitted to hospital) with a requirement for urgent psychiatric follow-up

Barriers

- Until recently, psychiatrist recruitment has restricted the establishment of the clinic at one campus
- Some outpatient psychiatrists were initially reluctant to work in multidisciplinary teams and to share clinical responsibility for patients
- Due to the volume of patients referred by the psychiatric emergency service, access by community family physicians has been limited
- There is limited sessional funding to allow adequate indirect care/education with family physicians

Strategies

- Recruitment of psychiatrists willing to work collaboratively in a multi-disciplinary clinic
- Development of a medical directive approved by the hospital administration to allow psychiatric nurses, social workers and psychologists to independently assess patients and open charts, and to arrange an assessment with a clinic psychiatrist within two weeks (this was necessary to assure timely outpatient follow-up after referral)

Funding

- Fee-for-service and sessional funding provided by the Ontario Ministry of Health and Long-Term Care
- Hospital outpatient psychiatric program funding provided for mental health program staff
- Funds are regulated by the Ottawa Hospital

Sponsoring organization(s)

- Department of Psychiatry, The Ottawa Hospital

Other participant(s) or organization(s)

- None

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Community Mental Health Program for Older Adults

Start Date

1997

Special Populations

Disorder-specific
Seniors/geriatrics
Serious mental illness

Human Resources

Family physician
Home-support worker
Nurse
Nutritionist
Occupational therapist
Program coordinator
Psychiatrist
Physiotherapist
Respite to caregiver
Social practitioner
Volunteer

Location(s)/Setting(s)

Community (client's place of residence)
Office

Evaluation

Yes, completed and ongoing.

Initiative Short Title

Community MH Program

Purpose

There was a pressing need to develop community-based services for older adults with mental health problems in a system that continued to be fragmented and disorganized, and that marginalized this population.

Goals/objectives

- To help and support adults, aged 60 years and older, with mental health problems
- To adapt services to the individual's particular needs in an effort to prevent and avoid a deterioration of the situation, and to identify and respond to the environmental factors that may affect that person's mental health; the team works with the individual, family, community and professional network

Description

The interdisciplinary mental health team (coordinator, social practitioners, nurses and home-support workers) provides two programs. The counselling program is aimed at the autonomous 60-years-and-older population (individuals, couples, families and groups), who are experiencing psycho-social distress or a transitory normative crisis in their lives (e.g., bereavement, anxiety, depression). The second program is centred on an ecological approach in community services to older adults suffering from severe and/or mental health problems.

A psycho-social or nursing intake worker receives all requests from the client or a third-party referral source (e.g., doctor, hospital, family member). Once the request is screened (using our risk-behaviour screening tool) and deemed appropriate for the program, it is sent to the team coordinator, who assigns the case for evaluation and follow-up. The client also has access (via the social-practitioner) to other internal services at the Installation CLSC René-Cassin (including family physicians, physiotherapists, occupational therapists, nutritionists and volunteers). Annually, the program provides direct services to more than 360 clients.

A psychiatrist provides consultation to the team and plays an important role in helping the team decide on appropriate interventions. In addition, the psychiatrist performs a liaison role with the psycho-geriatric clinic in the hospital, with which the team is most affiliated. Team members participate, on a rotational basis, at the weekly clinical meetings of the Department of Psycho-geriatrics at the hospital.

Sharing information about a client is one of the cornerstones of this program. There is team and inter-departmental consultation, co-ordination and collaboration with external resources. This is accomplished in several ways: all relevant information is entered into the client's file by members of the team; all new and difficult cases are presented at formal team meetings every two weeks (our consulting psychiatrist participates, as well); ongoing smaller meetings ensure that all members are aware of any changes. This allows for pre-emptive action to avoid crises, and fosters a greater unity of action and purpose. The responsibility for client care is shared.

Unique characteristic(s) to local community

- Faced with the oldest clientele in Canada (27 per cent of the population is 65 and older), the Installation CLSC René-Cassin has developed innovative programs that promote the questioning of existing practices and the development of new ones, with the support of research

Barriers

- There is an absence of any common practice in service delivery and a limited understanding of the dynamics related to older adults with mental health problems
- There are limited appropriate services and resources available, when compared to the general services and resources available for adults (i.e., housing, day centres, crisis services)

Strategies

- Identified and incorporated nine guidelines, based on best practices in community mental health services for older adults with severe mental illness
- Offer clinical trainings and monthly teaching rounds to the staff and partners in the network
- Conducted a preliminary study of our existing client population
- Developed and offer training on the psycho-geriatric and Risk Behaviour Assessment Scale (PARBAS), to help educate practitioners

Funding

- Provincial Ministry of Health and Social Services

Sponsoring organization(s)

- Centre de santé et de services sociaux de René Cassin et Notre Dame de Grâce, Montréal-Ouest
- Installation CLSC René-Cassin

Other participant(s) or organization(s)

- None

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Short-Term Mental Health Evaluation and Follow-Up Program

Start Date

September 1999

Special Populations

Children and youth
 Concurrent disorders
 Homeless/transient
 Rural
 Seniors/geriatrics

Human Resources

Family physician
 Nurse
 Psychiatrist
 Psychologist
 Social Worker

Location(s)/Setting(s)

Family physician office

Evaluation

No.

Initiative Short Title

MH Evaluation and Follow-Up

Purpose

The program began in an effort to support physicians who were evaluating patients who do not have family physicians and who consult through walk-in clinics. This team of physicians was concerned about the number of mental health problems encountered in the walk-in clinics. Mental health takes considerable time to evaluate accurately, and the busy clinics do not allow for this.

Goals/objectives

- To provide better mental health care to centre local de services communautaires (CLSC) patients by reducing the waiting time for detailed medical evaluation
- To assist physicians in the diagnosis and follow-up of the increasing number of patients with mental health problems seen in the walk-in clinic
- To assist physicians in the treatment of their patients by providing a second opinion before considering a psychiatric referral
- To support health professionals in the CLSC seeking medical advice or evaluation for a patient
- To provide rapid pharmacological treatment, when indicated, and to permit short-term follow-up of medication, while waiting for transfer to long-term follow-up
- To provide short-term follow-up after a crisis; to evaluate and agree on the best treatment plan and options for the patient; and, to create a link with known long-term resources in the community

Description

Currently, two family physicians with a special interest in mental health participate in this program, spending from one half to one day per week seeing patients with mental health problems. Appointments between one-and-a-half and two hours are scheduled for a new evaluation, and half-hour appointments for follow-up. Physicians or other professionals (e.g., a social worker or nurse) within the CLSC book the first available appointment for their patients. A referral note is written in the common file, and a detailed evaluation in the medical notes. When relevant, a case discussion over the phone follows between the physician and the referring professional. Physicians may offer a joint consultation with the referring professional and the patient.

The family physicians who see referred patients are connected to a Shared Care Program at Notre Dame Hospital and may receive consultative support from a liaison nurse and/or a psychiatrist. Ideally, an appointment for long-term medical follow-up is made at the time of referral to the program, in order to avoid additional delay. It is hoped that this service will be a starting point for the creation of a mental health team that includes other professionals in the CLSC.

Unique characteristic(s) to local community

- The high number of referrals has confirmed the need for this service. It has proven to be an ideal setting in which to teach interviewing techniques “live and in action” and to provide a role model for family medicine residents, through direct supervision

Barriers

- This type of clinical activity is both energy- and time-consuming. The high number of missed appointments (despite the fact that appointments are confirmed the day before) is frustrating, since there is a waiting list
- The program has not yet been able to meet its initial goal of a maximum two-week wait for evaluation
- As well, it is difficult to establish a “team feeling” when the two physicians work independently and, as their schedules do not overlap, there is no opportunity for informal case discussion and consultation

Strategies

- Insist on an appointment for long-term treatment at the time of referral
- Limit follow-up visits to what is necessary
- Advocate for a mental health team to be created in the CLSC structure to allow other professionals to be involved and share the physician task requirements

Funding

- No specific funding; reallocation of physicians’ time

Sponsoring organization(s)

- Centre local de services communautaires (CLSC) des Faubourgs
- The Department of Psychiatry, Centre hospitalier de l’Université de Montréal (CHUM)

Other participant(s) or organization(s)

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Project DIRECT: Depression Intervention via Referral, Education and Collaborative Treatment

Start Date

September 2004

Special Populations

Seniors/geriatrics

Human Resources

Depression care practitioner
 Family physician
 Nurse
 Psychiatrist
 Psychologist
 Social worker

Location(s)/ Setting(s)

Offices of family physicians

Evaluation

Yes, ongoing.

Initiative Short Title

Project DIRECT

Purpose

Major depression occurs in at least one to three per cent of the general elderly population; an additional eight to 16 per cent manifests clinically significant depressive symptoms. Yet, probably less than 25 per cent of these depressed seniors are detected in primary care settings and, even if they are detected, few receive appropriate treatment for a sufficient period of time.

The success of two recently published multi-centre clinical trials—Improving Mood-Promoting Access to Collaborative Treatment (IMPACT) and the Prevention of Suicide in Primary Care Elderly: Collaborative Trial (PROSPECT)—feature interventions for primary care patients aged 60 and over. Their success suggests that the treatment and outcomes of depression in this population can be improved substantially. The key elements of these two interventions are family physicians who were educated about depression (using a medication algorithm); and the use of a simple instrument to screen for clinically significant depressive symptoms and diagnoses. Both included a depression care manager, a specially trained nurse, and a psychologist or social worker, who also provided brief problem-solving treatment.

Goals/objectives

- Although successful, the above programs were implemented in the United States in the context of several Health Maintenance Organizations; the purpose of this study is to determine the feasibility and effectiveness of the intervention model in Canada

Description

This project is a feasibility study involving four steps. The first is to draft an intervention protocol. Investigators from these two American studies were consulted and an intervention suitable for Canada was drafted, with options for each aspect of the protocol, including: selection of study settings, qualifications and training of case manager, treatment algorithm, education of primary care physicians and a process for involving a psychiatrist.

Next, consensus was reached on intervention protocol; focus groups were conducted with three groups of health professionals (psychiatrists, family physicians and allied medical staff).

The methodology was then developed for the randomized control trial, including: method of randomization, outcome measures, other patient measures (confounders, effect modifiers), follow-up duration and method; methods to assess the impact of

the intervention on patient–physician concordance and on practice patterns; and methods for analysis of the costs of the intervention.

This randomized control trial protocol was then pilot-tested. Components are now undergoing pilot-testing, including: recruitment of physicians, screening and recruitment of patients, training of depression care practitioners, implementation of an abbreviated version of the intervention and collection of outcome data.

The key elements of the shortened intervention being pilot-tested include: education of family physicians about depression (using a medication algorithm), use of a simple two-question instrument to screen for clinically significant depressive symptoms and diagnoses, and use of a depression care practitioner, who provides problem-solving treatment, collaborates with the family physician and monitors the patient for two months. The results of this feasibility study will provide a solid basis for the subsequent design and implementation of a multi-centre randomized control trial of 12 months' duration or more.

Unique characteristic(s) to local community

- We have an FRSQ (Fonds de la recherche en Santé du Québec)-funded multidisciplinary research team (title: "Detection and Management of Depression in Seniors")

Barriers

- It has been difficult to recruit family physicians to participate in this project. Among those recruited, there are low rates of screening of older patients

Strategies

- An additional research assistant was hired to maintain contact with the family physicians and to encourage and provide help, as needed, with patient screening. In some practices, for example, we have placed research assistants in the waiting rooms to screen patients

Funding

- Canadian Institutes for Health Research

Sponsoring organization(s)

- St. Mary's Hospital Centre, Montréal

Other participant(s) or organization(s)

- Centre Local de Services Communautaires, Côte-des-Neiges, Montreal
- Department of Family Medicine, McGill University
- Douglas Hospital Research Institute, Montreal
- School for Social Work, McGill University
- School of Psychology, University of Ottawa
- The Verdun Family Medicine Clinic, Université de Montréal

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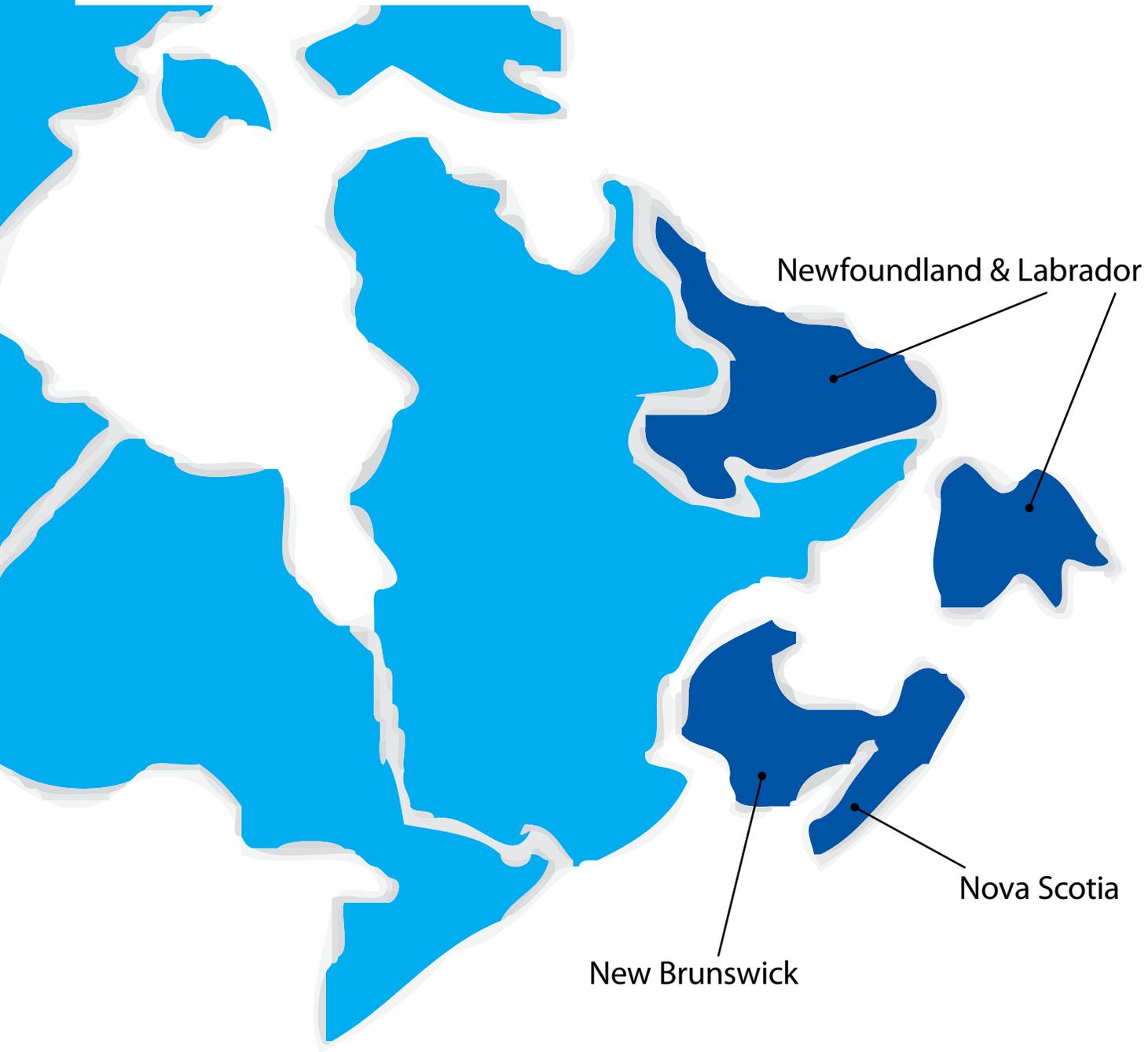
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appendixC

INVENTORY OF CANADIAN INITIATIVES - EASTERN



EASTERN

Community Mental Health Centre's Crisis Intervention Services

Start Date

1991

Special Populations

Other

Human Resources

Hospital
Outreach (clients' home)

Location(s)/Setting(s)

Family doctor
Human service counsellor
Nurse
Psychiatrist
Psychologist
Social worker

Evaluation

Yes, ongoing.

Initiative Short Title

CMHC Intervention Services

Purpose

The purpose is to ensure maximization of existing resources, emergency hospital services and other 24-hour emergency services, as well as to continue providing the first level of services and referrals to the Community Mental Health Crisis Services, as needed.

Goals/objectives

- To regroup elements of services aimed at preventing, evaluating and treating psychiatric crisis in the community
- To get the crisis situation under control quickly, through professional assessment and intervention
- To assess client needs collaboratively and to propose an individualized crisis intervention plan, outlining options available to clients, that can help them to overcome their crisis and remain in their surroundings

Description

A mental health professional (a clinician recognized by an association) is available 24-hours-a-day, seven-days-a-week, to evaluate the client in crisis and/or to provide consultation to first-line responders. The professional will evaluate the severity of the crisis, identify the various options available, and offer the individual and/or family a personalized crisis intervention plan. After the evaluation is completed, if the mental health professional believes that the individual needs to be taken out of his or her living environment temporarily, a crisis bed is made available. Or, the mental health professional will have access to a para-professional, someone like a community support worker, to sustain the individual in his or her living environment, if needed.

Depending on the region, clients and the population have access to Community Mental Health Centres through different mechanisms: direct access through a pager for known clients; the centre's phone number is redirected to another agency (calling centre or "Chimo help-line" and the clinician on call is being called by these agencies); or a message is left on the telephone, guiding the client to go to the emergency room (ER). Chimo help-line is a provincial crisis phone line that is accessible 24-hours-a-day, every day, to all residents of New Brunswick. All ERs have access to the Centre's on-call clinician. In Saint John, the population has direct access to the Mobile Crisis Team, where the nurse intervenes by telephone, on site, or in the ER.

Many regions have a mechanism (clinical committees) in place to discuss client care. A case plan is elaborated for clients with complex needs and is part of the client's file. The case plan is outlined to principle caregivers: family doctor, psychiatrist, nurse, psychologist and social worker. When a client goes to the ER, the ER team will follow the plan, ensuring consistency. If the client presents different symptoms than those in the plan, the ER staff can contact the mental health worker on call, and the mental health worker will provide consultation or organize for a crisis bed to be available, if need be.

Unique characteristic(s) to local community

- Provincially, New Brunswick Mental Health Reform, where community-based services were enhanced, was the main incentive to implement these after-hours crisis intervention services
- Based on a mental health needs analysis in Saint John, a mobile crisis program was recommended and implemented
- Each region has designed their services according to needs (i.e., rural, urban, frequency of calls) in collaboration with the regional health authorities

Barriers

- None

Strategies

- In developing new initiatives, we involve the stakeholders in the planning, design and implementation stages, in which fear and resistance to change are being managed and alleviated; being part of the process also creates ownership and a feeling of control, making change a more positive experience

Funding

- The Mental Health Services Division allocates funding, which is divided into 13 Community Mental Health Centres

Sponsoring organization(s)

- New Brunswick Department of Health and Wellness, Mental Health Services Division

Other participant(s) or organization(s)

- Chimo help-line
- Regional Health Authorities
- Special Care Homes

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Region 2 Health Authority: Collaborative Practice Initiatives

Start Date

March 2003

Special Populations

Rural
Urban

Human Resources

Dietitian
Domestic violence counsellor
Family physician
Nurse
Nurse-practitioner
Occupational therapist
Pharmacist
Social worker
Psychiatrist

Location(s)/Setting(s)

Community health centre
Rural setting
Urban family practices

Evaluation

Yes, completed and ongoing.

Initiative Short Title

Collaborative Practice Initiatives

Purpose

Our initiative recognized the need for closer collaboration between psychiatry and family practice, and the fact that many individuals with mental health disorders do not have access to a primary care provider.

Goals/objectives

- To provide collaboration and consultation to a team in a primary care setting (shared-care model)
- To provide primary health care to individuals who do not have access to a family physician (i.e., nurse-practitioner, mental health)

Description

Shared care occurs between our psychiatrist and the Saint Joseph's Community Health Centre collaborative team, including family physicians, nurses, nurse-practitioners, social workers, a pharmacist, an occupational therapist and a domestic violence counsellor. A nurse-practitioner is also part of the collaborative team and is available to mental health clients who do not have a family physician. The nurse-practitioner's role was just evaluated and accepted as a permanent role after a six-month pilot project. The centre was recently accredited for three years.

The community health centre is located in the downtown core, and our population tends to be from a lower economic level. Many have not had primary care in years and present with acute needs. We have a number of special care homes and residential facilities for individuals with mental health disorders, and a soup kitchen that provides a homeless clinic. A number of individuals from the soup kitchen have been referred to the nurse-practitioner.

The psychiatrist works with family physicians in a rural setting with mental health nurses, social workers, psychologists and physicians. In addition, the psychiatrist works with several family physician group practices in an urban setting. Each profession assumes liability for patient care. At the centre, there is a team that meets on a weekly basis. The psychiatrist is at the centre one day a week, and is available for consultation with the team. The nurse-practitioner is based at the centre.

Our psychiatrist uses tele-health to communicate with the rural setting. The Community Mental Health Services (CMHS) use an electronic health record, and the centre is in the process of bringing in an electronic health record. Both the psychiatrist and the nurse-practitioner at the centre have access to CMHS electronic records to enhance continuity of care.

We are working on an initiative to promote mental wellness in the city core, based on a life transitional adaptability and flexibility model. As part of the community health centre, we have initiated an ongoing sleep/hygiene/education series that is open to the general public.

Unique characteristic(s) to local community

- There was an openness to establishing and working as a team
- This is a teaching centre for medical students In addition, nurse practitioner students complete clinical rotations here
- Most of the positions are salaried, allowing more time to collaborate and share information about complex cases

Barriers

- For the nurse-practitioner, there was a concern that referring mental health patients to one clinician would, in a sense, ghettoize them
- From the family practice perspective, there were concerns that the practice (albeit a large one) was taking on a high percentage of individuals with mental health issues, and that this would burden the practice with complex cases

Strategies

- None

Funding

- Atlantic Health Sciences Corporation (AHSC)
- Community Mental Health Services (CMHS)
- Mental Health Program

Sponsoring organization(s)

- AHSC
- CMHS

Other participant(s) or organization(s)

- None

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Early Psychosis Program (EPP)

Start Date

November 2002

Special Populations

Serious mental illness

Human Resources

Family
 Family physician
 Occupational therapist
 Psychiatric nurse
 Psychiatrist
 Psychologist
 Social worker

Location(s)/Setting(s)

Community health clinic
 Outreach (e.g., homes, schools, workplaces)

Evaluation

Yes, ongoing.

Initiative Short Title

Early Psychosis Program

Purpose

Early intervention for psychosis can reduce the degree of functional disruption created by this mental illness (psychosis), and also helps to maximize recovery potential.

Goals/objectives

- To aid in the attainment and maintenance of an improved level of functioning for clients, encompassing educational, vocational, social and/or recreational goals
- To support and educate members of the clients' social, educational and work environments
- To reduce the degree of disruption created by the illness, maximizing recovery potential

Description

The Early Psychosis Program (EPP) is an outpatient service operating two days per week, which works within a bio-psycho-social framework. The interdisciplinary team works in therapeutic partnership with the client, his/her family and other involved professionals, including family physicians. Intervention is aimed at treating the client's primary psychotic symptoms. Practical, educational and supportive approaches are used to empower clients and their families to cope with a first episode of psychotic illness, and to facilitate clients' maximal recovery.

Referrals to the program come from family physicians and psychiatrists through the Intake Team at the Fredericton Mental Health Centre, and through the liaison coordinator of the psychiatry unit at River Valley Health (Chalmers Hospital). The treatment team includes a psychiatrist, care-coordinator (psychiatric nurse), family educator (social worker) and an occupational therapist. The services of a psychologist and a community support worker have been accessed, as needed, from another Community Mental Health Clinic program. Under the management of the clinic, staff members have liability insurance through the clinic and through their professional associations.

The client, his/her family and his/her family physician are considered important members of this team. In the case of one or two clients who live outside the immediate Fredericton area, but are still within our health region, teleconferencing and shared

computerized charting have been used to enhance communication with their health-care teams. The program refers clients, as appropriate, to pre-vocational and vocational programs in the community, and works collaboratively with these programs.

Clients and their families are seen primarily at the clinic, but also in their homes, schools and workplaces, as appropriate. Each client is given a “treatment folder,” which contains important information about the program and his/her treatment plan. Clients (as well as their family members) meet with individual team members to address specific goals, but also with the team as a whole, periodically, to develop treatment contracts, review progress and adjust treatment plans, and to prepare for discharge from the program. Clients may also be involved in group interventions. Clients have generally been involved with the program for up to two years. After goals of treatment have been met, clients are transferred back to the care of their family physicians/psychiatrists.

Unique characteristic(s) to local community

- A new psychiatrist to our area had trained in a similar program in Hamilton, Ontario, and was very impressed with the program’s capacity to make a difference for young adults with psychosis; she advocated strongly for the program when she moved to New Brunswick, although she is no longer a part of it (the program has continued with another psychiatrist)

Barriers

- With limited time allocated to the program, most of the time is spent on front-line contact with clients, leaving little time for evaluation, education and revision of the program; it was helpful to have some time before starting the program to establish some of this, but more is needed on an ongoing basis

Strategies

- We continue to advocate for expansion of the time available/ clinical resources for the program, in order to offer improved service to more clients

Funding

- New Brunswick Department of Health and Wellness through a Community Mental Health Centre

Sponsoring organization(s)

- Eli Lilly, the pharmaceutical company, provided some initial funding for staff training, as well as some educational materials for use with clients and families

Other participant(s) or organization(s)

- The Canadian Mental Health Association (CMHA), Fredericton/ Oromocto Branch, assisted with arrangements for staff training, and with obtaining educational materials for use with clients and families; the CMHA continues to be a resource for the program through its role in educating the public

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Emergency Room Psychiatric Nurse Program

Start Date

November 1997

Special Populations

None

Human Resources

Community agency
ER psychiatric nurse
ER nurse
ER social worker
ER physician
Family physician
Psychologist

Location(s)/Setting(s)

Hospitals

Evaluation

Yes, ongoing.

Initiative Short Title

ER Psychiatric Nurse Program

Purpose

Consumers, advocacy groups and the formal mental health system have recognized the need for specialized emergency services to meet the unique needs of psychiatric patients and their families. The recommendations brought forward are related to the onset of the interventions: triage, evaluation and management of the patient upon arrival at the emergency room.

Goals/objectives

- To enhance accessibility to mental health services for those who come to the emergency department seeking relief from emotional distress, with emphasis on comprehensive assessment and diagnosis, and the development of a disposition plan
- To provide a nursing liaison among inpatient psychiatric services, the emergency department and appropriate community resources, to create a seamless mental health service

Description

The program uses a specific emergency room (ER) psychiatric nurse position to facilitate the care provided to patients. The ER psychiatric nurse is available to the emergency department seven days a week, during the peak hours for admission to psychiatry via the ER.

The ER psychiatric nurse collaborates with other professionals (e.g., nurses, social workers and physicians), community resources and hospitals to ensure safe, quality care for the psychiatric patient. The ER psychiatric nurse supports other staff members during an acute psychiatric emergency that occurs in the ER, and may support and counsel families (when requested) in distress during a medical crisis. If a patient is to be admitted to the ER, the psychiatric nurse will co-ordinate the admission with the unit's staff and accompany the patient to the unit. An assessment form was developed to meet the needs of both the ER and inpatient psychiatry, so that the patient will not have to be interviewed twice.

Initially, the ER psychiatric nurse conducts a comprehensive assessment of patients who present as walking into the ER or are referred by community or staff clinicians, and reviews all collateral information forwarded by the referring party/agency. The ER psychiatric nurse provides a comprehensive written report of these assessments and verbally reviews the information with the psychiatrist, outlining risk factors and recommendations. In follow-up, the ER psychiatric nurse collaborates with the liaison nurse and Community Mental Health Services, and has telephone contact with the patient, family and community, as needed.

The ER psychiatric nurse provides education to patients, families and professionals regarding psychiatric emergencies, medication, approaches and resources. In addition, continuing dialogue with family practitioners and other agencies is offered.

Unique characteristic(s) to local community

- In Saint John, a mental health needs analysis was conducted with stakeholders, community members and clinicians; based on this analysis, an ER psychiatric nurse was recommended; the program was evaluated after six months and again, after a year, with positive results; these results were shared with the other mental health programs in the province and other regions started to implement similar programs
- In Edmundston, the occupation rate was above 100 per cent most of the time; by having a psychiatric nurse do the screening and initial assessment, community resources were maximized and the occupation rate was brought down to less than 90 per cent

Barriers

- New Brunswick would like to have such a program in all regional ERs, but the main obstacle is finding financing

Strategies

- The modified ER psychiatric nurse program was the strategy used to overcome the financial difficulties

Funding

- New Brunswick Department of Health and Wellness
- Regional Health Authority, Fredericton

Sponsoring organization(s)

- New Brunswick Department of Health and Wellness, Mental Health Services Division

Other participant(s) or organization(s)

- Regional Health Authorities

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Tele-mental Health and Tele-addictions Partnership Project: Mawi Wolakomiksultine

Start Date

January 2003

Special Populations

Aboriginal
Concurrent disorders
Rural

Human Resources

Addictions specialist
Biomedical engineer
Director
Family physician
Information technology staff
Psychiatric nurse
Psychiatrist
Psychologist
Social worker
Tele-health professional

Location(s)/Setting(s)

Addiction centre
Community health centre
First Nation community
Hospital

Evaluation

Yes, ongoing.

Initiative Short Title

Project: Mawi Wolakomiksultine

Purpose

This project will use tele-health technologies to deliver mental health and addictions services remotely. It represents a first step in the development of an integrated tele-mental health and tele-addictions service delivery model among River Valley Health (Regional Health Authority 3), five First Nations communities, and Community Mental Health Centres in Health Region 3. To further facilitate this integration, the project has also included an information technology standardization plan for Tobique Wellness Centre, as a foundation for increased sharing of health information among Regional Health Authorities and First Nations communities. The project will position River Valley Health and its project partners for inter-regional, inter-provincial and national links with specialty centres.

Goals/objectives

- To facilitate timely access to mental health/psychiatric consultations
- To reduce wait lists for emergency psychiatric assessments
- To decrease preventable hospital admissions for mental disorders
- To reduce the number of unnecessary sheriff transports to the regional hospital
- To support local management of psychiatric/addiction emergencies
- To improve relationships among health professionals (i.e., general practitioners, psychiatrists, mental health centre and hospital staff)
- To treat a larger number of patients in their own communities, and to improve patient satisfaction

Description

Mawi Wolakomiksultine (pronounced ma-wee wo-lock-mix-sul-tee-neh) is a Maliseet name meaning “together, let’s have good healthy minds.” There are three main components to the program: emergency room mental health assessments, collaborative case consultations and an educational program.

This project increases access to emergency mental health assessments for rural emergency rooms (ERs) within River Valley Health. Professionals, including ER psychiatric nurses, social workers and psychiatrists, are responsible for providing these assessments

educational services to enhance the use and understanding of tele-health programs in mental health and addictions services.

The tele-consultation service focuses on psychiatric/mental health assessments and follow-up care; concurrent addictive and mental health disorder consultations; discharge planning; and case conferences. A team, including psychiatrists and an addictions specialist (a family physician with specialty training in the area), provides local primary and mental health-care providers with consultative support, in order to strengthen the capacity of these providers to manage the ongoing care of patients with complex mental health needs. The local providers may include family physicians, psychiatric nurses, social workers and psychologists, as required on a case-by-case basis. The local primary or mental health-care provider may participate in joint consultations with the patient and the member of the tele-consultation team, as appropriate. Locations have included the Woodstock Community Mental Health Centre; Fredericton Community Mental Health Centre and River Valley Health Addiction Services; Dr. Everett Chalmers, Regional Hospital Mental Health Program, and Tobique First Nation Addictions Centre.

Unique characteristic(s) to local community

- None

Barriers

- External funding support for infrastructure was a major hurdle in getting this project started; the corporate direction was there, as defined in our River Valley Health Tele-health Strategic Plan; the partnerships were vital in moving forward
- We have had illness and position changes among some of our champions, which has delayed the start-up of some phases of this project

Strategies

- Too early to speculate; many lessons are being learned

Funding

- New Brunswick Department of Health and Wellness, Community Mental Health Centres, Health Region 3
- Health Canada, First Nations and Inuit Health Branch
- River Valley Health (Regional Health Authority 3)—Lead
- Tobique First Nation

Sponsoring organization(s)

- New Brunswick Department of Health and Wellness, Community Mental Health Centres, Health Region 3
- Health Canada, First Nations and Inuit Health Branch
- River Valley Health (Regional Health Authority 3)—Lead
- Tobique First Nation

Other participant(s) or organization(s)

- Fredericton Community Mental Health Centre and Addictions Services, Victoria Health Centre, Fredericton
- Hotel-Dieu of St. Joseph, Perth-Andover (ER)
- Tobique First Nation (Addiction Centre)
- Tobique First Nation, Wellness Centre
- Woodstock Community Mental Health Centre, Woodstock
- Dr. Everett Chalmers Regional Hospital, Fredericton (ER)

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Tele-mental Health

Start Date

February 2000

Special Populations

Children and youth

Human Resources

Emergency mental health nurse
Mental health nurse
Physician
Psychiatrist
Psychologist
Social worker

Location(s)/Setting(s)

Charlotte County Hospital Emergency Department
Grand Manan Hospital
Saint John Community Mental Health Centre
Saint John Regional Hospital
St. Stephen Community Mental Health Centre
Sussex Health Centre

Evaluation

Yes, ongoing.

Initiative Short Title

Tele-mental Health

Purpose

Difficulty recruiting psychiatrists in rural communities has placed considerable importance on developing innovative ways to access psychiatric consultations for individuals with complex mental health needs. Literature reports that tele-mental health programs are increasing in number, with a wider range of clinical applications, including therapeutic and diagnostic interventions. Tele-conferencing and tele-education have been used for many years as effective ways to offer remote training, conduct meetings and provide consultation to remote areas.

Goals/objectives

- To facilitate timely access to psychiatric consultations in rural communities
- To expand the consultation process among other professionals and between Community Mental Health Centres
- To facilitate the application of best practices by broadening access to training and expertise throughout the Mental Health Services Division
- To strengthen the capacity of family physicians and Community Mental Health Centre staff to manage the care of individuals with complex mental health service needs in their own community
- To facilitate appropriate access to psychiatric in-patient beds

Description

Phase I began in February 2000. In conjunction with Charlotte County Community Mental Health Centre, the Atlantic Health Science Corporation initiated a tele-mental health service. Family physicians and/or community mental health clinicians (social workers, psychiatric nurses or psychologists) can request psychiatric consults from a psychiatrist via tele-mental health. Pre-scheduled tele-mental health consultations have been provided regularly to adults and children in Charlotte County by psychiatrists at the Saint John Regional Hospital and the Saint John Community Mental Health Centre. Using video-conferencing equipment, calls are placed over an Integrated Services Digital Network. A small number of pre-scheduled consultations have been provided to patients at the Sussex Health Centre by the hospital's psychiatrists. Recommendations from the consultation are made to the family physician, and mental health clinicians are available for follow-up and ongoing treatment, if required. On occasion, and especially

in difficult cases, the family physician has participated in the psychiatric consult. The joint consultations involve the client and the clinician at one end of the video-conference, and the psychiatrist at the other.

In January 2002, the hospital and the Charlotte County Community Mental Health Centre launched Phase II, an emergency tele-mental health program that provides emergency psychiatric assessments to clients who are in crisis at the Charlotte County Hospital Emergency Department. After an initial triage assessment, a decision may or may not be made by the attending emergency room physician to contact the on-call crisis mental health clinician. If contacted, the clinician will do an on-site assessment to decide if a psychiatric consult is required. If one is, a similar process to that used in Phase I is employed. Key implementation tasks have involved deployment of video-conferencing equipment and the construction of clinical protocol.

There is also an educational component to the program, whereby training is provided to clinicians in local areas. Case conferences and grand rounds are also conducted.

In the last fiscal year (April 2004–March 2005), the following consults were completed: 15 emergency room to emergency room consults, 28 planned child and adolescents consultations and 23 adult planned consults.

Unique characteristic(s) to local community

- Charlotte County had been without a resident psychiatrist for seven years. The unique geography of Charlotte County, which includes three islands, resulted in clients having to travel considerable distance for psychiatric assessment

Barriers

- Difficulty recruiting the roster of on-call psychiatrists to provide emergency psychiatric assessments
- Discomfort of psychiatrists and clinicians with the use of video-conferencing equipment

Strategies

- The establishment of a clinical protocol
- Assurance of technical support

Funding

- The New Brunswick Department of Health and Wellness
- Region 2 Health Authority

Sponsoring organization(s)

- Atlantic Health Sciences Corporation
- Region 2 Community Mental Health Services

Other participant(s) or organization(s)

- None

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Primary/Community Services of the Capital Mental Health Program

Start Date

1999

Special Populations

Rural
Urban

Human Resources

Family physician
Manager
Psychiatrist
Psychologist
Registered nurse
Social worker

Location(s)/Setting(s)

Church basements
Community mental health centres
Primary care physicians' offices
Rural hospitals
Schools
Shelters

Evaluation

Yes, ongoing.

Initiative Short Title

The Capital MH Program

Purpose

Most people in the Capital District have some contact with the primary care system, whether through a family doctor or community agency. Collaborative initiatives make services more accessible by increasing the capacity of the primary care system (family physicians and community agencies) to recognize and respond appropriately to mental health needs.

Goals/objectives

- To increase the knowledge base of formal and informal care providers, as well as the general public, regarding the detection and management of mental health disorders
- To improve collaborative/consultative relationships between primary care and mental health providers

Description

The Capital Mental Health Program is involved in a number of initiatives. Formal shared care with family physicians involves assigning specific mental health clinicians to work in primary care practices and the communities surrounding those practices. In addition, in most of those primary care sites, on-site psychiatry consultation is also provided. The amount of time mental health clinicians are assigned to each practice varies, from three days per week to one day every two weeks. Clinicians and psychiatrists provide assessment and short-term treatment to patients of the practice, while the family practitioner has responsibility for ongoing care.

The clinician, psychiatrist and family practitioners engage in ongoing consultation and regular education sessions. The emphasis is on encouraging collaboration in providing for the individual's mental health care, and the transfer of skills and knowledge that increases the capacity to respond effectively in other situations.

Clinicians working with community mental health teams also work closely with people in various communities to provide services that meet their specific needs. In some areas, clinicians visit agencies and/or schools on a rotating schedule. The services provided vary, based on the needs of the agency and the population served. Examples include educational sessions for staff, jointly facilitated groups, consultation about specific clients or a general issue and advocacy.

Currently, there is also a strategic planning process underway as part of the Capital District Mental Health Program. The implementation phase is expected to occur in 2005, and will be heavily focused on transforming the entire system based on principles of collaboration, inclusion and recovery.

Unique characteristic(s) to local community

- Capital District covers a large geographic area, including urban, suburban and rural communities
- Formal shared-care resources have been allocated to areas of high need because of socio-economic factors and isolation due to geography; they are also given to practices whose primary mandate includes education of new practitioners

Barriers

- Staff isolation, long distances to travel, and staff turnover
- Lack of adequate and/or appropriate space and clerical support
- Issues of where to keep clinical records for clients who are not associated with a primary care practice
- Insufficient psychiatry resources
- Payment schedule for family physicians at fee-for-service sites
- Changing long-standing practices and expectations that impede collaboration (e.g., lack of awareness by some family doctors of the contribution and/or role of non-medical clinicians)
- Attracting and training new practitioners to this style of practice

Strategies

- Regular retreats that bring together family physicians, shared-care clinicians and psychiatrists
- Memorandum of understanding that supports discussion of expectations of all involved parties
- Funding to allow family physicians from fee-for-service sites to be compensated for time spent at retreats and case consultation sessions (arranged through Primary Care Division of Capital Health)
- Creation of a part-time coordinator's role

Funding

- Funded as part of the regular operating budget for Capital District Mental Health Program
- Funds are regulated by the Capital District Mental Health Program

Sponsoring organization(s)

- Primary/Community Services
- Capital District Mental Health Program
- Capital District

Other participant(s) or organization(s)

- Camp Hill Family Medicine Centre
- Cowie Hill Family Medicine Clinic
- Duffus Street Medical Centre
- Eastern Shore Memorial Hospital
- Hants Shore Health Clinic
- IWK Health Service Centre
- Musquodoboit Valley Family Medicine Clinic
- North End Community Clinic
- North Preston Health and Wellness Centre
- Rawdon Hills Health Centre
- Spryfield Family Medicine Clinic
- Many community agencies and schools

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Shared Mental Health Care at Cowie Family Medicine Clinic

Start Date

1997

Special Populations

Children and youth
 Concurrent disorders
 Disorder-specific
 Seniors/geriatrics
 Urban
 Other

Human Resources

Adult psychiatrist
 Adult social worker
 Child psychiatrist
 Child social worker
 Clinical director
 Family medicine resident
 Family physician
 Nurse
 Support staff

Location(s)/ Setting(s)

Cowie Family Medicine Clinic

Evaluation

Yes, completed.

Initiative Short Title

Cowie Family Medicine Clinic

Purpose

The project originally evolved from the development of shared mental health care as an alternative to traditional mental health delivery. The positive outcomes for patients and providers have provided the momentum to sustain the project.

Goals/objectives

- To improve patient access to mental health care
- To improve provider access to mental health-care providers
- To provide a vehicle for medical education for providers and learners (i.e., problem-based format, small group presentation)
- To improve patient outcomes related to symptom management, relationships at home and work, and medical management of chronic mental health issues in association with co-morbidities

Description

The clinic provides an academic teaching environment for family medicine residents. The staff includes family physicians, family medicine residents, nurses and support staff who are supported by two social workers (one adult and one child masters of social work) and two psychiatrists (one adult and one child). Every week, the adult and child social workers are available to the clinic staff for two sessions (five week days, divided into ten sessions per week). During this time, they review cases referred to them by the primary care team with the person who generated the request. The adult care psychiatrist is available for one session each week, and the child psychiatrist is available for one session every six weeks and also for consultation (through the child social worker), if needed sooner. These members of the mental health team come to the clinic to see patients on-site. Where appropriate, the social workers may link patients to community services. The attending physician assumes primary responsibility for care and follow-up, in collaboration with the resident and/or the family practice nurse. The clinic has approximately 30–50 client visits per month and sees 350–400 patients per month.

Each week, one hour is devoted to rounds, which are attended by all primary health care staff and the mental health team. They engage in case discussion and a review of disorders, therapy and treatment. Once a month, the primary care group meets with each of the adult and child social workers for half-an-hour to one hour to review cases which have been referred. Three times a year, a shared-care retreat is held to review how the “sites” are functioning; new educational and developmental initiatives are also discussed. This comprehensive system of meetings and case discussions enhances knowledge transfer between the clinic staff and the supporting mental health team members. In addition, communication is improved through the use of electronic patient records, which allow for sharing of important information about treatment and follow-up.

Unique characteristic(s) to local community

- There was the presence of the teaching centre within the community, and the presence of learners within the centre

Barriers

- Funding and its sustainability
- Buy-in by Capital District Health Authority and the IWK Health Centre
- Development of the model of collaborative care
- Learning to function as a team and the associated growing pains
- Legal issues related to recording visits, while the clinic transitioned to the use of an electronic health record system

Strategies

- Lobbying for the service and its benefits for patients and providers
- Discussion and building consensus for support within the primary care team
- Maintaining a good relationship with the mental health team
- Receiving support from champions (who saw the value in this initiative) within the care teams and administrative/ management structures
- Regular, candid and clear communication with all parties involved

Funding

- Capital District Health Authority (CDHA)
- Dalhousie Department of Family Medicine
- Federal Health Transition Fund
- IWK Health Centre

Sponsoring organization(s)

- None

Other participant(s) or organization(s)

- CDHA
- IWK Health Centre

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Family Help

Start Date

September 2002

End Date

August 2006

Special Populations

Children and youth
Rural
Urban
Other

Human Resources

Administrative staff
Family physician
Non-clinical support worker
Psychologist

Location(s)/Setting(s)

Home

Evaluation

Yes, ongoing.

Initiative Short Title

Family Help

Purpose

Most children with mental health problems do not receive timely care. Often, family physicians lack the time and expertise to diagnose and treat children and adolescents with mental health problems. In collaboration with family physicians, Family Help delivers care to children and their families in their own homes, using distance technology.

Goals/objectives

- To develop, evaluate and eventually implement a distance-based treatment model for children with mental health problems and their families that can be delivered in their own homes, using a handbook, videos and non-professional coaching

Description

Family Help is modestly advertised (e.g., PTA meetings, word-of-mouth) as a resource that is available to family physicians for delivering care to children with mental health issues and their families. Once connected with Family Help, the family physician screens potential candidates using a standard one-page referral form, which is then submitted to Family Help. The initiative then contacts the family by telephone and performs a more thorough patient assessment. Based on that assessment, the patients and their families are randomly selected to receive treatment or "usual care."

Families receiving Family Help treatment receive videos and manuals specific to their diagnosis, and have access to coaching provided over the telephone. This coaching is subject to research protocols, and is provided by trained non-clinical workers. Family Help is structured to research four key groupings: disruptive behaviour disorders, anxiety disorders, bed-wetting and recurrent pain (i.e., stomach pain and headaches). In total, the research serves 500 clients.

Family Help communicates with family physicians and pediatricians on an ongoing basis by mail, informing them of their patients' assessments and time-limited (approximately 10-12 sessions) treatment protocol. There is ongoing dialogue between Family Help and the family physicians, and consultations are available when needed.

Unique characteristic(s) to local community

- The initiative had a champion in the health district and identified an imaginative Canadian Institutes of Health Research program

Barriers

- Securing and sustaining funding

Strategies

- The initiative worked closely with the provincial government during the development phase and throughout the project's life cycle to ensure that the focus and expected outcomes of the project were in line with the government's framework
- Often, research projects that thrive in a research environment fail to succeed in work settings because resources are more limited; Family Help was designed to use inexpensive distance-based technology (e.g., telephone) and is therefore likely to be cost-effective in work settings

Funding

- Canadian Institutes of Health Research
- Community Alliance for Health Research

Sponsoring organization(s)

- IWK Health Centre
- Dalhousie University
- Nova Scotia Health Districts
- Capital Health District

Other participant(s) or organization(s)

- None

Contact(s)

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Managing Our Moods (MOM)

Start Date

June 2004

End Date

June 2007

Special Populations

Disorder-specific
Rural

Human Resources

Administrative support
Family physician
Non-clinical support worker
Public health nurse
Supervising psychologist

Location(s)/Setting(s)

Non-clinical, home

Evaluation

Yes, ongoing.

Initiative Short Title

MOM

Purpose

Mothers who are depressed have a significant impact on their children's development. Yet, most rural women have no access to effective non-pharmacological treatment.

Goals/objectives

- To develop, evaluate and eventually implement a distance-based treatment model for women with post-partum depression, which is delivered in their own homes through a handbook, videos and non-professional coaching

Description

Women are connected to Managing Our Moods (MOM) by a family physician or self-referral, or are introduced to the program by a public health nurse conducting a post-natal home visit.

Once connected with MOM, a thorough patient assessment is conducted over the telephone. Based on the assessment, the patient is randomized to receive treatment or "usual care." Women receiving MOM treatment are given videos and manuals specific to their post-partum depression, and have access to coaching provided over the telephone. This coaching is subject to research protocols, and is provided by a trained, non-clinical (peer) worker.

Where women are connected to their family physicians, the program communicates with the physicians on an ongoing basis through the mail, to inform them of their patients' assessments and time-limited treatment protocol. The program stays in touch with the family physicians, and consultations are available, when needed. The research is targeted to 20 patients.

Unique characteristic(s) to local community

- The initiative received strong support from public health, found imaginative opportunities from the Canadian Institutes of Health Research (CIHR) and had a champion in regional mental health

Barriers

- Securing and sustaining funding

Strategies

- The initiative worked closely with the provincial government to develop the project and throughout the project's life cycle, to ensure that the focus and expected outcomes were in line with the government's framework
- Often, research projects that once thrived in a research environment fail to succeed in work settings because resources are more limited; MOM was designed to use inexpensive, distance-based technology (e.g., telephone), and is likely to be cost-effective in work settings

Funding

- Canadian Institutes of Health Research (CIHR)

Sponsoring organization(s)

- Dalhousie University
- IWK Health Centre
- Nova Scotia Public Health, Health Districts 4, 5 and 6

Other participant(s) or organization(s)

- None

Contact(s)

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Shared Care Mental Health Program, Hants County, Nova Scotia

Start Date

1999

Special Populations

Children and youth
Rural
Other

Human Resources

General practitioner
Primary health-care provider
Psychologist

Location(s)/Setting(s)

Medical clinic
School

Evaluation

Yes, completed.

Initiative Short Title

SCMH Program

Purpose

The program provides front-line caregivers such as physicians, teachers, educational assistants and guidance counsellors with on-site support, and helps them deal more efficiently and effectively with clients with mental health problems.

Goals/objectives

- To improve the quality of care provided to clients, reduce wait times and improve accessibility

Description

The Shared Care Mental Health Program provides consultation services to two health centres and ten schools in Hants County. A regular visiting schedule is maintained with both the health centres and the schools; each health centre is visited once a week and each school is visited by a psychologist once every five to eight weeks for a half day (with the exception of one school behavioural program that is seen for a half day every two weeks).

In the case of the health centres, the program offers on-site assessment, follow-up and consultation with the referring general practitioner. While there, the consulting provider meets directly with the primary health care provider(s) and also writes assessments/comments directly in the clients' medical charts.

Within the schools, the same services are available. However, schools structure the visits to best meet their needs. This often involves conducting educational workshops with staff, as well as offering consultations and assessments. For example, in one school program for children with behavioural/emotional disorders, the psychologist consults with educators to develop strategies to deal with mental health issues in the classroom (e.g., disruptive behaviour, phobias, generalized anxiety). When assessments are conducted, they are sent to the child's primary care provider upon completion.

Unique characteristic(s) to local community

- The program began as a pilot project in 1999 and was successfully funded upon completion

Barriers

- Barriers were limited during implementation due, in large part, to well-developed, local inter-agency connections and professional collaboration
- The demand for shared care outweighs the available resources

Strategies

- It is easier for salaried physicians to engage in collaboration (e.g., it is easier for them to make the time needed to talk about and take part in shared care) than it is for those who work in a fee-for-service environment

Funding

- Capital District Health Authority (CDHA)

Sponsoring organization(s)

- Annapolis Valley Regional School Board
- CDHA
- Hants Mental Health Clinic
- Hants Shore Health Centre
- Shared Care Mental Health
- Rawdon Hills Health Centre

Other participant(s) or organization(s)

- None

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Short-Term, Assessment, Referral and Treatment (START) Clinic

Start Date

September 2002

Special Populations

Urban

Human Resources

Client care coordinator
Nurse
Occupational therapist
Psychiatrist
Psychologist
Social worker

Location(s)/Setting(s)

Hospital

Evaluation

Yes, ongoing.

Initiative Short Title

START Clinic

Purpose

A 2001 Task Force on Mental Health Care Re-structuring at the Health Care Corporation of St. John's (HCCSJ) identified the need for urgent assessment and rapid emergency room follow-up as areas of concern within the continuum of mental health-care services in the St. John's region. The creation of a daily interdisciplinary clinic that would take referrals from the emergency room and family physicians was recommended, and a working group was given the mandate of implementing the recommendation.

Goals/objectives

- To provide urgent care to clients with mental health problems
- To provide brief therapy (i.e., six to eight visits)
- To provide interdisciplinary care (treatment is provided by the discipline most appropriate to the client's needs)

Description

The Short-Term, Assessment, Referral and Treatment (START) Clinic is an urgent care clinic that sees clients from Monday to Friday. Clients are referred from general practitioners in the community or from the emergency room psychiatry service. Clients may be seen by more than one care provider (e.g., nurse, psychiatrist, psychologist, social worker or occupational therapist). Short-term care is provided for a maximum of six to eight visits, after which the client is referred back to the family physician for follow-up, or to another mental health agency for longer-term therapy. Some ongoing support is provided to family physicians by psychiatrists. Approximately 100–120 clients are seen per month, with this number continuing to rise. Liability is shared for client care. The clinic is also a teaching facility for psychiatry residents and nursing students, and is affiliated with Memorial University of Newfoundland. Individuals seen at the clinic may be invited to participate in teaching and research activities.

Unique characteristic(s) to local community

- The clinic suffered from a lack of resources to provide rapid follow-up with individuals in need of psychiatric care who presented for consultation at emergency rooms, but did not require admission to hospital

Barriers

- As this was the first of its kind in the province, the clinic was breaking new ground and was therefore forced to look for solutions internally, since there were no established programs that provided a basis for comparison

Strategies

- The strategies included: holding planning days and group discussions, participating in interdisciplinary collaboration and organizing staff visits to other mental health clinics outside the region

Funding

- Health Care Corporation of St. John's (HCCSJ)
- Provincial government
- Funds are regulated by the Director of the Mental Health Program

Sponsoring organization(s)

- HCCSJ
- Short Term, Assessment, Referral and Treatment (START) Clinic

Other participant(s) or organization(s)

- None

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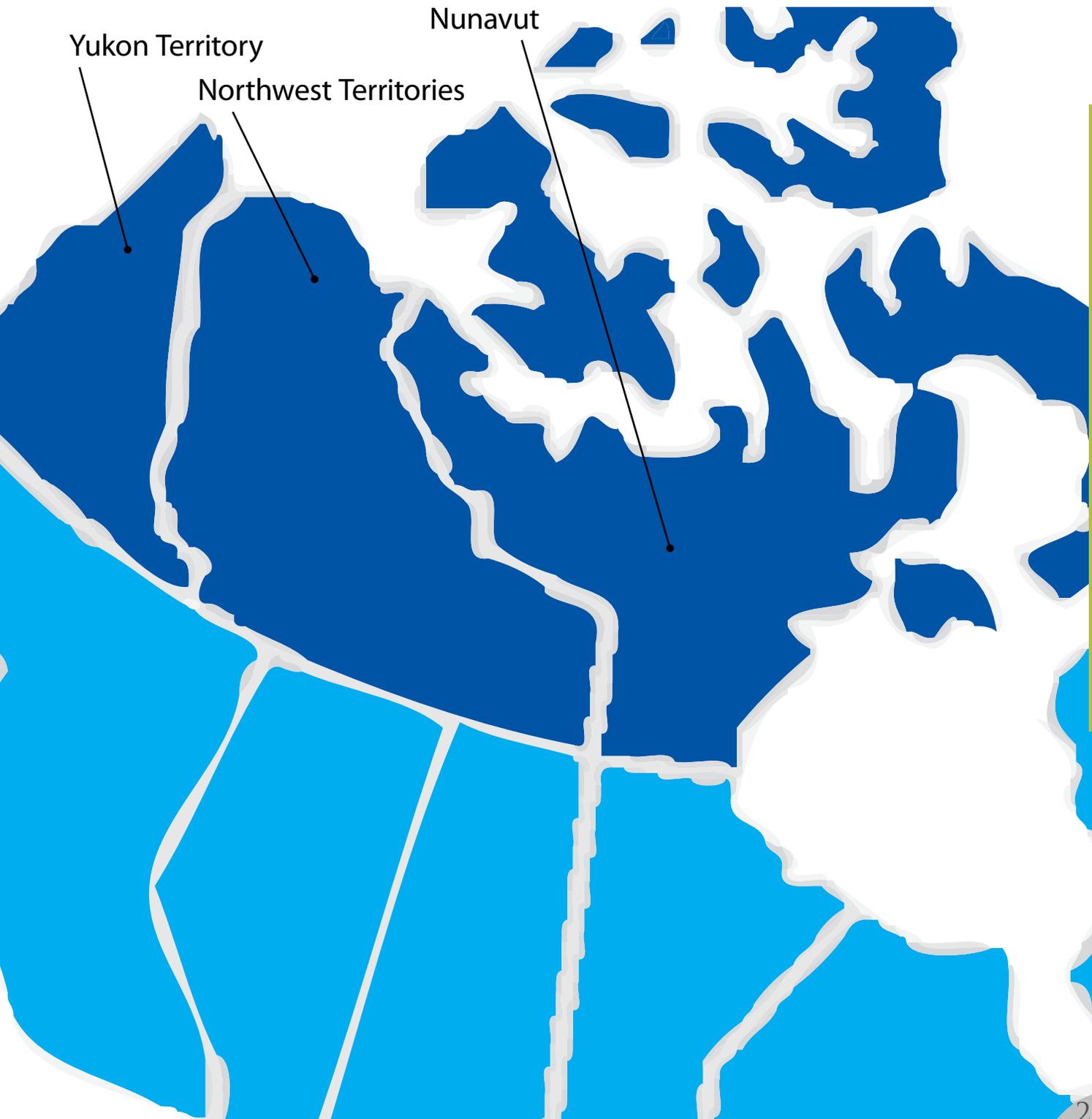
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appendixC

INVENTORY OF CANADIAN INITIATIVES - NORTHERN



NORTHERN

A Shared Mental Health Care Model for Whitehorse General Hospital

Start Date

February 2004

Special Populations

Aboriginal
Northern/isolated
Rural
Other

Human Resources

Administrative Assistant
Clinical Care Manager
Community Liaison
Dietitian
Family physician
Licensed practical nurse
Mental health nurse
Pharmacist
Psychiatrist
Registered nurse

Location(s)/ Setting(s)

Family practice clinics
Hospital

Evaluation

No.

Initiative Short Title

Whitehorse General Hospital

Purpose

Northern and rural communities have found there must be a collaborative approach to maximize resources and provide the highest quality of patient care. The foundation for this Shared Mental Health Care (SMHC) model has been identified and developed, based on key concepts of the national Shared Mental Health Care model.

Goals/objectives

- To increase awareness and understanding of the Aboriginal model, the SMHC model, and Integrated Medical and Aboriginal models of health care
- To uniquely incorporate First Nation philosophical, cultural and traditional healing practices

Description

The Shared Mental Health Care model incorporates the principles and values of First Nation culture and is integrated into the medical model within the hospital setting. The hospital is also partnered with as many community agencies as needed, and professionals provide consultation and support to community agencies, such as the Royal Canadian Mounted Police and community nurse-practitioners (especially those in rural communities).

The First Nation Health Program incorporates Aboriginal Holistic Health values and beliefs, taking into consideration wholeness and balance of the physical, emotional, cultural and spiritual needs of the individual, and is also reflective of Yukon First Nation cultural and healing practices. Ceremonies, prayers, the acceptance of traditional foods and medicines, and the First Nation Healing room are all a part of a patient's overall care.

The family physician is most often the first contact for the patient, who is in crisis and requires assessment and/or treatment. The family physician also acts as the case manager for the patient while coordinating and assuming primary care responsibility for his or her care. On a regular basis, family physicians consult with psychiatric specialists in urban centres, especially when caring for youth, or if a patient is being transferred out of Yukon for long-term assessment and treatment.

A consulting psychiatrist visits the hospital for two hour each weekday to see mental health patients for individual consultation, as well as offering education and support, both in person and via telephone. Patients can also be referred for consultation to the psychiatrist's clinic. Visiting psychiatric specialists, such as a child psychiatrist, have occasionally provided consultative services to patients admitted to the hospital.

Mental health nurses (registered nurses) and licensed practical nurses are responsible for the care of mental health patients when the mental health nurses or First Nation liaison workers are not available. Regular and ongoing communication and consultation occurs, and relevant information is frequently shared among the entire staff, using a variety of formal and informal strategies. For example, individual shared-care plans are developed for patients requiring regular emergency visits or admission; these plans outline the patient's history, issues, plan-of-care while in hospital, and a discharge community plan. Physicians and nurses input patient orders and view results, using a common clinical electronic health record for patient files.

Unique characteristic(s) to local community

- This initiative works as a comprehensive First Nation Health Program integrated into a community hospital setting; the initiative focuses on holistic health and healing, in terms of physical, emotional, mental and spiritual parts of the individual; this model includes direct practice professionals, administrators and other key support staff

Barriers

- At this time, joint consultations are not conducted with family physicians, psychiatrists and patients because of Yukon billing regulations

Strategies

- Some recent and progressive policy and practice initiatives have been developed and implemented to address the safety concerns of patients and staff
- Regular educational sessions are provided to all staff in the area of mental health; some are available in consultation with the University of Alberta

Funding

- No funding was received for this initiative

Sponsoring organization(s)

- Whitehorse General Hospital

Other participant(s) or organization(s)

- None

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Great Slave Community Clinic

Start Date

November 2005

Special Populations

Aboriginal
 Children and youth
 Concurrent disorders
 Disorder-specific
 Ethno-cultural
 Homeless/transient
 Northern/isolated
 Seniors/geriatrics
 Urban
 Other

Human Resources

Addictions worker
 Advocacy service worker
 Coordinator
 Dietitian
 Nutritionist
 Family physician
 Licensed practical nurse
 Mental health social worker
 Midwife
 Nurse-practitioner
 Public health nurse

Location(s)/Setting(s)

Community clinic
 Non-governmental organization
 outreach sites
 Walk-in outreach clinic

Evaluation

Yes, completed and ongoing.

Initiative Short Title

Great Slave Community Clinic

Purpose

The community health section of the Yellowknife Health and Social Services Authority (YHSSA) has been receiving increased requests from the community to enhance services for the “hard-to-reach” population. At the same time, community organizations realized that there was some duplication of services to this group. There was a recognized need to work together to provide services related to the determinants of health.

Goals/objectives

- To develop a multidisciplinary, community-based clinic and outreach services for our target population, using the principles of primary health care
- To emphasize disease and injury prevention, as well as the management of chronic diseases
- To enable interdisciplinary teams to provide care by the most appropriate provider, and to arrange opportunities for community and client input
- To improve coordination and integration of services within the clinic and the community

Description

The Great Slave Community Clinic (GSCC), a multidisciplinary clinic in downtown Yellowknife, has been developed to reach at-risk clients. The clinic is shaped and guided by an advisory committee that includes representatives from many Yellowknife non-government organizations (NGOs). In addition, a client survey was used to gather feedback from the target client group and recommendations have helped shape the vision and direction of the clinic. Focus groups held later with target client groups gave advice on a clinic name and the terminology to be used in promotional materials.

The interdisciplinary team at the clinic also has access to other providers, including a dietitian and a nutritionist. A client may present to any member of the team, or self-refer to the clinic. Client information is recorded using an electronic health record, which allows providers to share important details about the progress of clients. Team members meet periodically and have been involved in team-building sessions.

The clinic is also closely connected to the territorial hospital, which services all of the Northwest Territories and part of Nunavut.

Communication between staff at the clinic and the mental health staff at the hospital is strong, and care for clients may be transferred or shared between providers at the two locations. In addition, clinic staff members are connected with family counselling services, other mental health clinics in the community, and addictions services.

Unique characteristic(s) to local community

- Community organizations and individuals were invited to participate and were involved from the outset of this project; the local health authority worked closely with this group. Members of the advisory committee, although mostly from the non-governmental organization sector, represented people, not their sponsoring organizations

Barriers

- There is a large immigrant population in the city, which creates some language barriers; in addition, there are ten different Aboriginal languages that also create communication challenges
- Twice a year, there is limited access to the Yellowknife clinic, where fly-in services are required
- Primary health-care reform is not embraced by all health professionals
- Program funding, guidelines and timelines for use did not allow for much flexibility
- The change process affected people in different ways and meaningful communication was a big challenge

Strategies

- The coordinator and advisory committee developed internal and external communication plans
- Advisory committee members were part of smaller working groups to help meet our goals and objectives
- We looked for and engaged our navigators/champions
- We provided change management and team-building exercises for YHSSA staff, as well as NGO staff who were making the move to the clinic
- We had regular meetings with staff at the existing clinic, where we listened to their concerns and ideas, and involved them in planning the new facility

Funding

- Primary Health Care Transition Fund (November 2003 to November 2005)
- No additional funding has been provided for human resources; instead, the clinic is looking at changing ways that care is provided, by moving positions and creating new teams of care providers

Sponsoring organization(s)

- Health Canada
- Primary Health Care Transition Fund (PHCTF)
- The Yellowknife Health and Social Services Authority (YHSSA)

Other participant(s) or organization(s)

- Advisory Committee of the YHSSA, community organizations and individuals
- Department of Health and Social Services, Government of the Northwest Territories (GNWT)

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Tlicho Healing Path Wellness Strategy

Start Date

May 2004

Special Populations

Aboriginal
Children and youth
Disorder-specific
Northern/isolated
Rural
Seniors/geriatrics

Human Resources

Addictions counsellor
Director
Family physician
Healthy lifestyles coordinator
Manager
Mental health/addiction counsellor
Nurse
Principal
Psychiatrist
School community counsellor
School counsellor
Social worker
Volunteer caregiver

Location(s)/Setting(s)

Health centres
Outreach

Evaluation

Yes, ongoing.

Initiative Short Title

Tlicho Wellness Strategy

Purpose

Mental health and primary care providers were becoming increasingly aware of the need to provide counselling, addictions and wellness services to the four Dogrib communities. The services needed to be linked to the existing health centres in the communities, as well as to the services (social services and schools) provided by the Dogrib Community Services Board (DCSB). Because of the isolation of three of the communities (access only by air or winter road), it was also necessary to build upon the expertise of local elders and counsellors, as well as various local organizations that could provide support to those requiring assistance.

Goals/objectives

- To have a regional network of caregivers helping individuals, families and communities to develop and walk their healing paths on the road to wellness
- Mission of the Tlicho Healing Path Wellness Strategy is “to guide the residents of the Tlicho communities to accept personal responsibility for their own healing and wellness on an individual, family and community basis”

Description

The Dogrib Communities Services Board (DCSB) is a unique model of service delivery in Aboriginal communities in the North and elsewhere. It combines health, social services and education services (which include culture and employment services) under one community-elected board of directors. Services are provided in collaboration with the Government of the Northwest Territories. One of the components of this model are the Tlicho Healing Path Wellness Centres, located in Rae Edzo, Northwest Territories (110 km. northwest of Yellowknife), and Wha Ti, which serve residents of all the Dogrib communities.

The strategy is being developed and maintained by the staff of the Tlicho Healing Path Wellness Center in Rae Edzo. There are four Aboriginal counsellors, a wellness (lifestyle) counsellor, social workers and a nurse, who work together and meet weekly to discuss the progress of the program and specific patient cases, when needed. The program has access to a family physician one day per week and limited access to a psychiatrist one or two days per year. Information is shared by phone or fax among providers located in different communities.

In addition to providing counselling services in the Dogrib communities, staff members are involved in helping communities to set up their own core of local caregivers and to create a network of caregivers among the four communities. Support is also provided to community groups and educational programs; workshops and referrals to community and outside agencies are other components of the program.

Unique characteristic(s) to local community

- The Dogrib established the DCSB as an integrated model of services in 1997. This was the first step towards Aboriginal self-government, which will come into effect August 5, 2005. This momentum towards integration and self-government certainly was a catalyst for the development of the Tlicho Healing Path Wellness Strategy

Barriers

- No major barriers
- Experience has shown us that we must train and develop Dogrib caregivers, rather than hire professional, non-Dogrib workers who come from the outside; this provides ongoing stability, but takes time, and can limit capacities in the initial stages, until staff have more experience and receive more training

Strategies

- Capacity-building for Dogrib staff

Funding

- Aboriginal Healing Foundation (funding terminates, as of June 2005)
- Primary Health Care Transition Fund (funding terminates in 2006)
- The Government of the Northwest Territories has provided ongoing core funding

Sponsoring organization(s)

- Dogrib Community Services Board (DCSB) (soon to become the Tlicho Community Services Agency, as of August 5, 2005)

Other participant(s) or organization(s)

- Dogrib Treaty 11 Council
- Department of Health and Social Services, Government of the Northwest Territories

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Nunavut Addictions and Mental Health Services (Kivalliq Region)

Start Date

1999

Special Populations

Aboriginal
Children and youth
Concurrent disorders
Disorder-specific
Northern/isolated
Rural
Seniors/geriatrics

Human Resources

Aboriginal Elder
Administrative
Coordinator
Director
Family physician
Manager
Mental health consultant
Nurse
Occupational therapist
Physical therapist
Psychiatrist
Social worker
Speech language pathologist

Location(s)/Setting(s)

Community health care centres
Social service offices

Evaluation

Yes, ongoing.

Initiative Short Title

Nunavut Addictions and MH

Purpose

To develop and implement addictions and mental health services to meet the needs of the citizens of Nunavut. In 1999, the service model that existed was developed before the creation of Nunavut. The current Addiction and Mental Health Framework outlines a comprehensive set of guidelines that are culturally appropriate, clinically sound and meet the goals of “healthy communities:” simplicity, unity, self-reliance and continuing learning, as set out in *Pinasuaqtavut*.

Goals/objectives

- To build on the traditional values and strengths of Nunavut communities
- To provide the best possible services to addiction and mental health patients that integrates traditional and Western knowledge

Description

There are eight communities in Kivalliq. Each community has a health centre, where nurse-practitioners provide the majority of primary health-care services. The nurse-practitioners are able to refer patients to a see a family physician, if needed. Family physicians visit the centres once or twice a month. The nurse-practitioners may address the mental health issues of patients on their own or in consultation with other mental health specialists, including: psychiatric nurses, social workers, occupational therapists, family physicians or psychiatrists. They may refer patients to see a mental health specialist. Patients may also self-refer, or be referred by social services, the RCMP (Royal Canadian Mounted Police), their families or the health centre. In addition, the mental health consultants meet with individuals in the communities, specifically, Aboriginal Elders.

The primary services provided by the Northern Medical Unit involves sending psychiatrists to each community for one or two visits per year. The services total approximately 90 days per annum. Psychiatrists are paid ten per cent of their time for continuing care, which means that they are accessible by phone for consultative services. They also act as a doorway for acute care services for patients who are in crisis. The psychiatrists provide support, mainly to mental health workers and/or family physicians, although some support is given to nurses at the community health centres.

Mental health-care services in Nunavut are also supported by a tele-health system, which has only been in place for a few years and is still evolving.

Unique characteristic(s) to local community

- The communities are far apart, and people are very isolated
- There is a very high suicide rate compared to the rest of Canada (in parts of Nunavut, the rate is about five times higher); there is a tremendous need for services related to depression, addictions and major mental illness (acute and chronic) in these communities

Barriers

- Language barriers
- Confidentiality in small communities, where health-care providers are playing multiple (and at times, conflicting) roles

Strategies

- Use medical interpreters to overcome language barriers
- Emphasis on enhancing the capacity of Inuit mental health workers in the community
- Health-care providers in the communities are encouraged to maintain personal and professional boundaries, in order to address challenges with confidentiality
- There is a strong emphasis on using a holistic view, when addressing the needs of patients

Funding

- Government of Nunavut

Sponsoring organization(s)

- Department of Health and Social Services (Kivalliq Region), Government of Nunavut

Other participant(s) or organization(s)

- J.A. Hildes Northern Medical Unit, Inuit Health Program, University of Manitoba

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