CANADIAN MENTAL HEALTH ASSOCIATION, ONTARIO WINTER 2006

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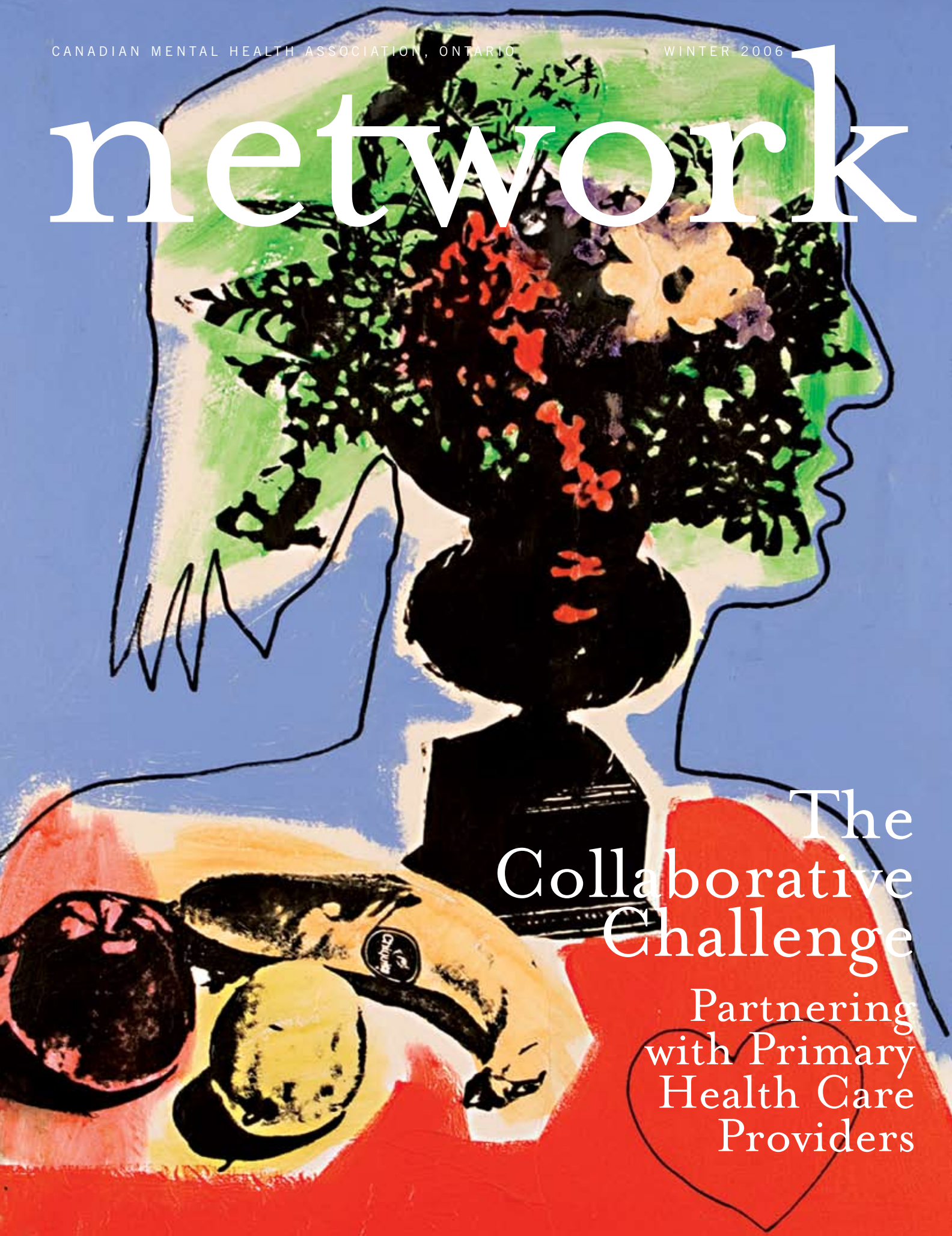

The Collaborative Challenge

Partnering with Primary Health Care Providers

network
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contents

Re: Cover
Henry B. Benvenuti, *Sister* (oil and acrylic on canvas, 19" x 26"). Reproduced by permission. This painting appears in the Being Scene 2005 art exhibit at the Centre for Addiction and Mental Health in Toronto.

CANADIAN MENTAL HEALTH ASSOCIATION, ONTARIO
L'ASSOCIATION CANADIENNE POUR LA SANTÉ MENTALE, ONTARIO

OUR MISSION
To promote the mental health of all individuals and communities in Ontario by providing leadership through knowledge enhancement, policy development, advocacy, and the advancement of best practices in service delivery.

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Network, c/o
Canadian Mental Health Association, Ontario
180 Dundas Street West, Suite 2301
Toronto, Ontario M5G 1Z8

TELEPHONE 416-977-5580
FAX 416-977-2264
E-MAIL network@ontario.cmha.ca
WEBSITE www.ontario.cmha.ca

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Maintaining the Patient-Physician Relationship in Family Practice

Jan Kasperski, RN, MHSc, CHE
Ontario College of Family Physicians

The father of family medicine in Canada, Dr. Ian McWhinney, reminds us that family doctors form a covenant, rather than a contract, with their patients. A contract means that the physician will do so much and no more. A covenant means that the physician will do everything and anything it takes to meet the needs of the patients.

On an operational level, the covenant between the patients and their family doctor is supported through a model of care known as "patient-centred care." Patient-centred care involves the development of a partnership between the patient and the family physician based on trust and mutual respect. The patient brings to the clinic setting knowledge of self, of family and of the community in which the patient lives and works. The physician brings to the table knowledge of clinical medicine and the health-care system. Together, they work through the assessment and diagnosis of the problem and then together make decisions about the most appropriate treatment plan.

The trusting patient-physician relationship develops over time, over multiple visits, and is key to patient-centred care. Patient-centred care results in better health outcomes, fewer tests and fewer referrals to specialists and specialty services. It is effective and cost efficient. As we move towards increased organizational structure in primary care that demands new accountability contracts with government, we need to be careful that they do not overshadow the vitally important covenant between family doctors and their patients. As we develop interdisciplinary teams and shared care models of service delivery, we need to be mindful of the importance of patient-centred care practiced within the trusting patient-physician relationship.

Patients value the relationship they have established with their family doctors. Regardless of the problem but especially in the area of mental health, patients prefer to have their care delivered by their own family doctor. Family doctors have told us, time and time again, that it is almost impossible for them to gain access to mental health care for their patients in those instances when the patient is willing to be referred or is so ill that referral is almost mandatory. As a result of both patient choice and lack of access, the main providers of mental health care in Ontario are family doctors and they are asking for help.

The Collaborative Mental Health Care Network (CMHCN) was established by the Ontario College of Family Physicians to provide that help. CMHCN borrows from the concepts of shared mental health care, bringing together family doctors, GP psychotherapists and psychiatrists and their specialty team into an educational model of support for patients. However, it maintains the special relationship between family doctors and their patients while providing the guidance, advice and support that family doctors need to deal with the wide spectrum of emotional and mental illnesses that their patients experience.

The results have been very positive. Family doctors report that they feel much more confident in their ability to provide care for even the most complex mental illnesses. They are less likely to refer patients to specialists or send them to the emergency department, and they are looked upon in their own communities as "opinion leaders" who are willing to share their expertise with other family doctors and to advocate for positive changes in the mental health care system locally. The increased level of respect for family physician members of the network amongst the specialists has resulted in positive changes in their own practice. Mentoring, rather than providing hands-on care, has freed them up to deliver care to those most in need.

The Ministry of Health and Long-Term Care is to be commended for its support of this project and for providing the encouragement needed to truly make a difference in the delivery of excellent mental health care services in Ontario and serving as an excellent model of care nationally and internationally.

Jan Kasperski, RN, MHSc, CHE, is the executive director and CEO of the Ontario College of Family Physicians.

IN PRINCIPLE AND IN PRACTICE

EVERYONE KNEW THAT COLLABORATION WAS THE KEY. FAMILY DOCTORS, DIETITIANS, SOCIAL WORKERS, OCCUPATIONAL THERAPISTS, NURSES, PHARMACISTS, PSYCHOLOGISTS, PSYCHIATRISTS, CONSUMERS, FAMILIES AND CAREGIVERS — THEY ALL KNEW THAT COLLABORATION WAS THE KEY TO IMPROVING MENTAL HEALTH CARE IN PRIMARY CARE. SO THEY GOT TOGETHER AND DID SOMETHING ABOUT IT.

They — or rather, colleges or associations that represent these professions — formed the Canadian Collaborative Mental Health Initiative (CCMHI), jumping at $3.8 million in funding from the federal government's Primary Health Care Transition Fund, which the first ministers set up in 2000 to support new approaches to primary health care. Together, they are finalizing a two-year effort to set out some principles and practices for improving integration. In fact, visitors to their website enter it by clicking on the words "Collaboration is the key."

The idea, says the initiative's executive director, Scott Dudgeon, was to create a group that "would identify what the barriers were to collaborative mental health care, that would research what's actually going on across the country and internationally, that would put in place some strategies, and that would create a charter to be signed off by all of the member associations so that this work on integration could take place continuously."

The Canadian Mental Health Association has been involved from the start. Penny Marrett, the CEO of CMHA National, says, "We're seen to be the organization that can bring the community voice to the table."

There are 12 organizations at the table, to be precise, amongst them the family doctors and social workers and psychologists. As of mid-January 2006, ten of the member organizations, including CMHA, had signed off on the CCMHI charter, one of the initiative's key deliverables. Dudgeon expects the rest to sign off before the initiative officially ends on March 31, 2006.

"The charter came out of a recognition that the funding was for two years," Dudgeon says, "and that we weren't going to solve all the problems in the space of two years but we were going to get some momentum going, and the charter was intended to be the vehicle by which that momentum could be continued beyond the life of the project."

The charter presents principles of effective collaborative mental health care, such as the right of Canadians who need mental health services to be full partners in their own plan for recovery, as well as commitments from the member organizations such as providing leadership, eliminating stigma, respecting diversity and being consumer-driven.

Dudgeon invited federal Minister of Health Ujjal Dosanjh to sign the charter on behalf of the Canadian people at the annual conference on shared care in May 2006. But with an election in January, says Dudgeon, "I can appreciate that this invitation isn't foremost in his mind at the moment."

If the charter is the guide to collaboration, and a series of 12 research papers the initiative produced are the evidence base, then the other major outcome of the CCMHI — a series of toolkits for service providers, consumers and educators — may have the most practical influence on how collaboration occurs.

Dr. Marie-Anik Gagné, the CCMHI project manager, was involved in the development of all 12 toolkits, including the "implementation" toolkits for service providers. "They're really for people who are on the ground and who want to either enhance their collaborative initiatives or create a new one," says Gagné. Dudgeon says the general toolkit "deals with the generic questions [such as], 'Having understood that collaboration will help me improve my practice, how do I go about planning this, who do I need to include in the planning, what are the potential partners I might have in this collaboration, how do we evaluate process, how do we document this,' things of that sort. It's not clinically oriented; it won't tell you how to treat depression. But it will tell you what professionals you

> Some of the principles of CMHA's *Framework for Support*, a policy paper that calls for the full involvement of consumers and their families in recovering from mental illness, are now part of the initiative's framework, particularly the focus on the consumer.

"IN ORDER TO MAKE CHANGE HAPPEN," SAYS DR. MARIE-ANIK GAGNÉ, THE CCMHI PROJECT MANAGER, "WE NEED TO MAKE SURE THAT THE NEW PROFESSIONALS ARE TRAINED TO THINK IN A COLLABORATIVE FASHION, AND TRAINED IN AN INTER-PROFESSIONAL WAY."

The CCMHI charter presents principles of effective collaborative mental health care, such as the right of Canadians who need mental health services to be full partners in their own plan for recovery, as well as commitments from the member organizations such as providing leadership, eliminating stigma, respecting diversity and being consumer-driven.

might want to work with and how you can get them to function as a team. So I regard that as the substrate, that's the basis of it."

To accompany the general implementation toolkit, the initiative developed eight "companion" toolkits about establishing collaborative initiatives to serve special populations, including rural and isolated populations, children and adolescents, seniors, ethnocultural populations, Aboriginal peoples, urban marginalized populations and individuals with substance use disorders or serious mental illness. The development of these toolkits was led by Dr. Martha Donnelly, who teaches psychiatry and family medicine at the University of British Columbia.

"If the general toolkit is 'how to,' the specialized toolkits are 'what about,'" Donnelly says. If service providers want to focus on a population, or they want to ensure they didn't leave a population out of their planning, then the toolkits provide information about how to work collaboratively to serve that special population. For example, the doctors, dietitians, social workers and psychiatrist who work at a clinic in the downtown core of a city may want to consult the toolkit on urban marginalized populations.

While the eight expert groups worked independently, Donnelly adds, some issues came up in almost every group: the need to work as a team, for example, and the need for more research.

Consumers, families and caregivers have their own toolkit, which features information on how to access services, what type of professionals can help them in their recovery, and information on self-care and the needs and contributions of caregivers. There's also a toolkit for Aboriginal consumers, families and caregivers, which discusses how historical, social, political and economic conditions may affect the mental health of Aboriginal peoples.

Lastly, there's a toolkit for educators that includes a sample lesson plan, case studies, and best practices in inter-professional education. In order to make change happen, Gagné says, "we need to make sure that the new professionals are trained to think in a collaborative fashion, and trained in an inter-professional way." Gagné expects the toolkits to be published in February 2006.

Dudgeon chuckles when he's asked if producing all these toolkits and the charter at the same time was a challenge. Since the project only had a two-year timeframe, he says, they had to do analytical work — research on best practices and barriers to collaborative care — and produce the toolkits and charter at the same time.

"It was a big challenge," he says. "One of the things we did very early on was establish a framework that allows us to look at the features of effective collaborative mental health care, and that framework speaks of quadrants that would include patient centredness,

*fast*FACTS

40%

Estimated percentage of individuals seen in primary care who have a mental health problem

25%

Estimated percentage of individuals seen in primary care who have a diagnosed psychiatric disorder

12%

Increase in the average number of mental health-related billings between 1992 and 2001

See www.ontario.cmha.ca/network for sources

structures of collaboration, richness of collaboration, and accessibility.... That was helpful, that was a reasonable way to offset the fact that we were doing all of these things concurrently."

Marrett thinks contributing to the framework was one of CMHA's biggest contributions to the initiative. Some of the principles of CMHA's *Framework for Support*, a policy paper that calls for the full involvement of consumers and their families in recovering from mental illness, are now part of the initiative's framework, particularly the focus on the consumer.

Donnelly says that the expert groups that developed the special population toolkits used the initiative's framework as a guide. For example, since accessibility is one of the fundamentals of the framework, the seniors toolkit group she co-led looked at accessibility issues for seniors. Since seniors may have trouble getting to a doctor's office, the toolkit suggests that service providers may need to go into seniors' homes or into long-term care facilities to offer care.

And how do 12 groups collaborate when teaching others how to collaborate? Keeping that focus on the person who needs mental health care was a means of keeping things running smoothly, Marrett says.

"I think there are always challenges when 12 organizations sit down and start to figure out what exactly does all this mean and what are we going to do? How are we going to do it and how are we going to work together in order to be able to achieve what we want to achieve? The challenge has been for all of us to be able to put our biases aside about any and every health professional or community organization, to be able to achieve what we're there for. We're really there for the individual who needs the service."

For more information about the Canadian Collaborative Mental Health Initiative, visit www.ccmhi.ca.

Jeff Kraemer is the e-content developer for CMHA, Ontario.

CONSUMERS, FAMILIES AND CAREGIVERS HAVE THEIR OWN TOOLKIT, WHICH FEATURES INFORMATION ON HOW TO ACCESS SERVICES, WHAT TYPE OF PROFESSIONALS CAN HELP THEM IN THEIR RECOVERY, AND INFORMATION ON SELF-CARE AND THE NEEDS AND CONTRIBUTIONS OF CAREGIVERS.

Jeff's Story

I have obsessive compulsive disorder.

For the majority of my life I was reluctant to admit that it was a problem. I just thought it was a quirk of my personality, definitely not an illness. It wasn't until I was 24 years old that I actually sought help from my general practitioner.

I started trying medication to help with my symptoms but then my symptoms, for whatever reason, took a serious turn for the worse. Ever since then, it's been a free fall down, which is where I am today. Roughly a year after I started taking medications, a year after it had gotten worse, I was able to admit that I needed even more help. That's when I started researching for more specialized mental health services.

For me, it's very difficult to do a lot of things, especially research. I have obsessions with reading. I have to re-read things. It was the hardest thing, it was almost torture. Research would take me probably ten times longer than the average person to do these things.

I don't have anyone overseeing the collaboration of different professionals. It's all up to me and I don't like that. Nobody's ever come to me and given me the "master plan" on how I'm going to get better. I'm just left to fill in the pieces. It's terrifying.

Access to psychiatrists in my region is very difficult — the waiting list is six months to a year for lots of them. Even when you get in to see a psychiatrist, they're only there to

prescribe medication. Because they have so many patients, they don't have the time to spend with you, get to know you, make a proper diagnosis, learn the intricacies of what's going on.

I'm lucky to have a GP who is pretty familiar with mental health issues. He's very open-minded, and he's knowledgeable about psychiatric drugs. I speak very highly of my GP but even then, besides medication, he has no real course of action. He's not a psychologist, he's not a cognitive behaviour therapist. He had no idea if there was any OHIP-covered cognitive behavioural therapy [one of the recommended treatments for OCD]. He's a busy guy, so he couldn't look it up for me. So I was left with the task of educating myself, of familiarizing myself with the system.

I called and I got my GP to make a referral to the treatment program at a local hospital. They specialize in providing therapy for OCD and other anxiety disorders.

When I first contacted them, there was a daunting waiting list — I thought the day would never come that I would even be considered to be treated there.

Eventually I got the application. I don't know if they realize this, but filling out those applications is something that I just can't do. I have an obsessional fear of official paperwork. Needless to say, it took me an incredibly long period of time to fill out those things.

Eventually I had my first appointment there and it went well. Then I had my second appointment, and it went well too, so we decided that I fit the criteria and they were willing to help me, to do CBT with me in a group setting. Unfortunately, by then so much time had elapsed, with me free falling, that I had fallen to a level where I was unable to leave the house. I'm actually being told the news that I've been waiting for, I don't know for how long, maybe six months, and when I'm told the news I have to respond — and they agree with me — that my symptoms are now too severe for CBT.

Subsequently, I had a mental health nurse coming to the house once per week, to fill the gap for two months, and it was pretty great. It was nice of her coming here, and she actually got me access to a psychiatrist in this area. He wasn't even accepting patients at the time, but she pulled a few strings and she got me to see him. But because he was fully booked, and he wasn't taking new patients, the appointments were only for a short time, just for a medication adjustment.

I've basically run out of medication now. I've been left to harshly withdraw from a medication, which has been extremely difficult. The symptoms of my OCD have spiked and gotten terribly worse. I don't want to sound morbid here, but they've gotten to an almost unlivable level.

I can't emphasize, there's a huge barrier for people with severe OCD because of our fears. It's not necessarily that we're afraid to go outside. But we can't get to see the doctors or even talk to them sometimes. I've met an individual who has very similar circumstances through the OCD Network [a self-help organization]. It's so difficult to even go to a bank or a doctor, to keep your appointments. I don't know how that could be addressed, unless they could come to you. I don't know if that's practical, if that fits into the budget of things.

As far as I know, I've done everything according to the book. Me and my family are basically left with "what the hell do I do now?" The "easy" answer is going to the local emergency room. I mean, that's what you do in an emergency, right? But there are so many barriers for me to get to an emergency room. I would have to complete an exhausting list of rituals just to leave the house.

My family is stuck in a very difficult situation. They see their son, their brother, their boyfriend, spiralling downwards, getting worse. Their hands are tied, they don't know what to do, they don't have access to anything. I feel so bad for them. I'm suffering the worst thing in my life, bar none, but I'm extremely worried about them. They need counselling or therapy too, because they've watched me suffer with this for a really long time. If somebody could come here and help them, it would be great.

> I don't have anyone overseeing the collaboration of different professionals. It's all up to me and I don't like that. Nobody's ever come to me and given me the "master plan" on how I'm going to get better. I'm just left to fill in the pieces. It's terrifying.

I find that there is a lack of continuity between these places. They're so segregated. I've never been hospitalized or had anything physically wrong with me, but I can imagine, it would seem like things would just flow.

I know that general practitioners have a role to play, but their knowledge of mental health issues… they're not experts in this. They're so bogged down with work that they don't have time to read about different programs in the area. I remember nights when I would say, "Okay, we're going to start from square one, I really have to do this now, I have to find out where to go and get better." There's a lack of communication between different programs, and other people don't know what other people are doing.

At least for me, and I'm sure for others, it's been very difficult figuring out what my next move is, where to go and what to do. I feel very alone in this process.

Partners & Peers

For people in Ontario, the family physician will most likely be the medical professional who handles their mental health and addiction issues. Not a psychiatrist or an addiction counsellor, but their local general practitioner, who in the course of a day may have delivered a baby, diagnosed chicken pox, managed the complex treatment of an elderly patient with heart disease, counselled an adolescent patient about birth control, and treated everyday coughs, colds and sore throats.

The nature of primary care allows the physician to treat patients at all stages of life, creating the opportunity for continuous, trust-based relationships. This is the up-side. The down-side is that family doctors may feel a lack of expertise and comfort in addressing complex treatment areas, such as serious mental illness and addiction.

Family doctors in Ontario reflected their unease in a survey published in 2000 by the Ontario College of Family Physicians (OCFP). Sixty-five percent of family doctors reported that they felt it was "often to always difficult" to diagnose and treat patients with addiction issues, and 63 percent reported that it was "often to always difficult" to help patients with a severe mental illness such as schizophrenia (see sidebar).

Considering that patients with severe mental illness and addiction issues will be treated initially in the primary care setting, and for some only by their family doctors, this could mean unnecessary and prolonged suffering due the physician's challenge of diagnosing and treating these complicated conditions. And when psychosis occurs, the need is even more pressing: evidence shows that there is a critical window for early intervention, and if left untreated, psychosis can lead to neurological damage. The burden of early intervention lies most often with the family doctor, who may have had as little as four weeks of psychiatry training in two years of family residency.

The OCFP offers continuing education for family doctors, with basic courses in addiction and mental health, but until recently, it had not addressed the relatively new field of early intervention in psychosis or a critical addictions issue, withdrawal management. Lena Salach, director of research and professional development for the OCFP, says, "At the college we're obviously very interested in education for family doctors. Early psychosis intervention and withdrawal management are two areas we have identified in the Collaborative Mental Health Care Network as needing education."

In November 2003, for the first time in its educational programming, the OCFP turned to leading service organizations in the field to collaborate on new educational modules for its peer presenter program. The peer presenter program delivers Continuing Medical Education (CME) credits to physicians who attend educational sessions delivered by specially trained peers. Historically, the OCFP had only collaborated with other medical specialties to develop curriculum for these modules.

The two co-principals on the new project, called "Interdisciplinary Mental Health and Addiction Education Project for Primary Care Providers," are Addictions Ontario (formerly Alcohol and Drug Recovery Association of Ontario) and the Canadian Mental Health Association, Ontario (CMHA). These two organizations, together with the OCFP, have taken on the task of developing and delivering a train-the-trainer module on two focused topics, "Early Intervention in Psychosis" and "Withdrawal Management." The Canadian Society of Addiction Medicine and the Ontario Federation of Community Mental Health and Addiction Programs are on board as supporting partners.

Project manager Janis Cramp, from Addictions Ontario, reports that the new module will be rolled out at the OCFP's February 2006 Collaborative Mental Health Care Network conference, where up to 20 physicians will be trained to deliver the new content to their peers. "An e-learning component will follow later in 2006," says Cramp, "and will be geared to a wider spectrum of health care professionals, including physicians, community care access workers, front-line workers, nurse practitioners and social workers."

Even before the training has been delivered, Cramp identifies two early successes. "First, the collaboration on this major project demonstrates that addictions groups and mental health groups can and do work together — we do work together! Secondly, the existence of a solid working relationship with OCFP is a significant marker." Many people have shown enthusiasm and amazing commitment, says Cramp, including the members of two content development groups and the physicians who provided peer reviews for the course content.

The main focus of the content is building physicians' capacity to understand and apply treatment protocols for both early psychosis and addiction

Treatment Troubles

In a recent survey, the Ontario College of Family Physicians asked their members, "How easy or difficult do you find it to treat each of the following mental health conditions?"

	Often to Always Difficult
Drugs and Alcohol Addictions	65%
Panic Disorder	10%
Depressive Disorders	5%
Obsessive Compulsive Disorder	19%
Bipolar Affective Disorder	50%
Schizophrenia	63%
Personality Disorders	78%
Eating Disorders	67%
Sexual Abuse	71%
Post-Traumatic Stress Disorder	52%

Source: Ontario Mental Health CME Main Questionnaire, OCFP, 2000

Sixty-three percent of family doctors surveyed in Ontario felt it was "often to always difficult" to diagnose and treat patients with a severe mental illness such as schizophrenia.

PARTNERS IN CARE: JONATHAN ZINCK (LEFT), EVALUATION AND SERVICE COORDINATOR AT CMHA COCHRANE-TIMISKAMING, AND JANIS CRAMP OF ADDICTIONS ONTARIO SPOKE ABOUT THEIR TRAINING INITIATIVES AT THE RECENT MAKING GAINS CONFERENCE IN LONDON, ONTARIO.

withdrawal. Michael Dean, manager of addiction services at St. Joseph's Hospital in Toronto and a member of the content development group, says that addiction treatment is challenging for physicians because they are used to responding to physical elements and test results in deciding on courses of treatment. "Addictions treatment is about talking, helping patients discover their strengths," explains Dean. "Our program helps physicians do this in their offices. It bolsters their confidence to develop effective treatment plans for patients, rather than use a hit-and-miss approach."

Both the early psychosis and withdrawal management programs use an interactive format, with videos of dramatized case studies giving participants realistic situations for discussion. For the early psychosis program, the videos also address the participation of family members in treatment and recovery — so common with early psychosis, which usually appears first in the teen years — to help health care providers understand how to manage this complex relationship.

A unique adjunct that grew out of the project was the collaboration between the OCFP and CMHA Cochrane-Timiskaming, a local branch serving the northern Ontario area of Timmins and vicinity. Jonathan Zinck, evaluation and service coordinator at CMHA Cochrane-Timiskaming, had been trying to address the problems of a severe physician shortage and lack of psychiatric services in the area through the development of a project called "Sharing and Caring."

"Sharing and Caring has two components," explains Zinck. "One involves bringing mental health perspectives into the physician's office, right into primary care delivery, and the second involves bringing a nurse right into the CMHA office to bring primary health care into the mental health setting."

"In the North, there is quite a shortage of both primary care physicians and mental health care, including psychiatry, in all of our districts. When I worked with the case management team at CMHA in Timmins, I found that we would be involved in shared care all the time. We would be the person trying to present the system to our client as seamless, so if someone had to go to a doctor's appointment or up to emergency and a client was intimidated by this (which was often the case), we would accompany them or help them understand what to expect. The Sharing and Caring project formalizes this approach."

In speaking with doctors, Zinck found that it's not that family physicians don't want to treat mental illness-related issues in their practices, it's that they don't feel they have enough tools to treat them effectively. Zinck continues, "For many people with their first experience of mental illness, they will go see their family physician. We wanted to enhance the capacity for family physicians to treat their patients effectively."

Zinck was in the early stages of developing his own educational modules when he heard about the OCFP's programs from Janis Cramp. Zinck says that the work of developing and

*fast*FACTS

10,439	Number of practicing family physicians in Ontario in 2004
598	Number of new family physicians since 1998
2,400	Estimated shortage of Ontario physicians in 2006
566	Average number of people per physician (including specialists) in Ontario in 2003

See www.ontario.cmha.ca/network for sources

accrediting courses is an arduous job, so to find high-quality, CME-accredited courses for family physicians ready-made was a perfect partnership. He and the OCFP have since collaborated on a multidisciplinary educational module that was rolled out this fall to family physicians in the North. The module was structured to include participation from not only a physician peer presenter, but also a nurse practitioner, a social worker and a consumer/survivor.

Participant satisfaction was high. "Very practical, take-home information. I learned more in a few hours than in weeks of residency," said one physician participant. Zinck credits the quality of the course content and the peer presenter model, because the unique challenges facing a busy family physician are completely understood by the instructor. Salach says that colleague-to-colleague education is effective for physicians because it creates a more comfortable learning environment where they feel less inhibited than when they have a specialist instructor.

The other half of Sharing and Caring is also showing success. A mental health nurse has been a part of the CMHA Cochrane-Timiskaming team since September 2004, serving CMHA clients with medical care, education and health promotion. In the next five months, says Zinck, the program will evaluate the nurse's impact on client health outcomes by tracking the number of emergency-room visits, conducting health-satisfaction surveys among CMHA clients, and holding focus groups of CMHA staff and clients.

As the common partner, the OCFP meets its own needs by adding a new educational module about early psychosis and withdrawal management to its successful peer presenter program. Through the Sharing and Caring project, the OCFP will be able to reach family doctors in an underserved area. Salach says that the collaboration with a local CMHA branch has been great because more than likely the college would not otherwise have been able to reach such an in-depth target. She adds, "We've been able to help because we already had the modules and facilitators available. Developing partnerships and linkages will hopefully eliminate reinvention of the wheel."

Addictions Ontario, CMHA, and the OCFP all report that the partnerships have been highly successful, not just in the delivery of new training, but also in the creation of strong relationships that will undoubtedly lead to future collaboration and ultimately enrich the primary health care of Ontarians.

The main focus of the "Interdisciplinary Mental Health and Addiction Education Project for Primary Care Providers" is building physicians' capacity to understand and apply treatment protocols for both early psychosis and addiction withdrawal.

Donna Hardaker is a community mental health analyst for CMHA, Ontario.

Matchmaking

The Ontario College of Family Physicians' Collaborative Mental Health Care Network is a mentorship program that connects family physicians to psychiatrists, GP-psychotherapists, and social workers. This clinical component, combined with small-group case-based sessions and the annual CME conference, creates a strong backbone of education and support for family doctors registered in the program. The program currently has 44 mentors linked to over 370 family physicians. The network has received funding to 2009 from the Ministry of Health and Long-Term Care and is currently piloting a residency program that matches psychiatry and family medicine faculty with psychiatrist residents and family physician residents so that connections have already been made before the family physician even begins independent practice.

Evaluation after one year indicates success, with all of the family physician participants reporting increased knowledge and skills and greater confidence in their ability to care for patients with complex mental illnesses, especially among physicians who were rated as heavy users of the mentoring service. Those physicians were able to decrease their reliance on face-to-face contact with specialists and instead found support through the more cost-effective means of e-mail and telephone contact.

"The network is always looking to expand and meet people's needs, with the goal of having all family physicians eventually able to participate in the program," says Lena Salach, director of research and professional development for the OCFP. Family physicians or psychiatrists who are interested in joining the mentorship program should contact Salach at ls_ocfp@cfpc.ca.

Barriers to Physical Care

Access to mental health care through general practitioners and other primary health care providers is becoming more and more of a reality. But what about access to physical care for people who are already in treatment and recovery from serious mental illnesses? Is there a role for collaborative care to make a difference in people's physical health as well?

Being able to access physical health care is as pressing an issue for people with significant mental health problems as it is for all Canadians. Perhaps even more so. People with serious mental illness have higher rates of a variety of significant physical health problems such as heart disease and diabetes. They also have high rates of cigarette smoking and obesity, both of which significantly contribute to ill health.

According to the Canadian Collaborative Mental Health Initiative (CCMHI), people with serious mental illness have a mortality rate that is four times higher than the general public. CCMHI is a national project whose goal is to inspire collaboration among providers to increase access to mental health care in primary care settings. Recognizing that a wide variety of people are affected by mental health problems, the initiative has developed a series of toolkits about establishing collaborative initiatives to serve specific populations, including children and adolescents, seniors, Aboriginal and ethnocultural groups, people with serious mental illnesses, and the "urban marginalized," among others.

Pat Larson, a nurse practitioner at the Sherbourne Health Centre in downtown Toronto, has experience working with people who fit the initiative's definition of the urban marginalized — people with mental illness and mental health problems, but also, more broadly, people who experience homelessness or unstable housing, people who have substance abuse problems, street youth, individuals with disabilities, and others who share lives of social exclusion and poverty.

Without the proper supports, the lives of some people with serious mental health issues can become chaotic, and this often leads to a multitude of problems. "When people's lives are in chaos, that chaos can lead to other things — homelessness, being in and out of shelters, in and out of rooming houses or other substandard housing," observes Larson. "That, in turn, leads to further chaos and lack of stability, which has an impact not only on mental health but also physical health" — problems related to exposure from living outside, and injuries from substance use and experiencing violence.

Not all people with mental illness end up homeless, of course. In fact, despite some common assumptions, only 20 to 40 percent of people who are homeless have a mental illness. But navigating through the mental and physical health care systems can be particularly difficult for many people because of the cyclical nature of their mental health problems, where periods of recovery are interrupted by periods of ill health.

"We have a physical health system and a mental health system, and we really haven't figured out how to mesh these two particularly well," says Larson. As a result of this divide between mental and physical health, people confront "lots and lots of issues when accessing physical health care, some of which are more concrete, some more esoteric."

Sadly enough, physical health problems can be related to the treatment of mental health problems. "We do know," Larson says, "that long-term use of certain antipsychotic agents seems to be associated with increased risk of diabetes, significant weight gain, and possibly with risks to the liver and kidneys, depending on the medication."

"And then, of course, there's the regular sort of health conditions like high blood pressure," and for women, preventative measures "like mammograms, pelvic and breast exams" that easily get overlooked when people are struggling to achieve basic needs like having a place to live.

Larson works with people who have extensive involvement with the psychiatric system, who may be homeless, and who have become marginalized in our communities. "They're at more risk for being 'rolled,'" she says. "They're subject to violence, to having things lost, or when their lives get more chaotic, just not knowing — things go missing, people end up in very chaotic situations."

Some people face concrete challenges getting health care, involving the things that most of us take for granted — having an OHIP card, or making an appointment to see a nurse or doctor. Larson says that the government of Ontario "made a choice" back in the mid-1990s to make applying for a health card more restrictive, requiring more paperwork and

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"When people's lives are in chaos, that chaos can lead to other things — homelessness, being in and out of shelters, in and out of rooming houses or other substandard housing…. [That instability] has an impact not only on mental health but also physical health."

— Pat Larson, Sherbourne Health Centre

supplementary identification. Having no ID and no health card is definitely a barrier to health care. "Even having an appointment-based system" is a barrier, observes Larson. "Having to serve very regulated systems [is a problem] when people's lives are at a point when they're not as regulated."

The way health care is funded can also be a problem. "If you're an OHIP-billing person, you may want to get people out of your office in 7.5 minutes," Larson explains. But this type of funding "doesn't reflect the time intensity that it takes to work with people whose lives are more chaotic — where the person doesn't have an OHIP card, or other ID, where their housing is in jeopardy, they've been using different substances, they've got bed bugs, they've got scabies, they haven't been on their medications for weeks, it can just go on and on. This isn't a 7.5-minute visit."

Beyond the concrete challenges, there are subtle barriers. The people Larson works with "will often have experienced trauma and significant abuse, deprivation or neglect in their lives." Building trust with people is key. She finds that nurses, among other health care providers, often have the skills to "just live with people where they are, not preaching" at people to change.

"The attitudes of health care providers make a very big difference in the lives of people who may be very mistrustful, or who have had extremely difficult experiences with the health care system. It takes a long time to build trust with people. It takes a long time to sustain that trust," says Larson.

Services need to accommodate the lives of people with serious mental illness who face multiple barriers. This could involve a range of activities, beginning with education for health care providers. "It takes a lot of skill to build and sustain people's trust, but we really haven't built a lot of that into our educational programs, as health care providers."

And it takes collaboration among health care providers. "This is a group [of clients] where teamwork may be the way to go" in order to overcome the division between physical and mental health care. "I think some of the most promising work that is being done is bringing the two pieces back together."

Larson believes that she and other nurse practitioners have an important role to play in collaborative care. There are nurse practitioners connected with some community mental health agencies, including a few CMHA branches in Ontario, and with psychiatric hospitals. "We have a bridging role. Others can do it too, but what's unique is that we can actually do both mental and physical health care."

Larson also feels that health care providers need training, and need to make the effort, to bridge both systems and to understand the roles played by different providers within those systems. To do her job effectively, says Larson, "I need to know how mental health care is organized and how physical health care is organized. I also need to know who my colleagues are — social workers, case managers, harm reduction workers, outreach workers — and how they fit together."

Psychiatrists who are willing to work in collaboration with health care providers beyond general practitioners are also needed to effectively serve this group of people with serious mental illness. "There are some psychiatrists who are willing to work with outreach workers, with family workers, nurses, and social workers in order to provide really good mental health consultation. There are some very good possibilities happening in the system, just not as many as we actually need."

Heather McKee is a community mental health analyst for CMHA, Ontario.

A-Way's Route to Wellness

Health involves more than the absence of illness — it also means being able to take care of oneself in order to keep healthy or to live with ongoing health problems. To get and stay healthy often requires doctors and pills. But it can also require basic things like having a home and a job — things that we don't often think of as related to health, but which are, in fact, essential.

When the Canadian Collaborative Mental Health Initiative (CCMHI) consulted with consumers, families and caregivers across the country to find out what people thought about collaborative care, they heard about the importance of traditional health care services, like doctors, therapists and medications. But they also heard about the "determinants of health," basic needs such as housing and nutrition which are considered "critical influences on overall health and well-being."

Putting "the needs of consumers at the core of collaborative mental health care" is a priority, according to CCMHI. This means that consumers must be "involved in all aspects of their care, from treatment choices to program evaluation." Collaborative care initiatives must be designed "to address the needs of specific groups; in particular, those that are often underserved or have a great need for both primary and mental health care."

CCMHI recognizes that peer support is one element of collaborative care. Peer support, peer advocacy, and consumer-run programs offer support from others who have similar experiences of living with and recovering from mental health problems. Around Ontario, there are many peer support and consumer-run programs that are ideally suited to respond to the growing recognition that collaboration is a key method of increasing access to health care services.

The Wellness Program at A-Way Express Courier Service in Toronto is an exciting example of this potential. The program was inspired by Mary Lucas, A-Way's executive director, who noticed "extraordinarily high levels of multiple health problems such as arthritis, heart problems, obesity and diabetes" among her couriers.

A-Way's employees are all people with direct personal experience of the mental health system. In business since 1987, A-Way was designed not only to provide excellent service to their 1200 customers, but also flexible and supportive part- and full-time employment to people who are too often shut out of the workforce. A-Way is one of a number of alternative businesses in the province which, altogether, currently employ about 800 consumer/survivors, according to the Ontario Coalition of Alternative

Businesses. "Some of our folks hadn't worked in 10 to 15 years before coming to A-Way," says Lucas.

Working at A-Way not only gives people a job, but also an opportunity to participate in running the business and creating a community. "Every year at the annual general meeting we fly some idea," says Lucas. Last October, she asked if people were interested in a wellness program addressing issues like losing weight, nutrition or quitting smoking. When the votes came in, people were clearly interested.

When Lucas asked people exactly what they wanted to learn, she quickly figured out they needed "two separate programs." One group of people wanted to learn new and healthy recipes, such as hearty soups and low-fat and low-salt cooking. The other group said they didn't know how to cook at all and needed "cooking for those who don't know how to boil water," or what A-Way calls the "Culinary Challenged."

The Wellness Program at A-Way Express Courier Service in Toronto was inspired by Executive Director Mary Lucas, who noticed "extraordinarily high levels of multiple health problems such as arthritis, heart problems, obesity and diabetes" among her couriers.

Lucas says one courier told her she was interested in a cooking class because, right now, she "eats mostly pastry." For people who haven't developed cooking skills and who are living on a low income, there is great temptation to rely upon junk and fast food, which is relatively cheap and easy to find. Even when you know that you're not eating healthily, it's hard to know how to begin to change your diet.

A-Way has already taken the first steps to respond to the needs of the couriers. They've partnered with a local restaurant, the Relish Bar and Grill, who provides healthy sandwiches at a reduced rate for their board, committee and staff meetings, instead of the usual fast-food pizza. They're encouraging people to order from the Good Food Box, a non-profit buying club run by FoodShare that offers fresh, low-cost fruits and vegetables.

A-Way has bigger plans as well, and Lucas is now seeking funding to turn those ideas into a reality. There is a lot that the staff can do together to support each other, says Lucas, but for "some things you need professional advice." Especially considering that some people have multiple health challenges. Not just diabetes, for example, but "diabetes, plus heart problems, plus arthritis, all in one package."

WORKING AT A-WAY NOT ONLY GIVES PEOPLE A JOB, BUT ALSO AN OPPORTUNITY TO PARTICIPATE IN RUNNING THE BUSINESS AND CREATING A COMMUNITY.

One particular goal is to provide support and advice from a dietitian, who can help people develop individualized nutritional plans. Lucas has seen the "huge difference in people's lives" that access to professional nutritional advice can make. Providing access through a consumer-run business helps to overcome the barriers both of cost and of transportation. "It's easy to put off trucking across town to some office where you've never been, paying for travel with money you don't have, and without the money to pay for the dietitian when you get there."

Lucas stresses that the people working at A-Way have the same physical health issues that everyone faces. Just like everyone else, people with significant mental health problems must cope with the frustration of waiting lists for health services. At the same time, however, they also have to deal with their mental health. Their physical issues are "not unique problems, but made worse" by the extra challenge.

Lucas describes the life many couriers had before coming to work at A-Way as "sitting on the couch for umpteen years." Unemployment among people with significant mental health problems is huge — some studies show the rate to be as high as 90 percent. People with mental illnesses are considered "unemployable" by many employers and, traditionally, even by mental health professionals. Alternative businesses, developed by consumer/survivors to provide supportive, flexible workplaces, have proven those other employers wrong.

Both physical and mental health depend on access to the basics of life that everyone is entitled to — a safe place to call home, work that provides an opportunity to give back to the community, and friends and family to share good times and bad.

Through their work at A-Way, the couriers and other employees are actively making social connections. "People do not flourish without social connections," says Lucas. "Work gives people a reason to get out of bed in the morning." And ultimately this benefits people's physical, as well as mental, health. As Lucas says, "It's all one piece."

For more information about A-Way Express Courier Service, visit www.awaycourier.ca.

Heather McKee is a community mental health analyst for CMHA, Ontario.

Dialing FOR Doctors

The typical day in a family physician's practice in northern Ontario is hectic, to say the least. The average workload for family doctors in Canada is more than 75 hours per week, and the much-publicized shortage of general practitioners across the country is even more pronounced in northern communities. According to the College of Family Physicians of Canada, 30 percent of Canada's population lives in rural, remote, and northern areas, but only 17 percent of family physicians practice in those areas, and the ratio of doctors to people is dropping even faster in rural areas than in cities. As the Centre for Addiction and Mental Health's Anne Hoelscher, who is based in Parry Sound, says, "Family physicians are on the spot with a wide range of primary care demands, and they're making the best decisions that they can, but they're often on their own."

While doctors' time is becoming more pressured, an increasing proportion of that time is spent addressing the mental health needs of their patients. According to the Canadian Institute for Health Information, the average number of mental health-related billings increased by 12 percent between 1992 and 2001. And mental health issues may be an associated reason for many other visits to family doctors — as many as 40 percent of individuals seen in primary care have identifiable mental health problems.

Family doctors must be able to respond appropriately to the mental health needs of their patients, because they are often the first and the only source of mental health services. According to the Institute for Clinical Evaluative Sciences, they are the sole source of support for as many as 84 percent of individuals seeking mental health care.

Given how much time family doctors spend addressing issues related to mental health, the question of whether primary care physicians receive enough mental health training is often posed. Dr. Peter Voore, clinical director of the General Psychiatry program at CAMH and an assistant professor of psychiatry at University of Toronto, says, "Much has been written in the past about how primary care physicians may not have sufficient training in the treatment of addictions and mental health issues, and given their busy clinical practices, they may not have enough time to access new research and best practice information."

Hoelscher feels that training is not the only issue. "I don't think it's just about having insufficient training. I think it's about the reality of how complicated some of the mental health needs are, the complexity in treating mental health problems, and just the fact that they're so prevalent. It's so much a part of what a physician is providing in terms of care."

In an attempt to respond to northern doctors' need for support in providing mental health care, the Centre for Addiction and Mental Health (CAMH) and the University of Toronto Psychiatric Outreach Program have developed the Mental Health Clinical Consultation Service (MHCCS), a six-month pilot project that allows family doctors in northern communities (as well as a limited number in the Toronto area) to call a toll-free number to access psychiatrists and pharmacists who can provide clinical advice. The project launched on October 1, 2005 and is slated to continue until March 31, 2006.

The Mental Health Clinical Consultation Service is a six-month pilot project that allows family doctors in northern communities to call a toll-free number to access psychiatrists and pharmacists who can provide clinical advice.

The benefits of the service are numerous. As Hoelscher, who manages the project, points out, the doctors can access not only the psychiatrists themselves, but an entire team of mental health-related resources. One particular call stood out, recalls Hoelscher: "It involved a reference librarian doing a literature search, the pharmacist saying, 'Have you come across anything like this?' and the psychiatrist saying, 'I'll check with my colleagues,' and so drawing on the whole team."

MHCCS helps address the isolation that doctors in northern communities experience. Says Hoelscher, "We recognized that the North was an under-serviced area, that it was an appropriate place to start." She adds, "It's like that hallway chat — here at CAMH or in other settings, we can walk down the hall and chat with each other. You can chat, come up with a plan, and move on."

Dr. David Mamo agrees. A staff psychiatrist in the Schizophrenia program at CAMH, Dr. Mamo was the expert on call during the first two weeks of the pilot. "The discussions [with family doctors] were not dissimilar to those I would have in a general hospital cafeteria: 'I've got this particular patient with this problem, what's your usual approach to managing such cases?' It is very collegial, very informal."

"If I had the opportunity as a psychiatrist to have this kind of service with, say, an internal medicine specialist, I would find it quite useful," continues Dr. Mamo. "The opportunity to informally discuss a case outside my area of expertise with another specialist, without having to go through a formal consultation process, would make for efficient use of resources in certain clinical situations, not to mention the educational benefits."

MHCCS builds on an understanding of the need to deliver primary care and mental health care in an integrated fashion. "That's the whole foundation of shared care — we know that physical health and mental health shouldn't be split," says Hoelscher. "You can treat one independent of the other, but you do better when you look at the whole picture."

The process for the service is straightforward. The calls to the service are received by CAMH's reference librarian who, after an initial consultation, decides if it should be directed to the pharmacy team or to the psychiatrist on call that day. An initial response to the call is made within 24 hours, although the difficulty of connecting with busy family physicians sometimes means that it takes a little longer for the psychiatrist and the doctor to connect to get further details if necessary. The team will then consult or conduct any research necessary, before responding to the family doctor with clinical advice. Hoelscher says, "We have very experienced psychiatrists and pharmacists, experienced in a range of topics, and so if one can't answer this question, they'll feel comfortable contacting a colleague. So really, when you call that number you have access to the larger resources that you wouldn't have if you were working in isolation in a family physician's office."

CAMH and U of T have come together as funding partners for the project, but they also share resources. Both institutions have psychiatrists who act as consultants, and they have worked together to share resources to ensure the best possible response for the family doctors calling in. The calls the service has received are sophisticated, reflecting the

knowledge and understanding that family doctors already have. According to Hoelscher, "This isn't 'Call the service if you want to know the initial dose of Paxil,' this is 'Call us if you have a complicated situation.' We're getting very well thought out kinds of calls, very appropriate."

"I have a lot of respect for family doctors," adds Dr. Mamo. "They're very well-rounded physicians. They're not going to call for things that are trivial. Some of the questions were very good, and led me to conduct a number of literature searches as well as stimulating interesting discussions with some of my own colleagues. For one particular excellent question, I recall, there was no good answer — the physician had completed all the relevant literature searches herself and it was simply one of those pharmacological questions in psychiatry for which we have no clear answer of yet."

"To be quite honest, I enjoyed the calls. I found them very stimulating. The questions were interesting — including questions relating to long-term effects of medications or the use of medication during pregnancy, as well as management of other behavioural issues."

The response doctors receive is very clearly advice, not direction — the family doctor must still decide on the best course of treatment for their patient. Hoelscher notes, "Basically, our response has to be, 'In this type of situation, or working with a patient with that type of symptom, I would look at or recommend this.' We're not saying 'You need to prescribe this, or you need to get this person cognitive behavioural therapy.'"

"It's called a 'consultation' service," explains Dr. Mamo, "but in truth it's not exactly a consultation because you're not seeing the patient and have not established a clinical relationship with the patient. You're being presented a case and you're giving your thoughts about it. When I interact with family doctors on the phone, I make it quite clear that my recommendations reflect what I would do if I were managing a similar clinical situation."

"The family doctors I've spoken with are happy to have this kind of service," continues Dr. Mamo. "The immediate feedback I got was positive — almost a sense of relief that they could talk about the case with another peer who happened to be a specialist in that particular clinical field. Even if I did not say anything that they were not already planning to do, just stating 'your plan seems to be reasonable, that's exactly what I would do,' can be very reassuring and validating, especially since some of the cases they're dealing with can be quite challenging."

MHCCS is modelled on a similar service that CAMH has been providing for a number of years now, called the Addiction Clinical Consultation Service. The advice that service provides is specifically related to addiction treatment, and is provided to any kind of addiction service provider, including family doctors, counsellors, nurses, social workers and pharmacists, across the province. As Hoelscher notes, "This mental health piece is really building on the ACCS experience."

While Hoelscher acknowledges that limited access to mental health services is problematic across the province, particularly in underserved rural and northern communities, she says that MHCCS cannot address that larger issue. "This service does not pretend to provide a comprehensive solution to the gaps in the very complicated spectrum of mental health care services. I think what we saw ourselves doing is saying, 'We can be one piece, but it's certainly not the solution.'" Further, she feels that there is a need for more services like this one. "There is certainly more demand for psychiatric outreach program consultants than there is funding or capacity to provide them, as an example."

But when asked about the future of the six-month pilot project, Hoelscher is enthusiastic. "There's lots of potential. We have to really work with it. I think a big part of it right now is getting family physicians to be aware of the service, increasing our promotion and getting more experience. Physicians are very, very busy. They do find this useful, but how can we get them to think about it when the need is actually there to make the call?"

For more information about the Mental Health Clinical Consultation Service, contact Anne Hoelscher at 705-746-7440 or anne_hoelscher@camh.net.

Liz Scanlon is the former public relations and policy coordinator for CMHA, Ontario.

*fast*FACTS

1,783	Number of practicing psychiatrists in Ontario in 2004
66	Number of new psychiatrists since 1998
6,148	Number of children with mental health needs per child psychiatrist in Ontario
21	Number of practicing psychiatrists serving rural Ontario
76,007	Number of people in rural Ontario per practicing psychiatrist
5,653	Number of people in urban Ontario per practicing psychiatrist

See www.ontario.cmha.ca/network for sources

THE GOLD STANDARD

By Michelle Gold

Placing Consumers at the Centre

This issue of *Network* focuses on the benefits of collaborative care for persons with mental health problems or mental illness. Much of the impetus behind collaborative care arises from the fact that the majority of persons with mental health problems first discuss their concerns with their family doctor. Patients with mental health problems account for a significant portion of family doctors' time, and family doctors are often uncomfortable or unsure how to manage the mental health concerns that patients bring to them. As a result, collaborative care strategies have been developed that emphasize improving communication between family doctors and psychiatrists, and developing new models of sharing care and information to support family doctors in their practice.

Situating other health professionals in family doctors' offices is a well-recognized approach that expands the vision from family medicine to "primary health care." As early as 1978, the World Health Organization convened an international conference on primary health care, culminating in the landmark Alma-Ata Declaration, which identified a vision for primary health care emphasizing health professionals working in teams to promote well-being as well as treat the physical, mental and social needs in a community. The benefit of multidisciplinary health providers working in collaboration was further endorsed in Ontario's "PCCCAR" report, presented to the Minister of Health in 1996.[1] These are two of the early direction-setting documents generating momentum for change in primary health care, although the Ministry of Health began funding multidisciplinary health care providers to work in teams in some Ontario communities through "alternate funding" beginning in the late 1980s, with the development of Health Service Organizations (HSOs) and through Community Health Centres (CHCs). We are now seeing the Ministry of Health and Long-Term Care fund family health teams across Ontario. I suggest we think of this as continuing progress towards collaborative care.

But what of individuals with serious mental illness? Oftentimes, persons with serious mental illness have no access to primary care, despite the fact that many suffer from serious physical health-related problems and chronic conditions. One solution is to embed primary health care in mental health programs. In one review, providers expressed satisfaction with this type of collaborative care model, identifying increased identification and treatment of physical health needs for persons with serious mental illness. As a result, individuals in embedded programs were less likely to use emergency rooms. Consumers expressed comfort receiving primary health care services in their usual program setting.[2] This is the thinking behind the primary care services provided at the Windsor-Essex County Branch of the Canadian Mental Health Association. In 2004, two full-time nurse practitioners and two part-time physicians provided primary health care to 1,280 clients with serious mental illness at this CMHA branch. The hospitalization of these clients was substantially reduced.

Many mental health consumers have complex, long-term needs that require services from a broad array of health care providers as well as community-based services. This includes specialized community mental health services, vocational support, housing, and social/recreational programs. Additional strategies need to be designed for the health system to effectively link primary health care services, wherever they may be

located, with community-based services.

One of the most promising approaches is the Chronic Care Model, which identifies six strategies to improve outcomes for persons with chronic conditions, such as serious mental illness.[3] The model emphasizes that consumers need to be "informed and activated" in their relationship with health care providers. This can include self-care and/or participating in one's own care as a collaborating "partner." The chronic care model extends the vision beyond shared care models that merely prescribe what the health care provider should do for the patient. The government of British Columbia has adopted a version of the Chronic Care Model to guide its approach to managing depression. I would urge primary health care policy-makers to next give their attention to incorporating chronic care approaches into primary health care reform to initiate true collaborative care.

The Canadian Collaborative Mental Health Initiative (CCMHI) also places the consumer at the centre of its collaborative care framework and uses the language of partnerships, roles and responsibilities to reflect the collaboration envisioned between health care providers and mental health consumers. CCMHI promises to provide consumers and families with tools in 2006 to describe what consumers can do to assist themselves to take an active role in their own care. Readers should watch the CCMHI website (www.ccmhi.ca) and take advantage of these new materials as they become available online.

Michelle Gold, MSW, MSc, is senior director of policy and programs at CMHA Ontario.

1 Provincial Coordinating Committee on Community and Academic Health Science Centres Relations (PCCCAR), Subcommittee on Primary Health Care. New Directions in Primary Health Care. Toronto: Ontario Ministry of Health, 1996.
2 Bazelon Center for Mental Health Law. Get It Together: How to Integrate Physical and Mental Health Care for People with Serious Mental Disorders. Washington, D.C., 2005. www.bazelon.org.
3 MacColl Institute for Healthcare Innovation. Overview of the Chronic Care Model. www.improvingchroniccare.org/change/model/components.html.

CALENDAR

February 17-18, 2006 Ontario Psychological Association Annual Convention. Delta Toronto Airport West Hotel, Toronto, Ontario. 416-961-5552, ope@psych.on.ca, www.psych.on.ca.

February 21-22, 2006 Moving Upstream Together: Partnering for Ontario's Future Health and Well-Being. Conference marking the 20th anniversary of the Ontario Prevention Clearinghouse. Toronto, Ontario. 1-800-397-9567, movingupstream@opc.on.ca, www.opc.on.ca.

February 22-26, 2006 Seventh annual Shadows of the Mind Film Festival. Galaxy Cinemas, Sault Ste. Marie, Ontario. 705-759-0458, info@ shadowsfilmfest.com, www.shadowsfilmfest.com.

February 23, 2006 The Power of Experience: A Self-Help and Peer Support Conference. Holiday Inn, Barrie, Ontario. 1-800-461-4319.

March 8, 2006 Progess through Partnership. CMHA BC Division's 4th Annual Bottom Line Conference on Depression, Anxiety and Addictions in the Workplace. Vancouver Conference and Exhibition Centre, Vancouver, BC. 604-697-5508, conference@cmha.bc.ca, www.bottomlineconference.ca.

April 10-11, 2006 Managing Legal Risks and Responsibilities in Mental Health Care. Canadian Institute's 6th Annual Conference. Sutton Place Hotel, Toronto, Ontario. 1-877-927-7936, customercare@canadianinstitute.com, www.canadianinstitute.com.

April 26, 2006 Sixth Annual When Something's Wrong Open Mind Workshop Day and Luncheon. Canadian Psychiatric Research Foundation. BMO Institute for Learning, Toronto, Ontario. 416-351-7757, admin@cprf.ca, www.cprf.ca.

April 26-27, 2006 25th Annual Ontario Gerontology Association Conference. Bank of Montreal Institute for Learning, Toronto, Ontario. 416-535-6034, ontgeron@idirect.com, www.ontgerontology.on.ca.

May 1-7, 2006 Mental Health Week. A Canadian Mental Health Association national event to increase awareness of the importance of good mental health. 416-484-7750, info@cmha.ca, www.cmha.ca.

May 11-13, 2006 Sharing the Care: Practice and Promise. 7th National Conference on Shared Mental Health Care. Calgary, Alberta. www.shared-care.ca.

May 20-25, 2006 From Science to Public Policy. 2006 American Psychiatric Association Annual Meeting. Metro Toronto Convention Centre, Toronto, Ontario. 703-907-7300, hball@psych.org, www.psych.org.

June 5-6, 2006 Bridging the Gaps: Inspiration to Execution. Addictions Ontario 2006 Annual Conference. Stage West, Mississauga, Ontario. 519-772-0113 ext. 226, debbie@highonlife.org, www.addictionsontario.ca.

July 13-15, 2006 Voices of Resiliency. National Conference of the Schizophrenia Society of Canada. Winnipeg, Manitoba. 204-786-1616, MSS-SSC-2006@mss.mb.ca, www.mss.mb.ca.

September 12-15, 2006 PSR and Recovery: Building on Basics. Psychosocial Rehabilitation Canada 2006 National Conference. Holiday in Waterfront, Kingston, Ontario. Conference2006@psrrpscanada.ca, www.psrrpscanada.ca.

November 5-8, 2006 Making Gains in Mental Health and Addictions. Fourth annual joint conference of Addictions Ontario, Canadian Mental Health Association, Ontario, Centre for Addiction and Mental Health, and Ontario Federation of Community Mental Health and Addiction Programs. Toronto, Ontario. 705-454-8107, rachel@haliburtonhighlands.com, www.makinggains.ca.

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PHYSICIANS: PLEASE PLACE IN YOUR PATIENT WAITING ROOMS.