



Hamilton Urban Core Community Health Centre

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Integrating Shared Mental Health Care in Primary Health Care Practice

MENTAL HEALTH INTEGRATION PROJECT (MHIP) SUMMARY

This unique mental health project is a pioneer in early detection, prevention and service provision. Known as “multidisciplinary shared care plus”, it integrates the full basket of mental health services into the centre’s daily operations and places the client at the centre of wrap-around, on-site care. It has helped clients move from instability to stability. It has achieved a significant increase in the delivery of mental health services at the primary care level and a decreased reliance on hospital-based mental health services. These outcomes could only have been realized under the CHC collaborative-care model with its strong multi-disciplinary teams operating within the same physical location, and fully integrating social determinants of health.

Focused on Medicare’s cornerstone principle of accessibility, the MHIP project findings and implementation respond to factors that are particular to Hamilton, including: a poverty rate of 20% (higher than the provincial average); a designation of Hamilton as one of Canada’s target receiving centres for new immigrants and refugees, many of whom have suffered through war, torture, and terrorism. Significant barriers to access are exacerbated by racism, xenophobia and other oppressions and inequities so that certain groups such as recent immigrants, people with visible minority status, and aboriginal people experience poverty rates greatly above 20%.

The economic decline of the downtown core, historical process of de-institutionalization, and rising rates of homelessness have resulted in a client population with pressing complex and chronic mental health needs. MHIP was therefore conceived to expand and enhance access to mental health services for the inner city’s most marginalized populations.

Important lessons were learned from the start-up project whose core competencies included a project coordinator, evaluator, social worker, nurse, administrative support, physician, and a consulting psychiatrist. One of the key findings – that primary health care is the best point of entry to mental health services, - is being supported by clinical and programmatic changes.

For example, providers are supported with appropriate resources to recognize, diagnose, and treat mental health and illness issues. Support includes education, access to professionals to assist centre clients with access when additional approaches, techniques, and interventions are needed.

Capacity building is a critical element and includes all team members and staff of the centre with a particular emphasis on knowledge exchange. For example, information from conferences and workshops is shared with all staff through formal presentations at internal meetings. This knowledge exchange and capacity building helps the centre more efficiently focus its limited resources. Indeed, just the existence of the project has increased staff perceptions and abilities to identify potential mental health issues.

Inter-disciplinary models developed elsewhere were precisely that, *between disciplines*, and typically modeled relationships between psychiatrists and family physicians, but did not account for advocates, housing or homelessness workers, community health workers or other services that form an important part of a CHC model. The full integration of mental health services as a multidisciplinary project in a multidisciplinary setting in which client care is the responsibility of all staff, produces a changed culture with a capacity to more effectively provide services. Indeed, our multidisciplinary shared care **plus** model includes advocacy workers who are not typically classed as being part of a discipline. This inclusion produces important external linkages with community partners, such as Urban Core's Round Table on Poverty in which shared knowledge of best practices, suicide prevention, solutions for homeless persons with mental health issues and other salient issues are collectively addressed.

The MHIP project has resulted in the formalization of a sustainable integration between primary care and mental health, and the daily operations and mental health through the

development of a changed culture that gives us a measurable and strengthened ability to provide life-changing support for homeless, under-housed and marginalized people.

However successful we have been to date in increasing access to crucial mental health services, no model can sustain a lack of federal and provincial funding combined with efforts to exclude classes of people because of who they are. When governments and social systems ignore the connection between issues - such as the direct linkage of poverty, homelessness, and mental health - services remain fragmented and cannot effectively assist those in need. Medicare was conceived for just this reason. We must redouble our efforts to protect and strengthen it to ensure that those most in need of mental health services – indeed all life-affirming services – are presented with access, rather than barriers.

