

# Developing Collaborative Mental Health Care for Homeless Persons at a Drop-In Center

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## **Introduction by the column editors:**

This is the second contribution to our column, which is based on the use of an electronic mailing list (e-list) to generate a collaborative problem-solving process. The process is modeled on a module of the academic curriculum of the Columbia University Public Psychiatry Fellowship (PPF) ([ppf.hs.columbia.edu](http://ppf.hs.columbia.edu)) in which PPF alumni who encounter a management problem at their work site present the problem to current PPF fellows and faculty and lead a discussion aimed at developing solutions. The column uses an e-list to stimulate discussion of selected problems. Readers are invited to submit management problems to Dr. Ranz at [jmr1@columbia.edu](mailto:jmr1@columbia.edu), who will send them to the PPF e-list and work with Dr. Deakins to help authors summarize discussions in future columns.

Homelessness remains a pressing problem across Canada. In Toronto, Canada's largest city, which

has a population of approximately 2.5 million, over 5,000 individuals are homeless on any given night (1,2). Physical illness and mental illness are highly prevalent in the homeless population (3,4). Despite high levels of need, homeless people frequently experience difficulty accessing medical care. Many do not have Ontario Health Cards, which are essential to obtain reimbursement from provincial health insurance for medical services received. Most homeless people do not have the means to travel to medical appointments, and many have experienced the negative attitudes of health care professionals (5). Homeless individuals often rely on emergency department visits or inpatient hospitalization to meet their health needs (4,5).

In 2006 Inner City Health Associates (ICHA) was created. ICHA consists of more than 40 physicians who provide primary care and psychiatric services to the homeless population in Toronto in settings such as shelters, residences, and drop-in centers. They also provide consultation services to outreach teams that provide intensive case management or assertive community treatment. ICHA physicians receive competitive stipends for both clinical and nonclinical time, thereby alleviating the immediate need for their patients to have Ontario Health Cards. In addition to providing clinical services, ICHA works to improve coordination between various providers, educates medical students and

residents, and participates in research on homeless health care.

## **Problem for the PPF e-list**

### *Background*

Collaborative mental health care happens when primary care providers and mental health providers work together to offer complementary services and mutual support, ensuring that individuals with mental health needs receive coordinated care in a timely fashion (6). The complex medical and social needs of the homeless population call for such a service delivery model (7).

I joined ICHA in 2008 to provide psychiatric care to its clients. In February 2009 a non-ICHA family physician, Louis Girard, M.D., and I established outreach services using a collaborative mental health care model at a community drop-in center in Toronto. Dr. Girard and I provide consultation services to the agency's housing and outreach program. Center staffing consists of a coordinator, an outreach worker, two housing follow-up workers, and two drop-in workers. The center's program assists drop-in clients with their housing, financial, mental health, and substance use issues.

The psychiatric clinic operates one morning every week, and the primary care clinic runs the same morning every two weeks. Dr. Girard and I meet with the team in the morning for an hour to discuss client issues before conducting our respective clinics

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in borrowed offices located on the same hallway. Case managers frequently sit in on appointments and assist in providing history and implementing follow-up plans. All clients provide written consent to allow their clinical information to be shared among team members.

### **Problem**

Dr. Girard and I formally meet face to face every two weeks during the morning meetings with the team. To facilitate communication between physicians, the collaborative care literature recommends the use of a joint medical record (8). A joint medical record, however, cannot be created and maintained at the drop-in center. The center's primary goal is to provide social services, and as such, is not a "health information custodian" (HIC) as defined under the Personal Health Information Protection Act, 2004 (PHIPA) (9). As a result, Dr. Girard and I maintain separate files. My records are stored electronically at ICHA on CAISI (Client Access to Integrated Services and Information), an open-source server developed by McMaster University in Hamilton, Ontario. The family physician stores his records on an electronic server at his regular office. We each print our records for the other, and upon receipt we each rescan them into our respective files. These housekeeping tasks result in a large expenditure of time. In the absence of a joint electronic record, how might we improve our collaboration?

### **E-list dialogue**

E-list respondents began by asking whether there are ways in which the drop-in agency could apply to become a HIC. One respondent asked, "I wonder if part of the agency has to be designated as some kind of health facility so that [it] can then be a HIC?" Another queried, "Is there a way to [amend] the Personal Health Information Protection Act to have an exemption for social services agencies [that also offer] both medical and psychiatric care?"

I responded: "The PHIPA actually does not exclude social agencies per se from being HICs. [According to PHIPA], a social service agency can

decide to become a HIC if it declares that the delivery of health care is one of its main functions. . . . The agency's primary mandate is to provide social services. The agency does not have any staff who are health care professionals. . . . Given this, I think it would be difficult for the agency to be designated a HIC."

Most respondents struggled with coming up with ways to develop a joint medical record in the current setting. One respondent approached the problem from a different perspective, asking whether the family physician could have access to CAISI: "I think you should both use the single electronic medical record provided through ICHA. . . . Although the primary care provider you are working with is not part of ICHA, [he is] providing medical consultation on ICHA clients and therefore it would seem reasonable for [him] to have limited access to the CAISI electronic medical record for those clients to whom you are both providing care. In this scenario, ICHA acts as the HIC."

I responded: "I like your suggestion about the family physician being granted limited access on CAISI to those patients whom we share. . . . He would first have to sign on and be approved as a CAISI user [but then he could] have access to clinical impressions and recommendations. This would do away with the need for me to print off my records."

Other respondents discussed relying on other means for the physicians to communicate clinical information in a timely matter. One respondent suggested establishing a formal and separate meeting for the two physicians: "There's a model that some New York State Office of Mental Health [primary care physicians] use for this exact issue—basically a quarterly (or monthly) meeting dedicated only to medical issues . . . attended by both the [primary care physician] and the psychiatrist."

I responded: "We find it helpful to discuss with the team present so that the outreach workers (who referred the patient to us initially) are also kept apprised of what the management plans are since they are instrumental in facilitating some of the plans. Regarding mental health matters, I also

use the opportunity to do some education about specific diagnoses, symptoms, etc."

However, a respondent felt that formal meetings are not always the best ways to get important information across: "Initially, we [had a] weekly meeting among all the psychiatrists in the clinic and [the primary care physician], but it was not working for all the parties as patients who were not relevant to us were discussed. . . . We decided to cancel the meeting and communicate with [the primary care physician] by written notes, brief interactions when she comes . . . and using technology: e-mails. So far, it is working well and it allows us all to be more efficient. . . . I think technology in this case is really helpful."

I responded: "[I] don't see this as a substitute for more in-depth discussions at team meetings, but using e-mail . . . helps with some practical matters."

Still another respondent asked whether the circumstances presented in the management case are problematic at all: "The fact that both the psychiatrist and [primary care physician] are concerned about the lag in communication is encouraging and impressive. But is there really a problem with a two-week lag in info? How exactly does this impact quality of care? I assume that if there is an urgent matter, there is a concerted effort to call each other."

I responded: "It is already good that we have colocated services at the drop-in center. [For] nonurgent issues, a two-week lag in implementation of recommendations may not be problematic. [The ideal is if we] always had two clinics running at the same time. Physicians would have access to one another, and clients could see both physicians on one day. That of course is the ideal situation. Perhaps we can try to schedule those clients whom we know have both mental health and physical health concerns to come in on those weeks when both clinics are running."

### **Changes implemented**

I believe that it is important for Dr. Girard to have timely access to my assessments and recommendations. In

response to a suggestion posted on the PPF e-list, I discussed with ICHA the possibility of granting the family physician access to view the records I maintain on the ICHA server. The medical director of ICHA approved this request. Dr. Girard will soon be able to view my records for clients that we share, eliminating the burden of my having to print them.

Dr. Girard found that he was seeing the same clients at both the drop-in center and in the community health center where his main office is located. Many of these clients also have mental health concerns, and he decided to see them only at the drop-in center and to operate a primary care clinic at the center every week. As the e-list respondents hoped, clients are now able to obtain medical services, psychiatric services, and case management services all on the same day at one place and by one team.

The majority of discussions take place with the team during morning meetings. In line with what other e-list respondents suggested, both Dr. Girard and I are taking advantage of other means of communicating. Because we are both located along the same hallway, we sometimes meet between appointments or at the end of the clinic to discuss clinical issues or to collaborate on a treatment plan. In addition to communicating in this way and at the morning team meet-

ings, we use e-mail to discuss issues pertaining to certain clients. The case managers, who often sit in on client appointments, pass messages to the other physician when requested. Just as one respondent predicted on the basis of her own experience, these informal interactions have worked well and so far there has been no need for us to schedule an additional formal meeting on the day of the clinic.

The e-list discussion highlights the fact that the ideals and standards that physicians strive for in the delivery of health care must be tempered when working in nontraditional settings with a difficult-to-reach population such as the homeless population. A joint medical record is preferred but is not always possible. It was thus invaluable to hear PPF alumni discuss innovative and alternative approaches to facilitating communication, ranging from e-mail or impromptu discussions between appointments to asking more broadly about the applicability of PHIPA to social services agencies that are increasingly becoming sites for outreach clinics. The discussion highlights the gradual progress that is being made toward improved communication between providers of psychiatric and general medical care to homeless individuals. Clinics that are colocated and integrated with community service providers are well positioned to meet

the complex health needs of the homeless population.

## References

1. Toronto's Racial Diversity. Toronto, Ontario, City of Toronto. Available at [www.toronto.ca/toronto\\_facts/diversity.htm](http://www.toronto.ca/toronto_facts/diversity.htm)
2. 2006 Street Needs Assessment: Results and Key Findings. Toronto, Ontario, Shelter, Support and Housing Administration, June 20, 2006. Available at [www.toronto.ca/housing/pdf/streetneedsassessment.pdf](http://www.toronto.ca/housing/pdf/streetneedsassessment.pdf)
3. Hwang SW: Homelessness and health. *Canadian Medical Association Journal* 164:229-233, 2001
4. D'Amore J, Hung O, Chiang W, et al: The epidemiology of the homeless population and its impact on an urban emergency department. *Academic Emergency Medicine* 8:1051-1055, 2001
5. The Street Health Report 2007. Toronto, Ontario, Street Health, 2007. Available at [www.streethealth.ca/downloads/shreport2007.pdf](http://www.streethealth.ca/downloads/shreport2007.pdf)
6. Craven M, Bland R: Better practices in collaborative mental health care: an analysis of the evidence base. *Canadian Journal of Psychiatry* 51(suppl 1):1S-72S, 2006
7. Stergiopoulos V, Rouleau K, Yoder S: Shelter-based collaborative mental health care for the homeless. *Psychiatric Times*, July 1, 2007, pp 23-26
8. Macfarlane D: Current State of Collaborative Mental Health Care. Mississauga, Ontario, Canadian Collaborative Mental Health Initiative, June 2005. Available at [www.ccmhi.ca](http://www.ccmhi.ca)
9. Personal Health Information Protection Act, 2004: An Overview for Health Information Custodians. Ontario, Ministry of Health and Long-Term Care, Aug 2004. Available at [www.health.gov.on.ca/english/providers/legislation/priv\\_legislation/info\\_custodians.pdf](http://www.health.gov.on.ca/english/providers/legislation/priv_legislation/info_custodians.pdf)