Environmental Scan of Mental Health, Substance Use, HIV and HCV Case Management and Community Support Models

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PHSP 508 B Culminating Report

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April 2014

Abstract

The Pacific AIDS Network (PAN) and the Mental Health, Substance Use, HIV and HCV Research Team (MHSURT) are committed to researching and implementing ways to improve services and support for people living with HIV/AIDS, HCV, mental illness and/or problematic substance use. A 2008 needs assessment commissioned by the Provincial Health Services Authority (PHSA) identified multiple barriers and gaps in effective services across the continuum of mental health support systems in BC for people living with HIV and/or HCV. PAN and the MHSURT, in line with their strategic direction to address these barriers, identified their priority research direction of examining whether an integrated case management and community development/capacity building service would better serve these populations. The first step in refining the research direction was a literature search and environmental scan identifying examples of case management programs and models of community development/capacity building and opportunities for linkages. A formal literature review was undertaken by the Ontario HIV Treatment Network (OHTN). The following environmental scan report shows examples identified by the MHSURT, by key informants, and through internet searching for grey literature relating to promising case management and community development/capacity building programs in BC and elsewhere. Results include 10 examples of case management programs and 11 models showing community development/capacity building approaches. Main themes including peer involvement, mentorship networks, and skill building programs, are discussed as possible pathways of integration. PAN, the MHSURT, and the extended research team will discuss opportunities for linkage between case management programs and community development paradigms in hopes of ultimately developing an integrated service model and evaluative framework.

Keywords: case management, community development, community capacity building

Acknowledgements

I am particularly grateful for the advice and constant support Janice Duddy, my practicum supervisor, and Andrea Langlois from PAN, have provided me throughout my practicum and with this final project.

I would also like to acknowledge the contributions from members of The Mental Health, Substance Use, HIV and HCV Research Team: Darren Lauscher, Stacy Leblanc, Carlene Dingwall, Dean Nicholson, Gary Dalton, Shelley Hourston, Amanda Walker, Rosalind Baltzer Turje, Kristen Kvakic, and Melanie Rusch.

I would like to offer special thanks to those who took to time to speak with me and offer suggestions of models to profile in this environmental scan: Carlene Dingwall, Joyce Forsythe, Denise Thomas, Rosalind Baltzer Turje, Kristen Kvakic, and Shannon Froehlich.

Additionally I would like to thank Dr. Catherine Worthington, my first reader, and Dr. Lyn Davis my second reader for their comments and suggestions for this final project.

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Abbreviations

ABCD	Asset Based Community Development
ACT	Assertive Community Treatment
AIDS	Acquired Immunodeficiency Syndrome
AVI	AIDS Vancouver Island
BC	British Columbia
CATIE	Canada's AIDS Treatment Information Exchange
CBOs	Community-based organizations
CRM	Community Resilience Model
HIV	Human Immunodeficiency Virus
HCV	Hepatitis C Virus
ICM	Intensive Case Management
IDC	John Ruedy Immunodeficiency Clinic
MAT	Maximally Assisted Therapy
MHSUAC	Mental Health, Substance Use, HIV/HCV Advisory Committee
MHSURT	Mental Health, Substance Use, HIV/HCV Research Team
OHTN	Ontario HIV Treatment Network
PAN	Pacific Aids Network
PHSA	Provincial Health Services Authority
PLBC	Positive Living BC
PN	Peer Navigator
SOLID	Society of Living Illicit Drug Users
SMART	Self-Management and Recovery Training
STOP HIV/AIDS	Seek and Treat for Optimal Prevention of HIV/AIDS
TAHAH	Towards Aboriginal Health and Healing
TRROP	The Transcultural Rural and Remote Outreach Program
VICOT	Victoria Integrated Community Outreach Team

Environmental Scan of Mental Health, Substance Use, HIV and HCV Case Management and Community Support Models

People living with HIV/AIDS and/or Hepatitis C (HCV) are disproportionately affected by mental health and/or substance use issues (Bradford, Coleman, & Cunningham, 2007; Weaver et al., 2008). The specific needs of people living with HIV/HCV are not well known in the mental health profession, creating gaps and barriers in services (Dingwall, 2008). The same can be true of the reverse; people working in HIV/HCV services may not be familiar with the specific needs of people with mental health or substance use issues.

The purpose of this project is to inform the Pacific AIDS Network (PAN) and the Mental Health, Substance Use, HIV and HCV Research Team (MHSURT), about services available to people living with HIV/HCV, mental illness and/or problematic substance use. The MHSURT is an interdisciplinary team made up of representatives from across the province, many of whom are also members of the provincial Advisory Committee formed in 2011 (MHSUAC). PAN is a member driven network assembled to provide support for its member organizations' efforts in responding to HIV/AIDS, HCV and related diseases and conditions in British Columbia (BC). PAN facilitates communication of best practices, provides professional/workforce development and leadership training to members and people living with HIV/AIDS in BC and aims to engage the community in the process of relevant and constructive research to improve programs, services and policies. PAN and the MHSURT are focused on researching the best ways to support people living with HIV/HCV, and dealing with issues related to mental illness and/or problematic substance use.

Through a participatory approach, the MHSURT is in the process of developing a research area of focus. The process has revealed gaps in knowledge and services available to

people living with HIV/HCV, mental illness and/or problematic substance use. As part of the development phase of this research project, the team has discussed focussing on case management programs and the community's capacity to engage people once they are released from formal health and social services. This environmental scan will identify and describe models and best practices of case management, strategies for community development/community capacity building, as well as examples and opportunities for overlap across the fields of HIV/HCV, mental illness and/or problematic substance use. This environmental scan, in combination with a literature review performed by the Ontario HIV Treatment Network (OHTN), will help inform the MHSURT in its process of developing a related research area of focus and informing a catalyst grant application.

Important Terminology

Case Management

For the purpose of this environmental scan the term *case management* will be used to describe a variety of models that offer client-centered support, helping clients navigate complex systems, and linking clients with health care, psychosocial, and other services required to meet the client's health and human service needs (Commission for Case Manager Certification, n.d.). This environmental scan will focus on case management models that support people in managing their health and wellness by assessing their individual needs, facilitating connections with health and psychosocial services, and advocating for access to timely and coordinated care.

Intensive Case Management

Intensive case management definitions vary across organizations, but generally refer to an integrated model of care nested within existing community-based services aiming to support

people living with multiple challenges including mental health and/or substance use problems. Differences between intensive case management and clinical case management or assertive community treatment include differing case loads, intensity of involvement, incorporation of an assertive outreach component, and the integrated nature of care delivery (Centre for Addictions Research of BC, n.d.).

Community

Community can be defined as: "the web of personal relationships, groups, networks, traditions and patterns of behaviour that exist amongst those who share physical neighbourhoods, socio-economic conditions or common understanding and interests" (Standing Conference for Community Development, 2001, p.4). Throughout this report *community* may refer to specific geographical regions and the people within them, or may refer to connected populations of people within larger geographical regions who share common experiences, traits or interests.

Community Development and Capacity Building

Jung and Choi (2013) describe *community capacity* as the ability of the community to recognize and respond to a local (health) problem by mobilizing resources and finding a solution. Capacity building strategies vary, but the ultimate purpose is to support individuals, groups and organizations by building skills and competencies, and empowering people within the community to engage in self-help and advocacy (Austin, McClelland, & Gursanksky, 2006). "Community development and capacity building seek to build strong social networks and social support, thus creating the social capital and social cohesion that has been strongly linked to the overall health and well-being of people in both spatial and non-spatial communities" (Ministry of Health Services, 2005, p.28). Community development aims to break down power structures to

allow members of the community to participate in their own progress towards active and sustainable, socially-just communities.

Peer

"Peer workers are community residents who share similar life experiences with the participants in the programs they design and deliver" (Region of Waterloo Public Health, 2013). Peers are trained in a variety of roles and through sharing their personal experience and knowledge, offer unique benefits to programs and program participants. Peer roles are discussed in different contexts in various programs identified in this report.

History and Background Information on Mental Health, Substance Use, HIV and HCV in BC[1]

In 2008, a needs assessment was conducted by the Provincial Health Services Authority (PHSA) that looked at services available to people living with mental health disorders, substance use, HIV/AIDS and/or HCV in BC – and where the gaps, barriers, and challenges existed for service providers and clients (Dingwall, 2008). In the fall of the same year, a working group was formed to strategize priorities in addressing mental health and HIV/AIDS/HCV in BC (Dingwall, 2012). In June 2011, members of the working group were restructured into an Advisory Committee (Mental Health, Substance Use and HIV/AIDS/HVC Provincial Advisory Committee [MHSUAC], 2011). PAN is responsible for facilitating this advisory group.

[1] *A substantial portion of the background information that follows was taken from the proposal for this environmental scan prepared by the author of this paper for PHSP 506: Public Health Research Method – fall 2013 term.*

Since its inception, the MHSUAC has been conducting trainings and webinars for frontline workers, mapping provincial resources, and collecting literature and tools for knowledge transfer supporting a community of practice for frontline workers—all of which are in line with the following vision and mission statements:

> **Vision:** All people living with or at risk for HIV/AIDS/HCV in BC will have timely and appropriate access to a continuum of optimal mental health and substance use services and support.
>
> **Mission:** To advise and provide strategic direction to address mental health and substance use issues among individuals with HIV/AIDS/HCV or at risk for contracting HIV/HCV in BC, based on recommendations identified in the 2009 Mental Health and HIV/AIDS/HCV in BC: Strategic Action Report.
>
> (Dingwall, 2012, p.2)

This environmental scan of case management and community capacity building models that have possible application to this population will help the MHSURT refine its research direction. The following background information is provided as context to this environmental scan in order to explain the climate and need for gathering this information.

Overview of *Trap doors: Revolving doors- A Mental Health and HIV/AIDS Needs Assessment*

The 2008 needs assessment conducted by PHSA acts as a frame of reference for this environmental scan by summarizing the services available for people living with mental illness, substance use and/or HIV/HCV and where gaps exist in these services. The needs assessment included interviews and questionnaires with community-based AIDS service organizations

(ASOs), leaders from Public Health and Mental Health and Addictions Services, as well as additional key informants (Dingwall, 2008). This assessment found increasing stresses and complexity of mental health conditions among people living with HIV and/or HCV, as well as increased diversity in the population of people living with HIV. The high prevalence of comorbidity of HIV/HCV and mental health conditions was confirmed. While approximately one in five Canadians experience a mental health disorder, the proportion is reported as much higher in people living with HIV/AIDS and/or HCV (Dingwall, 2008). A reported four out of every five people living with HIV also have, or have had, one or more mental health conditions (Dingwall, 2008).

In the 2008 PHSA needs assessment key informants from ASOs and Public Health and Mental Health and Addictions Services discuss how without proper support, people living with mental health issues are too often struggling to manage fundamental pieces of their lives, leaving little time or energy to focus on other aspects of their health and wellness (Dingwall 2008; Nurutdinova et al., 2012). The ASO's surveyed in *Trap Doors: Revolving Doors* indicate approximately 77% of the people they see whom are living with HIV have had, or are experiencing, a mental health condition. Of this 77%, only 11% are reported to have accessed formal mental health support; this is in contrast to the 40% of people with a mental health condition but without HIV who were able to access formal support (Dingwall, 2008). These numbers not only show the high prevalence of mental health issues in this population, but also the barriers, and missed opportunities to provide support. Though CBOs may try to respond by providing mental health support, they are often under-resourced and staff are not always trained to identify or treat mental health disorders across the continuum. As explained by Dingwall (2008, p. 39), "Service providers are often not trained to distinguish between mental health,

substance use or HIV/AIDS/HCV-related symptoms and are often left uncertain how to provide the best support."

Substance use and mental health disorders can compromise the health of individuals living with HIV/AIDS/HCV for a number of reasons: co-occurrence adds layers of complexity to treatment; people may be compromised in their ability to care for themselves or others; and compounding stressors, stigma, and discrimination can lead to further vulnerabilities. People living with HIV/AIDS and/or HCV are often subject to a great deal of stigma and discrimination. The same is true for people living with mental health and/or substance use issues. Stigma and discrimination are not only outcomes of these conditions, but also act to increase a person's risk to any or all of these conditions (Dingwall, 2008). Stigma also accompanies other circumstances that contribute to a person's risk for HIV/HCV infection and mental health conditions, such as homelessness, poverty, and addictions. Having unstable access to housing, medical care, food security and other social determinants of health increases a person's risk of contracting HIV and HCV as well as developing a mental health or substance use issue (Dingwall, 2008). Finally, people who are marginalized in one or more ways are also more vulnerable to victimization, violence and other crime (Dingwall, 2008).

Restructuring and policy changes within municipal, provincial and federal governments have led to challenges in the provision of comprehensive services (Dingwall, 2008). Although CBOs in principle may be prepared to respond to peoples' needs, changes to funding, resources, policy and practices within organizations can threaten the stability and consistency of services, and put up barriers for people who have been, or are trying to access their services (Dingwall, 2008). With the increasing complexity of mental illness and comorbid conditions, there needs to

be more attention and support paid to people early on before illnesses progress, more mental health promotion, and more providers with specialized knowledge (Dingwall, 2008).

Another barrier identified in *Trap Doors: Revolving Doors* is a disconnect between mental health services and the community. The report identified that most mental health services were delivered in clinical settings and were isolated from the community (Dingwall, 2008). Many people who face stigma in their lives have poor relationships with the healthcare system and clinical settings (Dingwall, 2008). Mistrust in healthcare systems and healthcare providers can stem from traumatic experiences, beliefs about governments' roles in the spread of HIV and other diseases, injustices in the past, as well as other preconceptions people may have (Whetten, Reif, Whetten, & Murphy-McMillan, 2008). Changes in policy and closures of institutions have resulted in more people with mental health conditions living out in the community without proper support to establish healthy and stable living conditions. Furthermore, most mental health services still "reflect a foundation of practice and service delivery based on an identified population moving through a structured, clinically contained setting" and are therefore not always effective in working with people within the community (Dingwall, 2008, p.60). This disconnect between mental health services and the community also translates as somewhat fragmented and ineffective services that are slow to respond to changes in community needs (Dingwall, 2008).

To summarize, the main barriers identified in the 2008 PHSA needs assessment are as follows:

- Only 11% of people living with mental illness and HIV/HCV accessed formal mental health support (compared to the 40% without HIV and who accessed support);

- Stigma and discrimination compound in people living with mental illness, substance use, HIV/HCV and interact with other social determinants of health, leading to further marginalization;
- CBOs come in contact with many people in this population, but often do not have the resources to respond;
- Restructuring and policy changes rearrange organizations and services and may lead to barriers for people accessing or trying to access mental health, substance use and or HIV/HCV support;
- Mental health services are often provided in clinical settings and therefore seem inaccessible to many people living in the community, thus creating a disconnect between mental health services and the community.

Priorities, Goals, and Next Steps

The barriers summarized above are contributing factors to many people living with mental health and substance use issues (with and without HIV/AIDS/HCV) not receiving the support they need. Part of the response to the disconnect between the community and mental health services (the last barrier identified on this list) has been the development and amplification of case management programs to link people with support services while they are living out in the community. For example, Assertive Community Treatment (ACT) teams are specifically designed to facilitate community living and psychosocial/physical rehabilitation for people living with serious mental illness and problematic substance use (Ministry of Health Services, 2008).

Case management programs offer formal support for a duration of time that these supports are required (Commission for Case Manager Certification, n.d.). When a person no

longer needs case management services, and is released from the program to manage their own care, where they access support may change. Personal support systems include networks of family and friends as well as an individual's skills and knowledge to support themselves (Dingwall, 2008). Personal supports will vary between individuals, but having supportive communities in place for people who may not have strong personal support systems may be essential in sustaining their health and well-being. Dingwall (2008, p.50-51) discusses how important these community support systems may be for a person including their role in building self-efficacy and self-esteem and how "for some people, community supports replace their personal support networks". Supportive community may mean networks of peers and allies, or programs within the community that help develop their own personal skills and knowledge.

In line with the goal to support people living with mental illness, problematic substance use, HIV and/or HCV, the MHSURT has identified its next steps as researching case management and community development/capacity building models. Successful case management programs are especially attractive for this population since people living with mental health or problematic substance use disorders and HIV/AIDS/HCV often have difficulties managing their own care (Dingwall, 2008; Nurutdinova et al., 2012). Additionally, there is a necessity to establish good community support for when people are released from formal services. Austin et al. (2006) discusses how inadequate community resources are a limiting factor in successful case management. The MHSURT has identified a need for this environmental scan of the case management and community development/capacity building models being used in mental health, substance use, HIV/AIDS/HCV services (and possible inclusion from other fields).

The MHSURT is interested in looking at models for both community capacity building and case management, as well as looking for linkages and opportunities for integration between the two. From the information gathered, the team will work to identify if interventions could be developed to support people in accessing services while building strong communities for once they have been released from formal support services. The literature search and environmental scan will help to inform a Canadian Institutes of Health Research (CIHR) HIV/AIDS Program Catalyst Grant to further develop a team and research question related to this area of study.

Methods

Rowel, Moore, Nowrojee, Memiah and Bronner (2005) describe the creation of an advisory committee as being the first step in developing an approach for an environmental scan. This advisory committee is important to identify places to start, questions the environmental scan should ask, and to lay out the goals and priorities of the scan; the advisory committee in this case was the MHSURT (Rowel et al., 2005). In the initial development of the plan for this environmental scan, the MHSURT discussed the benefits of an environmental scan, committee members provided examples of models they were already familiar with, and the consensus was reached to conduct a literature review and an environmental scan using interviews with key informants and review of grey literature. It was decided that as my practicum project I would conduct the environmental scan of grey literature and identify and describe examples of programs and models of case management and community development/capacity building. Conducting interviews with key informants requires ethics approval, and due to time constraints it was decided by the team that interviews would not be conducted as part of this environmental scan. Interviews may be conducted at a later date when resources allow, if consistent with the research direction taken by the MHSURT.

To supplement this environmental scan, the MHSURT requested a formal literature review from the OHTN Rapid Response Service. The OHTN Rapid Response Service is offered to community-based HIV/AIDS organizations to support evidence-informed programs, service delivery and advocacy (Ontario HIV Treatment Network [OHTN], 2009). Requests were made for two literature reviews: one searching for examples of case management/navigation models, and the other searching for community development/capacity building models (see Appendix A for Rapid Response request forms). The OHTN team was able to combine these two reviews into one report, allowing the potential to include overlap between models from each stream. The literature review, in combination with the environmental scan, will inform the MHSURT in developing a research question by presenting options and information regarding case management and community development/capacity building models.

Search Methods

As part of my project I met with the research team regularly to discuss the environmental scan focus and plans. During these meetings, the intent and content of the environmental scan were consistently discussed and revised throughout the duration of the scan. I prepared an initial outline for the environmental scan and presented it to the research team. The team was able to provide me with feedback which I incorporated into the plan. In addition, committee members offered suggestions of programs and models to include and other informants to speak with. These suggestions initiated the environmental scan process. At various stages throughout the scan I sought feedback from the research team to ensure the scope and direction was aligned with the team's purpose. While some resources were provided by the committee, I obtained others through internet search engines (Google and the University of Victoria Libraries site).

The "Programming Connection" online toolkit found through Canada's AIDS Treatment Information Exchange (CATIE) was another source that I used extensively. This resource presents case studies of programs across Canada that offer HIV prevention, care, treatment, and/or support. Each case study presented on the CATIE website was reviewed for elements of case management and/or community development/capacity building. Relevant case studies were included in the results.

Next, I contacted the informants identified by the MHSURT members. I contacted each informant first by email to explain the project and my intention to discuss programs being offered in their communities. An attempt was made to include informants from organizations and authorities across the province in order to provide a better picture of services across BC. Informants included representation from Positive Living North, AIDS Vancouver Island, The First Nations Health Authority, Northern Health, and the Dr. Peter Centre (Vancouver). Informants were able to suggest programs/models to include and where to find relevant information. All information reviewed was publically available.

Finally, I conducted Google searches to identify other examples of program/models offering case management/navigation services as well as examples of community development/capacity building. Examples of search terms used include: community capacity building; community development; rural community development; strategies of capacity building; HIV and HCV case management; mental health community capacity building etc. This method was primarily successful in identifying diverse examples of community development and capacity building models internationally (e.g. Asset Based Community Development and The Transcultural Rural and Remote Outreach Program).

Programs and models were summarized with key information (as identified by the MHSURT) highlighted. All relevant models identified by the MHSURT and key informant consultations were included if sufficient information was available publicly. Models found through internet searches were included if they demonstrated strategies of case management and/or community development novel to those identified by team members or informants. Models were excluded if information was not publically available. I performed initial analysis of the results by identifying key themes and common strategies utilized by multiple programs/models. These themes and strategies are considered in the discussion section of this report. In addition to common elements of the programs and models identified, opportunities for linkage and integration of case management and community development/capacity building are analyzed and discussed. The results presented in Appendices B and C along with the initial analyses of the results will be presented to the MHSURT to be discussed further as a team.

Results

Results found through the environmental scan are summarized in Appendices B and C. Appendix B includes summary tables of case management programs/models, and Appendix C includes summaries of community development/capacity building programs/models. In total, 10 examples of programs offering case management services and 11 examples of models/programs of community development/capacity building are summarized. Most examples come from Canada, with a few examples shared from Australia, The United States, and India. The results presented are not meant to form a comprehensive list, but rather provide of a variety of examples of programs and models to present the research team with a diverse picture of strategies and best practices being employed.

Discussion

Highlights from Identified Models

Case management. Although the case management programs in Appendix B have been presented as separate models, many offer similar services and utilize the same strategies for engaging clients. Some common strengths seen among the identified case management models include: accessibility; holistic, interdisciplinary care; peer involvement; and client centered, flexible care plans.

Accessibility. Sustained engagement in care and support services for people living with HIV, HCV, mental illness and/or problematic substance use can be a challenge for some. Case management programs use a variety of strategies to increase accessibility including: outreach services, drop-in services, 24 hour phone support, and/or streamlining services to decrease the number of appointments clients need to attend.

Outreach services are provided where a client lives: at home, work, or places of recreation. Meeting a client where they are in the community is particularly important to provide support for people facing multiple and significant barriers to accessing care. The Maximally Assisted Therapy Program (MAT), Peer Navigation through Positive Living BC (PLBC), Towards Aboriginal Health and Healing (TAHAH), The STOP Outreach Team, the AIDS Vancouver Case Management Program, Assertive Community Treatment (ACT) teams and the Victoria Integrated Community Outreach Team (VICOT) all offer case management through outreach.

Programs that offer services on a drop-in basis may be more accessible for some clients than services by appointment only. In addition to outreach, the MAT program offers a drop-in

space for clients to access services. At the John Ruedy Immunodeficiency Clinic (IDC) at St. Paul's Hospital, nurses, doctors and peer navigators are available by drop-in, as well as by appointment and offer streamline visits to reduce the number of trips clients must make to the clinic. The Access Case Management team through AIDS Vancouver, and TAHAH, also offer case management on a drop-in basis.

Holistic, interdisciplinary care. A key element to the success of many case management programs is addressing a wide range of client needs. Successful treatment (whether it be for HIV, HCV, mental illness and/or substance use) is difficult without addressing immediate medical and psychosocial needs. One of the principle functions of case management programs is addressing the social determinants of health that affect a person's vulnerability to contracting HIV or HCV, and their health and wellness while living with these diseases. Case management teams will often address housing, food security, mental health issues, crisis intervention, addiction support, social assistance applications and other client priorities before they begin to link clients with HIV or HCV treatment. The MAT Program, the IDC, The STOP Outreach Team, TAHAH, The Island Health 713 ICM Outreach Team and VICOT are all examples of programs focused on the social determinants of health and offering services that treat the "whole-person".

Client centered and flexible care plans. Determining a care plan based on a client's needs, priorities and goals is an important part of engaging people with their own health and wellness (Ministry of Health Services, 2008). For example, MAT offers access to antiretroviral therapy in three different ways: through daily directly observed therapy at the MAT site; through blister packages for weekly, bimonthly, or monthly pickup at the MAT site; or through outreach to clients who do not, or are unable to, make it to the clinic (Canadian AIDS Treatment Information Exchange [CATIE], 2013a). Clients and MAT staff determine together what the best

method of support is for each client. Constant revision and flexibility of care plans ensures adequate support while allowing independence and self-management when possible.

Involvement of peers. Peers can support case management programs in a number of ways as is seen with the Peer Navigation Services through PLBC and the IDC, TAHAH, Aboriginal Patient Navigators, ACT teams, and the Island Health 713 ICM Outreach Program. There are multiple advantages to including peers as part of case management programs. Peer involvement in programming is discussed further in the following section "Community development and capacity building".

Community development and capacity building. Community development and capacity building strategies, like case management, act to support the social determinants in a person's life that contribute to their physical and mental health. Amongst the community development and capacity building programs and models highlighted in this environmental scan emerge several themes and strategies that are key to their success. These themes and strategies include: involvement of peers and allies; focus on community assets – not deficiencies; offering trainings that provide the skills and power for people to support their own wellbeing and that of their peers; and development of culturally competent and flexible programming.

Involvement of peers and allies. As the task-shifting model included in Appendix C describes, the involvement of peers and non-professionals in programming can be beneficial in a number of ways: peers can offer a unique set of skills and experiential knowledge that many healthcare professionals do not; people may find it easier to trust and relate to people who come from similar backgrounds, or share similar experiences; and non-professionals may be able to share some responsibilities to relieve strain on overburdened/under-resourced systems. How

peers are involved in programming can vary, as is visible in the models presented in Appendices B and C.

The Legacy Project in Toronto has created a supportive mentor/mentee network of people living with HIV and their allies. Mentors may support mentees in a variety of ways, and may also benefit from the partnership themselves. Mentees may be paired with multiple mentors, or act as mentors themselves. This program is a good example of building/strengthening an intergenerational community, sharing human resources within the community, and focussing on the strengths people possess that can be shared with others.

Street College is another example where people are given the opportunities to learn skills and then pass them on to their peers. Participants begin by taking courses focused on stigma, leadership, and resilience (among others), and if they desire, can go on to teach the courses themselves. Currently, the anti-stigma course is completely peer-led (Society of Living Illicit Drug Users [SOLID], n.d.). This model allows growth, development, and empowerment of participants, as well as strengthens the community by training new leaders.

The Self-Management and Recovery Training (SMART Recovery) program also demonstrates an example of mutual support where people share their own experiences with their peers in in-person meetings, online real-time meetings, chat rooms, message boards and forums. People receive support from the meeting coordinators and the online resources, but are also able to reach out to each other through any of the available communication options.

Focus on community assets, not deficiencies. The Asset Based Community Development (ABCD) paradigm describes the benefit of programs and policies that focus on the strengths of communities, and how these resources can be used and expanded productively to

benefit the community (Kreztmann & McKnight, 1993). “The main goal of community capacity and resources development is to enable the community members and the vulnerable classes to take their places not merely as the beneficiaries of services supported from the outside but as the main agents of the community’s development” (Jung & Choi, 2013, p.81). Engaging and empowering community members to participate in problem solving and community development is important to avoid the manifestation of what Kretzmann and McKnight (1993) describe as “client neighbourhoods”. When development efforts focus on deficiencies and providing resources to solve these problems, residents can end up seeing themselves as consumers of services who require their needs to be met by services provided by outside programming (Kretzmann & McKnight, 1993). In these situations, energy becomes focused on finding ways to receive as much from the system as possible, and to keep emphasizing the community’s needs and deficiencies to sustain funding and outside aid (Kretzmann & McKnight, 1993).

> Providing resources on the basis of the needs map underlines the perception that only outside experts can provide real help. Therefore, the relationships that count most for local residents are no longer those inside the community, those neighbor-to-neighbor links of mutual support and problem solving. Rather, the most important relationships are those that involve the expert, the social worker, the health provider, the funder. Once again, the glue that binds communities together is weakened
>
> (Kreztmann & McKnight, 1993, p.3).

This “glue” is what Jung and Choi (2013) refer to as community capacity, the foundation of which is the relationships within the community.

Using non-professionals in supportive and leadership roles is a good example of utilizing community assets. People living with HIV, HCV, mental illness or problematic substance use have a great deal of knowledge and insights to share and can contribute to their community in very effective and meaningful ways. The number of models found in this environmental scan that include some form of peer support attest to the benefits, including: The Legacy Project,

Street College, SMART Recovery, The STOP Outreach Team, Towards Aboriginal Health and Healing (TAHAH), The 713 ICM Outreach Program though Island Health, and ACT teams.

Skill and competency training. Another strategy identified in this scan is programming that includes skills trainings for people to support their own wellbeing and that of their peers. Street College provides courses on a variety of relevant subjects for people who use(d) illicit drugs. The courses provide basic information about drug use, HIV, HCV, and poverty as well as skills training in leadership, resilience, and health and wellness. Participants are offered the skills and knowledge to increase their self-awareness and to become advocates and leaders in their community. Participants have gone on to teach Street College courses as well as work in other community organizations.

The Positive Leadership Development Institute (PLDI), a partnership between the Pacific AIDS Network and the Ontario AIDS Network (OAN), offers trainings that focus on leadership and developing peoples' skills to participate meaningfully in their communities. The Legacy project in Toronto is another program focused on skill building. As already described, mentors and mentees are paired to work towards specified goals. Mentors are able to share their expertise and support mentees in their personal development. Once one goal is reached mentees may be paired with another mentor to work towards another goal.

The Community Resilience Model (CRM) is designed to teach people the tools to manage their own well-being. One model of community resilience training, as described by the Trauma Resource Institute (TRI), is designed to "help individuals understand their nervous system and learn to track sensations connected to their own well-being, which CRM calls 'Resilience'" (Trauma Resource Institute [TRI], 2014, para 1). "CRM's goal is to help to create

'trauma-informed' and 'resiliency-informed' communities that share a common understanding of the impact of trauma on the nervous system and how resilience can be restored using the skills-based approach" (TRI, 2014, para 2). An important strength of this program is that participants are given the skills to support themselves and those around them, without being dependent on outside sources (TRI, 2014).

***Culturally competent, relevant, and flexible programming*.** A final element worthy of highlighting is the integration of cultural competency and flexibility into programming. When designing services and community development programs to support people living with mental illness, problematic substance use, HIV and/or HCV, it is essential to consider the cultural context within which these programs will exist. Different cultures have different priorities, capacities and systems of development. Understanding the cultural climate, and including community members in the entire process, results in more effective programming (while the reverse can have the opposite effect). Three models that show evidence of flexibility and community specific programming are The Remote Outreach Project, through Blood Ties Four Directions Centre, The Transcultural Rural and Remote Outreach Program (TRROP), through the Transcultural Mental Health Centre in Australia, and the Community Resiliency Model (CRM). One of the goals of the CRM is to revitalize language, cultural identity and spirituality through its trainings to foster individual and community resiliency. Both the Remote Outreach Project and TRROP, as described in Appendix C, include community consultation as an early step in planning, and develop community specific events and activities.

Opportunities for Linkage/Integration

As previously mentioned, one of the MHSURT's goals is to identify opportunities for linkages and overlap between case management and community development/capacity building strategies. The objective is to build community capacity to support people when they are released from formal support services. For example, a person receiving intensive support may be receiving help to navigate the system, remember appointments, adhere to medication, contact mental health professionals, etc. Once they no longer need this level of support, they may graduate from the program and be able to manage their own care. Once released, where this person will receive support will vary from individual to individual, but having a supportive community in place may be essential for some in order to sustain their mental and physical health.

A challenge with adding community development and capacity building agendas to established case management or navigation services is that teams are often overburdened and under-resourced. A strategy that could be helpful in fostering this linkage would be to use the principles of task shifting and the inclusion of non-professionals in community development practices integrated into formal case management/navigation programs. Many of the case management models presented already involve peers in some capacity and there may be potential to extend their responsibilities, or introduce peers and non-professional health workers into new roles.

Introducing a mentor/mentee network, as has been done with the Legacy Project in Toronto, may be possible in some of the service organizations described in Appendix B. Although some coordination and supervision is needed, the support provided by a mentor/mentee relationship has been shown to outweigh the resources required to establish the network itself (CATIE, 2012). Building a similar network, or community, of mentors and mentees who support

each other in skill building and working towards goals could be helpful in keeping people engaged with support after being released from formal services.

Another example could be the adaptation of the SMART Recovery model for people challenged by mental illness, substance use, HIV and/or HCV. SMART is designed as an addiction recovery program with four steps to empower people to manage their own addictive behaviour. Although specifically tailored to people challenged by addiction, SMART uses a variety of techniques that have shown to be effective in building a world-wide supportive community. These techniques include local in-person meetings, real-time online meetings, online forums, and trainings to become a meeting facilitator. With some changes to the curriculum, this model could be adapted to create a supportive community for people living with HIV/HCV, mental illness and/or problematic substance use (J. Forsyth, Personal Communication, February 17, 2014).

Some examples of community building activities that could be incorporated into formal case management services, if the capacity exists, include: community resilience training, community gathering events, and inclusive no barrier drop-in spaces offering a variety of resources. Community resilience training could be very beneficial for clients transitioning out of formal services. Community gatherings, such as those that are part of the TRROP in Australia and the Remote Outreach Project in the Yukon, have shown to be effective to increase awareness and understanding of mental health issues and HIV/HCV, decrease stigma, and expand and strengthen links between people and organizations in the community (Transcultural Mental Health Centre, 2010; CATIE, 2010). Inclusive drop-in places, like the one at Street Angel, provide people with a safe and supportive environment to access services, give and receive

support from peers, while improving self-esteem and skills important for their development and well-being.

Implications for Public Health

This environmental scan and the work of PAN and the MHSURT strongly reflect many core public health values including a commitment to addressing the social determinants of health, social justice and health equity, as well as emphasizing community participation and developing sustainable solutions to public health issues (Public Health Agency of Canada, 2013). As already discussed, living with limited access to the social determinants of health increases a person's vulnerability to contracting HIV, HCV and other blood borne illnesses, and is also linked to ill mental health and problematic substance use (Dingwall, 2008). Intersecting vulnerabilities including HIV, HCV, mental illness, problematic substance use, and unmet social determinant needs, contribute to large disparities in health and further widens the health equity gap. The intention of this work is to identify and develop the best ways of supporting people living with these intersecting vulnerabilities in a holistic and sustainable manner.

Some of the social determinants addressed or targeted in the interventions described in this report include income, food insecurity, housing, social exclusion, and Aboriginal status (Mikkonen & Raphael, 2010). As discussed, case management programs offer, or provide linkage to, a variety of psychosocial services including support with income, food security, and housing. A noteworthy element identified in this this environmental scan is the accessibility of programs. Public health programs are intended to decrease health disparities, but often barriers exist for the people who most need the programs (Commission on the Social Determinants of

Health, 2008). When barriers to access are recognized, it is possible for programs to adapt and include strategies to get around them, like offering outreach or low barrier drop-in spaces.

An additional goal of this project is finding ways to integrate community development strategies intended to decrease social exclusion and increase community members' capacity to support each other and themselves. Social exclusion, where certain groups of people are "denied the opportunity to participate in Canadian life" (Mikkonen & Raphael, 2010, p.32), is often a challenge experienced alongside HIV, HCV, mental illness and/or substance use. Social exclusion, together with stigma, may add to a person's vulnerability for contracting disease or developing mental illness or substance use issues, and may also have negative consequences for those living with any/all of these conditions. One intention of developing supportive communities is to counteract the social exclusion and stigma faced by many people in this population.

Next Steps

The next steps for the MHSURT are to finalize a research direction and develop a CIHR Catalyst Grant: HIV/AIDS Community-Based Research proposal. The team is discussing how to take an active role in developing and evaluating the important linkage between case management and community capacity building. The project will examine how best to include elements of community development into case management programs. The Catalyst Grant will be used to gather the research team by inviting members from existing case management teams in the province, as well as members of promising community development/capacity building programs to be part of the project. There will be team capacity building components included in the grant activities. The Catalyst Grant will also allow the team to work together to develop a CIHR

Operating Grant proposal involving community-based organizations, researchers, and peers to address how services are planned and delivered for people living with HIV, HCV, ill mental health, and problematic substance use while creating a supportive work environment for frontline service providers.

Strengths and Challenges of Environmental Scan

Strengths. This environmental scan was completed as part of the community-based participatory approach to research that PAN and the MHSURT are committed to. The purpose and direction of this scan were discussed by the MHSURT team and through a collaborative process the content was designed to support their research efforts. Consistent with community-based participatory research principles this environmental scan process was collaborative, change oriented, and inclusive of the knowledge provided by each team member (Pacific AIDS Network, 2012). Collaboration between community partners and academics, as well as inclusivity, was made possible through the MHSURT which include community, mental health and public health representatives who helped informed this scan.

Another strength of this environmental scan process was the inclusion of a variety of search methods. Members of the MHSURT were able to provide a variety of programs and models as a starting point, and were also able to suggest other key informants. Informants were chosen from a range of places and organizations across the province in an attempt to include diverse models, including examples from urban as well as rural and remote locations. The inclusion of internet searching also widened the scope to include international models exhibiting novel strategies of community development and capacity building.

Challenges. One challenge was the timing of the OHTN Rapid Response literature review. Originally it was discussed that the results of the literature search would be available in early January and would inform the initial stages of this environmental scan. Unfortunately, due to a number of unforeseen circumstances at the OHTN, a preliminary summary of results from the literature review were not received until the first week of March. The final review is still pending. Although the final review is not yet available, the preliminary version that was shared was helpful in providing some resources to inform this scan.

Initially the team had discussed how conducting interviews with program staff would be useful in obtaining relevant information about how these programs serve people living with HIV, HCV, and issues with mental health and/or substance use. However, conducting these interviews would have required ethics approval, and due to time constraints it was decided to postpone interviews until a later stage in this project, and to obtain information from publically available documents instead. It was challenging finding further information when there was incomplete information available through Internet searching, an issue that could have been resolved if interviews were built into the methods. Most programs had a contact email for further information, yet few responses were received when communication was attempted. Conducting interviews with service providers and clients across the country could have also provided more information about the differences between urban and rural services.

As part of the design I was able to contact key informants for suggestions of programs/models to include. However, this process started towards the end of my practicum and did not leave much room for snowball sampling, having the informants suggest other people to speak with. Many of the informants did suggest other people to speak with, but time was too limited to organize meeting will all of them. The purpose of this environmental scan was not to

create a comprehensive list of programs in BC, but if there had been more time perhaps additional models could have been included showing alternative strategies of case management and/or community development/capacity building.

Conclusion

Integration of community capacity/development strategies into case management programs is something PAN and the MHSURT would like to work towards. The intention of integrating formal case management services with supportive community building activities is to close the gaps that exists when people are released from formal services. Keeping people engaged in supportive communities, without stigma and discrimination, allows room for service providers and clients to improve the psychosocial conditions people are living in. People living with multiple intersecting conditions such as HIV, HCV, problematic substance use, and/or mental illness, often experience barriers in accessing support from formal services. An important theme identified by this scan is the benefits of engaging peers, and the effects this can have in removing some of these barriers. As discussed, peer involvement can benefit both case management and community capacity building efforts. Other resonating themes from this scan relevant to the proposed integration of community capacity building and case management programs include: skills and competency training; focussing on community assets, not deficiencies; culturally competent, relevant and flexible programming; and client-centered, low barrier, program development and implementation.

The information presented in this environmental scan will be presented to the research team to help inform their development of a CIHR Catalyst Grant to support the integration of one or more community capacity building strategies within a case management model of care. Case

managers work closely within a community context, and although often not able to take on the responsibility of community capacity building, may be in a position to link clients and passionate community members to facilitate community development (Austin et al., 2006).

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Appendix A

OHTN Rapid Response Request Forms

Rapid Response Request #1:

RAPID RESPONSE REQUEST FORM

The OHTN Rapid Response service is available to community-based HIV/AIDS organizations in Ontario that provide services to people with HIV in Ontario. We provide access to research evidence in response to questions from community-based HIV/AIDS organizations to help support evidence-informed programs, service delivery and advocacy. We conduct searches of the scientific literature and contact experts in the appropriate fields to locate key information resources

Please replace the yellow text below with your responses. If you have any questions, or would like our assistance completing this form, please contact the Rapid Response Coordinator.

NAME:
Janice Duddy & Joanna Mendell

ORGANIZATION:
The Pacific AIDS Network (PAN)

QUESTION:
What **case management models** exist for people living with or at-risk of mental health issues, substance use, HIV and HCV (Hepatitis C Virus)? *(or applicable models in other fields)*

WHY IS THIS REQUEST NECESSARY?
PAN and the Mental Health, Substance Use and HIV/HCV Advisory Committee (MHSUAC) are interested in researching the best ways to support this population. The research team is in the process of developing a research area of focus relating to people living with HIV/HCV, mental illness and/or substance use. The team is interested in applying a program science approach to researching case management models and/or strategies of building community capacity to support this population. This literature review will help to inform a catalyst grant to further develop a team and research question related to this area of study. A rapid response would help the team understand what models are being used, and where the gaps are – informing our research direction.

TIMEFRAME:
1 month

THE CONTEXT:
This rapid request is being requested to scan for **case management** (patient navigation) models. We have requested a separate rapid response scanning for community capacity building models.

We are interested in looking at models for both community capacity building and case management and looking for linkages and opportunities for integration between the two. This group is interested in seeing if an intervention could be developed to support people accessing services but also building strong community resources once they have been released from formal support services. The attached article is an example that discusses possible linkages between case management and community development in a population of older adult.

LITERATURE ALREADY LOCATED ON THE SUBJECT:
See attachment – (Austin, McClelland & Gursansky, 2006).

WRITTEN SUPPORT FROM YOUR ORGANIZATION'S EXECUTIVE DIRECTOR:
Attached in email

Rapid Response Request #2:

OHTN RAPID RESPONSE REQUEST FORM

The OHTN Rapid Response service is available to community-based HIV/AIDS organizations in Ontario that provide services to people with HIV in Ontario. We provide access to research evidence in response to questions from community-based HIV/AIDS organizations to help support evidence-informed programs, service delivery and advocacy. We conduct searches of the scientific literature and contact experts in the appropriate fields to locate key information resources

Please replace the yellow text below with your responses. If you have any questions, or would like our assistance completing this form, please contact the Rapid Response Coordinator.

NAME:
Janice Duddy & Joanna Mendell

ORGANIZATION:
The Pacific AIDS Network (PAN)

QUESTION:
What **community capacity and/or community development building** models exist for people living with or at-risk of mental health issues, substance use, HIV and HCV (Hepatitis C Virus) (or applicable models in other fields)?

WHY IS THIS REQUEST NECESSARY?

PAN and the Mental Health, Substance Use and HIV/HCV Advisory Committee (MHSUAC) are interested in researching the best ways to support this population. The research team is in the process of developing a research area of focus relating to people living with HIV/HCV, mental illness and/or substance use. The team is interested in applying a program science approach to researching case management models and/or strategies of building community capacity to support. A rapid response would help the team understand what models are being used, and where the gaps are – informing our research direction.

TIMEFRAME:
1 month

THE CONTEXT:
This rapid request is being requested to scan for **community capacity building** models. We have requested a separate rapid response scanning for case management models.

We are interested in looking at models for both community capacity building and case management and looking for linkages and opportunities for integration between the two. This group is interested in seeing if an intervention could be developed to support people accessing services but also building strong community resources once they have been released from formal support services. The attached article is an example that discusses possible linkages between case management and community development in a population of older adult.

LITERATURE ALREADY LOCATED ON THE SUBJECT:
See attachment – (Austin, McClelland & Gursansky, 2006).

WRITTEN SUPPORT FROM YOUR ORGANIZATION'S EXECUTIVE DIRECTOR:
Attached in email

Appendix B

Summary of Environmental Scan Results: Case Management Programs

Information found tables is all summarized from the sources listed
NAV indicates information was not publically available
N/A indicates information is not applicable to this model

Program		Peer Navigation Services
Organization(s)		Positive Living BC (PLBC), St. Paul's Hospital and the John Ruedy Immunodeficiency Clinic (IDC), Vancouver STOP Project
Date Started		2011
Location		PLBC and the IDC at St.Paul's Hospital, Vancouver, BC
Search Strategy Used		MHSURT identified
Source(s)		1. CATIE, 2013b 2. Positive Living BC, 2012
Program Description	Overview	Peer Navigators (PNs) are paired with people who are newly diagnosed or who require support becoming or staying engaged with care and treatment. PN teams offer support in two different locations: the clinic team works out of the IDC at St.Paul's Hospital and the outreach team works in the community out of PLBC. Peers provide support by any or all of the following: providing emotional support, and referral to professional counselors if necessary; sharing basic information on HIV and AIDS; building and expanding a client's own skills in self-management; preparing clients for antiretroviral therapy; supporting behavioural change through harm reduction education, referral to addiction counselling, and mental health support; accompanying clients to appointments; and facilitating self-management groups at PLBC and IDC (CATIE, 2013b).
	Goal/Mission Statement	To provide comprehensive peer support to improve self-management skills in relation to health and enhance an individual's comfort with and understanding of their HIV status. (CATIE, 2013b, Quick Facts).
	Recruitment	• Walk-ins (through IDC and St.Paul's 10-C AIDS Ward). • Referrals (through STOP Outreach Team and other community organizations).
	Eligibility	People who are newly diagnosed with HIV, who need support reengaging in care, or who are at risk of falling away from care.
	Scope/Duration of engagement	Clients are engaged for 2 months to 2 years.
	Team/Resources	• One full time peer navigator coordinator who matches clients with the ideal peer. • 10 other PNs.

		• PNs also work closely with a clinical team consisting of nurses, social workers, and physicians.
Evaluation		Evaluation was conducted March 2011-May 2012 which included confidential data collection on demographics and changing health status of clients, interviews, focus groups and a survey with clients. Key Findings: • Most people's self-confidence and their knowledge of HIV and how to manage it increased as a result of their interactions with peers. • Clinical staff appreciated having peers on their teams because they provided support and education on the basis of their experiences of living with HIV. (CATIE, 2013b, Evaluation tab) **Recommendations for future improvements include:** • Expanding the number and range of practices/sites that benefit from the role of PN to ensure we are supporting the patients with the highest need and providing required resources for practices. • To increase their number of patients for whom they are providing HIV primary care. • Expanding self-management tools to other languages • Improved communication and training for staff about the role of PN in interdisciplinary team. • Increase involvement of PN with IDC clinic through rounds, appointment attendance with clients, and sharing of resources. • Review reporting and evaluation tools to improve efficiency. (Positive Living BC, 2012, p.5)
Barriers	To Implementation	• Navigating varying approaches, values, and philosophies between clinical and community organizations. • Integrating PNs into clinical settings and care teams requires flexibility and negotiation. (CATIE, 2013b, Barriers to Implementation)
	To Access	• Only available in the downtown Vancouver core.
Strengths		• PNs engage clients in care cascade and provide referrals to support services. • PNs share their lived experience with HIV to demonstrate the possibility to live long, fulfilled, healthy lives with HIV. • Located in clinic as well as community. • Available in clinic immediately upon diagnosis to engage people in care and support. • PNs are trained to speak the language and structure of clinical services and bridge the communication gap that often exists between clinicians and newly diagnosed clients. • PNs can help clients develop trust in the healthcare system.
Client experiences		• Emotional support to enable acceptance of HIV status • Decreased feelings of depression/suicide, increased self-esteem and confidence • Knowledge of HIV self-management and care in areas such as medication management (ART) as well as aging with HIV

	• Social connections to family, friends, and other positive people • Overall health and wellness (Positive Living BC, 2012, p.20)

Program		John Ruedy Immunodeficiency Clinic (IDC)
Organization(s)		St. Paul's Hospital & Vancouver STOP Project
Date Started		1980
Location		Vancouver, BC
Search Strategy Used		CATIE Programming Connection
Source(s)		1. CATIE, 2013c
Program Description	Overview	The John Ruedy Immunodeficiency Clinic (IDC) operates out of St. Paul's and provides a plethora of support and services to people living with HIV/HCV, mental illness and/or substance use. The interdisciplinary team at the IDC provides services directed at caring for the "whole person" including services addressing the impact of poverty, addictions, mental health, food insecurity, housing instability. Primary HIV and HCV care is offered as well as mental health support, addictions counselling, and case management. The IDC in partnership with Positive Living BC and the STOP HIV/AIDS project also links clients with peer navigators.
	Goal/Mission Statement	**Goal (immediate)** To facilitate access to HIV primary care for people who experience barriers to treatment. **Goal (ultimate)** To provide comprehensive, low-barrier primary and specialized healthcare for people living with HIV who have complex healthcare needs and/or advanced HIV disease. (CATIE, 2013, Quick Facts)
	Recruitment	Walk-ins and referrals from primary care workers, public health nurses, AIDS service organizations, the STOP Outreach Team, the acute HIV care unit or point-of-care testing through St.Paul's, as well as from other community based organizations
	Eligibility	People living with HIV/AIDS who have complex barriers to HIV and primary care.
	Scope/Duration of engagement	NAV
	Team/Resources	Staff include general practitioners, registered nurses (2 HCV specialist nurses), social workers, peer navigators, a dietician, a clinical nurse, reception staff and a pharmacist.

Evaluation		Surveillance and evaluation are ongoing at the IDC through: • Bimonthly patient advisory groups that clients are invited to attend to share their experiences. • IDC's Quality Improvement Group that meets monthly. • STOP Project Evaluation.
Barriers	To Implementation	• Communication across disciplines within different care teams has proven to be challenging and led to implementation of daily patient rounds, and a monthly newsletter.
	To Access	• Waiting times – especially for walk-ins. • Limited mental health support due to lack of capacity and because outreach is not offered.
Strengths		• Interdisciplinary approach allows people to receive primary and HIV are on the same day. • Visits are offered on drop-in or appointment basis.
Client experiences		• Clients are able to share their experiences and suggestions bi-monthly at the patient advisory group meetings.

Program		Maximally Assisted Therapy (MAT)
Organization(s)		Vancouver Coastal Health & Vancouver STOP Project
Date Started		1999
Search Strategy Used		CATIE Programming Connection
Location		Downtown Community Health Centre (DCHC), Vancouver, BC
Source(s)		1. CATIE, 2013a
Program Description	Overview	MAT is a medication adherence program designed to address psychosocial and biomedical barriers to HIV treatment and care. The interdisciplinary team first addresses the immediate needs of the client, which many include housing, food security, mental health, and/or substance use support. Contact is made both in the clinic and through outreach based on individual needs and the program designed by the client and the MAT team. There are two outreach teams that work as part of the MAT program, the MAT Outreach team, and the STOP Outreach team, which provide many of the same services but have some differences in clientele and focus.
	Goal	The goal is to support people with complex issues and barriers in engaging with care and treatment.
	Recruitment	Referrals come from physicians, mental health teams, or the STOP Outreach Team.
	Eligibility	• Clients must be HIV positive and need assistance in managing their health. • Must live in inner city, be insecurely housed and frequent Vancouver inner city, or be clients of DCHC.
	Scope/Duration of engagement	Clients are engaged with MAT until they require less intense support, at which point they are referred to less rigid support programs, or are able to self-manage their care.

	Team/Resources	Clinical coordinator**;** community liaison workers ; pharmacist**;** program assistant; registered nurses; social worker; safe space.
Evaluation		MAT keeps detailed records of new referrals, ARV starts, CD4 counts and viral loads and gives regular reports to STOP. Formal evaluation has not been conducted. (CATIE, 2013a)
	To Implementation	• Space constraints • Challenges in communication and coordination across interdisciplinary teams • Insufficient referral options
	To Access	• Only offered to people living in Vancouver's inner city
Strengths		• Low barrier: o Contact is available on a drop-in basis or made through outreach. o Services are available to clients while they are using drugs and/or alcohol. o Interdisciplinary team that focusses on psychosocial as well as biomedical barriers to treatment • Care programs are designed by client and MAT team to provide the best support for each individual and are revisited and revised for optimal compliance (i.e. Daily/weekly/biweekly/monthly onsite visits, outreach for people unable to attend the clinic).
Client experiences		NAV

Program		The STOP Outreach Team
Organization(s)		Vancouver STOP Project
Date Started		2010
Search Strategy Used		CATIE Programming Connection
Location		Vancouver, BC
Sources		1. CATIE, 2013d
Program Description	Overview	The STOP Outreach Team is an interdisciplinary team that engages people newly diagnosed with HIV or in need of reengagement with care. The team offers short-term intense case management and linkage to more long-term supports in the community.
	Goal/Mission Statement	To increase the number of people who are aware of their HIV status and improve engagement and linkage to care among people living with HIV in Vancouver (CATIE, 2013d, Quick Facts)
	Recruitment	Referrals are made through: • STOP Outreach Team nurses at testing clinics • Primary physicians • Acute care facilities • Mental health and addictions services

		• Community health clinics
	Eligibility	People who experience complex and multiple barriers to HIV treatment and care.
	Scope/Duration of engagement	• Duration depends on individuals' needs and a client requires less intense case management they are linked with other programs that match the level of support needed. Examples of programs people may be referred to: o Supportive housing o Maximally Assisted Therapy (intensive adherence therapy) o Immunodeficiency clinic at St. Paul's (for more independent clients) o VCH Community Health Clinics (self-management)
	Team/Resources	• Interdisciplinary team of nurses, nurse educators, social workers, outreach workers, administrators, peers and a support physician . • Strong network of existing HIV care and treatment services, as well as developed mental health and addictions programs and varied housing options (CATIE, 2013d, Quick Facts)
Evaluation		The STOP Outreach Team maintains ongoing evaluation and tracks team outputs (number of clinics held, number of tests conducted, number of positive tests) as well as client health indicators (housing/income status, health status and stability, ARV stats, and viral loads).
Barriers	To Implementation	• Limited resources: this model of care coordination and support is involved and time consuming and care providers are often overextended. • Challenges coordinating and integrating work with other organizations in the community.
	To Access	• Weekend services are not offered except 24 hour phone support
Strengths		• 24 hour telephone line for clients and support workers • Intensive case management • Work on outreach which removes barriers for people who cannot attend clinic visits • Client centered approach allows clients to set their own priorities while team members act to facilitate their goals. • Collaborative community approach. The STOP Outreach Team works closely with peers, clinicians, hospitals and community organizations.
Client experiences		NAV

Program	Towards Aboriginal Health and Healing (TAHAH)

Organization(s)		Vancouver STOP Project, Vancouver Native Health Society (VNHS)
Date Started		2007
Search Strategy Used		CATIE Programming Connection
Location		Vancouver Native Health Society, Vancouver, BC
Sources		1. CATIE, 2013e 2. Vancouver Native Health Society, 2010
Program Description	Overview	TAHAH is a clinical and outreach team that works with a holistic model to provide support for First Nations people living with HIV and with some form of instability. Clients may have instability with regards to medication adherence or another social aspect of their lives. Services offered include acute care, intensive case management that includes housing, food, and drug and alcohol counselling.
	Goal/Mission Statement	**Goal (immediate)** Reach HIV-positive First Nation people who are currently not accessing care or treatment through intensive case management provided by a nurse, care manager, peers and an elder. **Goal (ultimate)** Improve overall health outcomes among First Nation people by connecting them with a holistic, comprehensive HIV support, care and treatment program that involves medicine provision and treatment of their physical needs but also includes social, emotional and spiritual support. (CATIE, 2013, Quick Facts)
	Recruitment	Referrals may come from a physician, nurse, support worker, the STOP Outreach Team, the community, or through another VNHS program.
	Eligibility	First nations people living with HIV and instability in one or more areas of their health and wellness. Most clients are dealing with addictions and many live with mental illness.
	Scope/Duration of engagement	People are engaged with TAHAH until they are able to manage their own care, or move out of the Downtown Eastside of Vancouver.
	Team/Resources	The team consists of nurses, an Elder, an intensive case manager, and peer community health advocates, HIV specialist (trained First Nations people living with HIV from the community).
Evaluation		A project evaluation was conducted in 2010 (Vancouver Native Health Society, 2010) TAHAH performs ongoing evaluation as part of the funding arrangement from Vancouver STOP Project. TAHAH outputs and client outcomes are measured.
Barriers	To Implementation	• Challenges in integrating and respecting both "Western" and First Nation knowledge systems

		• Human resource issues: hiring and keeping qualified and capable staff
	To Access	• Available only in downtown Vancouver.
Strengths		• Holistic model that focusses on self-respect, autonomy, and wellbeing that adapts to individual needs. • Accessible for individuals who may be unlikely to engage with other more conventional health services. • Approach that addresses social determinants of health. • Peer health advocates connect with clients in a different way than service providers.
Client experiences		NAV

Program		AIDS Vancouver Case Management
Organization(s)		AIDS Vancouver
Date Started		2001
Search Strategy Used		MHSURTidentified
Location		Vancouver, BC
Sources		1. AIDS Coalition of Nova Scotia, n.d 2. AIDS Vancouver, 2014
Program Description	Overview	AIDS Vancouver offers a two-tier case management model, access case management, and intensive case management. Access case management is offered on a drop-in basis or by appointment and provide the following services: assessing client needs, providing referrals, brief counselling, crisis intervention, short-term stabilization, and advocacy/liaison with service providers. Intensive case management works to build longer-term service plans to stabilize clients with complex needs and includes on-going support and follow up.
	Goal/Mission Statement	Case management services link clients with a range of government and community programs of benefit to persons living with HIV/AIDS as well as AIDS Vancouver's own support services.
	Recruitment	Engagement can happen on a drop-in basis at the Access Office (Downtown Vancouver), by making an appointment for a visit at the office or a home visit (self- or practitioner referred), or a hospital social worker can arrange a case manager to visit a client in a local Vancouver hospital.
	Eligibility	People living with HIV/AIDS who need help stabilizing their health.
	Scope/Duration of engagement	Clients remain engaged with case managers until they are stable enough to require less intensive support at which point they are referred to other support services, or until they are able to self-manage.
	Team/Resources	Case managers, information/intake worker, program coordinator.
Evaluation		NAV
	To Implementation	Funding for expansion and increased staff levels.

Barriers	To Access	Offered only in Vancouver.
Strengths		• Two-tier model helps stream-line case management services by differentiating between short-term and long-term needs. Staffing represents the different tiers (access vs intensive case management) and allows caseloads to be limited for intensive case managers. • Support based on social determinants of health (income, housing, psychosocial support, skills and capacity building, health services and testing) • Two-tier model allows effective management of more clients • Capacity for home visits allows access to more clients
Client experiences		NAV

Program		Aboriginal Patient Navigators (multiple programs in BC)
Organization(s)		Vancouver Coastal Health, Northern Health, Interior Health
Date Started		N/A
Search Strategy Used		MHSURT identified
Location		Vancouver, BC
Sources		1. Ministry of Health Services, 2012 2. Foreman & Stewart, 2011
Program Description	Overview	Aboriginal patient navigators (APN) offer advocacy and liaison services to Aboriginal people. There are multiple APN programs across British Columbia which combine knowledge of medical services with Aboriginal culture to help deliver culturally safe health care. Aboriginal Patient Navigators help Aboriginal patients through the health system and offer support in other social health determinant areas such as housing and income.
	Goal/Mission Statement	• To improve communication between health care providers and patient, family, and communities • To improve access to culturally safe and inclusive health care
	Recruitment	Referral from: self, family, health care provider, social worker, or acute and community service provider
	Eligibility	People who self-identify as being Aboriginal/First Nations receiving health care in British Columbia.
	Scope/Duration of engagement	APNs assist clients while they are engaged in the health care system.
	Team/Resources	NAV
Evaluation		An evaluation of the Northern Health Aboriginal Patient Liaison Program was conducted in 2011 (Foreman & Steward, 2011). The evaluation showed strong support for the Aboriginal Patient Liaison Program: • 93% thought it was extremely important or very important to have a Liaison working in the community to support improvements in the health of Aboriginal people.

		• 73% thought the Liaison service helped to improve Aboriginal people's access to care very significantly or a lot. • 75% thought having a Liaison has helped to improve partnerships between Northern Health, First Nations Bands, First Nations Organizations and First Nations Inuit Health in their area.
Barriers	To Implementation	NAV
	To Access	• Physical distance from and travel to health services
Strengths		• Some liaisons/navigators offer translation services or assist in access to translation services to facilitate communication between clients and healthcare providers • Having someone with similar background present for healthcare visits can increase comfort and trust in the system • Advocacy and facilitation with transportation, coverage, and medical supply access • Cultural competency education for providers
Client experiences		100% of patients interviewed as part of the Northern Health Aboriginal Patient Liaison Program reported contributions as follows: • Feeling that their health concerns were heard better • Feeling more comfortable about their health care received • Feeling that their health care needs were met

Program		Intensive Case Management 713 Outreach Team
Organization(s)		Island Health, AIDS Vancouver
Date Started		January 2014
Search Strategy Used		Key informant identified
Location		Victoria, BC
Sources		1. Island Health (2014)
Program Description	Overview	Team provides outreach services and engages, educates and build relationships with people living in the community. Links people with primary care services, addiction services, and housing support. The team works as a component of the Hard to Reach (H2R) Program through Island Health. The other components include two service hubs (The Access Health Centre and Mobile Harm Reduction Services, and Harm Reduction and Pyscho-Social Rehabilitation Services) that offer harm reduction services, primary care services, and a variety of other support services.
	Goal/Mission Statement	To meet the needs of the hard to reach population of people living with mental illness and/or problematic substance use.
	Recruitment	NAV
	Eligibility	Adults who have multiple and complex problems related to substance use and or mental illness (includes people at risk of, or infected with HIV and/or HCV).
	Scope/Duration of engagement	NAV

	Team/Resources	NAV
Evaluation		NAV
Barriers	To Implementation	• Cost/resources
	To Access	• Regional
Strengths		• Provides culturally safe and respectful services to Aboriginal clients (as well as non-Aboriginal) • Peer support • Harm reduction supply provision
Client experiences		NAV

Program		Assertive Community Treatment (ACT) Teams
Organization(s)		N/A
Date Started		N/A
Search Strategy Used		MHSURT Identified
Location		Various locations
Sources		1. Marshall & Lockwood, 2011 2. Ministry of Health Services, 2002 3. Ministry of Health, Services, 2008
Program Description	Overview	ACT is a client-centered, recovery oriented mental health service delivery model. ACT services are tailored to the individual client to address their own goals and priorities. The interdisciplinary team is mobile and is able to meet the client in the community.
	Goal/Mission Statement	To enable individuals with serious mental illness to live independent and self-sufficient lives in the community by receiving treatment in their own environment and appropriate to their needs. (Ministry of Health Services, 2002, p. 7)
	Recruitment	Referral
	Eligibility	ACT serves people with serious mental illness and substance use disorders who have not benefited from traditional outpatient programs. Priority is given to people with schizophrenia, other psychiatric disorders and bipolar disorder. Admission criteria are rigid and can be found in *British Columbia Standards for Assertive Community Treatment (ACT) Teams* (Ministry of Health Services, 2008).
	Scope/Duration of engagement	Clients are engaged until the individual and the team mutually agree that they requires less intense support, move outside ACT's service area (in which case ACT team works to link with another program), can self-manage when services are terminated (slowly over two-year period) or if clients refuse services and request discharge.

	Team/Resources	The team is directed by a team coordinator and a psychiatrist and includes a sufficient number of staff from the core mental health disciplines, at least one peer support specialist, and a program/ administrative support staff who work in shifts to cover 24 hours per day, seven days a week to provide intensive services (multiple contacts may be as frequent as two to three times per day, seven days per week, and are based on client need and a mutually agreed upon plan between the client and ACT staff). (Ministry of Health Services, 2008, p. 1)
Evaluation		Evaluation of the ACT model is extensive and has shown cost-effectiveness, reduction in hospitalizations, maintaining contact with services and improving functioning and quality of life among clients (Marshall & Lockwood, 2011). Evaluation should be ongoing and reflect specific community needs.
Barriers	To Implementation	• Requires extensive resources, staff, funding etc. • Difficult to implement in small communities where the population and/or budget is not sufficient to support an entire ACT team – modifications to ACT model would be necessary
	To Access	• Limited resources limit access to most severe cases • Clients must be over 19 years old
Strengths		• Support services are offered 24 hours, seven days a week • Low staff to consumer ratio for intensive level of support • Client centered approach where consumer directs the delivery of care • ACT Team provides outreach and support clients in the community • Interdisciplinary team/shared case load
Client experiences		NAV

Program	Victoria Integrated Community Outreach Team (VICOT)
Organization(s)	The Ministry of Housing and Social Development, the Vancouver Island Health Authority, Victoria Police Department and Community Corrections Division (Ministry of Public safety and Solicitor General) and the Victoria Downtown Service Providers
Date Started	2007
Search Strategy Identified	Key informant identified
Location	Victoria, BC
Sources	1. Vancouver Island Health Authority, 2012
Program Description Overview	VICOT was the first of four teams funded to serve hard to housed individuals living with mental illness and/or substance use issues. Provides intensive case management for individuals with a history of mental health and/or addiction difficulties who are homeless.

	Goal/Mission Statement	To support people living with mental illness, substance use and homelessness to stabilize their housing and health.
	Recruitment	Referral by community organizations or care providers.
	Eligibility	Anyone over 18 who is homeless in Downtown Victoria and living with mental illness and/or problematic substance use.
	Scope/Duration of engagement	NAV
	Team/Resources	Team members are from a variety of organizations including social service agencies, mental health and addiction services, housing services, and corrections. Service providers include nurses, outreach workers, social workers, a probation officer, and an MSD assistance worker.
Evaluation		Surveillance is ongoing and the collected data is analyzed twice per year (June and December). Information is collected on the following indicators: health indicators, police statistics, probation statistics, MSD and housing stats (Vancouver Island Health Authority, 2012). Successes: as a result of VICOT-support clients are: • Involved in less police interactions. • Successfully housed for longer. • Using emergency care facilities less. • Have better compliance with medication and resulting improvements in physical and mental wellbeing. • Have more opportunities to engage in social activities, groups, and productive work – building skills, abilities and confidence. • Increased ability to build and maintain healthy relationships with others.
Barriers	To Implementation	• Limited affordable and appropriate housing to refer VICOT clients to.
	To Access	• Police presence on VICOT team may deter some people from engaging with the team.
Strengths		• Participation of police, health, MSD and Community Corrections provide clients and staff members with more streamlined access to supports and services. • VICOT works closely with the Victoria Integrated Court (VIC) to plan for clients' court appearances and work towards a common goal, not solely taking punitive approaches. • VICOT clients are offered money management help by MSD to assist in planning and budgeting, and act as a liaison between the team and the MSD's Health Assistance Branch.
Client experiences		NAV

Appendix C

Summary of Environmental Scan Results: Community Development/Capacity Building Models/Programs

Information found tables is all summarized from the sources listed
NAV indicates information was not publically available
N/A indicates information is not applicable to this model

Program		Bridging the HIV Transmission Guidelines to Northern Remote Communities Project (The Remote Outreach Project)
Organization(s)		Blood Ties Four Directions Centre
Date Started		2006
Location		Remote Northern Communities (Yukon)
Search Strategy Used		CATIE Programming Connection
Sources		1. CATIE, 2010
Program Description	Overview	A series of workshops facilitated by the project coordinator focus on transmission, education, community resources and any community specific issues that arise. A series of workshops occur at least twice a year in each community. Some of the events are informal gatherings designed to attract people to the program and engage them in dialogue, others work specifically with service providers and finally there are educational sessions. While the project coordinator is in the community (usually two or three days) they are actively engaged in discussions to answer questions, assess community needs, and provide referrals. The project coordinator works closely with community health representatives (CHRs) from the community. CHRs are involved with health promotion and protection as well as community advocacy in the community but are often burdened by other health-related challenges (low literacy, lack of housing and clean water, domestic violence, drug use etc.)
	Goal/Mission Statement	The goal of this project is not only educate on and prevent HIV and HCV but to also increase the community's capacity to respond to HIV and HCV infections and support people living with HIV.
	Recruitment	Recruitment and engagement is a joint effort between the project coordinator and the CHR. Flyers are posted throughout the community and informal conversations with people in the community are both key strategies used to engage participants.
	Eligibility	Everyone in the community is invited and welcome to participate in workshops.
	Scope/Duration of engagement	At least 2 annual workshops (2-3 days each) for indefinite duration.

	Team/Resources	• Project Coordinator • Community Health Representatives • Canadian HIV transmission guidelines • Culturally relevant films for discussion • Food and refreshments • Extensive transportation to remote communities
Evaluation		The Remote Outreach Project initially was designed to provide workshops intending to train community members as HIV and HCV educators and supporters of people living with HIV. An evaluation of the original project led to a steering committee being formed through the partnerships of Blood Ties, the Council of Yukon First Nations, other local health and social service providers and stakeholders from First Nations communities. This steering committee decided that capacity building was best fostered by continuous delivery by the project coordinator and developed the Remote Outreach Project. In 2008 and 2009 Blood Ties performed two evaluations that included feedback from the community. The first evaluation recommended the following three actions that were implemented: 1. Visit each community for shorter periods of time but more frequently. This will allow for time to perform duties and will help build an ongoing presence. 2. Make clearer distinctions for participants between high- and low-risk behaviour as they apply to remote rural communities (e.g., clearly explain how sharing a bottle of beer has no risk of HIV transmission). 3. Build alliances with the Yukon First Nations community beyond health and social departments to expand community participation; include Elders, Council Members, Chiefs and youth group workers. (CATIE, 2010, Evaluation tab) The second evaluation showed that workshop material was useful when adapted to include examples relevant to northern living. The evaluation also showed that the majority of CHRs and program participants had increased general understanding of HIV and HCV, risk and harm reduction as well as a better understanding of where to seek additional information, advocacy and support services. In general the evaluations were able to demonstrate more open discussion about HIV and HCV in the communities.
Barriers	To Implementation	• Remoteness of communities and difficulties for the project coordinator to travel there. • Time needed to form trust as non-Aboriginal organizations from outside of the community. • Resistance from locals to acknowledge HIV and hepatitis C issues. • Turnover of Community Health Representatives, who are an important link to the community. • Difficulty securing ongoing funding.

	• Misunderstandings about the needs and priorities of First Nations Communities.
To Access	Workshops are available to all community members.
Strengths	• HIV and HCV education and prevention are often de-prioritized and may be sensitive subjects for someone within the community to discuss. For these and other reasons both the community and the Blood Ties Four Directions Centre agree that the project is most effective if the project coordinator returns the community to lead these workshops twice a year instead of tasking the CHRs. • The program is developed and implemented in close partnership with community members and organizations in order to ensure the most relevant and desired information is being covered. • The continuous engagement (bi-yearly workshops) help to establish a presence and a steady source of trustworthy information. • Activities during coordinator visits vary from movie nights, to information sessions, and informal conversations to engage as many people as possible.
Client experiences	People within the community shared how it is helpful to have an external source come in to provide HIV and HCV information and capacity building for a number of reasons. First of all service providers and CHRs are often overburdened and do not have the training to provide current and useful HIV and HCV education. In addition HIV and HCV can be sensitive topics and community members often find it helpful to discuss these topics with someone outside their community. This model was shown to work as long as the outsider was closely linked with community members to develop and share culturally relevant information.

Model	Asset Based Community Development
Organization(s)	N/A
Date Started	N/A
Location	N/A
Search Strategy Used	Google Searching
Sources	**About ABCD**: **1.** Asset Based Community Development Institute,2009a **2.** Mathie, & Cunningham, 2002 **ABCD Toolkit:** **3.** Asset Based Community Development Institute, 2009b **Introduction to** ABCD: **4.** Kretzmann & McKnight, 1993 **Examples of ABCD**: **5.** Kretzmann& McKnight, 1997

Model Description	Overview	Asset based community development (ABCD) is a strategy that builds from what is present in the community (capacity of associations, institutions, organizations, residents and workers) instead of focussing on what is missing or problematic in the community (Kretzmann & McKnight, 1993, p.5). A community begins by mapping out their assets and begins connecting them with one another to multiply their power and effectiveness. The Asset-Based Community Development Institute located at the School of Education and Social Policy at Northwestern University provides a toolkit for community based organizations to learn techniques of asset based community development. Key activities while employing ABCD: • Mapping community assets; • Forming a core steering group; • Building relationships among local assets for mutually beneficial problem solving within the community; • Convening a representative planning group; • Leveraging activities, resources, and investments from outside the community. (Mathie & Cunningham, 2002)
	Goal/Mission Statement	"To locate all of the available local assets, to begin connecting them with one another in ways that multiply their power and effectiveness, and to begin harnessing those local institutions that are not yet available for local development purposes" (Kretzmanna & McKnight, 1993).
	Recruitment	N/A
	Eligibility	N/A
	Scope/Duration of engagement	N/A
	Team/Resources	• Depends on the community, project and intended outcomes.
Evaluation		N/A
Barriers	To Implementation	• Finding a balance for external agencies to be facilitators while allowing the community to drive the process. • Fostering leadership within the community (individual or group) to maintain community-driven process.
	To Access	N/A
Strengths		• By focusing on assets and capacities rather than needs and deficiencies, energy is directed toward opportunities at the community level, while remaining conscious of how the policy environment could be changed to further strengthen citizens' capacity to drive their own development (Mathie & Cunningham, 2002). • Unlike needs-based approaches, where residents can begin to see themselves as people with needs that can only be met by outsiders, ABCD is designed to empower people to be producers instead of consumers (Asset Based Community Development Institute [ABCD], 2009a).

	• Attempts to break the cycle where people are focussed on outwitting the system, or on drawing more resources by highlighting deficiencies (ABCD, 2009a).
Client experiences	N/A

Program		The Legacy Project
Organization(s)		Committee for Accessible AIDS Treatment (CAAT) and partner organizations
Date Started		NAV
Location		Toronto, Ontario
Search Strategy Used		CATIE Programming Connection
Sources		1. Committee for Accessible AIDS Treatment, 2009 2. CATIE, 2012 3. Mossop, Li, & Yee, 2012
Program Description	Overview	The Legacy Project pairs people living with HIV with mentors (PHAs or allies) whom have transferable skills and/or experience to share. The mentor-mentee relationship is structured and includes mentor training, practicum opportunities for PHAs through partner organizations, facilitated meetings, and engagement with the community. The Legacy project is designed to build community, facilitate a continuous exchange of knowledge, skills, and support, and to connect people living with HIV across generations.
	Goal/Mission Statement	Legacy is an initiative to build on existing capacity-building programs and provide PHAs with an ever-expanding network of mentors to facilitate a continuous, ongoing exchange of knowledge and resources (CATIE, 2012)
	Recruitment	Mentors are recruited through community networks of long-term survivors, service partner agencies, and long-term community allies. Recruitment is enhanced through outreach events like presenting at conferences and attending community events.
	Eligibility	Mentees- PHAs who have completed "capacity trainings" available in Toronto Mentors – PHAs and allies who have transferable skills and experience. Mentees may also serve as mentors, or be meeting with multiple mentors simultaneously.
	Scope/Duration of engagement	Mentor training is offered twice a year and takes place over two days. Mentor/mentee pairs decide on paired meeting times. Workshop-style meetings are held to build and sustain connections and the sense of community four times a year. Group mentoring activities are also facilitated by Legacy.
	Team/Resources	• Program coordinator • Mentor network
Evaluation		NAV

Barriers	To Implementation	• Confidentiality issues that arise in the community through pairing mentors and mentees. • Patience, consistency and ongoing support are often needed to create trust in mentor/mentee relationships.
	To Access	• Geographical position and access to mentor/mentees.
Strengths		• Intergenerational community capacity building. • Mentees may also be acting as mentors sharing skills/experience/knowledge in a capacity other than that they are receiving mentorship for. • Flexible – mentor/mentee pairs decide on goals and terms of working together • Gives PHAs an extended community to be part of and a place to use the skills/experience they have gathered in other training programs. • Opportunity for employment (co-facilitators) or practicum placements (in partner organizations) after graduation.
Client experiences		NAV

Model		Task Shifting
Organization(s)		N/A
Date Started		N/A
Location		N/A
Search Strategy Used		MHSURT identified
Sources		1. Jain, 2013 2. Patel, 2012 3. Chatterjee, Patel, & Weiss, 2003 4. Patel et al., 2010 5. Zachariah et al., 2009
Model Description	Overview	The idea behind task shifting is to delegate and share some support activities with "lay health workers" (peers/non-physician clinicians/nonprofessional health workers) who are trained to deliver specific interventions and engage people. This model is especially relevant for low resource communities (ie. Few or no mental health specialists). Some tasks being suggested for "lay health workers" (with adequate training and supervision) include: psychosocial interventions, adherence management, and self-management support programs. Task shifting can refer to any number of interventions where activities are delegated or shared with peers, non-physician clinicians, or non-professional health workers, but for the purpose of this environmental scan we will are interested in task sharing of mental health, substance use, and HIV/HCV care and support. Including "lay health workers" as part of the community of care builds the community's capacity to engage and retain clients when resources are limited.

	Goal/Mission Statement	To address limited resources and the shortage in specialist health human resources by sharing tasks with lay health workers.
	Recruitment	N/A
	Eligibility	N/A
	Scope/Duration of engagement	N/A
	Team/Resources	• Collaborative team of health professionals and lay health workers – team will depend on program.
Evaluation		There is more and more research being conducted on task shifting. Following are some examples of research studies looking at task shifting in mental health and HIV treatment and care. a. Patel et al. (2010) explored the effectiveness of an intervention led by lay health counsellors for depressive and anxiety disorders in Goa, India. b. Chatterjee et al. (2003) evaluated the use of community based rehabilitation for schizophrenia in rural India. Community based rehabilitation is a model of care used widely for physical disabilities where clients, client families and appropriate professionals are involved in programming. c. Zachariah et al. (2008) look at the opportunities and challenges in using task shifting in HIV/AIDS care in sub-Saharan Africa.
Barriers	To Implementation	• Concerns with quality of care. • Safety concerns (for patients and lay workers). • Requires interaction and teamwork health professionals as well as constant supervision.
	To Access	• N/A
Strengths		• Fills gap where there the number of mental health professionals is not sufficient to serve all those in need. • Lay workers/peers may be able to share personal experiences which add another dimension of support and trust. • Access to lay health workers may be easier (time and geographically) for patients instead of making appointments with professionals. • Cost advantages.
Client experiences		N/A

Program	The Transcultural Rural and Remote Outreach Program (TRROP)
Organization(s)	Transcultural Mental Health Centre, NSW Health, Centre for Rural and Remote Mental Health
Date Started	2005

Location		Australia
Search Strategy Used		Google searching
Sources		1. Transcultural Mental Health Centre, 2010 2. Transcultural Mental Health Centre, 2013
Program Description	Overview	TRROP is a program designed to target access and equity to mental health services in culturally and linguistically diverse communities (CALD) in rural and remote Australia. TRROP combines mainstream capacity and community development strategies with innovative methods of clinical service delivery. The program includes a number of strategies used for building community capacity with respect to mental health support including: community focused events; stigma reduction campaigns; expanding and strengthening links with religious and community leaders; wellbeing workshops; and site specific community building activities. The project was rolled out in three phases: responding to stakeholder input, ideas developed by the governance process, and information acquired along the way (Transcultural Mental Health Centre, 2010, p.21)
	Goal/Mission Statement	To address the disparities in mental health between CALD and non-CALD populations by using a systemic approach, incorporating CALD populations in planning and development of services and policies (Transcultural Mental Health Centre, 2010).
	Recruitment	A steering committee was formed in the initial phases of program development that reached out to communities to recruit interested parties. Targeted advertisements were also used for each CALD community.
	Eligibility	People from culturally and linguistically diverse (CALD) communities across the age spectrum who live outside metropolitan centres of NSW who experience mental health problems, and their service providers, with particular reference to - • the ageing population, refugees, survivors of torture and trauma; • families and carers of CALD people with mental health problems; • principal service providers who provide direct services to people from CALD communities, their families and carers; • government and non-government providers of cultural support services to people from CALD communities. (Transcultural Mental Health Centre, 2013)
	Scope/Duration of engagement	Project took place 2005-2009
	Team/Resources	NAV
Evaluation		Evaluation was incorporated into TRROP from the earliest planning phase. It included impact evaluation for specific events as well as outcome evaluation for the four key performance areas (KPAs): systems capacity, service capacity, workforce capacity, and community capacity. For community capacity, building baseline data was documented, a consultation group was formed, and

		feedback was gathered from events. The following recommendations were made with regards to community capacity building: • Continue CALD community-focused events in rural areas aimed at increasing mental health knowledge and awareness. • Repeat the Community Consultation in project sites every five years. • Develop and implement stigma reduction campaigns for CALD communities. • Involve religious and community leaders in mental health promotion activities. • Expand and strengthen links with religious leaders with the aim of diminishing stigma and facilitating referrals from CALD communities. (Transcultural Mental Health Centre, 2010, p.64)
Barriers	To Implementation	• Limited resources. • Transportation to remote communities. • Language and trust in community. • CALD communities were often small in number and spread across a large geographical area. • New and emerging CALD communities with no "centre of population infrastructure that could be used to liaise with community powerbrokers" (Transcultural Mental Health Centre, 2010, p.62).
	To Access	N/A
Strengths		• Community consultation to determine needs of CALD communities, to understand how mental health issues are conceptualized by community members, to determine help-seeking practices, and identify potential barriers. For example, the findings that many CALD people turned to religious leaders to discuss mental health issues was the basis for the establishment of the Spiritual Leaders Information Sessions. (Transcultural Mental Health Centre, 2010, p.27) • Site specific events took place based on requests and needs identified. • Trainings were offered in multiple languages.
Client experiences		NAV

Model	Street Angel
Organization(s)	Ktunaxa Nation Council
Date Started	2010
Location	Cranbrook, BC/ Ktunaxa Traditional Territory
Search Strategy Used	MHSURT identified
Sources	1. Ktunaxa Nation Council, 2011

		2. College of the Rockies, n.d
Program Description	Overview	Street Angel, is a facility that provides a safe environment and services such as hot dinners, on-site laundry and shower facilities, computer access, medical services, employment services, warm clothing and bedding and support systems.
	Goal/Mission Statement	To link clients with services that help them deal with issues such as communicable disease, addictions, mental health, education , training, employment, accommodation and nutrition (Ktunaxa Nation Council, 2011). Street Angel is open 2pm to midnight seven days a week. Professional support workers that provide services at Street Angel include a nurse practitioner, an Aboriginal court worker, an addictions counsellor and a homeless outreach worker.
	Recruitment	Open access, word of mouth, service provider referrals.
	Eligibility	Everyone is eligible.
	Scope/Duration of engagement	N/A
	Team/Resources	NAV
Evaluation		The following outcomes have been reported by Street Angel: • 20 clients have secured housing. • 19 clients have sought drug and alcohol treatment services. • 9 clients graduated from the College skills training program: WHIP. • 2 youth clients graduated from high school while living in tents in the forest. • 5 people have reconnected and returned to their families and communities through social networking on the facility's computers. • 4 people have received HIV/AIDS and Hep C support and are now managing their health while others have access to testing. • Angels doing foot tours of known "party" spots are finding decreased activity. • Emergency and Police Response to street incidents has significantly decided. • At least 4 lives have been directly saved as a result of Street Angel intervention. • Clients have provided support to each other in emergencies. • Clients express desire to give back to the community and engage in volunteer activities (e.g. snow removal for those who are not able).
Barriers	To Implementation	• Resources (funding, food donations, full time staff/support workers).
	To Access	NAV
Strengths		• Available 2pm-midnight while many if not all programs are not available after 5pm. Additionally clients may access the facility before it opens to attend appointments or receive referrals. • College of the Rockies offering Adult Basic Education classes at Street Angel.

Client experiences	Many client testimonials are available attesting to the support they received from Street Angel and the positive effect it has on their lives. For testimonials see: http://www.youtube.com/watch?v=gTgYcy1Uqy0

Model		Street College
Organization(s)		AIDS Vancouver Island & SOLID (The Society of Living Illicit Drug Users)
Date Started		2010
Location		Victoria
Search Strategy Used		Key informant identified
Sources		1. Society of Illicit Drug Users, n.d. 2. The Victoria Foundation, n.d.
Program Description	Overview	Street College engages people who use(d) illicit drugs in an educational process that confronts stigma related to drug use, HIV & Hepatitis C (HCV), and poverty; increases self-awareness and supports, and builds skills in peer support, advocacy, prevention and leadership (SOLID, n.d.) Street College offers courses related to drug related stigma, leadership, resilience, gender, health and wellness, creative writing, and others. Some courses are run by Street College staff while others are peer led.
	Goal/Mission Statement	To build the knowledge and capacity of some of Victoria's most marginalized and vulnerable citizens in order to improve their health. The project increases participants' understanding of their health conditions, enhance their ability to access health care, and to speak about themselves (The Victoria Foundation, n.d.).
	Recruitment	NAV
	Eligibility	People who use(d) drugs living in Victoria.
	Scope/Duration of engagement	Trainings vary in length, and engagement with Street College can continue after completion of all the trainings by becoming involved with teaching courses.
	Team/Resources	NAV
Evaluation		NAV
Barriers	To Implementation	NAV
	To Access	NAV
Strengths		• Leadership training in stages that allows people to move through trainings with the potential to teach the trainings themselves. The anti-stigma curriculum is entirely peer led. • Offers a safe place for people who use drugs to learn and speak about themselves and relevant issues in their lives. • Stipend and food provided.
Client experiences		NAV

Model		Community Resilience Model (CRM)
Organization(s)		N/A
Date Started		N/A
Location		N/A
Search Strategy Used		MHSURT identified
Sources		1. Kirmayer, , Sehdev, Whitley, Dandeneau, & Isaac, 2009 2. Trauma Resource Institute, 2014
Program Description	Overview	Trainings designed to help people and communities develop the tools to overcome stress, trauma, and other life challenges (Kirmayer, Sehdev, Whitley, Dandeneau, & Isaac, 2009). One model is skills based trainings designed to help people understand their nervous system and learn to connect with their own wellbeing – increasing their resilience to deal with trauma or stress – as described by the Trauma Resource Institute. Trainings are designed for individuals to pass on skills to family, friends, and the wider community. "Community resilience looks at how people overcome stress, trauma, and other life challenges by drawing from the social and cultural networks and practices that constitute communities. At the same time, it draws attention to the resilience of the community itself" (Kirmayer et al., 2009).
	Goal/Mission Statement	To help people develop skills to understand and to connect with their own body and wellbeing – increasing resilience to deal with trauma or stress. Goals include: strengthening social capital, networks and support; revitalization of language, enhancing cultural identity and spirituality; supporting families and parents to insure healthy child development; enhancing local control and collective efficacy; building infrastructure (material, human, and informational); increasing economic opportunity and diversification; and respecting human diversity (Kirmayer et al., 2009).
	Recruitment	N/A
	Eligibility	N/A
	Scope/Duration of engagement	Models of community resilience training vary. Resources can be offered online, or workshops/training courses are available as well.
	Team/Resources	Vary depending on training model.
Evaluation		NAV
Barriers	To Implementation	NAV
	To Access	NAV
Strengths		• Training is designed to give individuals and communities the tools to strengthen their own resiliency and to be sustainable without outside intervention.
Client experiences		NAV

Model		SMART Recovery: Self-management and recovery training
Organization(s)		Smart Recovery
Date Started		1994
Location		Meetings are offered world-wide (over 30 found in BC). Central office is in Ohio.
Search Strategy Used		Key informant identified
Sources		1. SMART Recovery, 2014 2. Horvath, 2000
Program Description	Overview	SMART Recovery is a cognitive-behavioural model of addiction recovery that empowers people through a four-step program, world-wide face-to-face and online meetings, online message board, and 24/7 chat room. Participants benefit from a world-wide community of peers and are able to participate at no cost. Meetings are typically moderated by non-professional volunteers. Although SMART is designed specifically for addiction recovery, the model could potentially be applied to support other populations (ie. People living with HIV, HCV, or mental illness).
	Goal/Mission Statement	To empower people living with addiction and their families throughout the process of recovery. 1. Help individuals gain independence from addictive behaviour. 2. Teach how to enhance and maintain motivation to abstain; cope with urges; manage thoughts, feelings and behaviour; and balance momentary and enduring satisfactions. 3. Based on scientific knowledge, and evolves as scientific knowledge evolves. 4. Individuals who have gained independence from addictive behaviour are invited to stay involved with us, to enhance their gains and help others.
	Recruitment	N/A
	Eligibility	People with any type of addictive behaviour. Meetings may also be open to friends and family and others from the community.
	Scope/Duration of engagement	Indefinite.
	Team/Resources	To become a host/moderator for meetings there is a $75 training cost. Free tools and resources are available to participants online. SMART is governed by a board of directors, half of whom are behavioural health professionals. Trainings for coordinators, professional advisors and other interested professionals are held at least once a year.
Evaluation		NAV
Barriers	To Implementation	• Meetings are usually run by non-professionals and it is important that they do not confuse their roles with the roles of individual or group psychotherapists. • Uncertain funding.
	To Access	• In order to attend meetings you must have access to a computer or be able to attend in person meetings.

Strengths	• Coordinators have autonomy on how to organize their meetings. • Meetings are held in correctional facilities (approx. 40). • There are real time online meetings being held daily. • Client centred.
Client experiences	NAV

Program		Positive Leadership Development Institute (PLDI)
Organization(s)		Ontario AIDS Network (OAN) and Pacific AIDS Network (PAN)
Date Started		2006 as the *Leadership Development Program* by the OAN, and then relaunched as *PLDI* in 2009 in partnership with PAN
Location		Ontario and British Columbia
Search Strategy Used		MHSURT identified
Sources		1. Dunbrack, 2012 2. Ontario AIDS Network, 2010 3. Positive Leadership Development Institute, 2014
Program Description	Overview	PLDI offers a series of trainings "supporting people who are living with HIV/AIDS to realize their leadership potential and increase their capacity to participate meaningfully in community life" (Positive Leadership Development Institute, 2014, para 3). There are three levels of trainings: 1) "Who am I as a leader?"; 2) "Bored? Get on Board!"; 3) "Communications". Participants participate in PLDI for personal development goals, to develop skills for volunteering, or to obtain paid employment (Dunbrack, 2012).
	Goal/Mission Statement	To develop strong networks of leaders among people living with HIV/AIDS by helping them realize their leadership potential and their opportunities to participate meaningfully in community life (Dubrack, 2012, p.3; Ontario HIV Network, 2009).
	Recruitment	Interested participants must complete and submit an application form.
	Eligibility	People living with HIV who have had time to reflect upon their diagnosis and would like to increase their leadership skills and capacity to contribute to their communities.
	Scope/Duration of engagement	Participants are able to engage in three 3-4 day workshops covering three curriculum levels. Engagement can continue once all three levels are completed in other workshops and events.
	Team/Resources	• Program coordinators, trained leaders, space to hold workshops, funding to sponsor travel, accommodation and meals for participants.
Evaluation		An evaluation was undertaken in 2012 on behalf of the OAN (Dunback, 2012). Results from the evaluation suggest the following could enhance the PLDI program: • Maintain content while updating and providing more training on requested skills such as public speaking and facilitation • Develop timely progression for participants from Level 1 through Level 3

		• Educate more trainings to meet the high demand for the program and spread trainings to more regions of Ontario • Consider working with organizations connecting to Aboriginal, Asian and youth communities to increase their participation in leadership training • Develop post-training supports, largely electronic, for graduates to continue networking and supporting each other and exchanging news. Consider working with program graduates to develop these. (Dunback, 2012, p.4)
	To Implementation	• Demand exceeds supply. Many people are put on a waitlist and almost 20% end up waiting more than a year (Dunback, 2012). • Uncertain funding
	To Access	• Geographical barriers. Only offered in BC and Ontario.
Strengths		• Offered free of charge Clients who have participated in PLDI leadership courses have: • Gone on to volunteer at AIDS service organizations and other community organizations • Reported greater self-confidence • Taken on leadership roles • Improved skills at work • Secured paid work
Client experiences		The following are shared from PLDI participants (Dunback, 2012). • I'm happy to say that I recently accepted a contract position. • I am returning to school full time . • I have used my skills to gain two jobs – am working full time. • I've been asked to speak at a conference about being an HIV-positive person who returned to work. • The training helped me to find my path and make a career change.