Canadian Mental Health Association Durham
Helping people move forward

An Illustrated Map of a Client's Journey

First Service Registration

Canadian Mental Health Association Durham

Reception/Community Access Services

Group Living Services

Nurse Practitioner Led Clinic

Bond St. Pharmacy

Subsidized IAH Unit

Intensive Case Management Services

Discharge

Community Wellness Services

Second Service Registration

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H2H Hospital to Home

Hospital to Home

Short Term Case Management

Intensive Case Management Services

Subsidized IAH Unit

DMHS
LHO Pinewood
LHO Psychiatry
LHO Social Work

HealthLink

Coordinated Care Plan (CCP)

Nurse Practitioner-Led Clinic

Bond St. Pharmacy

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CMHA Durham: A Client's Journey through Services

In 2009, a client came to **CMHA Durham Community Access Services** where his needs were assessed and he was deemed eligible for **Group Living Services.** He received assistance in many areas of development, including medication management, psychiatrist support, coping strategies, appointment reminders and many life skills, such as budgeting, cleaning, grocery shopping, public transportation and more.

When this client successfully graduated from group living, he was placed in a **Subsidized IAH Unit** with CMHA Durham and transferred into the **Intensive Case Management** program. Case managers supported him by providing various supports to help him maintain his mental health and independence. During this time, the client participated in numerous group day programs at our **Community Wellness Services,** including life skills, social, vocational rehabilitation and education development groups. He was also registered with our **Nurse Practitioner-Led Clinic** for primary care services and received medication at the **Bond St. Pharmacy,** which is offered on site at the CMHA Durham building.

The integration of these various services provided this client with the comprehensive support he needed and he continued to flourish. After three-and-a-half years, he had stabilized his mental health and addictions difficulties, found and maintained full-time employment, developed a support network and no longer required rent-subsidized housing. Arrangements were made with the landlord to allow the client to stay in his apartment without subsidy. He received case management for a few more months, which led to a mutually agreed discharge.

One year later, the client presented at Lakeridge Health Oshawa Emergency Room several times for mental health/addictions reasons and a CMHA Durham **Hospital to Home** worker connected with him. The client had lost his job, which triggered deterioration in his mental health and addiction, resulting in financial difficulties and his housing being jeopardized. **Short Term Case Management** was provided via the H2H program and a **Coordinated Care Plan** was initiated. The following agencies attended the Coordinate Care Conference: Pinewood, LHO Social Worker, LHO Psychiatrist, DMHS and CMHA Durham. It was determined that the client should remain in hospital until his EI benefits were secured. Resources were identified and used to cover his rent arrears and clean his apartment. Addiction services and support were initiated, crisis service options were provided and the client was registered into CMHA Durham **Intensive Case Management Services.** As a result of his success with his services, rent **Subsidy** with CMHA Durham was reinitiated.

This client has been successfully living back in rent **Subsidized Housing** and receiving **Intensive Case Management** for almost one year. He has stabilized his mental health and found temporary employment. He is looking to return to school and is working with a debt counselor in regards to his finances. The client has experienced no relapses since his hospitalization and subsequent Health Links Coordinated Care Plan. He continues to seek support through Pinewood to remain abstinent.