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Annotated Bibliography of Collaborative Mental Health Care

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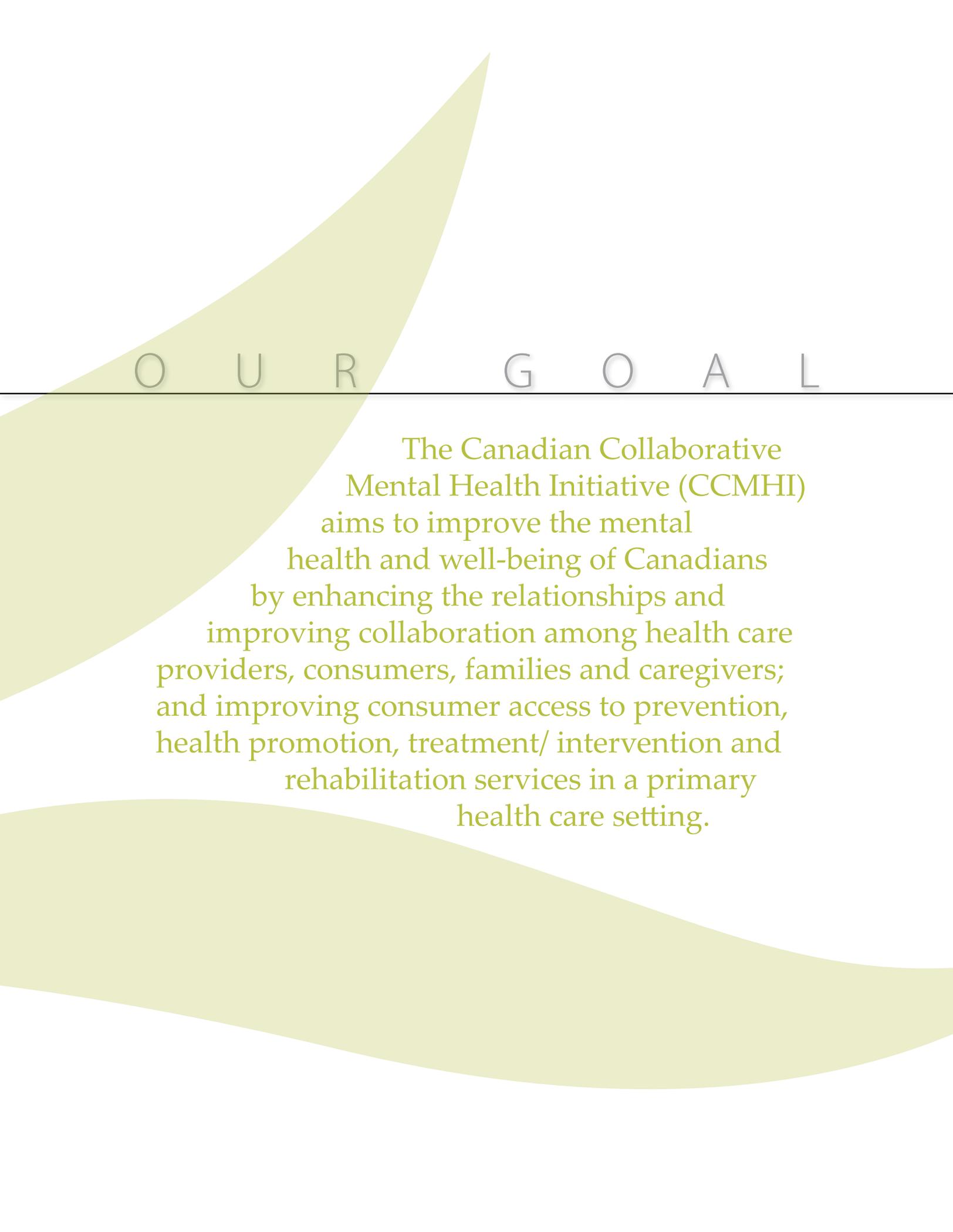
Annotated Bibliography of Collaborative Mental Health Care

*A paper for the
Canadian Collaborative Mental Health Initiative*

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O U R

G O A L

The Canadian Collaborative
Mental Health Initiative (CCMHI)
aims to improve the mental
health and well-being of Canadians
by enhancing the relationships and
improving collaboration among health care
providers, consumers, families and caregivers;
and improving consumer access to prevention,
health promotion, treatment/ intervention and
rehabilitation services in a primary
health care setting.

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EXECUTIVE SUMMARY

The Canadian Collaborative Mental Health Initiative (CCMHI), a federally funded two-year project conducted under the auspices of Health Canada, is grounded in the belief that collaborative mental health care in primary health care settings decreases the burden of illness of consumers who suffer from mental illness by optimizing their care and increasing their access to mental health services. Twelve national health care organizations participate in this project. **Its goal is to strengthen the capacity of primary health care providers to meet the mental health care needs of their consumers through interdisciplinary collaboration.**

Interest in collaborative primary mental health care is growing worldwide. Researchers and practitioners, alike, have embraced this approach and are publishing reports and articles about their programs at an increasing rate. To build on the *Shared mental health care: a bibliography and overview*, the annotated bibliography prepared by the Collaborative Working Group of The College of Family Physicians of Canada and the Canadian Psychiatric Association (Craven and Bland, 2002), **the CCMHI commissioned an updated annotated bibliography that would capture the literature published since 2000 and reflect the CCMHI Framework for Collaborative Mental Health Care** developed to conceptualize collaboration within a consumer-centred model of care.

The CCMHI Framework (Gagné, 2005) is defined by its key elements: consumer centredness, accessibility, richness of collaboration, and collaborative structures. The success and ease of implementing collaborative mental health care will be determined, in part, by fundamentals — by congruent policies, legislation and funding regulations, sufficient funds, evidence-based research, community needs, and readiness and resources.

The updated bibliography, *Annotated bibliography of collaborative mental health care*, uses the CCMHI Framework as an organizational lens through which to examine the most recent collaborative care literature. Chapter 1 provides an overview of the rationale for the project and the CCMHI Framework. It describes the methods and organizational structure of the paper. Chapter 2 focuses on the heart of collaborative care, reviewing the goals of collaborative care: the foundational paradigms, placement of collaborative care within the broader care continuum and the overall consumer groups for which collaborative care is relevant. The fundamental elements of the infrastructure — policy, funding, research and community — are covered in Chapter 3. Chapters

4 through 7 present the literature pertaining to each of the key elements: consumer centredness in Chapter 4; accessibility in Chapter 5; richness of collaboration in Chapter 6; and collaborative structures in Chapter 7.

Chapter 2, The Heart of Collaborative Care, begins by sorting through the many terms used to describe collaborative care: for example, “shared care,” “integrated primary care,” “primary behavioural health care,” “primary mental health care” and “the mental health/primary care interface.” **To date, the terminology has not been standardized**, placing the onus on the reader to double check meanings and cross-reference information about collaborative care across different health care systems to build a solid understanding of the field. **No one accepted definition of collaborative care exists**. To further complicate understanding of the field, not all authors choose to explicate the terms they use in their work.

Underlying most discussions of collaborative care are theoretical or conceptual paradigms, often dictated within the separate disciplines that shape the approaches taken to collaboration. The most often mentioned approach — the traditional medical mind–body dichotomy — is viewed as a fundamental barrier to the integration of primary medical and mental health care. Familiarity with the various paradigms and the way they influence researchers and practitioners is key to achieving effective collaborative care. One clear message about achieving integration of care is the need for a shared set of beliefs or goals for the collaborative program. **The challenge for practitioners often lies in being able to transcend their disciplinary beliefs to find common ground with other professionals** so that together they can provide integrated primary-based mental health care to consumers.

Defining the consumer groups for collaborative care is also part of the discussion in Chapter 2. Many authors favour a population-based approach to primary mental health care to meet the mental health needs of the entire primary care population, much as their physical health care needs are currently met. Covering a wide range of mental health issues, problems and disorders, this approach — a horizontal integration of care — serves the widest range of people. A second population-based approach, characterized by vertical integration of care, is designed specifically for high-use, high-cost groups needing primary mental health care. Need alone dictates that mental health care be offered in the primary care setting because most people with mental health needs, regardless of where they live in the world, have contact with primary care. Added to this group are the consumers with chronic physical problems or medical issues who would benefit from concomitant mental health care. Acknowledging these unmet needs for mental health care

could fully secure the place of collaborative care within the health care system.

Chapter 3, Fundamentals of Collaborative Mental Health Care Infrastructure, highlights the broad system elements required if collaborative care is to flourish, namely, policy, funding, research and community. **For collaborative care to advance beyond a new to a mainstream approach, policy makers and funders need to validate it.** In the prevailing environment of increasing competition for health care dollars in both developing and developed countries, the business case for collaborative care must be strong and convincing to secure the requisite investment in resources. Policies dealing with collaborative care and supporting changes in the delivery of care and management practices, care structures, funding, payment, training and education, standards of care, monitoring and quality assurance are needed. Policy alone, however necessary, is not sufficient to bring about more collaboration. **To truly support collaboration, funding schemes, payment programs and business models must be flexible and accountable.** The bottom line? – financial incentives and funding options can be extremely useful tools to leverage and reinforce change in the organization of the system and the behaviour of practitioners.

Constructing the business case requires good research. Recommendations about next steps for collaborative care are numerous. Foremost is the need for new paradigms to guide research based on interdisciplinary participation in the care and the broadest set of principles and behaviours. **Needed, too, is an expanded definition of primary mental health care that would encompass the full range of community resources beyond those of primary medical care** that could bring consumers from mental illness or distress to wellness and health. Innovative treatment practices that go beyond adapting specialized treatments for mental illnesses to the primary care setting, coupled with a focus on evidence-based practice, should be encouraged. **Research approaches that bridge the gap between research and real-life practice, between ideal models and everyday constraints, are vital** for the steady progress of this field of care.

Last, but not least, is a fundamental understanding of and an ability to work with the community where collaborative care takes place. Many opportunities for collaboration within local systems of care that require minimal time and attention to set in motion may go unrecognized. More elaborate, formal systems of collaboration should be built cooperatively from the ground up to take advantage of existing resources at the community level, and promote joint ownership and investment in this

approach to care. Linking with other community resources has the potential to spread or even defer the costs of care, and encourages the use of least intrusive, more economical responses.

Basic needs-assessment methods are useful to planners and practitioners wanting to establish or expand collaborative care programs. Investment of energy and commitment in this community-focused process will prove worthwhile over the long-term to the sustainability of the collaborative care program. As the experience of one Australian community proved, a united voice to save an inexpensive but highly effective collaborative care partnership between a psychiatric nurse, local general practices and the community at large can be instrumental (see Chapter 4: Malcolm, 2000; 2002).

Chapter 4, Consumer Centredness, examines the development of a consumer-centred approach to collaborative care. Such an approach demands that the mission of care focus on responding to the needs of consumers. Collaborative care is a mechanism for achieving these goals. Professionals unite in their care for consumers through a common vision, shared care goals and integrated clinical practices. Consumers must also take responsibility for their own care, including engaging in self-help. **Ensuring the fit of services to the needs of consumers also requires that they and their families be part of the planning and development of programming.**

Reaching special populations through collaborative care involves different approaches for different groups. These populations include people with serious mental illness; people with addictions or concurrent disorders; children and adolescents; rural populations; seniors; and other groups such as homeless people, people with HIV and specific ethnic groups. To meet the needs for the specialty and primary medical care of some of these groups, such as those with severe mental illness or addictions abuse, integration of care within the specialty care setting (i.e., bringing the primary care providers into that location) is recommended. This is the reverse of the normal approach to collaborative care, which most often involves mental health care providers moving into the primary care setting. Integration of care for children, adolescents and seniors means taking a more holistic approach to the medical and psychosocial elements of diagnosis, treatment and follow-up care. For other groups, collaborative care requires creative combinations of services that emphasize the psychosocial factor while providing the necessary medical care, and that are sensitive to the culture, diversity and social context of these groups.

Chapter 5, Accessibility, begins with the obvious question, Why should primary and mental health care be integrated?, and **examines the**

benefits of integrated care to consumers, the local system or community and the broader health care system. Intuitively, integrated care makes sense: it meets consumers' needs in a way that complements the way they live their lives and their preference for care that is delivered in a single setting. This is the very essence of increasing access to care. Delivery of care has traditionally been organized and segmented along long-standing, but artificial divides within health disciplines. These divisions present a major challenge for system reform and for practising professionals who wish to embrace more holistic approaches to care. The burden of the segmented system of care has often been placed on the shoulders of consumers and their families, and on those with mental health or illness problems.

The very nature of their distress often prevents them from being able to navigate this labyrinth of care. Understanding the benefits of changing the way care is delivered at all levels and the expectations of what this care can accomplish with input from all parties involved should confirm the necessity for this change. In turn, this change should inspire those involved in the process of change to continue to support collaborative care.

To that end, **numerous conceptual frameworks for collaborative care are presented** in Chapter 5. Although these frameworks organize the elements that characterize collaborative care differently, they share a common goal — to increase understanding about how to integrate discrete disciplinary approaches to care for consumers with mental health concerns treated in primary care and produce better health outcomes. Specific models of collaborative care are also examined.

Chapter 6, Richness of Collaboration, discusses the interactions that take place during the delivery of care and the types of professionals involved. **Collaborative care involves numerous professionals working together, and although the exact number varies greatly, working together is often defined as teamwork.** This chapter examines collaborative care as teamwork and analyzes the interactive elements that make it effective. **Successful collaboration requires a blend of personal and professional attitudes and characteristics that balance autonomy, power and control, responsibility, respect and trust.** Also relevant are styles of working and the elements that support teamwork, for example, communication (clarity, frequency, format and mutuality), listening skills, understanding the care pathway and clinical processes, awareness of one's own and others' knowledge base and skill sets, and decision-making processes.

A wide range of professionals is involved in collaborative care — psychologists, family physicians and general practitioners, psychiatrists,

psychiatric nurses, practice nurses, clinical nurse specialists, nurse practitioners, social workers, occupational therapists, chaplains, and pharmacists. **Collaborative care has also generated a number of additional positions**, such as counsellor, link worker, primary mental health care worker, gateway worker, care facilitator, and care extender that may be filled by persons from various disciplines. What is evident from this literature is the keen interest in sorting through the existing practices and beliefs of many disciplines to find a way to work together for the benefit of consumers dealing with mental health issues. The positive forces of openness, hope, and creativity are also inherent — to look within and beyond current approaches to care to define new cooperative ways of responding to consumers in need. An important element of effective team work is the emphasis placed on exchange of knowledge. Here, professionals from multiple disciplines learn from one another to provide the best care possible.

Chapter 7, Collaborative Structures, examines the concrete features or elements of the care process that support collaboration and the complex interaction among people and the structural elements. **Supportive structural features occur at three levels: the practice, local system of care and broader health care system levels.** Within the local primary care setting, adjustments to practice elements are required to accommodate collaboration with mental health professionals. Such things as assignment of adequate physical space in the shared milieu in which medical health care is provided, common administrative procedures, common waiting rooms and reception services, integrated appointment processing, one staff room, and joint charting have been identified. Other supportive processes include team protocols, job descriptions, joint understanding of participating professionals' expertise and skills, well-defined clinical processes and pathways, informal processes for consultation and sharing of care in an open-door style of working that tolerates interruptions and hallway chats.

Local system elements include a defined goal among providers to improve interactions between primary care and mental health care, development of training strategies that involve local specialized mental health staff training primary care health workers in mental health issues, provision of medicines to treat common mental disorders in primary care settings in developing countries, involvement of experienced staff in collaborative care and a commitment to the evaluation of implemented models. Featured at the broadest level are elements of continuing education for existing providers in collaborative care; changes in training so that future clinicians are versed in collaborative approaches, styles and skills; promotion of collaborative relationships among professional

associations, academic faculties and institutions; formation of national, regional and local health care policies that support collaboration; funding for collaborative care; and systemic strategic planning.

To understand what is going on in collaborative care, conceptual schemes that focus on the behavioural aspects of the collaboration and on measures to capture these behaviours are needed. Recognition that collaboration is a complex set of interactions is important — these interactions take place between a number of players, in time and space, and any combination of forces within this system may be responsible for the outcomes of the care delivered.

Practical and theoretical conceptualizations of the collaborative program are useful to the study or evaluation of this type of care. Here again there is no consensus about the optimal theoretical model of care, but suggestions include a cognitive rather than a behavioural model, the use of an input-intervention-outcome framework, systems theory and the process of structural reform. **Various measures of collaborative care** (structural and relational elements) also **appear in the literature**: frequency of collaboration, interdisciplinary collaboration, collaborative strength, operational integration, team motivation, collaborative values, decision-making and satisfaction. Overall, evaluation of collaboration must be comprehensive in its conceptualization, measures, stakeholder involvement and methods.

A pivotal tool is the computerized information system, ideally an electronic consumer record that integrates all clinical information and can program some aspects of the care process (e.g., recall system or reminders for follow-up care, register of subgroups). Other tools worthy of mention include hand-held computers to assist with information mastery, practice guidelines and protocols. During its review of the literature, this annotated bibliography highlights some of the research conducted on the relationship between various outcomes and collaborative mental health care. However, this document discusses only these findings. The CCMHI has commissioned a review of better practices, *Better practices in collaborative mental health care: An analysis of the evidence base*.

In summary, these are the key points of this annotated bibliography:

- The literature about collaborative mental health care is growing worldwide.
- The CCMHI commissioned an annotated bibliography to update the annotated bibliography produced by the Collaborative Working Group in 2002 (Craven and Bland, 2002).
- This new annotated bibliography builds on the CCMHI Framework, a conceptual framework that outlines the

fundamentals required to support collaborative mental health care and the key elements that define it.

- ✎ Each chapter of the annotated bibliography develops the fundamentals and key elements outlined in the CCMHI Framework.
- ✎ These key themes for successful collaborative mental health care are discussed in the bibliography:
 - Chapter 2 – In general, because the literature is evolving, clarity around language, terms and definitions is lacking. A number of paradigms influence collaborative mental health care. A shared set of beliefs and goals, and agreement about the definition of consumer groups for collaborative care are required.
 - Chapter 3 – Policies and funding mechanisms that support and encourage collaboration, and research and program evaluation that lead to the identification of best practices are required. The development of collaborative initiatives that are grounded in the needs, recourses and readiness of communities should also be the norm.
 - Chapter 4 – Consumer centredness is a key theme of collaborative mental health care. Consumers are experts in their own care, have a responsibility for it, and need to be partners in decision-making and goal-setting. Since some populations have special needs, primary mental health care approaches need to be adapted to these needs.
 - Chapter 5 – There are a number of important arguments for integrating mental health with primary health care. A number of approaches for integrating these services should be considered.
 - Chapter 6 – Effective teamwork is a cornerstone of collaborative mental health care. Awareness of the differences between the various disciplines involved, implementing team-building strategies, and creating positions that facilitate the integration of mental health and primary health care (e.g., link workers) are required.
 - Chapter 7 – A number of collaborative structures support effective collaborative mental health care, including common physical space, shared information systems, and evaluation of designs and methods. Important collaborative structures need to be considered.

Chapter 1:

INTRODUCTION

KEY MESSAGES

- *The large volume of recent research and the steady pace of implementation are indicative that collaborative mental health care is a fast-growing trend.*
- *This annotated bibliography builds on the solid foundation of a previous bibliography about shared care, uses the Canadian Collaborative Mental Health Initiative Framework for Collaborative Mental Health Care as its organizing principle and is based on an extensive on-line literature search.*

The growth of collaborative mental health care in primary health care over the last decade is clearly reflected in numerous jurisdictions worldwide that have made collaborative health care a key reform or focus of service. Further testament to this growth is the increased volume of professional publications about primary mental health care and, especially, about collaborative approaches to it. To help researchers, service planners and clinicians cope with this volume of information, this critical mass of literature warrants summary and analysis in an annotated bibliography that is readily available and easy to use. Although such bibliographies run the risk of being outdated soon after they are published, their value lies in their ability to guide readers through large volumes of information, documenting overall themes and advancements in knowledge.

Background

In 2002, the Collaborative Working Group, established in 1998 under the auspices of The College of Family Physicians of Canada and the Canadian Psychiatric Association, produced an annotated bibliography in response to requests for information and resources about shared mental health care (Craven and Bland, 2002). The working group's goal was to support the development of a national research agenda for shared mental health care, and to encourage individual persons and organizations to develop collaborative care projects and programs across the country.

Shared care annotated bibliography was published in 2002

Based on a thorough search of the literature, the original bibliography, called the *Shared mental health care: bibliography and overview* (Craven and Bland, 2002), provided a comprehensive analysis of the central topics:

- ∞ The need for increased collaboration between psychiatry and primary care.
- ∞ Shared mental health care — theoretical and conceptual perspectives.
- ∞ Models of sharing mental health care.
- ∞ Prevalence of initiatives in shared mental health care.
- ∞ Evaluation and research in shared mental health care.
- ∞ The seriously mentally ill and their primary health care.
- ∞ Education and training.
- ∞ Challenges and potential obstacles.
- ∞ References.

The Canadian Collaborative Mental Health Initiative (CCMHI) is fortunate to be able to build its annotated bibliography on such a recent, solid foundation.

CCMHI's Project

The CCMHI Framework for Collaborative Mental Health care provides a broader lens to review the literature

The CCMHI, a partnership project of the national health care organizations that promote and develop collaborative mental health care across Canada, has gathered information from the many participating disciplines to develop the CCMHI Framework for Collaborative Mental Health Care (see Figure 1). The CCMHI Framework is a typology of collaborative care that highlights the key elements that define collaboration and its fundamental philosophies. This typology is, in part, the result of a synthesis of existing knowledge about collaborative care derived from the themes of the first bibliography. The



Figure 1. The CCMHI Framework for Collaborative Mental Health Care.

The

CCMHI Framework thus provides a broader lens through which to examine the extant literature.

Given the substantial growth in publications in the collaborative mental health care field since 2000 and the publication of this first bibliography, CCMHI decided that the field would benefit from a second catalogue. To fulfill its goal to develop a national strategy for the implementation of collaborative mental health care, the CCMHI presents this bibliography as a catalyst to propel interested groups forward into best practices and successful integration.

The CCMHI Framework for Collaborative Mental Health Care

At the centre of the CCMHI Framework is the consumer, the person who faces or is at risk for mental health challenges or mental illness. This primary focus highlights the purpose and intended outcomes of collaborative care, namely, to optimize consumers' care by increasing their access to health prevention and promotion, and more intensive levels of care and rehabilitation, according to need, and, thus, to decrease the burden of illness.

Based on previous research and an analysis of existing collaborative mental health care initiatives, the CCMHI's new conceptual framework comprises the key components of collaborative mental health care. The CCMHI Framework (Figure 1) provides a unifying guideline for research and discussions conducted under the auspices of the project. Primary health care plays a central role in treating and supporting consumers, and in the interrelation of the consumers' mind–body health issues.

Collaborative mental health care is defined by the four key elements that surround the consumer in the CCMHI Framework (see Figure 1): consumer centredness, accessibility, richness of collaboration and collaborative structures.

Fundamental supporting characteristics of the infrastructure will determine the success and ease of implementing collaborative mental health care: congruent policies, legislation and funding regulations, sufficient funding and resources, evidence-based research, and community needs.

Growth in the collaborative care field is evident from the growing number of publications

Interactions between a team of professionals and the consumer decreases the burden of illness by optimizing the care received

The CCMHI Framework puts the consumer at the centre

Key Elements

Four key elements delineate the essential characteristics of collaborative mental health care: consumer centredness, accessibility, richness of collaboration and collaborative structures.

Consumer Centredness

Consumer centredness means involving consumers in all aspects of care

Consumer centredness means that consumers can and should be actively involved in all aspects of their health care. This concept is based on the idea that within the delivery of health care services, the consumer's well-being is the central concern, a challenging prospect for organizations faced with the demands of multiple stakeholders. Consumers should be involved in all aspects of their care, from the identification of issues to making treatment choices to contributing to the design, implementation and evaluation of programs. Collaborative mental health care must, therefore, deal effectively with a wide range of consumers' needs.

A growing number of collaborative mental health projects emphasize the role of the consumer through specific allocation of time and resources: for example,

- Making educational materials, sessions or information centres available to educate consumers, their families and caregivers about conditions and diseases so that they can make knowledgeable choices about treatment and self-care.
- Involving consumers, their families and caregivers in the development of collaborative mental health care initiatives (e.g., participation in focus groups, advisory committees) and program evaluations (e.g., designing instruments, taking roles as peer researchers and respondents).
- Adapting health promotion and treatment interventions to reflect the unique needs and cultural experience of each consumer.

Accessibility

The goals of collaborative mental health care are met by increasing consumers' access to mental health services. Accessibility includes providing mental health services in primary care settings or bringing the services to consumers in their communities. Primary care settings are usually a point of first contact for consumers when they have a health concern.

The provision of mental health services in the primary care setting is accomplished through various means. For example, mental health care is provided in a primary care setting by a mental health care specialist or team, or by a primary care provider who is supported by or consults with a mental health specialist.

Richness of Collaboration

A central feature of effective collaborative mental health care is the richness of the collaboration between mental health and primary care providers. This collaboration focuses on the interaction of the actual delivery of care with the means of fostering it. These are some of the characteristics of rich collaboration:

- ∞ Exchange of knowledge between providers about the best practices in mental health care through educational initiatives:
 - During schooling: courses, lectures, tutorials, seminars, rounds, rotations, case conferences or discussions, committees, placements or locums.
 - Continuing medical education: workshops, seminars, symposia, presentations.
 - Education materials: research papers, studies, books, treatment guidelines, manuals.
- ∞ Involvement of professionals from a wide range of disciplines (e.g., nursing, pharmacy, family medicine, psychology, psychiatry, occupational therapy, social work, dietary, peer support) in the collaborative care process.
- ∞ Interdisciplinary communication.

Collaborative Structures

Successful collaborative mental health initiatives recognize the need for systems and structures that support collaboration. First, providers create or are part of an organizational structure that defines the ways in which people have agreed to work together. This structure

The goal is to increase accessibility to mental health services within the primary care setting

Interactions among providers in the actual care delivery are important

We need to learn about the structures and tools that support collaboration

can be either formal or informal. Formal arrangements include service agreements, coordinating centres or collaborative networks. Informal arrangements may include having a verbal agreement to work together.

Second, providers organize or create systems that define how to accomplish specific key functions of collaborative mental health care: for example,

- Referral strategies (e.g., forms, referral protocols, referral networks).
- Information technology (e.g., electronic client records, Web-based information exchange, teleconferencing, video conferencing, e-mail, listservs).
- Evaluations (e.g., developing evaluation instruments and agreeing to adopt common evaluation instruments, methods and software).

Fundamentals

Policy and Legislation

Policy and legislation enable collaboration by defining how health care systems integrate mental health into primary care

The overall context for the delivery of collaborative care is important to its successful implementation and outcome. Within the health care system, policy and legislation are important to the development and support of collaborative care. Policy directs government's overall mission and implementation strategy for the delivery of primary mental health care — in simple terms, how a significant component of mental health care could be incorporated systematically into the existing primary care system (Jenkins and Strathdee, 2000). Such policy explains how common mental disorders will be dealt with; who will be responsible for assessment, diagnosis and management; how quality standards for service inputs, processes and outcomes will be monitored; how the implications for human resources development and training will be determined; and how services will be commissioned.

Legislation that supports policy about issues central to collaborative care may be necessary. Effective legislation is associated with regulations that highlight specific roles, expectations and steps required for corrective action. Also important is the interplay of other health and social care policies that relate to primary mental health care: barriers occur when the implementation of different policies conflicts or when policies for different reforms develop along parallel rather than convergent lines (Kates, 2002). Moreover, the actions of professional

organizations and health care standards bodies influence policy (see Druss, 2002, p.199 for an example).

Funding

Funding allocations within health care systems and methods of payment for professionals' services have a profound influence on the nature of collaboration. Within national government budgets, like those of England, Australia and Canada, overall funding for primary care mental health is increasing or has recently increased, prompting significant interest in and promotion of this field (Lester et al., 2004; Hickie and Groom, 2002). Governments seem to have recognized the need for a more comprehensive response to the wide range of mental health issues and needs. This is a positive development (Jenkins and Strathdee, 2000).

How funding is put to work, particularly for professionals, can enhance or detract from collaborative arrangements (Korda, 2002). Remuneration plans determine the degree to which collaborative behaviour is directly reimbursed and reinforced. Plans that do not pay for the employment of a variety of team members or for conversations between collaborating professionals are strong disincentives. Generally speaking, fee-for-service plans seldom provide direct reimbursement for collaborative care, whereas capitation care plans reward efficient and cost-effective treatments (Dewa et al., 2001).

Research

Establishing an evidence base is essential to collaborative primary care mental health initiatives. In this age of evidence-based practice, the emphasis is on doing what is known to work or be effective. Quality and accountability are the watch words of health care; implementation of evidence-based practices has emerged as the way to achieve both (Goldman et al., 2001). In the context of collaborative care, the three service-system elements — quality improvement, accountability through performance measurement and evidence-based practices — have a unique triangular relationship. Effective, accountable services are based on evidence-based practices, which, in turn, ensure quality improvement.

Building an evidence base for integrated primary mental health care is vital. No adequate base currently exists to guide policy and practice precisely and clearly. The very need for the CCMHI points to this gap in Canada. As the field progresses, funding must be available to promote and support research into all aspects of primary mental health care so

Funding and incentives are required to sustain collaboration among professionals

Collaborative care needs to build its evidence base through research

Community needs must drive the development of collaborative care

that we can begin to speak about what works best for whom. Until then, endorsement of specific models or approaches is not possible.

Community

The needs and resources of individual communities must be considered in the development of collaborative care initiatives. Four key questions require analysis (Jenkins, 1998):

1. What are the needs of consumers in each of the main diagnostic or consumer groups?
2. What approach to service will meet these varied needs?
3. Which health professionals and which skills does primary care require to provide optimal primary mental health care?
4. What models of collaborative care, communication and liaison would facilitate successful collaboration between primary health care teams and specialist services?

Primary mental health care initiatives occur within the existing health care system. The foundations for successful collaboration begin with a sound knowledge of the community in which the collaborative program is to be implemented. Important community variables that should be considered are inventories of services and their interrelationships (e.g., the intersection of primary care and secondary mental health care); the prevalence of common mental disorders or special needs groups within the community; and the community's characteristics, health funding arrangements, availability of health care providers, existing service patterns and care pathways, capacity for training, and available information systems and technologies, public opinion, and potential levers for change. Collaboration "can be challenging and ... communities must begin where they are today" (Bazelon Center, 2004, p. 5).

Methods

Databases

A comprehensive on-line literature search was done with six electronic databases from the year of each database's inception until October 2004: MEDLINE, CINAHL, PsycINFO, EMBASE, ERIC and Social Services Abstracts. The search strategy included interdisciplinary and the usual medical databases. Not all searches were fruitful: CINAHL and PsycINFO provided the best results, followed by ERIC. The Social

On-line literature searches were conducted with medical and other related databases

Service Abstracts yielded very little. Further searches with PubMed and Google search engines, and the Cochrane Library (Issue 4, 2004) were done.

Keywords and Thesaurus Descriptors

Keywords and thesaurus descriptors were used in the searches. Keywords included “primary care” and “mental health collaboration.” Studies identified by the secondary terms such as “models – organizational, professional role, education,” “medical continuing,” “referral and consultation,” “interdisciplinary work and teams,” “rural health service” were added to a master list of references upon completion of each search.

Relevant Journals

Many articles relevant to this project were found in the journals *Primary Care Psychiatry*, *Primary Care Mental Health*, *Journal of Interprofessional Care*, *Journal of Mental Health*, and *Clinical Psychology: Science and Practice; and Families, Systems & Health*. These journals are not fully indexed in MEDLINE, but are available in other databases such as CINAHL.

Many journals have information relevant to collaborative care

Grey Literature Searches

Also included was the grey literature (policy papers, reports, articles and summaries) held by relevant organizations, which is generally considered nonscientific. Searches for these resources were conducted with Google. Team members working on the project identified key Web sites by entering the keywords “multidisciplinary,” “interdisciplinary,” “interprofessional” and “primary care reform” separately into the search box for each Web site. The Web sites searched were those for Health Canada, each Canadian province’s and territory’s health and education departments, the World Health Organization, the National Department of Health and Human Services (Australia), the Department of Health and Human Services, the National Institutes of Health (United States), the Ministry of Health (New Zealand), and the Department of Health (United Kingdom).

Article Selection

Each entry in the master list of references and abstracts, when available, was reviewed by the author and project staff to determine its suitability for further review, based on how well it reflected the

The master list of articles is provided in back of this report

principles of the CCMHI Framework. Additional articles were suggested from a manual search of those articles deemed relevant for the bibliography. Studies were selected for review if they discussed the use of collaboration in the provision of any form of mental health care services in primary care. Articles were then cross-checked against those in the *Shared mental health care: a bibliography and overview* (Craven and Bland, 2002) to avoid overlap with this earlier document. In some instances, articles published before 2000 were included in this bibliography if they were not in the earlier shared care bibliography, but fit the CCMHI Framework. The master list of all the key literature is available from the CCMHI.

Limitations of the Search

The limitations of the search procedures must be acknowledged. The keywords and thesaurus descriptors were selected to focus the searches on the literature directly related to professionals working together to provide mental health care. The lack of a common, widely accepted terminology for this field (see Chapter 2), increases the probability that the searches missed related literature that has been described and indexed under different headings or within disciplinary journals that were not included in this process.

Organization of the Bibliography

The relevant literature is presented according to topics of the CCMHI Framework, working from the centre outwards. Beginning with Chapter 2, this review looks at the philosophies underpinning the goals of collaborative care, the placement of collaborative care in the broader continuum of health care and the overall customer groupings for which collaborative care is relevant. Chapter 3 covers the elements of the fundamental infrastructure: policy and legislation, funding, research and community. Chapter 4 presents the literature dealing with consumer centredness — examples of consumer participation in numerous aspects of the approaches to collaborative care and methods of integrating care for special populations. Chapter 5 highlights issues dealing with accessibility, including the rationale for bringing mental health into primary care, theoretical frameworks for integration and specific models. Issues related to the richness of collaboration appear in Chapter 6, which covers such topics as team approaches, key elements, participation of disciplines, and training and education. Collaborative structures are discussed in Chapter 7: the tools of collaboration, measurement of collaboration or integration and satisfaction, devices or practices that

facilitate collaboration, and methods of evaluation. Appendix 1 contains a summary of each document included in this bibliography.

This publication lists all the references reviewed for the bibliography that were published in print or on-line. Articles and on-line documents available on the World Wide Web are shown as links. Some links to abstracts (denoted <PubMed><Abstract>) are included, if available, as is the full text (denoted <Fulltext>), if available. In the print version of this bibliography the links are omitted because the addresses are too lengthy.

References used in the bibliography that were not reviewed provided background information for this current discussion of collaborative care.

Chapter 2:

THE HEART OF COLLABORATIVE CARE

KEY MESSAGES

- ≈ Collaborative mental health care is a growing field.
- ≈ The literature about collaborative mental health care discusses six underpinning philosophies that shape this type of care delivery (i.e., the mind–body split, psychosomatic medicine, biopsychosocial model, population health, chronic disease model and the recovery paradigm). Awareness of personal and professional paradigms is important when building collaborative mental health care because practitioners need to develop a shared set of beliefs and objectives for the collaborative program.
- ≈ In the population-based framework, horizontal and vertical integration can improve the mental health of the population. With horizontal integration, a large number of consumers benefit from a wide range of generic mental health services. With vertical integration, services are designed for specific subpopulations within primary care. Ideally, integrated services are maximized if horizontal integration balances vertical integration.
- ≈ According to epidemiological evidence, the majority of the population stands to gain from collaborative mental health care. The majority of people with mental health needs show up at the primary care door; the magnitude of this need necessitates collaborative mental health care. In addition, no country has enough specialists to deal with all consumers who have mental health issues: the societal and individual costs associated with the burden of mental disorders are too great for any country to ignore.

This chapter begins with the consumer who is at the centre of the CMHC Framework. The literature presented here is theoretical or somewhat historical; it explains the terminology, and the paradigms that shape this field and their application to a broad range of people. The literature search did not, however, reveal the paradigms for all disciplines that might participate in collaborative care.

Understanding the Terminology

After reading the information gathered for this bibliography, readers would surely have the overall impression that interest in the field collaborative primary mental health care is growing, that there are as

Consensus about terminology
lacking

many ways of doing it as there are types of health care systems around the world.

Collaborative care has many names or labels:

- Shared care (Kates, 2002).
- Integrated primary care (Blount, 1998b).
- Primary behavioural health care (Mauer/National Council of Community Behavioral Healthcare, 2003).
- Primary mental health care (Nolan and Badger, 2002a).
- Mental health/primary care interface (Druss, 2002).

Distinguishing collaboration
from integration

In the Introduction to his book *Integrated primary care*, Blount (1998b) discusses integrated mental health care, noting the relative youth of this developing field and its lack of standard terminology. Indeed, confusion may arise from the literature because of this lack of standardization: authors use similar terms that have slightly different meanings. Blount notes that the term “integrated” seems to be replacing “collaboration” as the descriptive term of choice. Collaboration originally referred to providers with separate sets of expertise and practice locations who brought their work closer together and thus enriched their communication. Although mental health treatment was considered a specialty, the impact of mental health problems on physical health was recognized. The reason for collaborating, therefore, was to better coordinate treatments between the two. “‘Integration’ implies one service consisting of various aspects. In an integrated setting, behavioural health service is seen as an aspect of primary care, rather than as a specialty service” (p. xiv).

The CCMHI deliberately chose the term “collaborative” for the whole initiative to reflect the wide range of options for this kind of care (see Chapter 5 on accessibility) and the way this innovation develops within specific contexts, each beginning at different points (see Chapter 3, which deals with needs assessment and fitting models to needs).

Underpinning Paradigms and Frameworks

A number of publications provide overviews of collaborative care, discussing the paradigms and frameworks that shape the delivery of this type of care. Understanding these foundational philosophies makes it easier to understand the rationale, ingredients and approaches to collaborative care, especially for those new to the issue or those coming from different disciplines or perspectives. Knowledge of and exposure to influencing paradigms promotes understanding of any differences that may arise during collaboration and brings each party’s needs into

Building common ground for
collaboration

perspective (Lorenz et al., 1999). Different paradigms are a problem only when they are mutually exclusive, and differences rooted in these paradigms can be resolved only if providers take time to look at the underlying suppositions. Realizing and respecting differences should help prevent power struggles among collaborators.

At the system level, some authors make the case for a paradigm shift — moving beyond these traditional underlying paradigms to a more inclusive, holistic approach that would enhance the potential of collaborative care and broaden the definition of primary care. In their discussion of a new approach to primary mental health care, Gask and Rogers (1998) go beyond the traditional medical perspective about psychological problems to incorporate an understanding of the social and economic determinants that contribute to such problems. They place primary mental health care in the context of other resources within the community that may be useful in resolving the problems (for a more detailed description, see Chapter 3). Similarly, Petersen (2000) supports a paradigm shift that would recognize the emotional labour (addressing consumer’s mental health means emotional work for practitioners) in primary health care, making it about more than quantity, as the population model would assert — making it about the quality of professionals’ work with mental health issues in the primary care context.

The Mind–body Split Paradigm

Lorenz et al. (1999) document the history of the mind–body split in Western medicine. Since the time of the Greeks, medicine has focused more on the problems of the body than on the problems of the mind. Medical training usually begins with anatomy. Physicians are trained to think spatially and structurally, the organization of medical data tends to be hierarchical, and events are viewed in terms of their cause and effect. Empirical science dominates; there is no room for personal meanings of illness. Across the centuries in Western cultures, organized religion has aligned the mind with the care of the spirit. Medicine has become interested in the mind only recently — with the advent of Freud, James and Janet, among other psychiatrists, psychologists and therapists looking at the psyche.

In parallel, nursing and social work developed a more holistic way of viewing people — social workers caring for the underprivileged, connecting their personal mental health with their life conditions; nurses blending physical care with attention to people’s emotional needs. The foundational paradigms of these two professions did not embrace the mind–body split favoured by the medical profession.

The mind–body split
— a dominant paradigm of
medicine

The more holistic paradigms of
other professions

The case for integration — mounting evidence of interaction between biomedical and psychosocial factors in the origins of disease

Blended paradigms

The population health approach — serving the needs of the population

The Biopsychosocial Model

Griffith (1998) provides an insightful discussion of the relationship between psychosocial experience and biomedical disease. The field of psychosomatic medicine has a long history, but until recently has been relatively ignored. In the last two decades, emerging evidence indicates that psychosocial and biomedical factors in the origin and treatment of disease form a considerable portion of the business case integrated mental health care. Griffith's review clarifies the inadequacies of the traditional mind-body split and the need to transcend this concept on many levels — in how we think about health and illness, how we organize and deliver care, how we conduct research, and how we evaluate outcomes.

Engel introduced the biopsychosocial model that is fundamental to family medicine (Blount, 1998c; Heldring, 1998). Often described as a blended paradigm, this model emphasizes the three spheres of a person — the biological, the psychological and the social elements — and the interplay among these elements in a person's life. Primary care or family medicine then becomes the place where consumers with any type or combination of problems can be cared for.

Population or Public Health Model

Strosahl (1998) places the integrated primary care model firmly in the realm of population health care, which has a pivotal role in the delivery of primary care. The roots of population health care are in the epidemiological public health view of planning the delivery of service. Focusing on the needs of the entire population rather than on those of any one person, population health asks the key question: What are the needs of the population served by this system of care? The overall goal of such care is the reduction of the incidence and burden of disease in the population. When treating a patient, the primary care physician considers similar consumers in the practice's population:

- Are there other consumers like this one who are not coming for care?
- Are there variations in the way care is being provided for similar consumers that result in differential health outcomes?
- How can we prevent conditions like this in consumers who have similar risk factors?
- Can a consistent process of care be organized to deal with the needs of this consumer class in the population served?

According to Strosahl, the population health approach dictates the structure and the process of primary care medicine through two key elements: case capacity (the number of consumers seen) and case-rate turnover (the speed with which cases are completed). Capacity dictates scheduling numerous short appointments. Case-rate turnover dictates problem-solving approaches that often make quick fixes the first priority, followed by secondary-level treatments, if needed, and if these do not work, referral to specialty care.

Chronic Care Model

Another framework used in primary care to enhance care outcomes is the chronic care model. In their excellent description of this model, Schaefer and Davis (2004) illustrate its application with case studies, including one for depression care. Here, quality care is predicated on productive interactions between consumers, and their families and caregivers, as well as with the individual provider or provider team. Services and supports are provided so that the consumer becomes well informed about his or her conditions and active in their management. Managing well requires awareness of one's role in self-management, as well as beliefs and skills. In their interactions with consumers, providers come prepared with information about the clinical condition and consumer-specific data, and understand their role in optimizing the consumers' experience and the outcome.

This chronic care model includes both macro and micro elements. At the macro level, the organization of health care and community linkages are highlighted. The macro elements are the policies and culture of the system. The micro level stresses the importance of linking consumers to other community resources beyond health care. The micro elements focus on the delivery of care and include support for self-management that emphasizes the consumer's role in the management of the illness; design of the delivery system that focuses on planned and proactive care to ensure effective interventions to support decisions; use of quality assurance mechanisms such as treatment guidelines, protocols, care reminders and standing orders; and clinical information systems that provide population and consumer data to facilitate effective and efficient care.

Recovery Paradigm

Given the interrelation of primary mental health care with specialized mental health care, understanding the recovery paradigm used in the latter sector is important. Anthony (2000), and Jacobson and

Extending chronic care approaches to the care of mental health problems

Living meaningful lives despite mental illness — the recovery approach

Greenley (2001), among others, highlight the key principles of the recovery paradigm and define recovery in these terms:

- A concept grounded in the fundamental belief that people can and do recover from mental illness, and are able to get on with living meaningful lives, despite their mental illness.
- A process, a state of being and becoming — something that is worked on or emerges over time.
- Something defined by the individual person working toward it, something that is highly personal and unique.
- Something achieved through many different paths supported by clinical and other services.
- An active, rather than a passive process that respects all rights of a person's full citizenship.

Principles of recovery, when applied to the community mental health system, require shifts in provider attitudes and practices (Trainor et al., 2004). The consumer is viewed as an active participant within a supportive community. The goal of recovery is primarily one of self-actualization. Clinical treatment and other sources of support are only one aspect of the total framework that assists consumers with their recovery; consumers' participation and membership in the community are the result of self-help and the implementation of other services such as supported employment and peer support.

The Example of Aboriginal Mental Health Care

Knowledge and use of consumers' health belief systems in the design of collaborative models for particular groups of people are vital to the successful implementation of care and the achievement of positive treatment outcomes. For example, the CCMHI-commissioned background paper on approaches to Aboriginal mental health (Gow and MacNiven, working paper) concludes that collaborative care initiatives for First Nations or Aboriginal groups must start with the paradigm of the medicine wheel. The medicine wheel is a key tool for teaching people about their place in the universe, their relationship to all things and all aspects of taking care of themselves in a balanced and healthy manner. The Aboriginal approach to health is holistic, rooted in the belief of the interconnectedness of all things under the Creator. The body, mind, emotions and spirit, person, family, and community — all life — are interconnected. Good health is not possible without acknowledging this connectedness and the reciprocal influences of these elements. Well-being flows from the balance and harmony of all elements of the personal and collective life.

Success of collaborative care programs dependent on understanding paradigms that shape consumers' beliefs about health

Effect of Clinicians' Belief Systems

Strosahl (1998) illustrates how beliefs in divergent belief systems and ideologies influence the work of different types of clinicians. All medical illnesses can be conceptualized along a biobehavioural continuum in which different aspects of a disease are influenced by psychosocial and biomedical interventions. Doctors, for example, excel at looking for a single pathophysiological process that links symptoms with a disease, a process that works well for those diseases at the biomedical end of the continuum. On the other hand, the clinician with a psychosocial focus (e.g., social worker) typically looks for patterns of interaction among the psychological, familial and cultural factors that influence illness, and values the unique meanings of illness for the consumer and his or her family. This approach does not work well when abnormal anatomy or physiology generates symptoms that affect the consumer's behaviour in his or her psychosocial world. These approaches to problem-solving relate to the belief systems within which these clinicians are trained. The biomedical perspective values empirical science and its units of understanding are diagnostic categories. The psychosocial perspective values the personal and social aspects, and draws understanding from personal, family and social narratives. These clinicians may have difficulty understanding each other's points of view and the way the other works. Overall, their patterns of work are quite varied.

The influence of the biobehavioural continuum — the need for a blend of psychosocial, behavioural and medical interventions

Defining Consumer Groups for Collaborative Care

Strosahl (1998) outlines the implications of the population-based framework in his definition of consumer groups that may benefit from collaborative care. Inherent in this approach are two ways of improving the health of the population being cared for: horizontal and vertical integration. Services that meet the behavioural health needs of the entire primary care population are characterized as being horizontally integrated. Since many people can benefit from generic mental health services, these services are set up to treat a wide range of problems and consumers. According to Strosahl, this is the traditional approach to mental health care within primary care medicine. Evidence supports the extension of this approach to the treatment of mental illnesses.

Horizontal integration — primary care-based mental health services for a wide population

Vertical integration —
care for higher-needs
subpopulations

Vertical integration occurs when services are designed for specific groups of people within primary care. High users of care (high in frequency or cost) such as consumers with depression, comorbid and complex conditions, chronic mental illness, or somatic disorders are often the focus. (See Chapter 4 for a review of the needs of special groups). Vertically integrated programs are designed to have systematic assessment, treatment and follow-up processes so that better care can be delivered for the specific condition.

Strosahl suggests that taking advantage of all opportunities, both horizontal and vertical, should maximize the impact of integrated services, especially for these three types of outcomes:

1. “Improving the immediate clinical outcomes of primary care health and/or behavioral health interventions for people with mental health or medical concerns;
2. Producing better outcomes over time in those people with recurrent, chronic or progressive medical or mental health disorders; and
3. Limiting unnecessary medical utilization and costs in patients who have dramatic social support needs and/or chronic and treatment resistant health or mental health problems” (p. 147).

Primary care — the first point
of contact for the majority of
people with mental health
needs

Numerous papers (e.g., Strosahl, 1998; Jenkins, 1998; Jenkins and Strathdee, 2000; Druss, 2002; Lorenz et al., 1999), highlight epidemiological evidence that describes the customer groups who benefit from collaborative care. The majority of people with mental health needs (both known and unknown) show up at the primary care door — a consistent trend across many jurisdictions and cultures. The sheer magnitude of this need is enough to justify the development of collaborative programs in the primary care setting. Jenkins (1998), and Jenkins and Strathdee (2000) add that no country has the specialist capacity within its health care system to deal with all consumers with mental health issues who would benefit from treatment. The costs associated with this burden of mental disorders and milder mental health concerns make it unthinkable that any country might simply ignore these needs.

Limited capacity of specialty
mental health care to deal with
all the mental health needs of
the population

Jenkins (1998), and Jenkins and Strathdee (2000) advocate a public health approach to the delivery of mental health care for the majority of consumers with mental illness. Such people must be seen and cared for “by non-specialist members of the primary health care unit” (p. 278). The reasons for building the capacity to treat mental illnesses in primary care differ between low- and high-income countries: in the former, there may be little if any specialist resources, while in the latter, the high

prevalence of mental disorders demands action in primary care settings. Specialist care is also often inequitably distributed between urban and rural areas, and it may be available only to those who can afford to pay.

In the *Report of a Surgeon General's Working Meeting on the Integration of Mental Health Services and Primary Care* (U.S. Department of Health and Human Services, 2001), Satcher, then Surgeon General of the United States, adds that, although primary care providers are already overburdened with the responsibilities and demands of the health care system, they are in a unique position to be able to “quarterback the health care team that collaboratively makes the system work for patients and their families” (p. 2). He emphasized the primacy of mental health — defined as the personal ability to function and be productive in life, to adapt to changes in the environment, to cope with adversity, and to develop positive relationships with others — as being central to good overall health and well-being. Primary care and mental health partnership are crucial for overall balanced health. Satcher identified a number of groups that require special attention, among them those suffering with mental illness who do not seek treatment (more than half of those with mental illness), and among those who do make contact with the health care system, those who do not make contact with the mental health care system because of their illness or the stigma attached to it, or because they are simply unaware of their illness.

Overall Fit of Collaborative Care in the Continuum of Care

Where does collaborative care fit into the overall continuum of care for mental health issues? Many writers speak about collaborative care being between two different health care silos — general or family medicine and mental health services.

Druss's concise history (2002) of the relationship between primary care and the intersection of mental health and primary care in the United States facilitates an understanding of why separate streams of care have arisen and how entrenched some of the barriers encountered in collaborative care innovations are:

- ∞ As a discrete discipline, primary care itself arose in reaction to rapid specialization within the health care system. The key distinction is the provision of primary, continuing medical care rather than episodic or consultant care.
- ∞ Care of people with chronic mental illness shifted from the community to the hospital in the mid to late 1800s; state institutions dominated the scene until the 1950s.

Mental health — an integral part of overall health and well-being

Partnerships crucial to effective, practical treatment of mental health problems

The fit of collaborative care with various health care continuums

The two solitudes of primary and mental health care in many health care systems

- ❧ The community mental health movement, which started in the 1950s, sought to shift the locus of care back to the community and to a more active treatment model, away from custodial care.
- ❧ The U.S. 1963 Community Mental Health Center Act was envisioned as an integrative policy. Its goal was to bring mental health back into the mainstream of medicine, but this effort failed because of a lack of funding, weak organizational ties to general hospitals, and a philosophy that emphasized social rather than medical models of mental illness.
- ❧ Within general hospitals, consultation–liaison psychiatry flourished, but mirrored the larger medical system, namely, episodic consultation rather than treatment of consumers in a continuous process within in-patient settings.

Druss (2002) also details more recent developments, such as managed care and the impact that it has had on the delivery of mental health care in the United States. Although the U.S. approach to managed care may not characterize that of other jurisdictions, the underlying reasons for it are evident in most health care systems in developed countries. Governments are grappling with cost containment, the major theme of managed care. Health care costs have escalated with the introduction of new technologies into systems that largely insulate their workers from these costs.

Jenkins and Strathdee (2000) remind us that, even in rich countries where specialized care is available, there is not enough capacity to meet the needs of people with serious mental illness, let alone surplus capacity at the secondary and tertiary levels of care to deal with people with more moderate or emergent mental health problems. At the same time, in any given year, the majority of the population with mental health needs is seen within the primary care system. Added to that are the people who have chronic illnesses with concomitant mental health issues and those who have medically unexplained symptoms — all of which add up to a great need for the delivery of mental health services within primary care.

In the broad continuum of care, primary mental health care takes on a number of functions. Miles and Goetz (1999) detail the gatekeeping role of primary care in the U.S. managed-care system. They define gatekeeping as a process of managing access. Gask et al. (1997) offer these criteria for the gatekeeping role of primary care in the consultation–liaison model:

- ❧ Face-to-face contact occurs regularly between the psychiatrist and the primary care team.

No surplus capacity in specialized mental health care for treatment of mild or moderate mental health conditions

Gatekeeping role of primary care for mental health issues

- ∞ Psychiatric referral takes place only after discussion of the case in a face-to-face meeting.
- ∞ Some cases are managed by the primary care team only (after discussions with the psychiatrist).
- ∞ After the referral, the psychiatrist provides feedback to the primary care team who manages the case.

Lester et al. (2004) question whether there is a genuine opportunity for or a threat to integrated primary mental health care in the recent efforts to reform primary and mental health care in Great Britain. Another consequence of the largely parallel, seldom convergent development of primary care, specialization of medicine and community mental health is the dominance of the specialist perspective that influences models of collaborative care at the intersection of primary and mental health care. The authors describe four models:

1. Community mental health teams that provide increased liaison and crisis intervention.
2. Shifted outpatient clinics where psychiatrists operate clinics within health care centres.
3. Mental health workers, usually community psychiatric nurses, who are designated to work with those with mental health problems in a primary care setting.
4. The consultation–liaison model in which specialist mental health providers provide primary care teams with advice and skills.

“While it could be argued that these models are part of a continuum that patients can access to meet varying needs at different points in their illness pathway, in practice the variation in availability of local resources means that primary care practitioners are often only able to access one, at best two, of the models” (Lester et al., 2004, p. 287).

The continuum of care —
myth or reality?

Chapter Summary

These summary points are at the heart of collaborative care:

- ✎ The literature of collaborative mental health care discusses six underpinning philosophies that shape this type of care delivery. Awareness of personal and professional paradigms is important when practitioners build collaborative mental health care because they need to develop a shared set of beliefs and objectives for the collaborative program.
- ✎ In the population-based framework, horizontal and vertical integration can improve the mental health of the population.
- ✎ According to epidemiological evidence, the majority of the population stand to gain from collaborative mental health care.

Chapter 3: FUNDAMENTALS OF COLLABORATIVE MENTAL HEALTH CARE INFRASTRUCTURE

KEY MESSAGES

- *Supporting infrastructure is required to bring collaborative care into the mainstream of health care systems.*
- *Policy is necessary to ensure that health care systems actually define and incorporate collaborative care in a systematic way to respond to the needs of consumers with common mental disorders.*
- *Collaborative care needs to build an evidence base through research.*
- *Funding and financial incentives are required to encourage providers from many disciplines to participate in collaborative care.*
- *Community needs are central to the development of collaborative care programs.*

This chapter provides a synopsis of the recent literature that deals with the key features of the outer supporting circle of the CCMHI Framework for Collaborative Mental Health Care (Figure 1): the fundamental infrastructural elements of policies, legislation and funding regulations, evidence-based research, and community needs.

Policy

Without the support of policy makers and payers, and the development of national, provincial, and local policies, the implementation of integrated health services, such as primary mental health care, may not be sustainable in the long-term. Integration of health services, such as those of primary and mental health care, may make intuitive sense to those already involved in them, but often requires the support of policy makers and payers, and the development of national, state or provincial, and local policies for long-term sustainability.

Policy must support the overall mission and implementation strategy for collaborative care within a health care system

Policy is a key to the overall mission and implementation of collaborative care

International Reform

Many authors have documented the developmental path taken by various jurisdictions to bring collaborative care into the mainstream of health care delivery. Hickie and Groom (2002) describe the key features of the primary care–led reform of mental health services in Australia. Nolan and Badger (2002a) and Lester et al. (2004) detail the recent progress of integrated primary mental health care in England, whereas Mann et al. (1998) catalogue the situation there in the late 1990s. Through systemic planning in these jurisdictions, governments have defined a national mental health policy agenda with a specific focus on the delivery of mental health services in primary health care settings for people with common mental illnesses.

At the international level, the World Health Organization’s 1983 Alma Alta Declaration provided the impetus for the integration of mental health and primary care that has dominated health discussions for two decades (Jenkins, 1998; Jenkins and Strathdee, 2000). Although both rich and poor countries have examined this issue at the national policy level, some of the most developed models of primary mental health care are found in low-income countries where its organization and development have been closely aligned with the World Health Organization and the implementation of a public health paradigm (Jenkins and Strathdee, 2000).

Support for a Paradigm Shift

Policy in developing countries supports the integration of mental health within primary care because some framework for primary care usually exists, but supporting specialist care or infrastructure is largely lacking or nonexistent (Jenkins, 1998). If the goal is the comprehensive integration of mental health care within primary care, a paradigm shift is required, even in developing countries, because a number of factors within the primary health care system, and within the health care system as a whole, sustain the delivery of biomedical care (Petersen, 2000). This paradigm shift requires the transformation of the primary health care system on many fronts to ensure that primary care has these characteristics:

- ☞ Supports all health professionals in maintaining life–work balance and self-care management.
- ☞ Systematically promotes health (i.e., health promotion).
- ☞ Empowers consumers.
- ☞ Supports care that takes the subjectivity of the consumer’s experience of illness into account.

Since 1983, the World Health Organization has emphasized the integration of primary and mental health care

Emphasis in policy varies, depending on the nature of the national and local health care systems

Policy needs to support the paradigm shift to collaborative care

In their overview of recent integrative efforts in South Africa, Swartz and MacGregor (2002) recommend caution when pursuing this policy. Balance is especially necessary in the response to special populations, such as those with serious mental illness. Swartz and MacGregor warn that without the paradigm shift Petersen describes, the needs of these consumers will not be met in a reformed primary mental health system that is narrowly focused on reducing the burden of mental health problems for the majority of consumers at the population level. Jenkins and colleagues (Jenkins, 1998; Jenkins and Strathdee, 2000) affirm this challenge, calling for comprehensive national policies that deal with the full spectrum of needs.

Collaborative care policy must balance population needs with those of special groups

Critical Elements of Primary Mental Health Care Policy

Primary mental health care policy must cover these critical elements (Jenkins, 1998):

- ∞ How care for common mental disorders will be delivered.
- ∞ Who will be responsible for assessment, diagnosis and management of common mental disorders.
- ∞ How quality standards for service inputs, processes and outcomes will be monitored.
- ∞ What the implications for manpower development and training are.
- ∞ How services will be commissioned.

These critical elements must be part of primary mental health care policy

Contextual Factors Affecting Policy

Two recent papers (Jenkins and Strathdee, 2000; Bazelon Center, 2004), among others, have identified contextual factors for the development of primary mental health care policy: service delivery, structures, access, financing, monitoring, quality assurance, training and education, privacy protection laws, consumer issues, government agency communications and national funding.

Policy must take contextual factors into account

Service delivery

Policy about collaborative care must take into account the way in which clinical integration of care actually occurs (Bazelon Center, 2004).

Structures

Policy must be predicated on knowledge of all aspects of existing primary and mental health care systems, such as staffing, basic and continuing training for each professional group, information collection

systems, provision of specialist care, the degree to which the system has moved from a hospital- to a community-based system, and organizational details of each system (e.g., who is on the front line meeting the consumer). Policy should also consider the degree to which primary care is the gatekeeper for specialty care when separate systems exist. Integration policy must address integration differently for specific population groups if it is to be successful (Jenkins and Strathdee, 2000; Bazelon Center, 2004).

Access

The degree of difficulty for consumers trying to obtain care must be a consideration. Transportation subsidies may be required (Jenkins and Strathdee, 2000).

Financing

Policy must ensure financial support for clinical integration. Changes in financing alone will not result in the integration of care (Bazelon Center, 2004). Salary structures that support clinical service delivery, strategic planning and program development should also be considered (Jenkins and Strathdee, 2000).

Monitoring

Standards must be put in place and monitored. Monitoring depends on the availability of good data. Policy should require independent evaluations of costs and benefits three years after implementation (Bazelon Center, 2004).

Quality assurance

Financial and recognition incentives to promote integration of care should be considered, for example, surveys of consumers about their views of integrated care and preferences for care, provider surveys, chart reviews for permission to share consumer information, communications between professionals, identification of people receiving medicines for both physical and mental health care, and identification of high service users (Bazelon Center, 2004).

Training and education

Policy should also be based on an understanding of what basic training consists of for each tier of care and for the professionals involved, especially for professionals in primary care; and how much

training and education is available. These questions should also be considered for continuing education (Jenkins and Strathdee, 2000). Activities to compensate for lack of training for the disciplines involved in integrated primary mental health care might include annual conferences and funding for yearly local meetings for those involved in primary mental health care (Bazelon Center, 2004).

Privacy protection laws

Privacy laws must be fully understood and appropriate processes put in place so that consumer information is protected. This should involve seeking the consumers' permission through documented discussions and appropriate release forms, sharing any restrictions about the release of information, giving authorization to inform mental health providers when the consumer follows up on a primary care referral, not sending records to a third party without permission, and protecting electronic records by using secure fax, e-mail, and data transmission and encryption (Bazelon Center, 2004).

Consumer issues

Policy should provide communication training for consumers to encourage them to fully appreciate the connections between mental health and primary care (Bazelon Center, 2004). They need education and training to be more assertive with providers and to learn self-management techniques for both physical and mental illnesses. Policy should advocate for the development of materials for education in a variety of educational mediums such as Web sites.

Government agency communications

Many barriers exist within regional government, for example, a lack of integration of health and related policies such as social welfare and housing (Jenkins and Strathdee, 2000; Bazelon Center, 2004).

National funding

National funding through targeted investments, provision of technical resources and expertise, and funding to improve the infrastructure of programs and agencies (e.g., client-linkage data systems, electronic health records) should be leveraged to promote the integration of care in provincial or state systems (Bazelon Center, 2004).

An evidence-base for collaborative care must be established

Research questions are evolving

Early primary mental health care research had limitations

Research

As with any new approach to the delivery of service, research is both a starting point and an outcome that is central to the legitimization of collaborative care.

Early Research

The traditional question asked in an emerging field is What works? Initially, the focus in primary care was on discovering which mental health treatment worked, and the emphasis was on the physician's actions. More specifically, early studies, especially those of depression, examined the ability of physicians to detect and manage the mental health issue. According to Callahan (2001), efforts were aimed at improving the knowledge and attitudes of physicians through education, which, it was assumed, would improve consumer outcomes. Overall, the evidence illustrated that education was necessary, but not sufficient to change the care process.

Limitations of Early Research

Gask and Rogers (1998) point to the limitations characteristic of early research work on primary mental health care:

- ❧ The starting point was identification of the mental illness treatments from secondary care that could be adapted for use in primary care.
- ❧ Diagnostic schemes developed in secondary care, a founding principle of primary mental health care, often do not apply to the mental health problems encountered in primary care.
- ❧ Western medicine's separate approach to primary specialized mental health care resulted in the use of highly limiting criteria to define those with serious mental illness. Not meeting the criteria that define a serious mental disorder implies that other conditions or problems are not serious, thus underestimating the degree and long-term nature of the psychological distress associated with many of the mental health issues consumers bring to primary care. The authors argue that this assumption tends to narrow the scope of response to mental health problems in primary care, the way these are examined through research, and the definition of need for mental health care.

Limitations of Traditional Medical Research

A number of authors reflected on the limitations of the traditional medical research approach:

- ∞ The inclusion criteria of randomized control trials (RCTs) are highly focused or too restrictive (Churchill and McGuire, 1998, Schwenk, 2002; Blount, 2003). Indeed, most RCTs are targeted to specific populations, so the studies provide a body of evidence for targeted services (Blount, 2003).
- ∞ Research about the use of psychotherapies in primary mental health care is polarized (Friedli and King, 1998). Proponents of RCTs adhere to the principles of randomized control assessment of these treatments (as used in other areas of medicine), whereas others claim that only the process of psychotherapy can be monitored. It is neither reasonable nor practical to expect consumers and providers to remain blind to the nature of the intervention since consumers' cooperation is more critical here than in drug trials and patient preferences have a known impact on the variables of the trial design.
- ∞ Exclusive focus on a medical hypothesis is too narrow, and denies other real, relevant psychological and social factors. More complex modelling is needed when research studies are framed (Martin, 2003).
- ∞ Efficacy studies produce targeted results true to limited settings and groups of patients. Findings do not necessarily transfer well to real-life practice settings (U.S. Department of Health and Human Services, 2001; Gask and Rogers, 1998).
- ∞ Typically, specialists conduct trials in clinical settings, which limit the kinds of professionals involved in the research (Caan, 1998).

Broader Focus on Recent Research

Callahan (2001) suggests that enough research had accumulated by the turn of the 21st century to shift the focus of research to the system of care, away from the single professional, namely the physician. Indeed, the inclusion of collaborative practices in studies has advanced the goals of the field by supporting the involvement of other professionals and suggesting interventions other than education.

Gask and Rogers (1998) concur in their recommendation that research begin with a broader view of the paradigms inherent in collaborative and integrated care (see Chapter 2 for a discussion of

Research focus should shift to the system of care and away from uni-disciplinary care

Research must now come from the broader perspective of collaborative care

Consumers and families are partners in research

these paradigms) to truly capture the essence of the care offered in these models. In their discussion of the implementation of the public health view of mental health, Gallo and Coyne (2000) suggest that the emphasis of research is changing from Does it work? to Why does it work, and for whom and under what circumstances?

The importance of involving consumers and their families as research partners has also been identified (U.S. Department of Health and Human Services, 2001). The potential of this partnership is most obvious when the research focuses on quality and outcome measures (e.g., consumers' and families' satisfaction with services). Gask and Rogers (1998) also point out the need to consider consumers as more than recipients of care since they (and their families) are often also providers or co-providers of care. Therefore consumers' and families' perspectives of and experience with primary mental health care must be integral to a comprehensive research agenda for collaborative care.

Need for Research about Efficiency

Now is the time to shift from efficacy to efficiency research

Former U.S. Surgeon General, Satcher (U.S. Department of Health and Human Services, 2001), and Gask and Rogers (1998) call for a shift in the research agenda from efficacy to efficiency studies that focus on the outcomes of real practice. This shift would better reflect the heterogeneity and diversity among consumers, the comorbidity of their illnesses and the challenges of monitoring outcomes. Satcher notes that, with the exception of depression, research on the development or evaluation of programs integrating mental health and primary care is sparse. Jenkins (1998), making a similar point about international research, recommends funding the evaluation of the different systems that primary care uses to tackle mental health problems.

Research needs to focus on real practice situations

The shift from pure efficacy trials to effectiveness studies necessitates closer attention to issues of research design. Sturm et al. (1999) advise researchers to pay attention to issues of sample size and statistical power. In randomized controlled trials, small sample sizes (under 100 subjects per cell) are often sufficient to detect differences in clinical symptoms. However, large changes in health-related quality of life require several hundred cell observations, and those in cost estimates require sample sizes in the thousands. "Estimating effects on broader health outcomes measures or costs is more difficult and there is much less experience with these measures....We believe that the trend towards broader health outcome measure and cost or cost-effectiveness studies has not been accompanied by changes in study design that would allow researchers to address those questions with sufficient statistical precision" (p. 282).

New or stricter research designs are needed

New study designs may be required, along with funding for alternate designs.

Need for Broader Outcome Measures

The issue of outcome measurements also needs to be re-examined. In their discussion of psychotherapy in primary mental health care, Friedli and King (1998) suggest that outcome variables must account for complex psychological processes, yet be simple enough for wider use. Mann et al. (1998) and Mann and Tylee (1998) recommend the use of more sophisticated, objective measures that examine shifts in practices and outcomes (i.e., capture actual change) in primary mental health care. Again, these changes require researchers to look beyond immediate situations and treatments to reflect on the broader influences and factors involved. Although this makes research more challenging, the results are likely to be more relevant and applicable to real practice. Blount (2003) suggests that researchers tend to report only those impacts that their intended audience most values, for example,

- ∞ Improved access to mental health services.
- ∞ Increased consumer satisfaction with medical services.
- ∞ Improved satisfaction of medical providers.
- ∞ Improved compliance of consumers with treatment regimens.
- ∞ Improved clinical outcomes for consumers.
- ∞ Sustained improvement in clinical outcomes.
- ∞ Increased cost-effectiveness in service delivery.
- ∞ Medical costs offset by the addition of behavioural health services.

Other Limitations of Research

Three other limitations of research have been discussed. Caan (1998) suggests that the number of researchers examining mental health in primary care is insufficient, and recommends developing more training programs to produce such researchers and recruiting more academic investigators with established research skills for primary care research. To overcome the dearth of research partnerships in early research studies, more multi-disciplinary and interdisciplinary research on collaborative care is needed (U.S. Department of Health and Human Services, 2001; Gask and Rogers, 1998; Caan, 1998; Martin, 2003).

Blount (1998a), and Gask and Rogers (1998) challenge the assumption that research is legitimate only when conducted within academic medicine's controlled training centres. According to Patterson et al. (1998),

Outcomes of collaboration need to be conceptualized on a broad scale

Existing challenges include few researchers, lack of credibility, and keeping abreast of developments in the field

innovations in integrated mental health care occur at such a rapid rate in real practice settings that academic researchers need to learn from the field and train their graduating medical professionals to have the skills to work in integrated programs. Gask and Rogers (1998) argue that primary care is the real setting in which mental health interventions that are not reliant on primary care professionals are most likely to be fruitfully developed and tested.

Need for Qualitative and Quantitative Research

Miller et al. (2003) advocate the use of qualitative research methods to identify the complex and multi-faceted interactions that take place in collaborative care. Using focus groups, they evaluated the process of care in an integrated primary care clinic for veterans with major psychiatric disorders and found that these methods effectively untangled the multi-faceted interventions people received.

Overall Recommendations

Overall, a review of the literature reveals numerous recommendations for research and development in integrated mental health care.

A new paradigm is needed. Primary mental health care is delivered by many types of professionals with a broad range of skills. This knowledge must be incorporated into the research agenda (Gask and Rogers, 1998).

Different degrees of integration characterize the integrated care approaches evident in many models (Blount, 2003).

Definitions of primary mental health care need to be expanded so that they capture the full range of relevant resources. A more inclusive definition is required to capture the social and economic determinants of psychological distress in the community and should include the less visible self-care and informal primary care provided by nonprofessionals in the community (Gask and Rogers, 1998).

Innovative, brief, effective interventions that are more than adaptations of treatments and methods formerly developed in specialty mental health care settings should be based on the fact that consumers with mental health issues who come to primary care settings are different from those who come to secondary care, as are the variety of professionals who practise in primary care (Gask and Rogers, 1998).

More research is needed to identify the most appropriate care that benefits consumers in primary and secondary care (Gask and Rogers, 1998), and to explore the use of stepped care.

Research should use both qualitative and quantitative methods

Recommendations for research are numerous

Research needs to consider the relationship between primary mental health care and the community as much as, if not more than, its relationship with secondary mental health care (Gask and Rogers, 1998).

Research evaluating primary care that considers mental health and mental illness should be expanded to explore mental health promotion and prevention activities (Jenkins, 1998; Murray and Jenkins, 1998).

Transdisciplinary research needs to be conducted (Martin, 2003). Defined as various research disciplines working together to develop new solutions for complex primary care reforms, including primary mental health care, transdisciplinary research should comprise these factors:

- ✎ Complex modelling that recognizes the dynamics, complexity and nonlinearity of biological and human systems.
- ✎ A system of values that encourages research that synthesizes findings and translates them to real-world situations, rather than to academic endpoints; that involves the active participation and ownership by the subjects of the research; and that respects the different traditions of the researchers.
- ✎ Carefully designed research that explores a multi-faceted, dynamic understanding of the issue; explicit processes that generate knowledge and challenge underlying assumptions; and novel hierarchies of evidence.
- ✎ Development of transdisciplinary roles for a variety of professionals that includes family physicians.

A shift is required from the scientific paradigm that seeks to isolate and test treatments without recognizing system-level factors to a punctuated equilibrium model that captures the dynamic interchange between research and practice — between ideal models and real-world constraints (Druss, 2002). System-level factors are relevant in this equilibrium model because they determine the applicability of an intervention and needed modifications.

Role of Evidence-based Practice

Issues related to evidence-based practice in primary mental health care are also raised in the literature. Although no definitive studies clearly establish best practices for collaborative care, it is, by extension to all medical research, oriented to such ends. Evidence-based practice provides the correct, proven, cost-effective type of care in the right amount at the right time, according to individual needs (Goldman et al., 2001). The evidence base is formed through the accumulation of rigorous research findings that delineate effective outcomes for those being treated. The argument that care should be evidence-based has two

The role of evidence-based practice must be considered

key aspects: care should be of a specific quality (positive outcomes obtained cost-effectively) and should be accountable (documented adherence to evidence-based practice) (Goldman et al., 2001). Implementing an evidence-based practice is, in essence, undertaking a quality-improvement process (Goldman et al., 2001). Its accountability lies in the fidelity of practice to models whose effectiveness has been corroborated by research (Goldman et al., 2001).

In their discussion of the evidence base for primary care psychiatry, Churchill and McGuire (1998) assert that deciding on effective, appropriate management of care is dependent not only on clinicians applying their knowledge, experience and judgment, but also on their application of up-to-date evidence. The authors highlight many challenges to the implementation of evidence-based practices such as practitioners' insufficient time to examine all the emerging evidence; inadequate access to research evidence; and lack of critical appraisal skills, which limits their interpretation of the research evidence. These limitations lead to an over-reliance on reviews of evidence, which in turn have their own limitations (Churchill and McGuire, 1998). Traditional narrative reviews are both subjective and unsystematic, and have a high potential for bias (Churchill and McGuire, 1998). Practitioners and planners need to distinguish high- from low-quality research.

Funding

Funding and financing — who pays for collaborative care and how professionals practising integrated collaborative care are paid — are central issues that must be considered. Funding is often cited as a significant system barrier to collaboration; health care funding has traditionally reflected service streams within medicine, funding providers directly, rather than basing funding on consumers' actual care. Funding allocations and remuneration plans do not typically accommodate holistic approaches to care that may involve more than one professional delivering service to a person at one time. Payment for collaboration is seldom available. A number of publications reflect on these issues and provide an overview of the way change has been handled or proposed for this fundamental element of collaborative care.

Economic barriers

The overall economic barriers to the creation and implementation of integrated mental health care have been highlighted (U.S. Department of Health and Human Services, 2001):

Barriers to funding collaborative care need to be removed

- ❧ Current funding for mental health services and primary or general medical care is divided, reflecting the structural divisions inherent in developed health care systems.
- ❧ Parity in the funding for mental health services with that for general medical health is lacking. Over the last decade or more, funding for mental health, as a percentage of overall health care spending, has decreased in many jurisdictions.
- ❧ Little economic incentive, if any, exists to promote collaboration between mental health and primary health care providers across disciplinary lines or the development of integrated team approaches to care.
- ❧ Within the U.S. context, separate systems of financing, delivering and managing specialty mental health care are increasing within health care plans. These carve-out programs have little incentive to support integration of care because they have no method of recouping the reductions in overall health care costs that result from the treatment of mental illness (cost-offsets).

The economic solution

Strosahl (1998) places the issue in the overall context of mental health needs and the way society chooses to respond. Rising mental health needs around the globe demand a response, but how can health care systems afford this response? Since the structure of developed health care systems separates general medical and mental health services, an enormous expenditure of health care resources is required to staff a model that would provide primary care consumers with appropriate access to specialty mental health care services.

The answer lies in the integration of care within the primary care setting.

Is it possible to meet the population's mental health needs without breaking the bank? To answer this question, Quirk et al. (2000) use the example of psychotropic medication. Overall, system goals must be aligned so that the collective system of care has these characteristics:

- ❧ No medication unless it is necessary (e.g., not medicating for minor disorders).
- ❧ Discontinuation of medications when they are no longer needed (e.g., after an episode is complete for uncomplicated major disorders).
- ❧ Introduction of medicines earlier during a major episode of depression (for which diagnostic acuity is strongest).

Health care systems must choose an affordable response to unmet and rising mental health care needs

Integrating primary and mental health care provides an affordable solution

Some think integration is part of a hidden agenda

The net overall outcome is measured in cost savings for thousands of people. “The equation includes additions and subtractions of costs of necessary and unnecessary care and reasonable cost-offsets where one targets this group and assures appropriate care. Targeted offsets are possible and will need to be effectively incorporated into programmatic efforts” (Quirk et al., 2000; p. 91).

Some stakeholders perceive a hidden agenda in the push for collaborative care (Nolan and Badger, 2002b), believing that the agenda is focused on the integration of disciplines and budgets to manage scarce health care resources. Blount (1998c) suggests that, in fact, in the United States, costs have become less of an issue as managed health care systems have matured (as is evident in the larger, successful systems). In the early years, managed care focused almost exclusively on reducing costs, so most savings have been found. The emphasis now is on competition that is based on the quality of care. This includes such elements as customer satisfaction, retention rates of plan membership and clinical outcomes.

Remuneration plans

It is essential to understand funding and remuneration schemes

In their work on the financing and remuneration plans needed for collaborative care, Dewa et al. (2001) examine the reimbursement schemes and associated financial incentives of the consultation–liaison model of shared care (i.e., an assessment of the most popular Canadian approach). A critical concept in reimbursement is risk-sharing: Who bears the cost of care and to what extent? The parties involved are the payer and the provider. Whoever bears the costs has the incentive to control them. Risk-sharing can be shifted from one party to the other, according to the timing of payment for the delivery of care. Prospective payment (before service) is made in capitation plans; retrospective payment (after service), in fee-for-service plans.

Incentives for these different payment plans are quite varied. Dewa et al. (2001) suggest the application of reimbursement models that promote shared care. First, they discuss fee-for-service plans to promote shared care:

- ✎ Credentialed nonphysician mental health care providers should be able to bill for consultations with family practice physicians to increase the number of these consultations. However, this action is unlikely to change physicians’ behaviour because they are not compensated for the longer visits that consumers with mental health issues require.

- ✎ Credentialed nonphysician mental health care providers should be allowed to bill for mental health treatments, which would increase the number of mental health treatments provided, but would not build team responses or improve communication. Currently, this is not the politically preferred option.
- ✎ Under fee-for-service, doctors should be able to bill for mental health treatments delivered by mental health professionals affiliated with their practice (similar to arrangements for dentist-dental hygienist relationships).
- ✎ None of these proposed plans would narrow the schism between primary mental health care providers and psychiatrists. These plans are more feasible and financially rewarding for primary care practitioners treating consumers with mild issues in primary care, but risk changing psychiatrists' case mix so that they would see only the most severe cases.
- ✎ Reliance on fee-for-service financing in its present form does not support shared care: physicians see shared care as viable only when they can recoup additional costs through revenues from an increased quantity of services.

Second, Dewa et al. discuss the use of capitation payment plans to support collaborative care:

- ✎ Capitation payment would work if the focus were on the services delivered and not the provider delivering the care: this payment plan would allow the development of practice groups involving a variety of full- and part-time professionals. The physician would be reimbursed no matter who actually provided the services.
- ✎ Financial incentives would encourage psychiatric consultations or the use of other specialists to provide services beyond the scope of primary care practitioners.
- ✎ Capitation payment would have to be high enough to equal the costs of referrals.
- ✎ The risk of a capitation payment plan is the potential purposive selection of other professionals employed within primary care based on their lesser credentials to minimize costs. The policy issue here hinges on the alternatives for treatment: potential delay in or lack of treatment by a specialist mental health clinician, as opposed to timely treatment offered by mental health providers with less training.
- ✎ Incentives to attract healthier consumers are maintained in capitation payment plans because of low financial risks. However, modified capitation plans with risk reduction related to the degree to which the objectives are met may be more fruitful in

getting practitioners to participate in collaborative programs. For example, salaried doctors can be offered bonuses to work in collaborative programs.

Finally, Dewa et al. (2001) discuss the use of blended payments to promote shared care:

- ✎ Blended payment plans are the logical place to start because full-scale change in reimbursement plans is not likely to occur.
- ✎ Blended payments build on fee-for-service, introduce capitation to support shared care working and reduce incentives to provide unnecessary services.
- ✎ Capitation provides guaranteed payment and subsidizes the use of mental health specialists in primary care settings where specialists provide consultation or direct care.
- ✎ Capitation would also extend the scope of the primary care physician's practice beyond direct patient care and encourage the coordination of responsibilities for care.
- ✎ Also, receiving fee-for-service would counteract the tendency to undertreat that occurs with capitation reimbursement plans. However, the rate should be set at a level that discourages billing for unnecessary consultations, yet encourages necessary consultations.
- ✎ Prerequisite for any capitation plan is patient rostering – assigning consumers to a single practice for a period of time, theoretically leading to a loss of choice on the part of the consumer.

Other reimbursement incentives

Other literature supports the negotiation of new approaches within the overall framework of health system goals.

Hickie and Groom (2002) discuss a number of incentives introduced during the reform of primary care–led mental health service in Australia to provide affordable access and promote the integration of the medical and psychological care that consumers with mental disorders require. Payments to family physicians were introduced: for example, AU\$150 for registration to participate after completing training; and AU\$150 for each consumer completing a three-step episode of care plan, with an initial maximum of \$10,000 per doctor per year. Family physicians were given an increase of 20 per cent per payment for longer consultations and an initial maximum of six payments that could be increased to 12 payments after appropriate clinical review. Ongoing education was also supported. Access to allied health specialists providing

Other incentives support collaborative care

nonpharmacological treatment was promoted through pilot projects, and service arrangements were purchased from a variety of practitioners. The plan also called for additional remuneration for psychiatrists who respond to family physicians' emergency consultation requests. However, this element had not yet been implemented at the time the article was written.

In a report on stakeholders' views of integrating care for the treatment of depression, Korda (2002) also provided a list of possible reimbursement incentives. Providers want to be paid for collaboration and to have access to training about treatment. Incentive payments that recognize the use of evidence-based guidelines and tools were supported. These are some of the types of reimbursement supported:

- ∞ Reimbursement attached to accountability.
- ∞ Resources to cover the costs of collaboration, including the use of care managers and explicit acknowledgement of primary care and behavioural specialists' participation.
- ∞ Contractual arrangements that reduce financial fragmentation.
- ∞ Tiered reimbursement and co-payments for providers using behavioural approaches.
- ∞ Reimbursement for dealing with addictions issues in primary care settings.

Lee et al. (2002) identify lessons learned during the primary care-led phase of commissioning of mental health services in England during the 1990s. In this plan, family physicians were given a budget to purchase secondary mental health services. Through a study of the Total Purchasing and Extended Fundholding sites, the authors found that primary care purchasing resulted in better communication and better working relationships with mental health providers. Results for communication and relationships with social care providers were less positive, except when initiatives were jointly funded. Purchasing also resulted in the location of more mental health providers in the primary care settings. Primary care providers did not make use of detailed contracts to promote these changes. Absent, however, was any consumer involvement in crafting these new arrangements.

Costs of collaborative care

Only one article touched on the related issue of the costs of delivering collaborative care. McCrone et al. (2004) explored the economic implications of shared care arrangements in a primary care-based study of severe mental illness in an inner city. They profiled the resource implications of different levels of shared care by comparing service use and costs between primary and secondary

More information about costing is needed

levels of care services. They categorized the levels of shared care as low, medium or high and made statistical comparisons between the groups after controlling for participants' characteristics. Consumers with low levels of shared care used residential care less and were less likely to see a psychiatrist or social worker than those in the medium or high levels of shared care. Mean costs for the low level of shared care were significantly lower than those for the medium level, but not significantly lower than those for the high level of shared care. The different levels of care reflect different patterns of service use: consumption of resources at the medium level of shared care was greater. Although the study was not geared to finding the causal links between service use and costs, its reflection on actual costing and discussion of cost-effectiveness are important contributions to discussions about how better to fund a collaborative system of care.

Flexible funding plans

Quirk et al. (2000) emphasize that funding plans must be more flexible to support innovations and collaborative care. They call for reasonable annual increments to cover expenses to maintain positive commitment to these plans. Funding plans must be engineered to benefit the entire system, rather than particular groups of professionals, to encourage implementation of new care prototypes that are more effective and satisfying than usual care. In other words, the financial model should not be a barrier to the implementation of these new treatment methods, nor should this model allow medical responses to be the default option for treating psychological problems in primary care.

Similarly, Dea (2000) argues for investments that support the whole continuum of implementing integrated mental health care, from project planning to the development stages to full-scale implementation. Although implementation is not without costs, a lack of proper investment and sustained funding jeopardizes the long-term success of models. Such costs include the cost of staffing, development of call centres, learning and professional development for physicians and staff, redesign of office space, and application of information technology.

Barriers to dealing with financial issues

System stakeholders in the United States (Korda, 2002) identified a number of economic or funding elements that are little understood or result in much confusion. Although financial barriers such as the lack of payment for collaboration, methods of setting rates for collaboration, and monitoring and assessing the costs and benefits of collaboration are easy to identify, many participants in the study indicated the lack of solid

Health care systems require more flexible funding plans

Gaps in knowledge about funding and incentives must be filled

evidence or understanding about how to effectively deal with these barriers. Key concepts of cost-offsets, parity, and financial incentives and disincentives are confusing. The issue of knowledge about the health care market and market leverage is significant, but poorly understood. The gap in knowledge about this important aspect of collaborative care infrastructure is wide. Much work remains to be done.

Community

An important fundamental element of collaborative care is the community. Focus on this local context is necessary to assess the existing resources and care pathways, and to determine the need for collaborative approaches. Knowledge of these features is important to the design of a successful program. The relevant literature about the role of community surveys the importance of community, conducting needs assessment and adapting models to local needs.

Importance of community

The importance of community articulated in some British literature potentially reflects that country's dynamic and evolving health care reform over the last 20 years. Considerable political emphasis has been placed on partnership, collaboration and participation as important principles for health care reform (Nolan and Badger, 2002b). As a result, collaborative care (in a broader sense of the word) is often recommended. In spite of numerous rounds of reform, Nolan and Badger (2002b), in the preface to their book, note that serious inequities still exist in that health care system; policy and high-quality research have proven insufficient to bring about major change. "There is more power in committed and creative individuals reflecting on their working practices and on the nature of their interactions with others – their clients and other professionals and agencies – and, in doing so, improving their focus on what is actually happening, where, when and how. By becoming more aware of those factors that determine the outcomes of health care, they have found that collaboration has the 'potential to improve procedures, interpersonal relationships and organizational factors related to power'" (p. xii). This quotation clearly identifies the importance of knowing the community, the determinants of health and the consumers in need of service to the development of effective responses to service.

Gask and Rogers (1998) echo this point in their discussion of a new paradigm for primary mental health care. This paradigm challenges the historical and structural givens about mental health and illness

Community needs are the foundation of collaborative care at the local level

The rhetoric of partnership in health care reform is no longer sufficient

Care paradigms are shifting

Integrated primary care has more facets than just clinical treatment

Community linkages are essential

in health care delivery (e.g., separate streams of primary and specialty mental health care):

- New ways of seeing and understanding mental health problems that incorporate a wider view of need are required. Traditional definitions of primary care tend to be narrow and do not capture all of the relevant resources: not acknowledging social and economic determinants of psychological distress in the community strips away the context in which consumers develop these problems, which limits responses. As Quirk et al. (2000) caution, medical responses to psychological problems should not become the default option.
- Collaborative care delivery can make use of the wide-ranging mix of professional roles and skills available to consumers and can treat these consumers, not just as passive recipients of care, but also as providers or co-providers of care through self-help and other informal sources of care.
- Primary care practitioners are well positioned to draw on community resources and lay care in their treatment of consumers. This access results in treatment and intervention programs designed specifically for primary care populations that complement community-based or community-generated supports that also help alleviate the psychological distress of consumers and communities.

The importance of communities has also been articulated within direct care initiatives, such as the Health Disparities Collaborative, a multi-year U.S. initiative to implement models of consumer care and change management to transform the system of care for underserved populations. The manual of one project, the Depression Collaborative, states that community should

- “Establish linkages with organizations to develop support programs and policies
- Link to community resources for defrayed medication costs, education and materials
- Encourage participation in community education classes and support groups
- Raise community awareness through networking, outreach and education
- Provide a list of community resources to patients, family and staff” (Mauer/National Council for Community Behavioral Healthcare [NCCBH], 2003, p. 12).

Needs assessments

A number of authors discuss conducting needs assessments to support developing collaborative care programs. Strathdee (1998), and Jenkins and Strathdee (2000) document the elements of a comprehensive planning process for new program development. A wide range of information from needs assessments and audits, and about local practices is required for service planning.

Needs assessment and audit information provide this type of information:

- ∞ Analysis of local morbidity patterns.
- ∞ Type and level of information technology in practices and programs.
- ∞ Case registers for consumers with chronic conditions such as diabetes, asthma and serious mental illness.
- ∞ Number and type of professionals in mental health programs and primary care practices.
- ∞ Analysis of primary care practice populations or rosters.
- ∞ Number and characteristics of practice admissions.
- ∞ Number and outcomes of referrals to specialized mental health care.
- ∞ Psychotropic prescribing patterns and costs.
- ∞ Practice policies about consumers with mental health issues.
- ∞ Related protocols.
- ∞ Skills analysis and training needs.

This type of information about local practices is required:

- ∞ The nature of the practices (sole practices, group practices, community health centres).
- ∞ Contacts for mental health training.
- ∞ The nature of practice relationships to mental health program.
- ∞ Family physicians' practice affiliations.
- ∞ Sessional appointments.
- ∞ Current level of training and skills of staff.
- ∞ Reimbursement model and other information about funding sources.

Strathdee (1998) also suggest a set of guiding questions for needs assessments:

- ∞ What are the needs of consumers in all groups?
- ∞ What mental health strategy will meet these needs?

Community needs must be determined

- What are the optimal skills providers in the program should have? What is the optimal mix of professional services the program should provide?
- What model of shared care, communication and liaison should be in place and between which partners?

Practical strategies

Stichler (1998) suggests these practical strategies for developing collaborative practices:

- Providing continuing education and skills development to enhance the level of professional knowledge and competency, and encouraging others in the profession to learn as well.
- Creating interdisciplinary committees to develop consumer care goals and to discuss roles and responsibilities; encouraging formal and informal discussion of patient care issues.
- Discussing similarities, differences and overlapping responsibilities in roles; determining ways that different roles can complement consumer care; and allowing the unique contribution of each professional, based on skills and expertise.
- Organizing forums for the open exchange of communication, problem-solving, decision-making and planning.
- Celebrating success and using examples of collaborative behaviours and practices as case examples for others.

Implementing collaborative care in the community

An environmental assessment tool (Mauer/NCCBH, 2004) has been developed to assess state-level policy and financial support for collaboration. This tool gathers detailed information about the impact of these two factors on the integration of clinical service with the Four Quadrant Model (for details, see Chapter 5) and a working-group approach. With permission, this tool could be adapted for use in other jurisdictions.

The process for developing collaborative programs requires the participation of many stakeholders in the community, including consumers and families, and primary and secondary care and social service providers. In their example of a recent planning process, Fuller et al. (2004) describe the creation of an integrated primary mental health care plan for a rural region in Australia. They highlight the structural elements and processes undertaken. Similarly, Byng and Jones (2004) present an intervention and related conceptual framework for developing shared care for consumers with long-term mental illness.

An environmental assessment tool is useful for assessing policy and support

Broad participation of stakeholders is required

Their intervention, called Mental Health Link, is a facilitated quality-improvement program aimed at expediting the development of services by bringing stakeholders together to agree on a model for shared care to suit local needs, skills and interests, and by supporting the development of practice systems.

Other authors offer local practical advice about how to develop a collaborative approach. Blount (1998c), Peek and Heinrich (1998), and Lorenz et al. (1999) discuss a range of issues involved in getting started. Their main advice is compiled in this list:

- ∞ Start by offering integrated care as the answer to perceived problems within a practice, rather than as a good idea to be implemented for some higher purpose. This will increase the staff's adoption of the new model of care (Blount, 1998c).
- ∞ Consider the location of providers, then the basic elements of coverage, service structure and mission (Blount, 1998c).
- ∞ Consider the types of problems the introduction of the collaborative program may create that the leaders of the integrated program need to manage thoughtfully (Blount, 1998c):
 - Undertaking a new type of project.
 - Creating new ways of understanding and working with problems that consumers present.
 - Creating a new cohesive team in the organization.
 - Mitigating the impact on people who did not participate in the development of these new approaches when the broader implementation unfolds (e.g., when moving from the pilot project to full-scale implementation).
- ∞ Set time frames for implementation that are realistic for the type and breadth of the desired collaborative relationships. Timing should be dependent on such factors as readiness to collaborate, attitudes towards teamwork and degree of fit of the new mental health team members (Peek and Heinrich, 1998).
- ∞ Follow these steps when launching the pilot (Peek and Heinrich, 1998):
 - Ensure that the vision is sufficiently functional, that it actually works on the first day. For example, have the physical space and basic support functions such as scheduling in place ahead of time.
 - Schedule frequent review times in the first months of operation to check how implementation is progressing and to troubleshoot any issues.

Others offer advice about how to implement collaborative care

- Begin by employing seasoned mental health professionals who are acquainted with the culture of primary care practice.
- Establish a supportive background network of advisors who have been through an implementation and professional support networks for members of the team.
- ☞ Keep it going (Lorenz et al., 1999):
 - Model respect and good manners.
 - Acknowledge and solicit the expertise of mental health professionals.
 - Focus on the purpose of the collaboration. Consider short-term goals, but understand the different goals of the partners involved in the collaboration.
 - Do not take differences personally and be interested in the perspectives of other team members.

Chapter Summary

In sum, these are the fundamentals of collaborative mental health care infrastructure:

- ✧ Policy is necessary to ensure that health care systems systematically define and incorporate collaborative care.
- ✧ Collaborative care needs to build an evidence base through research. New research methods need to be explored.
- ✧ Funding and financial incentives are required to encourage providers from any discipline to participate in collaborative care. Payment mechanisms that can be adapted to include these incentives do exist.
- ✧ Community needs are central to the development of collaborative care programs. Nonhealth community resources should also be incorporated into collaborative care.

Chapter 4:

CONSUMER CENTREDNESS

KEY MESSAGES

- *When care is centred on the consumer, the focus is on responding to the consumer's needs. Care goals are jointly defined by the consumer, family or caregiver to make the ill consumer healthy.*
- *Collaborative mental health care is a mechanism of choice for consumer-centred care. It promotes cooperation and joint work among health professionals, informal caregivers and the consumer to meet these needs.*
- *Recognition of the consumer's role and responsibilities in the collaborative care process characterizes consumer-centred care.*
- *Special populations such as consumers with severe mental illness and addictions who require customized approaches to collaborative mental health care emphasize the need for flexibility in collaborative models of care.*

The primacy of the consumer in need of care is the starting point in the delivery of all types of mental health services, including primary mental health care. The literature on this topic focuses on the principles and rationale for consumer involvement in the development and delivery of collaborative initiatives, and on the needs of and approaches to special populations: consumers with serious mental illness, or addictions or concurrent disorders; children and adolescents; rural populations; seniors; and other high-needs groups.

Consumer centredness is predicated on the concept that consumers can and should be actively involved in all aspects of their health care, including identifying issues of concern; making informed treatment choices; and contributing to the design, implementation and evaluation of programs. Within the delivery of health care services, the consumer's well-being is the central concern, a challenging expectation for organizations faced with demands from multiple stakeholders (Goscha and Rapp, 2003). Consumer centredness depends on collaborative mental health care to effectively deal with the wide range of needs of people receiving services and on the broad array of community resources available to the consumer (Gask and Rogers, 1998).

Being consumer-centred means working with people in partnership to deal with their needs

The focus on consumers in service design, delivery and evaluation needs to be transparent

Formalizing the Consumer Focus in Collaborative Care

Ensuring a consumer-centred approach within primary mental health care is an essential starting point. Many authors discuss the challenges of establishing collaborative approaches and having different kinds of professionals work in teams to deal with the wide range of mental health needs. Mauer/National Council for Community Behavioral Healthcare (NCCBH)(2003) suggest practical steps to establish a transparent consumer-centred approach to care:

- Mission or vision statements and supporting service objectives should be developed to help practitioners and staff attain their and consumers' mutual goals for the health and well-being of consumers and the practice's population.
- These statements should be used to develop operational standards, business plans and procedures that explicitly place the consumer at their centre.
- These operational standards should be used to evaluate how well a service is meeting the goal of focusing on the needs of consumers.

Formalizing the consumer focus must also involve these considerations:

- Government policy directives for the integration of mental health and primary care.
- Creation of a best-practices framework for the planning, development and implementation of integration.
- Establishment of guidelines that ensure mental health is part of the discussions about broader health system integration and provide a roadmap to the complex, often ill-defined topic of integration (Washington County Mental Health Council, 2002).

The core principle of consumer centredness is the focus on consumers and their families, which has been described in many ways:

- "Emphasis on consumers and their families. The needs of mental health consumers and their families should drive service delivery and systems of care. Cultural and ethnic diversity should be respected." (U.S. Department of Health and Human Services, 2002, p. 5).
- "[P]atient centred care with a minimum of 2 caregivers from different disciplines working together with the care recipient to meet assessed health care needs" (Northwest Territories Medical Association and Northwest Territories Registered Nurses Association, 2000, p. 12).

- “Desired outcomes of integration need to include: increased access to care (no wrong door for consumers), improved patient/consumer health/mental health status and clinical outcomes, improved patient/consumer satisfaction, improved cost management and cost savings, and administrative simplification” and “Consumer, family member and advocate input, preferences and feedback should be an integral part of integration planning, implementation and evaluation” (Washington County Mental Health Council, 2002, p. 1.)
- “Shared vision: specifying what is to be achieved in terms of user-centred goals, clarifying the purpose of collaboration as a mechanism for achieving such goals, and mobilising commitment around goals, outcomes and mechanisms” (Hudson et al. 1997, as cited by Glasby and Lester, 2004, p. 8).

Consumer Involvement — A Standard of Primary Mental Health Care

Over the last few decades, many jurisdictions have introduced consumer involvement as a criterion standard. The aim was and still is to give consumers a greater say about how they live their lives and about the services they need to help them do so. Such involvement is now recognized as part of good practice (Barnes et al., 2000).

Partnerships

Partnerships define the essence of collaborative care. The consumer, the recipient of care, is essential to these partnerships. There are two aspects to health care’s partnership with consumers: involvement in negotiations about their individual care, and involvement in the planning and management of services.

Best practices for either type of consumer involvement are still elusive. As Barnes et al. (2000) illustrate, the different models used in various settings produce a range of outcomes. The emerging stakeholding paradigm in England has these elements:

- All stakeholders, including consumers, participate as partners.
- Such partnerships acknowledge the differentials in power without demanding equality (see also McAllister and Walsh, 2004).
- These partnerships involve a negotiated agreement about roles and responsibilities, and an understanding of the locus of power.
- It is imperative that consumers’ voices are heard, that their perspective is valued and that their views have influence.

Care partnerships acknowledge that consumers have a responsibility to take charge of their own health

Program design and evaluation, and care delivery require partnerships

"[P]atients are the end users. Whatever we do, our work should and will be judged in relationship to them" (Quirk et al., 2000)

"If collaboration does not produce positive results for users and practitioners. . . nothing has been gained by the venture, and the exercise remains a mechanistic response to policy without tangible gain for any of the individuals concerned" (Nolan & Badger, 2002b)

Consumers bring expertise to the health care situation

Consumers as end-users

Quirk et al. (2000) make the powerful point that "patients are the end users. Whatever we do, our work should and will be judged in relationship to them. Patients should expect that their health care plan will have a care process that is relevant to them as individuals, meaningful given their disorder, and broadly available when they connect for care..." (p. 86). Establishing clear lines of accountability for primary mental health care is essential.

Collaboration as a means to an end

Similarly, Nolan and Badger (2002b) state: "Collaboration is not an end in itself, only a means to an end. If collaboration does not produce positive results for users and practitioners — in terms of easier, more rapid access to resources, more suitable and sensitive service provision, and the satisfaction of a job well done — nothing has been gained by the venture, and the exercise remains a mechanistic response to policy without tangible gain for any of the individuals concerned" (p. xiii). Although these positive outcomes would not be possible if the individual consumer were working alone, the emphasis is primarily on the individual consumer's outcomes. Benefits for providers are secondary.

Consumers as experts

Badger and Nolan (2002) also highlight the growing recognition that consumers are experts because of their experience of health and social services, and their experience of living with their illness. From the perspective of the consumer, "there is no distinction between health, social services and the voluntary sector or between qualified or unqualified staff. Expert care is expected from all. Users assume, not unreasonably, that service providers will share information among themselves" (pp. 252–253).

Emphasis on personal involvement in care planning is essential to the underlying values of the public health or population and chronic care models of the delivery of care. Consumers have to assume responsibility for their health and mental health, and take an active role in managing their own care. Dea (2000) provides useful questions for ascertaining the consumer focus in care planning:

- ☞ "How can patients be provided with a more complete clinical experience that focuses on prevention, detection and effective treatment?"
- ☞ "How can the system not waste patients' time?" (p. 19)

Importance of self-care

Mauer/NCCBH (2003) note that informed, engaged consumers interacting with a prepared, proactive practice team achieve the best outcomes. This finding points to a vital dimension to shared care — the partnership with the consumer. Taking responsibility for their own care includes such self-management. Self-management involves consumers setting goals with practitioners for the things that they, the consumers, can do on their own to cope with current conditions and work towards improvement using a variety of self-management tools (Health Disparities Collaboratives, 2005).

Consumers' attitudes to care

The goal of one study (Cooper et al., 2000) was to develop an instrument that measures consumers' attitudes toward depression care. Although many studies had designed interventions focused on providers' barriers to care, this study's hypothesis maintained that being able to identify consumers' attitudes would assist in the creation of programs better targeted to meet their preferences for care. To construct the new instrument, focus groups and a survey of the important elements of care were conducted to collect input from consumers with mild-to-major depression. Two versions of one instrument were successfully constructed to reflect the elements of care deemed important by these consumers — elements such as health providers' interpersonal skills, primary care providers' recognition of depression, treatment effectiveness, treatment problems, consumers' understanding about treatment, intrinsic spirituality and financial access to services. The authors highlighted the connection between respecting consumers' values, preferences and expressed needs, and improving care outcomes: "the patient-provider relationship is particularly important and should be considered in decisions affecting health policy for patients with depression. Policies that reduce continuity of care and limit the amount of time primary care patients spend with their physicians may ... lead to poorer depression outcomes" (p. 172).

Partnerships between providers and consumers can enhance care and outcomes

Creating opportunities for consumer involvement in program design and service delivery is important

Innovative strategies for increasing openness to consumer involvement in the mental health system are needed

Involving consumers in program design

Moreover, involving consumers in the planning and management of primary mental health care alleviates health care providers' burden to be all-knowing about consumers' needs and the appropriate range of responses to them. A broad definition of multi-disciplinary collaboration acknowledges that it is not solely about what providers can offer to users and to each other (Badger and Nolan, 2002). Growingly, it is also about what consumers can offer to their own care, and to service planning and evaluation. The opportunity for consumers to give back is important. Some wish to do so by giving back to the health care system. The effects of consumer involvement in the planning and delivery of care on improving its cost-effectiveness, however, are largely unevaluated (Freeman et al., 2002).

Working for change in the system

McAllister and Walsh (2004), using the concept known as the politics of difference, make a cogent case for professionals and consumers working together to create enduring change in the health care system. Active commitment, educative processes and novel strategies are required to make the consumer's voice heard in mental health services. Some tensions inherent in applying the theories of difference to consumer partnerships in mental health care do exist: for example, the tension between avoiding fragmentation in working groups, and resisting consistency and conformity, or the tension between creating more participatory processes and acknowledging the authority inherent in the provider's role. These strategies may strengthen and promote the consumer voice:

- ☞ *Prepare for differences:* use the process of internal reflection and reflecting on shared common goals.
- ☞ *Listen to consumers' voices:* avoid speaking for consumers when it is possible for them to speak for themselves; provide reassurance that their voices will be heeded, opportunities to practise voicing their ideas, and positive reinforcement when they use their voices; and understand when they falter.
- ☞ *Raise awareness and declare differences:* bring differences to the surface to clarify and understand them early in the process; allow time for reflection, sharing and identifying differences in values; recognize that existing boundaries between consumers and providers may change and have to be redefined; clarify one's position and limits in relation to those of others to know the other

and appreciate the richness of the differences in the relationship; and find common ground.

- ∞ *Reflect on experiences and theories of difference:* develop processes within the group to work through differences, such as establishing group norms that value all voices, and providing decision-making and conflict resolution techniques that everyone is comfortable with; and do not allow suppression of conflict.
- ∞ *Encourage a different kind of power:* overcome the mental health system's resistance to change, especially that of those with power who find it easier not to change; recognize that shared work presents an opportunity to introduce radical change; learn to moderate hierarchy, and trace its sources and effects; and use authority and influence differently.
- ∞ *Form coalitions and value dialogue:* explore common values and issues, and maintain dialogue while ensuring that differences are heard.
- ∞ *Prepare to be enriched and enriching:* create a climate of mutual support and ongoing development, avoid the use of stigmatizing or dehumanizing language, acquire skills of persuasion and influence, and be fraternal rather than paternal.
- ∞ *Plan projects together:* recognize that the three priorities are more education, more support and more humanizing spaces; start small; use the skills at hand; and use the impetus of personal experience.
- ∞ *Maintain momentum:* anticipate obstacles that threaten to divide the consumer and provider, build capacity for influence, find new allies, maintain members' enthusiasm and momentum, use the media, celebrate successes, and have fun together.

Overall, these strategies would be most useful for service planning and evaluation activities rather than for direct patient care.

Shaping power

Two studies reflect on continuing power differentials in consumer-provider partnerships. Examining consumer involvement in planning and delivering mental health services in two mental health provider trusts in London, England, Rutter et al. (2003) found evidence of consultation rather than partnership with consumers. Providers retained control over decision-making and expected consumers to endorse the existing agendas of the trusts and to conform to management practices. Rutter et al. recommended engaging a wider range of consumers with more varied, creative approaches and learning to share power.

Power must be shared in the provider–consumer partnership

Columbo et al. (2003) reported similar findings for their qualitative study of the influence of implicit models of mental disorder on shared decision-making within mental health teams and on the power relationships between provider groups and providers, and consumers. Mental health teams need to recognize consumers as part of the team and to redefine the balance of power within the decision-making process for care. The consumer's needs should be "reached through an informed consideration of a range of options that may or may not include medical solutions" (p. 1569).

Collaborative Approaches for Special Populations

Consumers with serious mental illness

Special attention is required in the provision of integrated mental health and primary care to consumers who experience serious mental illness. Consumers who have serious mental illness are more likely to have significant physical health needs that are often ignored (Bazelon Center, 2004; Miller et al., 2003). A significant number of people with serious mental illness are not in touch with any part of the health care system (U.S. Department of Health and Human Services, 2001). Some who are in contact with primary care are not diagnosed at all or are not diagnosed effectively.

Consumers with serious mental illness have higher needs for these reasons:

- Mental illnesses put consumers at higher risk of multiple comorbid conditions (e.g., Dickey et al., 2002; Lean and Pajonk, 2003).
- Consumers with schizophrenia have particularly high rates of comorbidity (Dixon et al., 1999).
- Several factors increase the risk of serious medical conditions, including smoking, obesity, and lack of physical exercise, which are common to consumers with serious mental illness (Bazelon Center, 2004)
- Consumers with serious mental illness have a greater incidence of certain disorders such as diabetes, cardiovascular disease, weight gain and obesity (Bazelon Center, 2004).
- Mental illness is comorbid with substance abuse (Dickey et al., 2002; Druss et al., 2002).

Therefore, health screening, preventative services and regular access to primary care for consumers with serious mental illness should be a high priority (Bazelon Center, 2004).

Consumers with serious mental illness have higher, often unmet physical health care needs

Access to primary care, however, is problematic for consumers with serious mental illness. They experience common barriers to integrated care (see Chapter 5, for a review of these common barriers), as well as some that are specific to consumers with serious mental illness. Normalizing primary health care for people with serious mental illness — namely, coming to primary care because that is where the community is treated — is not a theme in any of the articles about serious mental illness retrieved in this search. Rather, this recent literature highlights these serious mental illness-specific barriers:

- ∞ Mental health providers' (including psychiatrists') inattention to consumers' physical health needs (Bazelon Center, 2004).
- ∞ Main locus of consumers' care in secondary or specialty care and consumers' infrequent contact with primary care (Meadows, 2003; Miller et al., 2003).
- ∞ Consumers' desire for privacy and resistance to letting other health care providers have access to their mental health information (Bazelon Center, 2004).
- ∞ Consumers' fear of stigma (Bazelon Center, 2004).
- ∞ Consumers' fear or denial of a health problem (Bazelon Center, 2004).
- ∞ Consumers' lack of knowledge about how to get services (Bazelon Center, 2004).
- ∞ Consumers' inability to navigate the complexity of the health care system (Bazelon Center, 2004; Miller, 2004).
- ∞ Consumers' problems related to mental illness, such as lack of coping skills, difficulty interacting with others, lack of genuine understanding of illness and lack of agreement about medication treatments (Miller, 2004; Meadows, 2004).
- ∞ Consumers' lack of transportation to get to the primary care location (Bazelon Center, 2004).

One study examined consumers' satisfaction with primary care and shared care. Using semi-structured qualitative interviews about the elements of satisfaction for consumers with schizophrenia, Lester et al. (2003) found that satisfaction was mediated by five factors: the exceptional potential of the consultation itself, specific aspects of the organization of primary care, the nature of the consumer in the physician-consumer relationship, the influence of stereotypes on family physicians' behaviour and the importance of hope for recovery. Interpersonal skills were also important to consumers' satisfaction with medical encounters. Moreover, the involvement of the mental health consumer in primary care depends

Many forms of stigma prevent access to primary care for consumers with serious mental illness

Vertically integrated programs are preferred for providing primary care to people with serious mental illness

on issues that cannot be mandated, such as providers' understanding, respect for consumers and requests for consumers' views.

A number of approaches for overcoming the lack of access to primary care for people with serious mental illness have been suggested. The Bazelon Center's recent report (2004), the most comprehensive discussion of the topic, reviews four models, according to the extent to which they overcome common barriers to integrated care:

1. Primary care embedded in mental health programs for people with serious mental illness.
2. Unified programs in which behavioural health and primary care are combined, wholly or in large part, at the administrative and financial levels.
3. Co-location of behavioural specialists within primary care.
4. Improved collaboration between separate providers.

Of these four approaches, the report found that embedded, then unified programs provided the best primary care to consumers with serious mental illness.

A few authors present examples of specific program approaches for people with serious mental illness: one for consumers with schizophrenia (Meadows, 2003), a second involving the partnership of a psychosocial rehabilitation centre with a nursing faculty (Marion et al., 2004), and a third involving a partnership between a designated provider of all publicly funded outpatient mental health services and a medical centre (Crews et al., 1998). Two of these models involve unified or embedded approaches, whereas the other is a model activated in and through the primary care setting.

One study (Fitzpatrick et al., 2004) that identified factors associated with different levels of shared care for people with serious mental illness found high levels of shared care were not associated with demographic or clinical characteristics. A randomized trial (Druss et al., 2001) found that on-site integrated care was associated with improved quality and outcomes of medical care. Another trial (Byng et al., 2004) that compared usual care with a quality-improvement program aimed at creating shared care programming for people with serious mental illness demonstrated improved satisfaction of providers, but no effects on patient care.

Serving consumers with addictions or concurrent disorders in primary care

Many consumers with addictions do not receive medical care, in spite of their having acute and chronic medical conditions that may be related to their addictions (De Alba et al., 2004; Marshall and Deehan, 1998). The same is true for consumers with concurrent disorders (i.e., mental illness and addictions together) (Osher, 2001). Dickey et al. (2002) found a higher prevalence of certain medical disorders among adults with serious mental illness. Having a substance use disorder is an important risk factor that requires early detection and integrated treatment. Saitz et al. (2004) reported that although linking substance abuse services with primary care is recommended, the best way to forge these links and to determine which consumers will benefit most from such care, or conversely, which are at greatest risk of going without primary care, is unknown.

Basic assumptions about collaborative care's overall improvement in health are applicable to consumers with addictions or concurrent disorders. In a randomized control study, Weisner et al. (2001) demonstrated that adults with addictions and medical conditions related to substance abuse were more likely to be abstinent when assigned to integrated primary medical and addictions care. Friedmann et al. (2003) found that providing on-site primary care in an addiction program was associated with improved scores of addiction severity. Receiving primary care reduced the severity of the addictions of consumers with alcohol and drug abuse problems (Saitz et al., 2005).

There are many barriers to service linkages and collaborative care, for example, those related to professional responsibility, financial disincentives, consumer confidentiality, and stigma.

Professional responsibility barriers:

- General practitioners' negative attitudes towards substance abuse and addictions often preclude their involvement with consumers who have addictions (Marshall and Deehan, 1998).
- Family physicians do not perceive treating alcoholism and drug abuse as medical care, putting it beyond their purview (Samet et al., 2001).
- Medical practitioners report being ill-equipped to deal with substance abuse disorders (Samet et al., 2001).
- Substance abuse providers view medical and mental health issues as secondary in importance to the substance abuse problem (Samet et al., 2001).

Consumers with addictions or concurrent disorders also have unmet primary health care needs

Collaborative care is also viewed as a positive approach to meeting these unmet primary health care needs

Such collaborative care must overcome significant barriers

Financial disincentives:

- Payments for treating addictions and for mental health care are lower than those for medical treatments (Samet et al., 2001).
- Many payment plans do not cover the substance abuse services provided by primary care physicians (Samet et al., 2001).

Consumer confidentiality barriers:

- Many providers do not realize they can share consumer information and records after obtaining appropriate signed consent from consumers (Samet et al., 2001).
- Substance abuse information is intentionally kept out of medical records (Samet et al., 2001).

Stigma-related barriers:

- The stigma of mental illness often prevents consumers from recognizing their needs and affects their readiness to accept services.
- Stigma affects providers who do not want to spend time dealing with drug and alcohol issues or who do not wish to be perceived as health care providers for consumers with addictions (Samet et al., 2001).

Information about the best approach for integrating primary medical care and addictions treatment is inconclusive. As for the integration of care for consumers with serious mental illness, some authors (Weisner et al., 2001; Osher, 2001) support offering medical care on-site within the addictions program for those people with more severe addictions. Friedmann et al. (2000) found that on-site delivery was the most reliable means of facilitating the use of ancillary services by consumers of drug abuse treatment, while transportation and on-site case management were also important linkage mechanisms. Samet et al. (2003) found that a multi-disciplinary health evaluation offered on-site, along with motivational counselling, could increase the linkage to medical care for adults with addictions who had no regular physician. Saitz et al. (2004) took this a step further and were able to identify factors associated with linkage to primary care among consumers receiving detoxification services: women, those who had social support for abstinence, those with no recent incarceration, and those who had visited a medical clinic or physician recently were likely to engage in a collaborative care program off-site of the addiction service. The authors suggest that on-site programs should focus on those consumers who are unlikely to otherwise use primary care services.

Primary care delivered within addiction programs is proposed

In a set of nested randomized control studies, O'Malley et al. (2003) suggest that combining chemotherapy and different forms of counselling for alcohol dependence that are traditionally provided in specialty programs could be adapted successfully to primary care settings and yield similar outcomes. Making such programs available in primary care would increase access to effective treatments for alcohol dependence by increasing the number of treatment sites and providing a new, potentially preferable site for care for subgroups of consumers who might otherwise not enter treatment. These programs could conceivably use professionals other than physicians to deliver the counselling or monitor the program (similar to approaches to depression care).

Feasible models of linked primary medical, mental health and substance abuse services are available (Samet et al., 2001). Broadly speaking, models may be classified as centralized or distributive. Centralized models involve services brought together at a single site, whereas distributive models rely on effective referrals to get consumers the proper services in a service system. These are some of the features of these models:

Centralized model:

- ∞ Centralized models are typically found in primary care clinics or substance abuse treatment programs.
- ∞ Care is integrated and involves multiple professionals.
- ∞ Centralization of services overcomes the geographical problem of distance between services, and consumers' disorganization and poor motivation.
- ∞ A centralized approach within primary care may be effective for those consumers who have tobacco dependence, at-risk drinking habits and moderate illicit drug use.
- ∞ Substance abuse is best dealt with in settings that offer specialty addiction services.
- ∞ All consumers should have preventative and primary health care that is integrated with other types of care.

Distributive model:

- ∞ Successful referral is the cornerstone of the distributive model.
- ∞ Referral alone, however, cannot integrate care if organizational gaps between mainstream health care and addictions treatment programs are substantial.
- ∞ Case management is typically used to facilitate referrals.

Addiction treatment within primary care increases consumers' access to care

Linking mental health, addictions and primary care is feasible

Flexibility within models is required to accommodate subgroups of consumers

- Linkages are defined between the substance abuse treatment unit and primary care practices or community health centres working within existing service systems.

Which groups of people benefit from particular models of care requires ongoing research. In their study of the use and cost of integrated substance abuse treatment and medical care, Parthasarathy et al. (2003) found that such integration is not necessary or appropriate for all consumers. Samet et al. (2001) found that addiction interventions in medical settings may be appropriate for these types of consumers:

- Heavy drinkers.
- People with moderate substance abuse disorders.
- Medically ill substance-dependent consumers who refuse referral for formal treatment.
- Substance-dependent consumers who receive rehabilitative counselling elsewhere, yet would benefit from medical therapy.
- Minimally motivated consumers who will accept only harm-reducing interventions.
- Consumers requiring outpatient detoxification.

The State of New York defined a model for providing care to people with concurrent disorders that includes the severity of the mental illness and the addiction (Osher, 2001). The model defines four subgroups of dually diagnosed consumers: less severe mental disorder and less severe substance abuse disorder (group 1), more severe mental disorder and less severe substance abuse disorder (group 2), less severe mental disorder and more severe substance abuse disorder (group 3), and more severe mental disorder and more severe substance abuse disorder (group 4). Responsibility for care is assigned to primary care providers in consultation with behavioural health specialists for group 1; one of the specialty sectors for consumers with either severe mental illness or severe substance abuse, in collaboration with the mental health sector for group 2 and the addictions sector for group 3; and a joint set of providers providing integrated care to the most disabled consumers for group 4.

The benefits of linking addictions and primary medical care have been identified at the patient, provider and societal levels (Samet et al., 2001).

Patient perspective:

- Provides benefits from overall care.
- Facilitates access to substance abuse treatment for patients in medical care settings.
- Enhances access to primary medical care for clients receiving substance abuse treatment.

Linking primary and addictions care offers benefits at consumer, provider and societal levels

- ∞ Improves patients' well-being, reducing the severity of substance abuse and medical problems.
- ∞ Provides care that is more convenient.
- ∞ Increases patient satisfaction with health care.

Primary care providers' and mental health care providers' perspective:

- ∞ Promotes screening for alcoholism in patients.
- ∞ Facilitates inclusion of alcoholism and drug abuse when a differential diagnosis is considered.
- ∞ Broadens access to the overall substance abuse treatment system.
- ∞ Improves prevention of relapse into alcoholism and drug abuse.
- ∞ Encourages mental health services for primary care patients.
- ∞ Improves adherence to appointments and medical regimens.
- ∞ Provides substance abuse training for staff.

Substance abuse providers' perspective:

- ∞ Improves substance abuse treatment outcomes.
- ∞ Reduces medical providers' perceived stigma associated with substance abuse.
- ∞ Provides training in substance abuse-related medical conditions.
- ∞ Promotes overall healthier behaviour (e.g., improves smoking and sexual habits).
- ∞ Improves medical providers' appreciation of substance abuse treatment.
- ∞ Creates support for parity in reimbursement for substance abuse services.
- ∞ Develops ongoing quality improvement in substance abuse programs.

Societal perspective:

- ∞ Reduces health care costs and overall long-term costs.
- ∞ Diminishes duplication of services and administration costs.
- ∞ Improves health outcomes in specific populations.

Serving children and adolescents with mental health needs in primary care

A number of international articles (Wells et al., 2004; DeBar et al., 2001; Zygowicz and Saunders, 2003; Garralda, 1998, 2001; Kramer and Garralda, 2000; Bower et al., 2001; Walker and Townsend, 1998) deal with the mental health needs of children and adolescents, making

Needs of children and adolescents for mental health care are high

the case for detection, treatment and prevention delivered within primary care.

Authors of these articles cite epidemiological evidence and highlight the level of need among children and adolescents:

- Incidence of mental disturbance is one in ten in the general population of children (Bradley et al., 2003).
- The prevalence of psychological disturbance among adolescents is 15 per cent (Walker and Townsend, 1998). Morbidity is increasing for all aspects of health during adolescence (Jacobson et al., 2002).
- Many adult mental illnesses — obsessive-compulsive disorder, panic disorder, antisocial disorder and schizophrenia — have their onset in adolescence; adolescent suicide rates are high, especially for males (Jacobson et al., 2002).
- For two to five per cent of children who attend primary care, mental health issues are the main presenting complaint (Garralda, 1998). This percentage increases when others who have psychosocial issues are included in the counts (Garralda, 1998).
- Depression is increasing among children and adolescents, paralleling the trend in adults; as many as 25 per cent of adolescents have had a least one depressive episode (Jacobson et al., 2002; Wells et al., 2001).
- Children with disorders are higher users of medical services. Oppositional defiant disorder is the most prevalent disorder among preschoolers, whereas school-aged children and adolescents present most often with emotional rather than conduct disorders (Garralda, 1998).

Primary care is an important setting for serving children and adolescents with mental health needs for these reasons:

- Most children are seen in primary care (Kramer and Garralda, 2000).
- The overall number of children with mental health problems served in specialty mental health programs is small; a large number of children go untreated (Garralda, 2001; Cockburn and Bernard, 2004).
- Poor mental health among adolescents has been linked with behaviours that can damage physical health over the short- and long-term, and with mental health problems in adulthood (Walker and Townsend, 1998).
- “[R]ecent meta analyses show that opportunities for prevention and early intervention are more extensive in childhood than

Primary care is a logical setting in which to deal with the mental health needs of children and adolescents

adolescence, and that enhancing individual skills and building social protective factors may be as important as diminishing individual risk factors” (Birleson et al., 2000, p. 38).

- ✎ Children in the child welfare system have high needs for mental health (Burns et al., 2004; Jacobsen et al., 2002) and physical health care (Blatt et al., 1997).
- ✎ Additional risk factors associated with mental illness in adolescence include parental disharmony and divorce, physical and sexual abuse, bullying, family history of mental disorder, relationship problems, lower socio-economic status and poor educational attainment (Jacobson et al., 2002).

A number of publications discuss the importance of the continuum of child and adolescent primary mental health care:

- ✎ Identifying mental health problems early (Bower et al., 2001), and perhaps including screening (Zygowicz and Saunders, 2003).
- ✎ Identifying and attending to children with a disorder (Garralda, 2001).
- ✎ Offering appropriate interventions and treatments for milder disorders (Garralda, 1998; Bower et al., 2001).
- ✎ Referring to specialist services (Garralda, 2001).
- ✎ Supporting the work of specialist services and families after recovery or during relapse (Garralda, 2001).
- ✎ Pursuing health promotion and prevention of problems (Bower et al., 2001, Birleson et al., 2000; Walker and Townsend, 1998; Garralda, 2001; Jacobsen et al., 2002), prevention resources (Walker, 2003), and primary and secondary prevention for adolescents (Walker and Townsend, 1998).

Providing services within primary care has these advantages (Kramer and Garralda, 2000):

- ✎ The general practitioner often has knowledge of the family and its circumstances over time.
- ✎ General practice is seen as less stigmatizing.
- ✎ Consumers prefer this option.

However, the ability to meet the mental health needs of children and adolescents within traditional primary care settings is limited by a number of factors. In a study of a sample of 324 general practitioners, Cockburn and Bernard (2004) found gaps in physicians’ self-reported mental health knowledge, skills, competency and training:

Emphasis should be on early identification, development of appropriate interventions, involvement of the family, and prevention and mental health promotion

Primary care practitioners need more training to deal with children's and adolescents' mental health problems

Learning about roles in the full continuum of child and adolescent mental health care is needed

More evidence is required to determine efficient and effective treatment

Collaborative care has the potential to increase effectiveness, reduce duplication in service, and promote shared responsibility and decision-making

- Many respondents rated their competence when treating three age groups of children as less than satisfactory, and felt least confident about dealing with preschool children's mental health issues.
- Their competence varied with the type of problem: more general practitioners perceived themselves as less able to deal with disruptive behaviour disorders and eating disorders.
- Perceived knowledge was rated less than satisfactory for the nature, course and treatment of children's and adolescents' mental health problems.
- Few respondents rated the training they received as useful. They requested more training for a wide variety of topics such as the use of psychotropic medications, treatment and management of child and adolescent problems, assessment of suicide risk, and eating disorders.

These gaps in knowledge, skills and competency create uncertainty about what constitutes appropriate referrals to secondary-level child and adolescent mental health services, and limit treatment of problems that may be managed within primary care. Mildred et al. (2000), in their report on an Australian pilot project, suggested that establishing specific links between consumers in a public child mental health program and family physicians increases the opportunities for shared care.

There are many questions about possible effective interventions for children and adolescents in primary care. In one systematic review, Bower et al. (2001) found the lack of evidence for efficient, effective programs was stark. They commented that preliminary evidence from many weak studies showed that treatment by specialist staff working in primary care was effective, but no data were available about its cost-effectiveness. Additionally, some educational interventions aimed at increasing the skills and confidence of primary care staff were promising, but few controlled evaluations were done and few reported changes in professional behaviour. Overall, little about the process of implementing different models in regular practice settings is reported (Macdonald et al., 2004). The consensus among many authors is that a significant program of research and evaluation is required in this area.

Discussions about collaborative primary mental health care for children and adolescents are apparent in a few jurisdictions (e.g., England and Australia), and in adjacent sectors calling for expanded partnerships (e.g., education). Generally speaking, these advocates for collaborative care cite many of the same reasons for a collaborative approach to primary mental health care for children and adolescents as for that for adults or other specialty groups (Flaherty et al., 1998):

- ∞ Placing the emphasis on reaching out effectively to people.
- ∞ Reducing duplication of costly and scarce services — a benefit to funders.
- ∞ Increasing the quality of care by applying the broader experience of a number of professionals to the development of a more effective treatment plan.
- ∞ Encouraging shared decision-making and responsibility among providers.
- ∞ Increasing and enhancing communication and negotiation.
- ∞ Having peer supervision and support networks.
- ∞ Increasing sensitivity to other providers.
- ∞ Creating a broader awareness of clinical and ethical issues.

There are six models for collaborative approaches with children and adolescents that mirror those used with adults and may strengthen the role of primary care:

Many models are possible

1. Increased management by primary care and community professionals such as family physicians and public health nurses (Bower et al., 2001).
2. Management by specialist mental health professionals working in primary care (shifted outpatient clinics) (Bower et al., 2001; Garralda, 2001; Kramer and Garralda, 2000; Appleton and Hammond-Rowley, 2000; Abrahams and Udwin, 2002).
3. Consultation–liaison approaches in which the specialist supports management by primary care practitioners rather than takes responsibility for individual consumers (attachment models) (Bower et al., 2001; Garralda, 2001; Kramer and Garralda, 2000).
4. Primary care interdisciplinary team approaches (Kramer and Garralda, 2000, Bower et al., 2001, Gale and Vostanis, 2003).
5. Single primary mental health workers within a child and adolescent mental health service offering all aspects of care to a defined population or selected aspects (e.g., consultation, training and liaison) to a larger population (Gale and Vostanis, 2003).
6. Family support teams that include members of health, education and social work disciplines, and span three agencies — all working under one operational manager (Walker, 2003).

Bradley et al. (2003), in their study of provider trusts in the United Kingdom, examined the availability and frequency of work at the intersection of primary care with child and adolescent mental health care. They found that although a majority of trusts (124 of 150 surveyed) had joint training and education with primary services, only one-third had implemented any type of joint programs or collaborative work. The small

percentage of formal programs in general practices involved structured clinical consultation, joint casework or shifted outpatient clinics. Of all of these, workers in this last option spent the highest average time with consumers, although they reached fewer.

Macdonald et al. (2004), in a more in-depth study of six trusts, found three models of organizing primary mental health care workers: outreach from the specialty service managed by the child and adolescent mental health team, services based in primary care with some contact with the specialty service, and teamwork managed independently of primary care or the specialty service. These factors, which emerged from this study and influenced implementation, may be important to consider for other applications:

- Focused preliminary negotiation and planning with primary care staff to set up positions for primary care workers.
- Flexibility in the mix of direct work and consultation–liaison in the early stages of service development to create good working relationships and goodwill.
- Accommodation for workers close to the primary care staff.
- Good interpersonal skills of workers involved in service development, and education and preparation for effective provision of advice and support.

Rural populations

Supporting collaborative mental health care in rural communities requires an understanding of the broader challenges of delivering health and mental health service outside of urban settings. These challenges have been discussed in the mental health literature. A number of authors (Ryan-Nicholls et al., 2003; McCabe and Macnee, 2003; Badger et al., 1999, Fuller et al., 2004) highlight these points:

- Rural health care needs are no less diverse than those in urban settings.
- Typically, access to and provision of an adequate range of health care services is much more difficult.
- Rural residents have more injuries, are in poorer health, have more chronic diseases and perceive themselves to be less healthy than their urban counterparts.
- Rural residents have inadequate access to health care resources and higher rates of rural hospital closures.
- Many rural areas have a shortage of primary care physicians and psychiatrists.

Mental health care needs in rural communities are higher than those of urban communities

Resources to respond to mental health needs are lacking

- ∞ Rural communities suffer during economic downturns, and residents feel they have lost control over their own lives and communities, often with serious acute, chronic psychological and behavioural consequences that go undiagnosed.
- ∞ Rural settings are less likely to have mental health services, and if services do exist, the range is narrow and care is often delivered by nonprofessionals.
- ∞ Geographic isolation from centres where mental health services are available is a significant barrier.
- ∞ Stigma about mental illness is often higher in rural communities. There is a lack of anonymity when everyone knows one another, so people avoid being perceived as having a mental health issue. For example, they do not want to enter a stand-alone community-based mental health program.
- ∞ A lack of specialized mental health support services in rural communities may cause those with high needs to move to urban centres where supports are available.

Badger and colleagues (1999) report some additional challenges:

- ∞ For primary care physicians who do diagnose consumers with mental health problems, questions remain: Who will treat the person? What treatment will be offered? Where will that treatment will take place?
- ∞ Some studies have found rural residents are more resistant to referral.
- ∞ Long waiting lists, having to travel to specialist services and inadequate follow-up are also barriers.
- ∞ Rural residents may not see their problems as being psychiatric, and they do not want treatment that focuses on psychiatric symptoms.
- ∞ Rural residents prefer to be cared for in primary care settings because of their more inherently holistic view of mental, physical and social conditions.
- ∞ Rural residents value their independence and privacy.

Three articles present approaches to integrated mental health care in rural settings, two are conceptual and one is based on a study in the American Veterans Affairs' health care system. Badger et al. (1999) propose the integration of psychosocial services into rural primary care practices by employing social workers skilled in psychosocial interventions. The authors recommend that primary care physicians provide leadership to oversee this implementation at the local community level since this service is in the best interests of the

More health care professionals are needed at the frontline of primary care

Leadership for change and staff attitudes have an impact on the successful implementation of collaborative programs in rural areas

consumers in need and overburdened physicians. McCabe and Macnee (2003) propose a model of advanced practice nursing to care for rural residents with mental illness and their families. This model emphasizes the use of community networks of informal helpers, medical providers, faith communities, police, pharmacists and others. Of particular interest are the three stages of the integration model, each of which illustrates partners in care coming together to better serve the consumer. These stages reflect the key dimensions of physicality, structures (e.g., interpersonal relationships, communication, provider mix, point of access to providers, information management), and provider roles and recipient roles of care.

Kirchner et al. (2004) analyzed the implementation of an integrated model of care in two separate Veterans' Affairs rural outpatient clinics where trained advanced practice nurses were placed to provide mental health and substance abuse care. The approach was successful at only one site. Analysis of qualitative data, collected through a series of interviews with key personnel in both locations, revealed a number of key contextual and organizational factors that influenced the success of the innovation. Leadership for internal change, and staff attitudes and beliefs were critical contextual variables. Organizational characteristics of the clinics and the local communities were also influential. The successful implementation had these characteristics:

- A consistent champion of internal change over the duration of the project.
- Staff who believed that depression could be successfully treated in primary care and that adding a qualified staff member would help more consumers with mental health and addictions issues get treatment.
- Positive attitudes about the type of person to fill the position (persons with appropriate personality traits and the ability to fit in).
- Accountability of the person in the position to senior clinical staff, clarity of the role and focus on that work (i.e., not taking on additional nursing responsibilities unrelated to mental health addictions treatment).
- Regular involvement in meetings and collaborative management of consumer care characterized by equal participation of providers.
- Openness to change.
- Malleable formal and informal power structures.

- ✎ Recognition of the limitations to the safety net within the community and thus the need to respond to issues within the clinic setting.

Four articles from Australia offer creative approaches to rural primary mental health care. Malcolm (2000, 2002) documents positive outcomes for consumers, physicians and the community at large for an inexpensive shared care program employing a psychiatric nurse working in general practices and in the community. Unique here was the nurse's multi-faceted role, which included direct consumer counselling; education for other human services professionals, community groups and the general public; upgrading family physicians' counselling skills and primary care staff's ability to identify and refer consumers for mental illnesses; and research. Notably, when funding for the project was in jeopardy, the community supported the continuation of the position, based on their perception of the program's value.

Judd et al. (2004) reported on efforts in rural Victoria where separate mental health education programs were brought together in an integrated approach and were used to establish a stepped collaborative model of care. The education program's underlying principles were evidenced-based approaches to care, integration and continuity of care. The program also acknowledged the general practitioner's central role in the management of consumers with mild-to-moderate mental health problems. Training needs of general practitioners and other clinicians were linked to develop a system-wide language for and approach to treatment. The stepped program offered skills upgrading and support for general practitioners.

Fuller et al. (2004) describe a community development process with rural stakeholders to improve primary mental health care strategies in another rural area. Findings confirmed hypotheses that access to service, acceptability of providers and teamwork were difficult issues for the delivery of rural mental health services. One barrier to the integration of care was the different organizational approaches to providing care: doctors were self-employed and worked alone or in group practices, and mental health teams were salaried employees of the state. Collaboration was encouraged through the development of new partnerships and joint definition of roles and expectations of all stakeholders. A new umbrella structure made all relevant providers members. The goals for this group were to break down rigid boundaries between providers, encourage staff to identify with new working arrangements, provide system planning for a wide range of mental health needs and leadership through a new system coordinator for mental health and primary care, and support local human services workers (who are often the first point of contact in

Rural responses to needs
emphasize practicality

Depression in seniors has been the subject of much research

rural communities for people having a mental health crisis) through the operation of local networks.

Serving seniors with mental health needs in primary care

Most of the literature about mental health needs in primary care is about the treatment of depression. Considerable attention has been paid to the needs of older adults and, most recently, to collaborative approaches to care for late-life depression. Surprisingly, no articles about primary care for dementia emerged in the literature search. At least four review articles provide comprehensive examinations of depression (see Callahan, 2001; Oxman et al., 2003; Schwenk, 2002; Speer and Schneider, 2003). Other publications from around the world discuss the mental health needs of seniors and report examples of other collaborative care models.

The incidence and prevalence of mental health disorders in seniors has been cited in the literature. Callahan (2001) notes that in the United States, 12 per cent of the total population are seniors, two million of whom are older adults suffering with depressive illnesses; seniors account for 20 per cent of 30,000 suicide deaths annually (see also Luoma et al., 2002). Of those seniors seeking treatment, depression accounted for 16 per cent of 500,000 hospitalizations; people older than 65 years of age spent \$700 million on three top-selling psychotropic medications. Crawford et al. (1998) note prevalence rates of up to 16 per cent for the United Kingdom where depression is the most common psychiatric disorder in seniors. Gallo and Coyne (2000) note that the current worldwide aging of the global population will mean an increase in the number of seniors suffering with depression.

The needs of seniors for mental health care are well documented, as are the challenges primary care providers face to meet these needs (e.g., Ólafsdóttir et al., 2001). Late-life depression results in functional impairment that affects both quantity and quality of life (Callahan, 2001; Gallo and Coyne, 2000; Schwenk, 2002). Such depression often complicates the treatment of other medical conditions (Callahan, 2001; Fisher et al., 2003; Schwenk, 2002) and is often concomitant with many conditions, such as dementia, stroke, Parkinson's disease, myocardial infarction, and hip fracture (Callahan, 2001).

Challenges to caring for seniors who experience depression have been widely discussed. These are some examples:

- ✎ The misconception that depression is a natural consequence of events associated with aging, leading to the possible conclusion

that treatment may not help (Gallo and Coyne, 2000; Schwenk, 2002; Unützer et al., 2001).

- ∞ Time pressures within primary health care settings that do not allow for treatment when longer appointments may be required (Oxman et al., 2003; Unützer et al., 2001).
- ∞ The inclination of both doctors and consumers to focus on presenting symptoms and acute problems rather than to investigate underlying problems (Gallo and Coyne, 2000; Oxman et al., 2003).
- ∞ The limits of reimbursement that prevent accurate coding and billing for mental health care (Oxman et al., 2003; Schwenk, 2002).
- ∞ The lack of parity in mental health insurance, which affects primary care physicians' ability to provide a full spectrum of fully reimbursed care similar to that for other chronic diseases (Schwenk, 2002).
- ∞ Stigma experienced by older consumers that prevents effective health care-seeking behaviour and accurate reporting of symptoms (Gallo and Coyne, 2000; Schwenk, 2002).
- ∞ Like other groups, seniors' preference for treatment in the primary care setting and potential reluctance for referrals to specialty mental health programs (Callahan, 2001).

Service approaches to treating the elderly in primary care settings are discussed in a few articles. Raymond et al. (2004) describe the development of a seniors' mental health service in the Australian Capital Territory. The initial development of a consultation-liaison model for general service providers, which was staffed by one part-time psychiatrist and one full-time nurse with experience in old-age mental health, evolved into a more collaborative, multi-disciplinary shared care model over time.

To answer the question about where best to treat older people with mild depression, Arthur et al. (2002) conducted a randomized control trial of the effective management of older people in primary care. All participants underwent a health checkup that included testing with a geriatric depression scale. Those at or above a threshold score were assigned to follow-up assessment by a community mental health team or usual care by a general practitioner. Follow-up care did not effectively improve outcomes for mildly depressed consumers. The authors recommended that mental health specialists work with general practice staff to improve care directly in the primary care setting.

Only one paper discussed the issue of addictions issues in older people and medical settings. In reviewing three addictive disorders, smoking, excessive consumption of alcohol and gambling, Stewart and Oslin (2001)

Since seniors prefer to be treated in primary care settings, the emphasis should be on specialist care working with primary care to improve treatment

pointed out the opportunities for extending or improving treatment for each of these conditions in primary care. Overall, they recommended that behavioural health specialists work within primary care settings to coordinate and provide assessments and treatment services as part of a comprehensive collaborative approach.

Oxman et al. (2003) review in detail three generations of health service research about collaborative care to meet the needs of depressed consumers in primary care settings. The first generation of research illustrated that collaborative care involving an on-site mental health specialist and primary care clinician overcame many of the systemic barriers to care, and improved the quality of care provided and the outcomes for consumers with major depression. At this point, questions were raised about the high cost and intensity of this approach to collaborative care. A second generation of randomized control trials introduced the concept of chronic disease management and explored such additions as physician and consumer education, consumer registries, and on-site nonspecialist health providers to extend service supervised by a mental health specialist. Generally speaking, this model increased the frequency of consumer contact, provided closer monitoring of outcomes and adherence, and facilitated referral to the primary care level for consumers with adverse outcomes. Overall, these studies showed that the use of treatment guidelines integrated into a practice with a multi-pronged and longitudinal treatment approach, and intervention practices are superior to usual care. They resulted in better treatment adherence, outcomes and consumer satisfaction. These issues, however, were still outstanding: How could findings from trials be translated into real community practice and maintain a strong effect? How well would these interventions apply to older adults? How could the difference between the results from efficacy trials be translated into effectiveness trials when the research is conducted in nonacademic settings?

Many of these observations are supported in other review articles, including those of Callahan (2001) and Schwenk (2002).

The latest generation of trials focuses specifically on older adults and the delivery of collaborative primary care. Four major system-oriented studies that are underway in the United States are summarized in the review of Oxman et al. (2003) and many related publications retrieved in the current literature search.

The trial Primary Care Research in Substance Abuse and Mental Health for the Elderly compares the use of services, outcomes, and costs of integrated and enhanced referral models of mental health care for seniors with depression, anxiety or at-risk alcohol use in ten

Four major research trials focus on seniors' depression care

health care organizations and 30 practice sites. In their report on the trial, Bartels et al. (2004) found that more consumers, regardless of their problem, were treated in the integrated model than in the enhanced referral group and that integrated care was associated with more visits about mental health and substance abuse per consumer. Integrated care and higher mental distress because of depression and alcohol use predicted greater engagement in care. Greater engagement was also associated with the closer proximity of mental health and substance abuse services to primary care.

The Improving Mood: Promoting Access to Collaborative Treatment (IMPACT) study combined collaborative and stepped care for seniors with depression, and incorporated brief psychotherapy and medication management (see Unützer et al., 2001, for a detailed description of the study's design). Results reported for both older adults (Unützer et al., 2002) and older adults with arthritis (Lin et al., 2003) affirm that the collaborative model seems more effective than usual care in both instances. In their qualitative study, Oishi et al. (2003) explored the integration of the IMPACT model into various primary care cultures from the perspective of depression care managers.

Prevention of Suicide in Primary Care Elderly: Collective Trial, or PROSPECT, study, a trial funded by the National Institute of Mental Health, was designed to assess whether treatment of depression in primary care settings could reduce the risk of suicide for seniors. In the treatment arm of the study, a manager of depression care facilitated adherence to a depression treatment algorithm. A series of articles about key aspects of the trial were published in 2001 in volume 16 of the *International Journal of Geriatric Psychiatry*:

- ✎ A discussion of interventions for depressed elderly primary care consumers (Alexopoulos and the PROSPECT Group).
- ✎ Early lessons of the study about the use of a broader strategy for identifying depressive disorders in older primary care patients to include those with depressive symptoms and those who report taking psychotropic medication or having a history of depression (Coyne et al.).
- ✎ Factors in the selection of instruments for use in primary care settings (Raue et al.).
- ✎ The study's sampling approach (Coyne et al.).
- ✎ The health specialist's role in managing depression care in the primary care setting (Schulberg et al.).
- ✎ Development of the treatment algorithm for the study (Mulsant et al.).

- Development of risk-management guidelines for older suicidal consumers in primary care (Brown et al.).

Reynolds (2003) also provides an overall description of the study. To date, study findings have not been reported in peer-reviewed journals, although Oxman et al. (2003) comment that preliminary findings revealed that the depressive symptoms of consumers given care management were more quickly reduced — both their response to the treatment and the remission of their depression.

Finally, *Reengineering Systems for Primary Care Treatment of Depression* examined a three-part clinical model for primary care management of depression and a practice-change model to support local use of the clinical model. The model was applied to diverse health care organizations in three phases. Oxman et al. (2003) and Dietrich et al. (2004) report that preliminary findings of system use and program modifications demonstrated strong clinical participation and excellent short-term clinical response rates. Phase two results will examine whether the practices maintain systemic changes and whether the changes spread to additional practices beyond those participating in the trial.

Oxman et al. (2003), in a collective summary of these controlled trials, note that system changes produce better outcomes for older consumers than usual care for depression in a wide range of primary health care settings. Although treatment in specialty mental health care might provide more intensive and expensive treatment, and possibly superior clinical outcomes, the authors note that older and younger consumers are more likely to accept treatment of depression if it is available in primary care. Some of the program's features could be implemented in a majority of primary care practices supported by specialty mental health care providers working in consultative and supervisory roles. Factors required to support system change include strong administrative support, physician leadership for the change and availability of credible data for feedback.

Other special needs groups

Few articles in the literature examine mental health and primary care for other special needs groups. In their review of the health needs of people who are homeless, Wright et al. (2004) describe the principles of best practice for the management of their common health problems and identify a number of obstacles to serving this group, among them, the medical practices' hours of operation, appointment procedures, location, financial disincentives and discrimination. The authors support the development of specialized primary care programs for homeless people,

Homeless people in larger urban centres need specialized and integrated primary care programs

when feasible, in larger urban centres that employ a dedicated general practice liaison and resettlement worker. Further, the policy statement of the Royal College of General Practitioners in England about homelessness and primary care recommends that primary care organizations provide resources for ongoing homeless services; collect data about the number of homeless people in their service area; and promote interagency links and the development of protocols and operating procedures that support integrated working and coordinated care. Additional linkages should include housing, social services and voluntary organizations that could serve this population.

Holleman et al. (2004) describe such a collaborative model for homeless people that was developed in a transitional living centre in Houston, Texas. The number of problems and barriers homeless people experience necessitates creative and collaborative approaches. This model had four components that were administered by mixed teams of professionals:

1. Achieving Independence and Medical Empowerment, a psychoeducational support group for consumers with chronic illnesses and disabilities, co-facilitated by a family physician and family therapist.
2. Building Better Families, a family-of-origins class, taught by family psychologists, family therapists and family practice residents.
3. Family Health Coaching, a program of family health screenings and coaching, combined with case management and family therapy.
4. Collaborative Medication Management, a program in which a family physician and family psychologist supervise a medication management program.

Collectively these innovative programs had beneficial effects on both the participants and the professionals.

Similar needs are noted for people with HIV, especially women and people of colour. Dodds et al. (2000, 2004) reported on the Whole Life project that integrates mental health and primary HIV care for women. The project was the result of collaboration between the departments of psychiatry, and obstetrics and gynecology at the Miami School of Medicine. The strength of this program lies in its process: a theoretically derived model was first developed, then implemented and evaluated with a group of women of colour. This project clearly demonstrated that principles of and strategies for implementing the integration of service can be applied successfully to a clinically complex population.

People with HIV also need integrated program approaches to meet their high needs

Ethnic groups require collaborative care that is sensitive to, knowledgeable about and specific to various cultures

Similarly, in their report of the use of psychiatric services integrated with primary care for people with HIV in a community medical clinic in New York City, Budin et al. (2004) found that culturally responsive psychiatric services integrated with primary care better meet the needs of consumers with multiple diagnoses. Broader psychiatric interventions are required, along with medical interventions. The results of the work of Hoffman and colleagues (2004) planning the combined HIV, hepatitis and addictions care program conducted in Massachusetts concurred that integrated approaches can promote greater efficiency, and improved communication and coordination among consumers, providers and funding agencies.

Collaborative care with specific ethnic groups, such as Chinese immigrants, requires an in-depth understanding of cultural issues. Yeung et al. (2004) discuss a collaborative mental health primary care program designed to improve referral to the program and acceptability of its treatment among Chinese Americans in Boston. This program, a replication of the Bridge Program originally implemented in New York City, involved a training module to enhance primary care physicians' recognition of common mental illnesses, cultural sensitivity training for the nurses and doctors, use of a nurse as the bridge or care manager to overcome structural barriers between primary and behavioural health care, and an on-site liaison psychiatrist. Although this program successfully increased referrals to mental health services and study subjects' compliance with treatment, compared with the rates of the previous year, the overall rate of consumers going for treatment remained very low at five per cent.

In a related editorial, Hollifield (2004) questions why people of Chinese descent use fewer mental health services and highlights a number of cultural barriers to care that must be taken into consideration:

- ☞ The explanatory model of illness: how a particular culture views mental illness.
- ☞ The threshold to seek care: under what conditions a person will seek help and from whom.
- ☞ Language barriers: often insufficient straight translation; need for semiotic explanations; potential problem with the translator not revealing all symptoms, if from the same close-knit community.
- ☞ Stigma.
- ☞ Rational mistrust of authority, especially among people who have experienced war or political oppression.

The author (Hollifield, 2004) proposes a new paradigm for collaborative care for people of Chinese descent or other immigrants that

challenges Western cultural elements, including the mind–body dualism, and increases the number of “bi-directional bridges so that physicians and other health care workers are willing and able to walk into the world of the patient as well as having the patient brought to them ... facilitating models that have the capacity to integrate and use various medical and business paradigms instead of relying solely on current models that first manages care and then, regardless of co-location, separates it out into ‘medical’ and ‘psychiatric’” (Hollifield, p. 254).

Chapter Summary

These points recapitulate the essence of consumer centredness presented in this chapter:

- ✧ Consumer centredness is key to collaborative mental health care. A true partnership should exist between consumers and providers. Consumers should be recognized for their expertise, and involved in negotiations about their individual care, and in the planning and management of services offered.
- ✧ These strategies may strengthen the consumer voice: listening to consumers, raising awareness and declaring differences, encouraging a different kind of power, forming coalitions and valuing dialogue, and preparing to be enriched and enriching.
- ✧ Consumer centredness also means adapting collaborative care to suit the needs of special consumer populations: for example, consumers with serious mental illness or concurrent disorders; and rural populations, seniors, and children and adolescents with mental illness.

Chapter 5:

ACCESSIBILITY

KEY MESSAGES

- *Improving access to mental health care for consumers with common mental disorders is a key benefit of collaborative care.*
- *Benefits to consumers include providing a full range of health care services close to home in the primary care setting, integrating care so that consumers' undifferentiated biological and psychological distress can be treated holistically, and removing the stigma from the normal setting for all.*
- *The many benefits of collaborative care for providers and local systems range from improving the quality of care by focusing on the functional status of consumers rather than on their symptoms only; providing greater continuity of care due to lower turnover of primary care personnel; increasing efficiency by reducing unnecessary or inappropriate referrals to specialty care; sharing the burden of care among professionals; and increasing the range of possible response.*
- *At the level of the broader health care system, collaborative care increases the opportunities for prevention in primary and mental health care, provides earlier access and treatment, makes effective use of health professionals, increases the likelihood of achieving parity between the treatment of mental disorders and the treatment of other health conditions, increases the intrinsic value of breaking down barriers between disciplines and views health holistically.*
- *Despite a lack of consensus about a best model, the conceptual frameworks for collaborative care described in the literature share a common goal — to increase understanding about the integration of discrete disciplinary approaches to improve service for common mental disorders and produce better health outcomes.*

Accessibility means being attainable. In the context of collaborative care, this means making access to mental health care in the primary care setting easy for consumers with a broad range of mental health needs. The need for this accessibility in the primary care setting is well documented: around the world, people with common mental disorders are not getting the treatment and support they require to improve their mental and overall health. The relevant literature raises many discussion points for improving access: Why integrate primary and mental health care? What are the best approaches to integration? Specifically, which collaborative models should be included?

Many people with common mental disorders lack access to care

Integration of care means sharing responsibility for assessment and treatment, and providing multiple approaches to consumers' problems to make them healthy

Benefits have been demonstrated at many levels

What levels of care and continuums of mental health and health care should be offered?

Rationale for Integration

The rationale for integrating primary and mental health care is a frequent subject of the literature. Typically, these discussions highlight positive reasons for supporting integration because of the great need for mental health care within the primary care setting and the need to overcome the barriers to such integration. Blount (1998b,c) and Lester et al. (2004) discuss how the integration of primary and mental health care transcends the traditional cross-boundary work of these two health care sectors. "In practical terms an integrated approach to primary mental health care involves breaking down the interface boundaries with services that are traditionally provided by secondary care, led by staff employed by or working in a primary care setting and utilizing many of the strengths of primary care. It also encourages a new way of thinking about mental health" (Lester et al., 2004, p. 288). Blount (1998b) defines integrated care as care that unifies medical and mental health care in a primary care setting and avoids the mind-body dichotomy. Integrated care goes beyond collaborative care and good communication at the intersection of primary and mental health care to the coordination of care and integration of service delivery in one setting.

Reasons for integration may be clustered into three broad categories: the consumer, the local system or community, and the broader system.

Benefits for consumers

Holistic care can be provided: Primary mental health care has the potential to treat multiple dimensions of consumers' problems in one place: many consumers come to primary care with mental health issues, although they may not be aware that their problems are psychological or mental (Peek and Heinrich, 1998). The majority present their distress to their primary caregivers as undifferentiated biological or psychological problems (Blount, 1998c). Consumers' mental health needs are not perceived as isolated from the physical, the social and the spiritual (Bazelon Center, 2004).

Access in a preferred nonstigmatizing environment is possible: Consumers and their families prefer treatment in primary care settings rather than in secondary care (Nolan and Badger, 2002b). People are more satisfied with care in integrated settings (Blount, 1998c; Bazelon Center, 2004). Primary mental health care provides consumers with easy access to services (Nolan and Badger, 2002b). Consumers find that their needs are

met in a nonstigmatizing way (Jenkins and Strathdee, 2000; Nolan and Badger, 2002b).

Many consumers with mental health problems are not seen in specialty care. For those with problems that are clearly psychological or psychiatric, such as depression or anxiety, primary care is the dominant locus of treatment (Dea, 2000; Mauer/National Council for Community Behavioral Healthcare [NCCBH], 2003). Primary mental health care provides good care for consumers who may not be able to see a specialist. In rich countries, these consumers are those with common mental disorders. In poor countries they are a majority of the population, including those with psychoses (Jenkins and Strathdee, 2000).

Collaborative care improves access to behavioural health care for people with chronic health conditions (Mauer/NCCBH, 2003). Consumers benefit because family physicians are well placed to provide long-term follow-up and support (Jenkins and Strathdee, 2000).

Quality of care and outcomes are improved: The quality of care for medical conditions for consumers with serious mental illness is improved (Bazelon Center, 2004). Targeting stepped-up care and support for preventing relapses for those treated for depression improves quality of care (Mauer/NCCBH, 2003). Appropriate recognition, medication and management of co-occurring physical and psychological problems improve the safety of treatment (Bazelon Center, 2004).

Treatment responses that better fit the consumers' distress result in better adherence to treatment (Blount, 1998; Bazelon Center, 2004).

Consumers' outcomes are better because their care is improved by the consistent communication among team members and the coordination of clinical care, according to needs that are characteristic of collaborative care (Dea, 2000).

Collaborative care improves the quality of care because primary care personnel focus their concern on the functional status of consumers, rather than merely on their symptoms (Nolan and Badger, 2002b).

Benefits for providers

Integrated care unburdens family physicians: Even when trained in psychiatry and counselling, primary care physicians should not be expected to deal with the entire array of problems consumers present (Blount, 1998c).

Job satisfaction is increased: General practitioners have more job satisfaction when they work as part of an integrated team (Blount, 1998c).

Family physician skills are improved: Collaborative primary and mental health care is the best way to potentiate primary care physicians' skills to deal with the psychological aspects of primary care. Regular involvement in teams engaged in the transference of expertise hones the skill sets of all practitioners involved. They train each other. In working together to respond to a consumer's need, they become more willing and able to respond to a wider range of mental health problems (Blount, 1998c).

Benefits at the broader system level

Opportunities for prevention are increased: Opportunities for prevention are very great when mental health and primary care are integrated. Interventions are generally based on reducing risk and strengthening protective factors because usually patient risk factors are recognized and illness is detected in primary care, and because a majority of consumers treated in primary care have some common mental health issue (Jenkins and Strathdee, 2000).

Collaborative care maximizes access: For less developed countries, mental health care integrated with primary care is the only hope of providing any care for consumers with mental health issues (Saxena et al., 2002). Integrated care promotes earlier access to care for both physical and behavioural problems.

Primary mental health care is a more efficient, effective use of resources because care is shifted from expensive in-patient settings or outpatient clinics to community-based family practices (Nolan and Badger, 2002b; Bazelon Center, 2004).

Primary mental health care is a more efficient, effective use of resources because care is shifted from expensive in-patient settings or outpatient clinics to community-based family practices (Nolan and Badger, 2002b; Bazelon Center, 2004).

Over the long run, integrated care results in breaking even or in cost savings because it redefines how care is delivered. Improvements are found in a number of areas, not just in-patient savings, such as retaining patients as members of a health care plan (as in managed care) and reducing physician turnover. Employers also gain through reduced premiums and reduction in claims for disability days (Blount, 1998c).

In low-income countries where specialty resources are few and in high-income countries where these resources are insufficient, integrated primary mental health care ensures a more efficient deployment of health human resources so that everyone with a significant mental disorder can be cared for (Jenkins and Strathdee, 2000).

Collaborative care meets the needs of special populations: The needs of specific groups such as those with serious mental illness and the broader population are met appropriately in collaborative care (Mauer/NCCBH, 2003). Collaborative care makes expertise in behavioural health care available for the treatment of chronic medical conditions in primary care settings (Griffith, 1998).

Collaborative care decreases perceived barriers between primary care and mental health: Collaborative care promotes true parity between the treatment of mental disorders and the treatment of other health care conditions (Bazelon Center, 2004).

In integrated care, the value of making connections across the disciplines places individual disciplines in a larger context and teaches nonspecialists about specialties. It has potential to overcome the perception that interdisciplinary work is risky and professionally unrewarding by breaking down the disconnection between the scientific community and the broader public, and by eroding the presumed authority of academic medicine over consumers' perspectives (Grazier et al., 2003).

The early lessons of integrated care inform current policy debates about how services should be organized, delivered and financed (Mauer/NCCBH, 2003).

Collaborative care can challenge many myths about mental illness in communities by teaching people about the ubiquity of mental illness and encouraging the general public not to fear those with mental illness, but to recognize the many effective interventions that can assist their recovery (Nolan and Badger, 2002b).

Primary mental health care improves the general efficiency of the traditional system of health care. Typically, primary care physicians provide most of the consumers' care, then refer consumers to other specialties for ancillary treatments. Often, little documentation or communication between primary and specialty care occurs after the referral. Primary mental health care overcomes these communication barriers (Dea, 2000).

Conceptual Approaches to Integration

The wide range of evidence from the literature about collaborative care is not easily summarized. In addition to such schemas as the CCMHI Framework of Collaborative Mental Health Care created for this project, a number of authors have presented conceptual frameworks to accomplish these goals:

Conceptual frameworks are the starting point for increasing understanding of the nature and content of collaborative care

- To promote understanding of current models (Blount, 1998c; Strosahl, 1998; Goetz, 1999).
- To organize the body of evidence (Blount, 2003; Katon, 2003).
- To describe the intersection of primary care and mental health (Paxton et al., 2000).
- To plan for the implementation of collaborative care programs (Mauer/NCCBH, 2003).

Although these frameworks organize the elements characterizing collaborative care differently, some overlap is evident. Overall, their shared goal is to increase understanding about how to integrate the spheres of care to improve the delivery of service and health outcomes for consumers with mental health concerns.

Strosahl's framework

The framework presented by Strosahl (1998) compares collaborative and integrated mental health care on nine points:

1. Mission.
2. Location.
3. Primary provider.
4. Service modality.
5. Team identification.
6. Professional moniker.
7. Referral statement.
8. Philosophy of care.
9. Consumer's perception.

In Strosahl's definition of collaborative care, specialty mental health care is provided, but primary care providers are kept informed about the care. Services are delivered in separate locations or are co-located in the setting, but are set apart from medical services. The therapist is the primary provider of mental health care. The service modality is the therapy session, which may occasionally involve the primary care provider. The primary care staff views this therapist as an outsider — the specialist — and the professional title of therapist is emphasized as being distinct from that of primary care provider. Behavioural health care is outside the context of routine medical care, as reflected in the phrasing of the referral: "Go see a specialist I work with in the mental health wing." Consumers receiving care think that they are getting a separate service from a specialist, albeit one who collaborates closely with their health care provider.

In Strosahl's framework (1998), collaborative care means changing the way professionals work — from side-by-side to working together

On the other hand, integrated care involves the delivery of a primary care service that is focused on behavioural health issues and is delivered in the medical practice area. The primary care provider is the health care provider. The service modality is the consultation session, making conjoint visits with the primary care provider less likely. The behavioural health provider is identified as part of the primary care team. Here the referral statement is “Go see another member of the team who helps out with these kinds of issues.” Thus, mental health care is part of the delivery of general health care, and consumers perceive mental health care as a routine part of their general health care.

Strosahl notes that an integrated program is characterized by vertical integration: targeted psychological services are provided for a well-defined group of patients. The collaborative program, however, is characterized by more horizontal integration: the primary care provider seeks to serve many consumers, based on their wide range of needs.

Blount’s collaborative care continuum

Blount (1998c) conceptualizes collaborative care between primary and mental health care providers as a continuum. He highlights the perspectives of the consumer receiving care and the provider in his scheme, which depicts five levels of care. At the lowest level of integration of care in the continuum, the mental health or primary care professional supports the consumer’s visit to the other professional, and the treating provider provides the referring provider with a courtesy report. At the second level of collaborative care, each provider appears to actively engage and support the work that the consumer does with each provider, and providers make referral calls to exchange information. At the third level of collaboration, providers collaborate on a treatment plan and the referral relationship between providers is developed. The fourth level of care involves both providers meeting with the consumer (and family) to define a treatment plan and providers regularly meet to discuss these cases. Finally, in the most integrated form of collaborative care, each provider presents the unified team response for treatment to the consumer, and providers routinely work together to deliver services.

Blount’s more recent relationship framework

More recently, Blount (2003) has elaborated on his framework to create a method for categorizing the increasing amount of evidence supporting and describing primary mental health care programs. This revised framework is organized along two dimensions: the

In Strosahl’s framework, integrated care means that primary care includes a behavioural health care team member

In his framework, Blount (1998) considers collaborative care to be a continuum

Blount, in his 2003 revised framework, developed schema for sorting out the increasing evidence about collaborative care

relationship of the medical and mental health providers, and the relationship of services to populations. Blount notes that these dimensions are not mutually exclusive categories and that a hierarchy of levels of integration exists. In characterizing the relationship of medical and mental health providers, Blount defines three types of care—coordinated, co-located and integrated:

1. Coordinated care means that providers are situated in different settings, but do exchange some information on a routine basis when the consumer is seen by both providers. The referral process acts as the trigger for information exchange. Possible issues may arise about confidentiality of consumer information, different communication styles of the mental health and primary care providers, and varying expectations about how to provide treatment. This type of relationship between professionals requires a high level of personal commitment and can be time-consuming and difficult to manage. Over time, this type of relationship may prompt changes in both settings.
2. Co-located care occurs when both medical and mental health services are provided in one setting, and office staff and waiting rooms are shared. Intake of a consumer begins as a medical case. The consumer may then be referred to the mental health professional. This process usually leads to further integration over time as each type of provider becomes more aware of what the other can provide and how this can work within the primary care context. Collaboration increases with incidental contact between providers. Typically, co-located care does not result in a decrease in the number of behavioural interventions provided by the primary care provider. However, the provider's satisfaction with providing this care and willingness to approach more psychosocial problems improve because he or she knows that if something comes up that is beyond his or her comfort zone, the mental health professional can see the consumer. Overall, the behavioural interventions provided by the mental health professional and the quality of this care increase. Moreover, fewer people in need of care refuse the referral, particularly if the medical provider provides an introduction to the mental health professional before the next behavioural appointment.
3. Integrated care is defined as the inclusion of medical and behavioural elements in one treatment plan for a specific consumer or population of consumers. Two approaches here are evident in practice, either a team approach in which professionals work closely together, usually serving a well-defined population,

or a prescribed protocol approach, usually defined for a chronic disease, as has been defined for major depression.

Blount also discusses the relationship of services provided to populations served and focuses on three dimensions:

1. Targeted versus untargeted service: Targeted service is aimed at a specific population. Blount notes that randomized control trials offer the most evidence for targeted services. Usually the person these services are targeted to accepts them because they are presented as fitting that person's specific needs. Untargeted service is aimed at any person identified as having mental health needs. Since it is typically presented as an added service because the person has psychological problems, there is a greater risk that the person may reject the referral.
2. Specified versus unspecified care: Specified care means a defined treatment protocol or a set of procedures offered to all people under consideration in a study such as a randomized control trial. Unspecified care is that in which the treatment offered depends on the particular skills and judgment of each clinician. As a result, unspecified care is difficult to compare over settings and providers.
3. Small versus large scope of implementation: Small-scale applications are usually unique programs that operate in very few settings or in a single setting. These programs are usually described as pilot projects that may be tried elsewhere. Large-scale applications, on the other hand, take place across similar settings and are usually centrally designed. These applications require more management because of varying contingencies and personnel in the different settings. Such large-scale projects are difficult to replicate, but are more appropriate for the design of a health care system.

Goetz's framework

Goetz (1999) developed a framework for mapping the relation between primary care and mental health within the managed-care environment so that providers could be sure they were addressing the same issues in their collaboration. This scheme sets up two concepts in a grid: the type of problem and the view or perspective. The type of problem has three possible dimensions:

1. Clinical: for example, who has the decision-making authority over day-to-day care.
2. Administrative: for example, who has the ability to hire and fire providers.

Goetz's framework (1999) presents a map of the multiple perspectives of care

3. Financial: for example, who is responsible for payment.

There are four possible views: those of the consumer or patient, the provider, the agency and the system. The consumer's concerns include "How will I be treated?" "Whom do I see?" and "What will it cost me?" The provider asks "How can I prescribe?" "Do I need to ask permission?" and "Will I get paid for talking with the family?" The agency's questions are "Are there guidelines for brief therapy?" "How do I get more of the provider's time?" and "Who pays for the medication?" System level concerns are "Is treatment of this common mental illness in primary care effective?" "Does shared care lead to fewer complaints?" and "Is there enough funding to pay for it all?"

Katon's framework

Katon (2003) also presents a framework for collaborative care, based on work in the U.S. Institute of Medicine's recent report *Crossing the quality chasm: a new health care system for the 21st century*, which depicts four levels of care in the health care system. Katon correlated the barriers to depression care and related collaborative care trials at each of the four levels:

1. The consumer and community level is the level at which consumer-centred care should help improve consumers' knowledge about illness, respect preferences, provide social context and values, and be equitable.
2. The microsystem level is the level at which consumers are actually cared for by doctors, nurses, medical aides, and other health providers. At this level, care is supported by the laboratory.
3. The organizational level is the level at which issues affect the clinic, group practice, hospital and health plan. This level includes information technology to improve access to information and to support decision-making, education and training in the techniques of quality improvement, investment in time and change management to alter medical systems, alignment of organizational incentives with process for improvement of care, and development of leadership to inspire and model care improvement.
4. The infrastructure level is the level at which the environment of rules, laws, payment, accreditation and professional training operates.

Katon's scheme identifies a number of barriers and lessons from collaborative care trials. At the consumer's level, common barriers

In Katon's 2003 framework, levels of care typologies aid understanding of collaborative care

to depression care include a lack of knowledge about depression and treatment options, stigma about mental illness, frequently strong preferences for treatment, the view of depression as a personal and family issue, and a preference for depression care within primary care.

Collaborative care trials suggest these related lessons: educational materials should be provided to improve knowledge and decrease stigma; consumers with depression should have access to case management by a range of professionals to assist with education and remove stigma; and mental health professionals should be integrated into the delivery of primary care.

At the micro-level of the system, barriers to depression care are numerous. For example, infrequent visits and total reliance on a physician are obstacles to dealing with depression. When only the physicians are involved in care, time for consumer education and close follow-up, and long-term monitoring of outcomes are lacking. Time needed for encouragement and support of behavioural change is not available. Again, collaborative care trials suggest that case management and delivery of care by a team can alleviate these types of barriers. More time is available because more team members are involved in the care, resulting in more visits and telephone follow-up. Collaborative care integrates specialty mental health knowledge into primary care and improves clinician decision-making.

Common organizational barriers to depression care are also evident. The lack of electronic technology, specifically the electronic patient record, impedes the sharing of consumer information among professionals. Support for a long-term focus on quality improvement and the alignment of incentives for clinical systems with improvement of care are often lacking. Added to this is a lack of leadership at the organizational level to improve the quality of care. Lessons from collaborative care trials show that innovative use of technology, including web-based approaches and hand-held and desktop computers, can enhance the delivery of care because of increased adherence to quality outcomes. Quality improvement becomes feasible if organizations provide financial incentives and leadership training. Finally, the trials have demonstrated that it is possible to implement clinical practice guidelines for major depression and schizophrenia.

Other models

Two recent models take another approach that focuses on defining the levels of care, associated populations and roles, responsibilities and organization of services between primary care and specialty mental health services.

Paxton's framework: Paxton et al. (2000) present a four-level-of-care framework, based on the varied complexity of mental health problems and their impact on corresponding services. Services differ by the depth of specialization and the range of needs assessed. The goal of this framework is to clearly specify who should do what to manage conflicting pressures. "Collaboration, including shared care, is a principle throughout, but the nature of the collaboration and the balance of responsibilities and duties may be different from those in the past. There is acceptance that mental health services should retain responsibilities for some problems that are agreed as the main concern of primary care teams and increasingly mental health services will be working with and supporting primary care teams rather than taking some cases over and having no involvement with the others" (pp. 141–142).

Level one covers the common, transient or mild-to-moderate mental health problems (e.g., adjustment reactions, mild-to-moderate anxiety and depression, simple grief reaction, relationship difficulties of a nonchronic nature and unrelated to more complex problems). The affected consumer presents with distress, but limited functional impairment. Here service should focus on providing support or counselling from appropriately trained members of a primary health care team. Self-help materials or programs may be used. If available, referral to counsellors may be made.

Level two deals with consumers who have moderate mental health problems (e.g., moderate depression and anxiety states, panic disorder, phobias) that are not likely to improve without specialist therapy. The day-to-day functioning of these consumers is not badly impaired. Service delivery here provides evidence-based therapies by appropriately trained mental health professionals. Interventions may be of short-to-medium duration, and involve some medication and use of group approaches.

Level three includes consumers with complex mental health problems (e.g., severe obsessive-compulsive disorders; more stable schizophrenia; personality disorders, sometimes with a history of physical, sexual or emotional abuse) that are long-standing and recurrent, and have resulted in significant functional impairment. Interventions used at this level include psychotherapy or drug therapy by appropriately trained professionals, supplemented by liaison with other agencies, as required. Long-term episodic care is provided.

Level four is reserved for those consumers with severe mental illness (e.g., acute schizophrenia, bipolar affective disorder, severe personality disorder with high risk, severe depressive disorders, and severe eating

disorders) who are highly functionally impaired. Interagency approaches characterize service delivery that includes in-patient hospital care. Involvement with formal service provision occurs over the long-term; the major focus is on psychosocial supports.

NCCBH model: The NCCBH (Mauer/NCCBH, 2003) presents a model of clinical integration based on the degree of clinical complexity, risk and level of consumer functioning. Developed as a tool for planning collaborative services in a local system of care, this model focuses on the various subpopulations that have mental health and medical needs.

The model is called the Four Quadrant Clinical Integration Model because it depicts the behavioural health risk and status of a consumer along the vertical axis, and the physical health risk and status along the horizontal axis. In each quadrant, the type of care is outlined according to the competencies required for the range of issues the consumer is likely to present.

Quadrant one is characterized as the group of consumers who have low physical and behavioural health risk and complexity. They are best treated in primary care with behavioural health staff on-site. Consumers who have very low health or behavioural risks are served by primary health care staff, whereas consumers with slightly elevated health or behavioural risks are seen by the mental health care staff. The primary care provider provides medical care, and uses common mental health screening tools and practice guidelines to serve the majority of consumers in the primary care setting. Screening results are used to determine the need for referral to mental health providers. A subset of consumers may be monitored through a tracking registry system. The mental health practitioner in the primary care setting provides both informal and formal consultations to the primary care provider, mental health triage and assessment, brief treatment services, referral to community and educational resources, and health-risk education. Direct services may include individual or group approaches, cognitive behavioural therapy, psychoeducation, brief substance abuse intervention and limited case management. The primary care provider prescribes psychotropic medications using treatment algorithms and has access to psychiatric consultation about medication management.

Quadrant two is characterized as the group of consumers who have high behavioural and low physical health risk and complexity. They are best served in a specialty mental health system that coordinates with the primary health care provider. The primary health care provider ensures primary medical care and collaborates with the specialty mental health system. Psychiatric consultations may be an element in these complex

Clinical integration is a key concept for depicting collaborative care

A four-quadrant model presents the behavioural and the physical health risk and status of the consumer

mental health situations, although psychotropic medication management is more likely handled in the specialty mental health setting. The role of the mental health clinician is to provide a mental health assessment; arrange for or deliver specialty mental health services; ensure case management for housing and other community supports, and access to health care; and create a primary care communication approach that ensures coordinated service planning, especially for medication management.

Quadrant three is characterized as the group of consumers who have low behavioural and high physical health complexity and risk. They are served in the primary care and medical specialty system with mental health staff on-site in the primary or medical specialty care setting, coordinating with all medical care providers, including disease managers. The primary health care practitioners provide medical services, and work with disease managers and other medical specialists to manage the physical health issues. They use standard mental health screening tools and practice guidelines to serve most consumers within the primary care setting. A subset of the population identified through the screening tools and tracking system are referred to the mental health provider, who provides mental health triage and assessment, consultation to the primary care provider or treatment services to the consumer, referral to community and educational resources, and health-risk education. Treatment may use individual or group approaches, cognitive behavioural therapy, psychoeducation, brief substance abuse intervention and limited case management. The primary care provider prescribes psychotropic medications using treatment algorithms and has access to psychiatric consultation for medication management.

Quadrant four is characterized as the group of consumers who have high behavioural and high physical health complexity and risk. These consumers are served in both the specialty mental health, and primary care and medical specialty systems. Both mental health case and disease managers may work together, and in turn relate to other members of the health care team. Psychiatric consultation is a key element for consumers with complex needs. The role of the specialty mental health provider is to provide mental health assessment, arrange for or deliver specialty treatment and services, ensure case management for housing and other community supports, and collaborate at a high level with the health care system team.

Delivery of Care

Consultation–liaison

The knowledge base for models of collaborative care continues to grow. Early discussions of collaborative care focused on the consultation–liaison approach in which mental health care experts, primarily psychiatrists, supported primary care practitioners in their treatment of consumers with mental health needs through a variety of service models (e.g., conjoint model, modified outpatient clinic or replacement model, increased throughput model). Definitions of consultation–liaison vary in different health care systems (Bower and Gask 2002). In the United Kingdom, this model reflects the gatekeeping role of primary care in the health care system that supports psychiatrists and primary care physicians working together to control the flow of referrals into secondary levels of care. In contrast, in the United States, whose health care system is characterized by a wider variety of structures, consultation–liaison refers to processes at two levels: psychiatric consultation that relates to direct consumer contact and liaison that refers to educational work done with the primary care provider.

A number of articles deal with the consultation–liaison approach. In their evaluation of a primary care partnership with psychiatric services in the inner city of Perth, Australia, Kisely et al. (2002) found that referral practices changed significantly after the introduction of a partnership program and that doctors were positive about the consultation–liaison service. Similarly, in their study of the style of working relationship between general practices and community mental health teams in East London, England, Hull et al. (2002) found that, when good consultation–liaison relationships existed, the number of referrals was greater for consumers with serious mental illness who required the long- and short-term care of the community mental health team. When primary care psychologists worked with general practices, the team had a greater number of referrals, but less use of psychiatric services, suggesting that those practices with access to psychology services were able to manage more complex, but nonpsychotic cases in-house. In their first-year evaluation of primary care liaison services to general practitioners for the management of anxiety and depressive disorders in Bologna, Italy, Berardi et al. (2002) found the service both effective and well received.

Consultation–liaison approaches offer another model of care

Definition of consultation–liaison varies across jurisdictions

Consultation–liaison schemes have typically been medically focused

Comparison of integrated and consultation–liaison models of care

Two studies compare integrated and consultation–liaison models for providing mental health care. The older study (Harmon et al., 2000) examined the range and severity of psychiatric problems, levels of general practitioners' and psychiatrists' involvement, and patterns of care in a new integrated mental health care service and an earlier consultation–liaison psychiatry service. The integrated service consisted of nurse counsellors practising in a specific group of general practices. Compared with the consultation–liaison service, the integrated service treated a broader range of diagnostic groups with higher levels of disability, general practitioners were significantly more satisfied with the integrated service and consumers gained better access to secondary mental health services.

The second study (Hedrick et al., 2003) was a randomized control trial comparing a consultation–liaison program for depression care with a collaborative program. Collaborative care, in this instance, followed the disease management model and included a team working with primary care providers to diagnose and treat people, whereas consultation–liaison involved the primary care physician taking responsibility for initiating treatment of depressive symptoms, coordinating the consumer's overall care and consulting with or making a referral to a specialist, as necessary. The collaborative approach produced greater improvement in depressive symptoms from baseline to three months, but no significant differences between the two approaches were evident at nine months. Overall, more rapid and sustained improvement in mental health status occurred as a result of collaborative care than consultation–liaison care. The differences in treatment between the two approaches were the systematic formulation and communication of a treatment plan, and the systematic evaluation of consumers' progress and updating of the treatment plan. The authors suggested that service provision without adequate care processes does not produce optimal outcomes.

Depression management models of care

A growing body of evidence has also been amassed on primary care treatment of depression, a field of study firmly based in the tradition of medical research that tests models of care with randomized control trials. Research began with testing the more simple models of consultation–liaison approaches to depression care and has evolved to testing multi-faceted complex systems of care based on chronic disease management (Bower and Gask, 2002). Although the complexity may more accurately

Depression management models of care emerged within medicine

reflect the reality of care delivered in real-life practices, the complexity of detail also makes it more difficult to truly understand how and what makes the collaboration work. The sheer volume of research is large and overwhelming, but a clear definition of best practices for depression care is emerging (Mauer/NCCBH, 2003).

Several themes have emerged:

- Populations served in primary and secondary level of services seem to be fundamentally different, especially their consumer characteristics and preferences (Van Voorhees et al., 2003; Dietrich et al., 2003). However, that does not mean that consumers with depression who present in primary care should be moved elsewhere for treatment. Numerous studies (e.g., Wells et al., 2000) indicate that improving detection and treatment of depression in primary care is possible (Kessler et al., 2003).
- Such care needs to be sensitive to a number of consumers' characteristics. Being male and belonging to particular ethnic groups are disadvantages for the detection of depression (Brownhill et al., 2003; Borowsky et al., 2000). People who are depressed tend not to be good communicators and do not see themselves as worthy of taking up a doctor's time (Gask et al., 2003). These are significant barriers to diagnosis and ongoing treatment in fast-paced primary care settings.
- Screening for depression in Canada (MacMillan et al., 2005) and the United States (U.S. Preventative Service Task Force, 2002a,b; Pigone et al., 2002a,b) is endorsed for adults in primary care practices that have systems to provide treatment and follow-up care.
- Screening and diagnostic tools need not be demanding (Henkel et al., 2004) and are readily available (Staab et al., 2001; Anfinson and Bona, 2001).
- Enhancement of usual care is indicated for depression treatment, although the use of counsellors in primary care is debated in the literature (Bower et al., 2000, 2003); Jenkins, 2002; Mellor-Clark et al., 2001; Rost et al., 2000; Rost et al., 2001; Simpson et al., 2000; Ward et al., 2000).
- Integrated and multi-faceted treatment programs are recommended (Thompson, 2001).
- For primary care, Katon (2003) states such collaborative care has four features:
 1. A negotiated definition of the clinical problem phrased in terms that both the consumer and physician understand.

2. Joint development of a treatment plan with goals, targets and implementation strategies.
 3. Provision of support for self-management and cognitive behavioural change.
 4. Active sustained follow-up that uses visits, telephone calls, e-mail, and Web-based monitoring and decision-support systems.
- ☞ Three types of models have been extensively tested and are discussed in a large number of trials and program descriptions in the literature (e.g., Dwight-Johnson et al., 2001; Feinman et al., 2000; Katon and Ludman, 2003; Mynors-Wallis et al., 2000; Nutting et al., 2002; Oxman et al., 2002; Saur et al., 2002; Schaefer and Davis, 2004; Simon et al., 2000; Wells et al., 2000):
1. Integration of mental health professionals into primary care.
 2. Integration of the mental health team in which nurses and master's level therapists provide extra visits and support that are closely supervised by a mental health professional.
 3. Integration of care extenders such as nurses or care managers.
- ☞ Stepped care has been developed to address the needs of consumers whose depression does not readily improve through a usual course of care, with intensity of service being customized according to individual outcomes (Araya et al., 2003; Katon, 2003; Katon and Ludman, 2003).

Models of care for other common mental disorders

The depression-treatment approach is now being extended to other types of common mental disorders. Three recent publications considered collaborative approaches to the treatment of panic or generalized anxiety disorders in primary care. Price et al. (2000) adapted the model for depression care to the treatment of anxiety disorders and anxiety disorders mixed with depression, and compared this with usual care in a study of matched-cohort experimental design. The intervention group had significantly reduced anxiety symptoms at six months. This cohort was also significantly more satisfied with care.

Craske et al. (2002) presented a model for the collaborative treatment of panic disorder in primary care that combined cognitive behavioural therapy and medications, and involved primary care physicians, behavioural health specialists and psychiatrists. Consumer education materials were also incorporated. Some features of care were modified from the research-based versions of treatment; the intervention was

The depression-treatment model is being extended to other common mental disorders

condensed and combined with telephone follow-up care by nonspecialist personnel.

Similarly, Rollman et al. (2003) described a stepped collaborative treatment program for panic and generalized anxiety disorders used in a National Institute of Mental Health clinical trial. A telephone-based care manager performed timely, consumer-specific clinical and case-management tasks, and was supported by an electronic consumer record system for the care of affected consumers.

The results of the evaluations of the Craske et al. (2002) and Rollman et al. (2003) models have not yet been published.

Broadening the scope of collaborative care

The use of different components of the care and treatment process to extend collaborative care approaches is also being examined. For example, one pilot study (Matalon et al., 2002) describes an innovative short-term intervention in a multi-disciplinary referral clinic for primary care frequent attenders in Israel. Here the focus was on shifting the burden of care for consumers with somatic complaints from busy primary care practices. The multi-disciplinary referral clinic was based in the community and simply called a consultation clinic to avoid any stigma. It was staffed by a primary care physician with training in psychotherapy and a medical social worker who were supervised by a senior psychiatrist. Consumers referred to the clinic filled in three short questionnaires on their first encounter. They also completed detailed medical and psychosocial interviews with the physician, followed by a physical examination. Then together, the doctor and consumer presented the combined narrative to the social worker. A therapeutic strategy was defined according to the consumer's preferences, and cultural and personal beliefs, and brief treatment approaches were used. The results indicated that the intervention had the potential to modify illness behaviour, and decrease the number of consultations and the costs of medical investigations, referrals, and hospitalizations.

Self-help component of collaborative care

Three other articles dealt with self-help treatment components. Bowers et al. (2001) completed a systematic review of eight randomized and nonrandomized self-help studies to determine the cost and clinical effectiveness of self-help treatments for anxiety and depression in primary care. Self-help in these studies was defined as written interventions based primarily on behavioural principles. The trials reported some significant advantages in the outcomes associated

Extending collaborative care beyond the treatment function is being examined

Self-help is now being considered an element of collaborative care—an acknowledgement of the consumer's role

with self-help treatments, but the studies were methodologically weak and few in number. Long-term effects and costs were not available.

Richards et al. (2002) examined self-help therapies in a randomized control study that enhanced the role of practice nurses to facilitate cognitive behavioural self-help care for people with mild-to-moderate common mental health problems and compared these therapies with usual care. Again, short-term clinical effects were found, suggesting a cost-benefit and another type of therapy that may be used within the primary care setting.

Finally, Lovell et al. (2003) evaluated a fast-access self-help clinic within primary care for acceptability (number of referrals, consumer attendance and satisfaction), efficiency (therapist input per consumer, consumer use of other health services), and effectiveness (problem severity at follow-up). Self-help through the clinic was supported by a nurse therapist who did a 30-minute assessment within one to two weeks of referral and a 15-minute monthly follow-up assessment. Overall, this pilot study suggested that these clinics may be a useful complement to traditional psychological therapy services. Full value, however, requires further testing.

A key element of the CCMHI Framework is accessibility – that is how mental health care services are incorporated in primary health care. This chapter reviews a number of existing frameworks and models for collaborative mental health care. These models were often developed for specific populations. The intent of the key element accessibility in the CCMHI Framework is to capture the wide range of existing models of providing primary mental health care, regardless of the population.

The discussion about these various approaches to collaborative mental health care and the role of teamwork and team composition, infrastructures that support collaborative care, and the role of the consumer and self-help are initiated in this chapter. The literature that examines these topics is reviewed in more detail the next three chapters.

Chapter Summary

Overall, collaborative mental health care in primary health care increases consumer access to mental health services, and benefits the consumers, providers, and the system at large.

A number of frameworks and models have been developed to review that growing literature. Many of the models focus on the level and type of need, both physical and mental, of consumers. These frameworks and models share a common goal — to increase understanding about the integration of discrete disciplinary approaches to improve services for common mental disorders and produce better health outcomes.

Chapter 6:

RICHNESS OF COLLABORATION

KEY MESSAGES

- ≈ *Teamwork is a functional approach to collaborative care that brings many professionals together in partnership with consumers and their families.*
- ≈ *The preferred mix or number of professionals for a collaborative care team has yet to be defined.*
- ≈ *The range of professionals involved in collaborative care may be wide. In past it has involved nurses and physicians of many types, psychologists, social workers, occupational therapists, pharmacists and chaplains.*
- ≈ *Teamwork is challenging for professionals because of their disciplinary training, especially in the primary care setting where the delivery of care is often quick and focused on single biological issues.*
- ≈ *Some jurisdictions have created new positions such as gateway workers, counsellors, link workers, primary mental health care workers, care facilitators and extenders. These functional positions are filled by persons from a variety of disciplinary backgrounds.*

A central feature of effective collaborative mental health care is the richness of the collaboration between mental health and primary care providers. This richness derives from the actual interaction among team members that characterizes collaborative care delivery and methods of fostering such interactions.

The main characteristics of rich collaboration are reviewed in this chapter:

- ≈ *Teamwork of providers, consumers, and other formal and informal care providers.*
- ≈ *More holistic care that is able to deal with complex and comprehensive needs than is traditionally available in primary health care.*
- ≈ *Effective interactions between all members of the team, including consumers and their families, resulting in greater satisfaction with the job and the service.*
- ≈ *Involvement of a number of professional groups to provide the most appropriate care.*

Collaborative care focuses on the content and nature of the interaction of partners

- Knowledge transfer, training and educational opportunities for all involved in collaborative mental health care.

Providers and Consumers Working as a Team

Using teams to deliver mental health care is an established practice of many jurisdictions (Freeman et al., 2002). This approach has been used in the United States, Australia, Canada and Great Britain to deliver specialized mental health care (e.g., assertive community treatment). The team approach has also been extended to primary mental health care, particularly in England.

Characteristics of Teamwork

A number of articles in the literature deal with the team approach. Researchers have indicated that true integrated primary mental health care involves a team of professionals working jointly in the primary care setting with consumers who have mental health problems. Teamwork unifies medical and mental health care, and avoids the dichotomy of body and mind. Teamwork goes beyond collaboration and good communication at the intersection of primary and mental health care to coordination and co-location of care (Blount, 1998b,c; Strosahl, 1998; Lester et al., 2004; Badger and Nolan, 2002; Felker et al., 2004; Getler et al., 2001; Kanapaux, 2004; Thomas and Hargett, 1999).

Akhavain et al. (1999) indicate that teamwork is a dynamic process that requires combining assertiveness with cooperativeness, being true to individual principles while working on a common goal, and balancing autonomy and togetherness. Ultimately, collaboration is defined as giving of oneself without giving up of oneself while working in the system.

Advantages

The literature (Buszewicz, 1998; Borrill et al., 2000; Hart, 1999; Badger and Nolan, 2002; Zeiss and Thompson, 2003) points to a number of advantages of mental health teamwork in primary care:

- Sharing consumer information.
- Making joint decisions about whether referral is appropriate and to which team member the referral should be made.
- Making opportunities for staff to learn from one another.
- Providing support for the providers.
- Sharing therapeutic risk management.

Teamwork is a well-established practice in mental health care

Functioning as a team of caring partners unifies different ways of dealing with common mental disorders

Teamwork is dynamic and demanding, and requires balancing personal traits and professional skills

- ∞ Managing therapeutic or clinical caseloads within the context of the team's work.

Obstacles

Although effective teamwork has clear advantages, a number of obstacles also exist (Buszewicz, 1998; Herrman et al., 2002; Hart, 1999; Bateman et al., 2004; Valianti, 2004):

- ∞ Ambiguity or conflict over roles.
- ∞ Conflict or confusion over leadership.
- ∞ Different understanding of responsibility and accountability.
- ∞ Interprofessional misconceptions.
- ∞ Different rewards for different professionals.
- ∞ Different conceptual approaches.
- ∞ Different models of working with consumers.
- ∞ Fear of change.
- ∞ Lengthy team meetings with a single focus on mental health problems.
- ∞ Traditional hierarchical structures of medicine.

Effects of collaboration

Felker et al. (2004) report on the effects of establishing a multi-disciplinary mental health primary care team in an internal medicine primary care clinic. After one year of operation, they found decreased fragmentation of care and improved collaboration between providers. The relational elements of some issues required more attention, for example,

- ∞ Communication.
- ∞ Consumers' expectations of care.
- ∞ Understanding of roles.
- ∞ Rapid supervision when semi-urgent problems are dealt with.
- ∞ Close clinical collaboration with primary care providers.

Coping strategies

Lankshear (2003) discusses six strategies for coping with disparities between the stated purpose of the team and actual practice: isolation, homogenization, fraternization, negotiation, manipulation and demarcation.

Participants must be willing to identify and overcome challenges in teamwork

Effective interactions between providers and consumers

Understanding the actual interactions of collaborative care is important to ensuring effective delivery of service, quality improvement and desired outcomes for care. Descriptive studies or summaries, the first type of evidence reported in the literature in most emerging fields, help foster this understanding. Champions of integrated primary mental health care have recorded their experiences and observations, which benefit those considering this innovation. Generally speaking, these descriptive pieces are one of two types — conceptual or narrative. In some instances, authors discuss key elements of collaboration, whereas in others, they identify a key element in the informal evaluation of the program they describe.

Two broad categories of topics emerge in these articles, namely relational and structural. In the relational realm, three subcategories were identified: personal characteristics of providers, interactions among team members, and interactions between members and consumers. (See Chapter 7 for a discussion of structural elements.)

Personal characteristics

A number of authors (e.g., Akhavain et al., 1999; Badger and Nolan, 2002; Pollin and DeLeon, 1995; Lipkin, 1999; Herrman et al., 2002; Spruill et al., 1998; deGruy, 1999; Patterson, 1998; Mauer/National Council for Community Behavioral Healthcare [NCCBH], 2003) discuss the personal characteristics providers bring to the collaborative care interaction. Some of the basic elements identified as important to working with other people are respect and empathy, pleasant personality, reliability, flexibility, and ability to cope with uncertainty or change. Control, autonomy and personal differentiation also affect a person's ability to be a team member.

Interactions among team members

Collaborative care authors also identify characteristics that affect the relationship among providers working on a team. These conditions under which professionals work together or attitudes each brings to the interaction have been identified:

- Proximity in space: being co-located as a starting point. Optimum proximity is experienced in integrated care when more than one professional is present in the interactions with the person receiving care (Patterson et al., 1998; Badger and Nolan, 2002).

Relational and structural characteristics of care are important

People bring personal traits to their collaborative care role, including respect, need for control, coping skills and cooperation

Interpersonal interaction characteristics have an impact on the delivery of care

- ∞ Proximity in time: actual time spent together in the workplace beyond the interaction with the consumer (Kates, 2002; Patterson et al., 1998; Badger and Nolan, 2002).
- ∞ Improvements in communication: increasing clarity, frequency, style and mutuality (Kates, 2002; Stichler, 1998; Patterson et al., 1998; Lorenz et al., 1999; Pollack, 1999; Davis and Blitz, 1999).

Interprofessional attitudes are also highlighted:

- ∞ Commitment to building interprofessional relationships (Lorenz et al., 1999).
- ∞ Sharing common goals in collaboration, especially those related to the consumer with mental health needs (Davis and Blitz, 1998; Stichler, 1998; Lorenz et al., 1999; Patterson et al., 1998; Pollin and DeLeon, 1996; Buszewicz, 1998; Badger and Nolan, 2002).
- ∞ Respect for one another's role, knowledge and expertise (Stichler, 1998; Pollin and DeLeon, 1995; Lorenz et al., 1999; deGruy, 1999; Herrman et al., 2002; Buszewicz 1998).
- ∞ Mutual trust (Davis and Blitz, 1998; Stichler, 1998; Lorenz et al., 1999; Pollin and DeLeon, 1996).
- ∞ Balancing power in relationships, which includes these attributes (Herrman et al., 2002; Davis and Blitz, 1998; Stichler, 1998; Lipkin, 1999; Pollin and DeLeon, 1996):
 - Being aware of traditional hierarchies among professions.
 - Defining work roles to balance differences in power.
 - Recognizing and valuing every person's contribution and knowledge.
 - Viewing every person's contributions as equal.

Interactions between team members and consumers

Interactions with consumers have also been raised (Badger and Nolan, 2002):

- ∞ Need for professionals to understand the impact of the stigma of mental health and illness on people's lives (Mauer/NCCBH, 2003).
- ∞ Intense, active listening skills (Lipkin, 1999).
- ∞ Focus on issues and changing function of the consumer, rather than on personality (Mauer/NCCBH, 2003).
- ∞ Awareness of and sensitivity to culture and other sources of diversity (Mauer/NCCBH, 2003; Akhavain et al., 1999).

Interprofessional attitudes play an important role in collaborative care

Ability for providers and consumers to relate effectively is critical

- Openness to involving consumers in their own care and in planning and monitoring services (Jenkins and Strathdee, 2000; Badger and Nolan, 2002).
- Use of incentives to engage consumers who are unaware of their own behavioural health issues (Pollack, 1999).

Tools of Collaboration

One article (Hyvönen and Nikkonen, 2004) explores the content of mental health care delivered in primary care and identifies the mental health tools that practitioners use. Both doctors and nurses participated in this small qualitative Finnish study. Although the authors capture the provider's perspective, the set of tools they describe is relevant to collaboration between the practitioner and the consumer. They identify four types of tools:

1. The practitioner: the knowledge, skills, values and attitudes that he or she brings to the work or interaction with the person. Personality is a meta-tool when it affects decisions about the choice of the tools used and the way they are used (i.e., even practitioners with similar training can care for their patients differently). The practitioner as a tool refers to his or her personal way of carrying out mental health care — this requires balance and self-knowledge. The practitioner is part of the foundation of care since he or she determines the use of other tools.
2. Interactive tools: informative, supportive or contextual tools that are central to the care process:
 - Informative: by using interviews, observation and listening, the practitioner gets information about the consumer's situation, needs and wishes. Active listening is a critical skill here.
 - Supportive: the act of consciously giving support through touch, listening or other actions makes the consumer feel comfortable.
 - Contextual: use of humour, intuition and creativity is strongly related to the context of their use. Context includes the practitioner, the consumer and the individual contemporary situation that affects the manner and time in which the practitioner uses these tools. Contextual tools are supplementary to other tools.
3. Ideological tools: the principles that guide the actions of the practitioners who carry out the care. Examples of these tools are

consumers' orientation, acceptance and permissiveness, honesty and genuineness, and sense of security:

- Consumer orientation: dimensions of individuality, cultural understanding and the dimension of good service. This means getting to know the consumer's needs in a holistic way. Good service includes being friendly and polite, and the use of small gestures, such as introducing oneself and shaking hands, especially in the first meeting.
 - Acceptance and permissiveness: accepting the consumer for who he or she is, without prejudice. The practitioner sees the consumer as a subject and respects his or her autonomy, and sees mental health care as a process, an interaction between people.
 - Honesty and genuineness: direct discussion of all matters of concern with the consumer. Actions are openly explained to the consumer. The practitioner takes genuine interest in the consumer and his or her situation. The practitioner's verbal and nonverbal communication is aligned. The practitioner is present in the moment of care and shows complete interest.
 - Sense of security: trust in the continuing relationship between provider and consumer. The practitioner is active and available when serving the consumer. The consumer can trust in the continuation of the collaboration with the practitioner and in his or her maintaining confidentiality. Familiarity is important in building this sense of security, which takes time. The practitioner needs to give the consumer enough time to realize that the practitioner is there for the consumer and that his or her problem is important. Having a peaceful place in which to meet without interruptions is also important.
4. Technical tools: medical measures or concrete tools. These tools are used to monitor the consumer's health or to medically treat the consumer. These tools may be interactive and are supplemental to or enable the use of ideological tools.

Knowing the interactive elements of mental health work in the primary care setting is critical to understanding the impact of collaborative care on provider behaviour and consumer outcomes. This research needs to be replicated in different health care systems to enable broader generalization. It would be useful to include other members of the primary care collaborative team. Hyvönen and Nikkonen (2004) also suggest that this information is important to the implementation and development of primary mental health care practices and education.

Many professionals may play a role in collaborative care

Professionals Participating in Collaborative Care

Many types of professionals participate in collaborative care. Discussions in the literature are varied, from those promoting the team approach to those focusing on the interaction of two professions. In part, the type of collaboration called for is reflective of the overall progress in the field: older articles emphasize the possible benefits of any type of collaboration and the way professionals can begin to work together; more recent publications emphasize the joining and integration of clinical practices. As well, the volume of literature about the involvement of the nursing, psychology or behavioural sciences, social work and physician professions is large. Also prevalent are articles describing the unique roles ascribed to collaborative care that may be filled by any number of professionals — the mental health worker, link worker and so forth.

Psychologists

Overall, the support for the participation of psychologists in primary mental health care is growing, especially in the U.S. (Spruill et al., 1998), Canada (Romanow and Marchildon, 2003) and Australia (Jackson-Bowers et al., 2002). There are a number of theoretical perspectives proposed in the literature to characterize the psychologist–medical provider interaction. McDaniel (1995) and Pace et al. (1995) discuss the biopsychosocial model and systems theory as compatible theories to underpin such collaboration.

Zeiss and Thompson (2003) indicate that psychologists working in collaborative care require a basic set of skills, for example,

- Knowing what other professionals bring to the team and the population being served.
- Attending to team roles to understand how members complement and add to one another's knowledge and skills in the delivery of collaborative care.
- Understanding the coordination of team planning and handling shared leadership or power.
- Being knowledgeable about team development processes and methods of handling the difficult aspects of becoming a team.

Various roles are suggested for psychologists in collaborative care. For example, Pollin and DeLeon (1996) discuss the psychologists' direct involvement with consumers in their provision of brief, focused therapy in the primary care setting. Callahan (1997) and Weene (2002) claim that psychologists are well versed in the use of psychotropic medications

and alternatives to drug therapy, and are best able to educate and help other members of the primary care team understand these complex issues. Coyne (2003) suggests that psychologists not work as frontline members of the primary care team, but instead provide leadership and expertise in the design, supervision and evaluation of collaborative services.

Two studies examined specific programs involving psychology and primary care. Bray and Rogers (1995) detail a pilot project in a rural setting that successfully linked psychologists and primary care physicians dealing with drug and alcohol problems. Vines et al. (2004) summarize an Australian matched-cohort study of a collaborative care model that found improved outcomes for people receiving collaborative care compared with those for people receiving usual primary health care.

Physicians and psychiatrists

Collaborative care is often examined from the perspective of the general or family physician, or the psychiatrist, two professionals who are involved in a variety of collaborative models. In their collaborative relationships with psychiatrists, family physicians want some basic things — face-to-face relationships, respect for their practice skills, knowledge and awareness of working in the primary care environment (Burley 2002); and increased access to specialty care for their referred consumers (Kushner et al., 2001). Fritz (2003) raises similar points about collaborative relationships between pediatricians and child psychiatrists. Other articles discuss the involvement of psychiatrists. In their survey of Canadian psychiatrists, Kates et al. (2001) found that collaborative relationships were highly rated. Pirkis et al. (2003) reported on an innovative program to increase interactions between private psychiatrists and the public mental health system through the creation of a coordination unit and remuneration for psychiatrists' nondirect care activities. Two articles discuss pharmacology: one (Sederer et al., 1998) details the development of guidelines for prescribing psychiatrists involved in collaborative care, and a second (Hales et al., 1998) outlines a psychiatrist mentor-training program to provide the skills and knowledge that nurse practitioners with prescribing privileges need. In their presentation of a theoretical framework for understanding how primary care doctors work with mental health problems, Sigel and Leiper (2004) recommend awareness of this work process and building on its strength.

Finally, two articles note the potential role for collaborative care in meeting the needs of special populations: consumers with serious mental illness (Brown et al., 2002) and consumers with eating disorders (Walsh et al., 2000).

Pharmacists

The involvement of pharmacists in collaborative care is in its infancy. Of the five brief reports (Baldwin, 1999; Finley et al., 1999; Zillich, 2004; Howard et al., 2003; Norton et al., 2003) found in the literature search, only Finley et al. (1999) directly discusses mental health collaborative care. Pharmacists' knowledge of medicines and their interpersonal skills in working with patients and doctors — key elements of their role — make them well-suited to collaborative care (Baldwin, 1999). Barriers to collaboration between these professionals have been documented, including role conflict (Howard et al., 2003), involving pharmacists believing that they could take on more responsibilities for consumers' care than family physicians were prepared to give; limited time for joint discussions; greater need for clinical education of pharmacists; and lack of structured meeting places and times (Norton et al., 2003).

Social workers

The involvement of social workers in the delivery of collaborative care is supported in a few discussions (e.g., Badger et al., 1997; Corney 1995; Firth et al., 2003; Firth et al., 2004; Chisholm and LeMoine, 2002) found in the literature search. Medical social work has always emphasized the need to pay close attention to the impact of social forces and conditions on the health of consumers (Badger et al. 1997). What social workers bring to collaborative care is not simply a skill set transferred from secondary care; they provide primary care providers with a broader perspective on the consumer — an understanding of the effects of the pressure of the environment and the impact that personal internal reactions to this stress has on the consumers' social network of families, other relationships, and work (Firth et al., 2003). Elements of social work practice in the primary care team also include direct rather than indirect work with consumers, managing the context and process, and therapeutic social work as a contextual practice (Firth et al., 2004). Chisholm and LeMoine (2002) describe a shared care program in Nova Scotia in which social workers had a significant role.

Nurses

The long tradition of mental health nursing (Godin, 1996) is reflected in the literature about the different types of nurses (e.g., community psychiatric, practice, advanced practice, clinical nurse specialists) and their potential contributions to collaborative care. A critical characteristic of nursing that is integral to collaborative mental health care is nurses' holistic approach to consumers (Shanley et al., 2003). Like social workers,

nurses view consumers in broad terms — their physical attributes and conditions, their emotions, their social context and their environment. The involvement of nurses offers alternatives to a strictly medical approach to dealing with mental health challenges or mental illnesses. More specifically, Shanley et al. (2003) suggest nurses are experienced in these areas:

- ∞ Using a consumer-centred approach to care that views an episode of mental illness as an occasion when consumers are not making good use of their coping mechanisms.
- ∞ Helping consumers identify and use their coping strategies to deal with their concerns.
- ∞ Using both formal and informal contact with the consumer to build awareness of consumers' needs within their broader personal, social and physical contexts.

McCann and Baker (2003) highlight three reasons for nurses to collaborate with family physicians in mental health care:

1. Greater numbers of consumers with mental health illness are treated in primary care than in mental health care.
2. Doctors are better equipped than nurses to diagnose a medical illness.
3. Consumers benefit from greater continuity of care when these professionals work together.

Nurses embrace their role in collaborative care (Shannon-Jones et al., (2003), recognizing that they are an important link between primary and secondary mental health care (McCann and Baker, 2003). Nurses recognize their need for enhanced diagnostic and therapeutic skills, especially when dealing with serious mental illnesses (Nolan et al., 1999). A number of authors have discussed the opportunities to expand the role of nurses in such areas as medication clinics (Gray et al., 1999; Millar et al., 1999; Kaas et al., 2000), depression treatment (Mann et al., 1998), telehealth care (Hunkeler et al., 2000) and developing countries undergoing significant primary care reform (Sokhela, 1999).

Nursing involvement in a variety of collaborative models is described in numerous articles:

- ∞ McCann and Baker (2003), Badger and Nolan (1999), and Roberts (1998) describe specialist–liaison models in which nurses who were members of community mental health teams collaborated with general practices about consumers with mental health needs.
- ∞ McCann and Baker (2003), Shannon-Jones et al. (2003), and Badger and Nolan (1999) describe programs in which community-based

nurses had close contacts with general practitioners while managing consumers experiencing acute episodes of mental illness.

- ✎ Lyles et al. (2003), and Badger and Nolan (1999) discuss replacement models in which nurse practitioners assumed responsibility for delivering multi-faceted interventions directly to consumers with somatic issues with back-up support from doctors and other professionals. Hales et al. (1998) describe a similar model in which nurse practitioners trained in prescribing and managing medications by psychiatrists directly managed a caseload of mental health consumers.

Other professionals, such as doctors, appreciate the role and involvement of nurses in collaborative care (Atkin and Lunt, 1996; Badger and Nolan, 1999; Walker et al., 2000).

Occupational therapists

Cook and Howe (2003) examine the involvement of occupational therapists in primary mental health care. These professionals' contribution to primary mental health care is their ability to improve the social functioning of consumers, especially those with more serious mental illnesses.

Dietitians

Kates et al. (2002b) describe the participation of dietitians in a collaborative care model. These professionals are involved in direct consumer care, and provide support and education to other members of the primary care team.

Chaplains and clergy

One study by Felker et al. (2004) documents the involvement of a chaplain in a collaborative care model. The chaplain was directly involved in the diagnostic evaluation of mental health consumers and was responsible for exploring spiritual issues. Chaplain services were included in the range of treatment options and were accessed by consumers.

Consumers and peer support workers

The growing trend is to recognize consumers as experts and to involve consumers as partners in the collaboration for their care. Some collaborative teams involve self-help or peer support workers. For a

discussion of the importance of involving consumers see Chapter 4 on consumer centredness.

Primary mental health workers, counsellors, link workers, facilitators and health specialists

A number of unique positions defined in terms of function rather than discipline have emerged in the delivery of collaborative care. In some jurisdictions, like Great Britain, these positions have been prescribed in primary care and mental health reform policy. Often they are formulated to liaise between primary and mental health care. People trained in a variety of disciplines fill these roles because the emphasis is on their combined personal characteristics, attitudes and skill sets, rather than on their specific training.

In the latest round of health care reform in England, two functional positions relevant to collaborative care have been sanctioned by policy: the primary mental health care worker and the gateway worker. The government called for 1000 of these new graduate primary mental health care workers trained in brief interventions to support primary care by 2004. Bower and colleagues (Bower, 2002; Bower et al., 2004; Bower and Sibbald, 2004) examine this position in a series of articles and one study, whereas Lacey (1999) reviews a proposed child mental health worker position. Bower (2002) reviews four dimensions relevant to the implementation of the primary mental health care workers:

1. The types of mental health problems these workers will manage.
2. The degree to which these workers will work autonomously or as part of the system of care.
3. The stage of the illness trajectory at which these workers will intervene.
4. The relationship of the role to clinical interventions, or the broader nonclinical role in the organization or monitoring of care.

Bower et al. (2004) reported that the implementation of primary mental health care workers was proceeding, but the majority of the filled positions focused on clinical work and not on the broader scope of application. Bower and Sibbald (2004) conducted an evidence-based practice review of mental health workers and found that the mental health workers in the consultation–liaison model had a direct effect on the prescribing behaviour of primary care practitioners (e.g., reducing prescriptions of psychotropic medications and referrals) when used as part of multi-faceted interventions, but the effects were short-term, lasting only while mental health workers worked alongside the primary care providers. Although there was some evidence that this was also true in

Unique positions are being created to support true collaboration

replacement models (in which the mental health workers substitute for the primary care providers), the effects were not reliable.

The gateway workers (United Kingdom Department of Health, 2002) are placed between general practitioners or primary care teams and accident or emergency departments to respond to consumers who need immediate mental health help. These gateway workers take on the task of contacting the crisis response team when necessary. Their role is to strengthen access and to provide community triage so that consumers can be fast-tracked to specialist care.

Link or key workers are also described in the English literature. Link workers focus on improving connections between general practitioners and local mental health teams to enhance collaboration. Two studies examined the impact of link workers: Bindman et al. (2001) examined the effects on admission rates and costs, and Emmanuel et al. (2002) looked at consumer outcomes.

The role of the mental health facilitator has also been studied (Bashir et al., 2000). The goal of this position within primary care settings is to facilitate improved recognition, management and outcomes of mental illness. The worker establishes personal relationships with the primary care personnel and encourages the adoption of best practices and better service organization. Bashir et al. (2000) found that training generic facilitators to take on this mental health role was possible, but it had no effect on treatment and outcomes, suggesting that the facilitator's role needs refinement.

Kates and colleagues (2002a) discuss other types of roles involved in the Hamilton collaborative care program. They studied the involvement of counsellors and found that they effectively helped a majority of consumers achieve positive treatment outcomes.

Counsellors have also been employed extensively in the British primary care system. Jenkins (1999; 2002) documents this involvement, debates its effectiveness in primary care and argues for the value added by the integration of this service. Mellor-Clark et al. (2001), in their national survey of British counsellors working in primary care, found that a majority of them met the national criteria for good practice. However, the debate about the effectiveness of counselling continues. Friedli et al. (2000) used a randomized controlled study to test the economics of employing a counsellor in general practice and found that counselling was no more effective or expensive than care by a general practitioner over a nine-month period. Cape and Parham (1998) found mixed results for the effects of counselling and referral to secondary care:

a greater number of referrals to clinical psychology, but no difference in referral rates to outpatient psychiatry.

Knowledge Transfer, Training and Educational Opportunities for All Involved in Collaborative Mental Health Care

Importance of education and training

Two things must occur if collaborative or integrated mental health care is to become the norm. First, future students in related disciplines must receive training so that they know how to work collaboratively, in particular how to meet the mental health needs of a wide range of people in the primary care setting (Blount, 1998a). Second, those already in practice who are interested in providing collaborative mental health care must have frequent, engaging opportunities to upgrade their knowledge and skills. Kates (2002) highlights the need for innovative continuing education approaches, including practice-based models, and the use of the Internet and simple education aids, such as drug information sheets to go with discharge summaries.

Many of the advances in integrated mental health care occur in the field, especially in the larger, sophisticated capitated health care systems in the United States (Blount, 1998b). Medical training centres are the usual source of innovations in practice. In these centres, with the guidance of academic teachers, models are refined under stringent conditions and then moved out to the field. Trainers and educators must therefore maintain close contact with innovations in primary mental health care in their communities and beyond. Knowledge is being created in actual practice, making the exchange between the real world and academia dynamic. Keeping pace with this change, and using it to generate sound education and training initiatives will continue to be a challenge until research and evaluation produce more reliable, useable findings of best practices for integrated primary mental health care.

Training needs

A study (Russell and Potter, 2002) about the training needs of primary care personnel, distinguished their unique needs from those who work in secondary mental health care:

- ✎ Primary care workers need basic knowledge and skills about mental health and illness to be able to respond to a wide range of mental health issues.

Future collaboration depends on educating the workers about working together and providing ongoing training for those already in the field

The challenge is to take what is learned in real programs and incorporate it into education curricula

Training needs vary by type of professional and locus of work

Collaborative care clinicians must develop specific skills for collaborative care

- ❧ These workers need knowledge about how to work with and refer to secondary mental health care, using protocols customized to local circumstances.
- ❧ Information and training are required to shift the way health care professionals work to promote practices that truly foster psychological well-being.

Blount (1998c) calls for the development of these skills for collaborative care clinicians:

- ❧ Speaking jointly with consumers about their issues.
- ❧ Working as team members.
- ❧ Interviewing family members.
- ❧ Practising solution-focused interviewing.
- ❧ Using brief cognitive or behavioural interventions.

Collaborative education

Collaborative work should be linked to interdisciplinary education and training

A number of authors agree that, if collaborative care is to become the norm, interdisciplinary educational programs are required.

The American Association of Community Psychiatrists (2002) identified a number of training principles needed to achieve the goals of integrated primary health care:

- ❧ Psychiatrists and other mental health professionals who work in community-based settings must become aware of the clinical culture of primary care and the types of psychiatric disorders that are encountered in that setting.
- ❧ Behavioural health programs need to train most of their providers to understand how to most effectively collaborate and communicate with their primary care colleagues, especially in the care of consumers with severe and persistent mental illness.
- ❧ These programs should identify and train specific clinicians who can more directly collaborate and consult with primary care providers, either through a co-location consultation model or in a more systematic behavioural health integration program.

Attention also needs to be focused on the educational strategies and tools used to teach future collaborative care practitioners. Freeth and Reeves (2004) provide a template of factors for learning experiences that enhance collaborative practice, according to the presage-process-product model:

- ❧ Presage factors: The context in which the learning experience is conducted influences its planning, realized form, and outcomes

with three central categories — the learning context, teacher and program developer characteristics, and learner characteristics:

1. The characteristics of the learning context include such things as the political climate, regulatory frameworks, funding, geography and demography, learner numbers, space and time constraints, and competing curricular demands.
 2. Teacher or program developer characteristics include concepts of learning, teaching, collaboration, and learners' perceptions; and enthusiasm.
 3. Learner characteristics include prior learning and beliefs, preferred approach to learning, concepts of collaboration, competing learning needs, and expectations and motivation.
- ∞ Process factors: These are the most important process factors for learning associated with collaborative practice:
- Uni-professional, multi-professional or interprofessional approaches.
 - Selection of the appropriate stage, before or after qualification.
 - Duration of the training.
 - Formal or informal learning.
 - Classroom or placement-based activities.
 - Work-based learning.
 - Distance learning.
 - Compulsory or optional experience.
 - Underlying theory.
 - Assessment.
 - Facilitation style.
 - Team teaching.
- ∞ Product factors: What emerges as a result of the learning is both intended and unintended products, which are also described as competencies:
- Attitudes: improved attitudes toward other professional groups and in favour of collaboration.
 - Perceptions: better understanding of other professionals.
 - Knowledge: conflict resolution within teams.
 - Skills.
 - Behaviour.
 - Practice.

One integral feature of collaborative education is the opportunity for placement in collaborative care settings as a part of the overall program. Patterson et al. (1998) describe a joint education program to train medical

and behavioural science students, whereas Dobscha and Ganzini (2001) highlight the value of the collaborative care setting for training psychiatric residents.

Tarren-Sweeney and Carr (2004) examine the instructional methods and techniques of collaborative care, and offer these topics for the development of multi-disciplinary mental health learning modules for undergraduate, graduate and continuing education:

- Modules with multi-disciplinary applications.
- Adaptable modules for presentation in multiple education domains.
- Modules accessible to rural and remote practitioners.
- Modules that combine structured solutions and focused lessons (directed learning) with elements of problem-based learning.
- Modules that describe normal, abnormal and cross-cultural manifestations of problems.

Interprofessional approaches

Interprofessional education is defined as any occasion when two or more professions learn interactively together to facilitate collaborative practice (Horder, 2004). Multi-professional education, in contrast, is defined as professionals learning side-by-side (Horder, 2004). This approach to collaborative learning has been written about extensively in the literature.

Interprofessional approaches may be used in prequalifying and post-graduate education. The basic premise of interprofessional education is that it is preparation for the demands and expectations of collaborative care.

The literature discusses the specifics of interprofessional education, once again largely in England, which has more than 25 years of experience with this activity. The underlying beliefs about interprofessional education are twofold: first, that better communication and teamwork between different professionals and agencies will benefit consumers with mental health issues, their carers and the professionals who deliver the care; and second, that interprofessional education about how to deliver collaborative care will help develop collaborative practices in the field that will combat ignorance, prejudice and tribalism by increasing understanding, respect and mutual support (Lester et al., 2004; Horder, 2004).

The method of delivering interprofessional education to build collaborative skills and practices has also been thoroughly examined

Learning together is valued

— issues such as appropriate program approaches (e.g., directed learning, problem-focused, action learning sets) (Horder, 2004; Albrecht et al., 2004; Lester et al., 2004) and specific barriers within universities that stand in the way of interprofessional education (Horder, 2004; Albrecht et al., 2004; Barrett et al., 2003).

Barnes et al. (2000) capture the outcomes of interprofessional education from the service users' perspective. Participants in interprofessional education programs are expected to develop skills such as developing their capacity to be humane, and learning how to complain and how to involve carers in assessing their own and the consumer's needs, rather than use a textbook approach.

Education programs for specific disciplines and joint initiatives are described in the literature. For example, training programs for doctors are described in a number of articles (Goldberg, 1998; Alkin et al., 1996; Hahn, 1997; Blashki et al., 2003; Dobscha and Ganzini, 2001; Richards et al., 2004; van Os et al., 1999). A few references (McBride et al., 2000; Twilling et al., 2000; Daw, 2001; Anderson and Lovejoy, 2000) highlight joint training programs that include doctors and counsellors or psychologists. Nurses also receive training (Secker et al., 1999; Secker et al., 2000; Stark et al., 2000; Sorohan et al., 2002). Examples of training for psychologists are provided by Spruill et al. (1998) and Dobmeyer et al. (2003). Cook et al. (2001) discuss joint training for health care and social workers. Although the content of each of these programs is unique, they share the common goal of increasing teamwork skills, raising awareness about other disciplines that may share care and detailing opportunities for collaborative practice placements.

Training

The range of approaches to training activities for practising professionals found in the literature is wide and indicative of both innovation and the absence of a strong evidence base about what training works with particular disciplines. A sample of these approaches is listed here:

- ✎ Kerwick and Tylee (1998) discuss medical education in primary care psychiatry in the United Kingdom, noting that most general practitioners are prepared to assume the mental health role expected of them.
- ✎ Wilson and Howell (2004) suggest the use of small-group peer support for general practitioners treating mental health problems to improve response to consumers with mental illness in primary health care settings.

Once in the field, opportunities for professionals to learn together requires innovation and resources

- Scott et al. (1999) suggest that general practitioners use problem-based interviewing to improve primary mental health care.
- Chur-Hansen et al. (2004) propose joint training of doctors and nurses practising in rural areas to enhance psychiatric skills that are useful in the primary health care setting.
- Qureshi et al. (2001) describe the use of condensed psychiatric courses for general practitioners and paramedical staff as part of a project aimed at integrating mental health into primary health care in Saudi Arabia.
- Interdisciplinary approaches have been tried in other contexts, for example, a mentoring program for both primary health care providers and administrative staff (Bellman, 2003); the use of practice development frameworks to influence teamwork, team culture and philosophy of practice (Eve, 2004); an intensive two-year training program for professionals working in primary care (both health care and social services) dealing with families (Larivaara and Taanila, 2004); interdisciplinary training focused on improving detection and management of depression in the older person (Mayall et al., 2004), combining geriatric care and team functioning (Lichtenberg and MacNeill, 2003), and depression care management in primary health care (Stevens et al., 1997); and training programs dealing with child and adolescent mental health issues (Thompson et al., 2000; Papa et al., 1998).

Chapter Summary

In conclusion

- ∞ Richness of collaboration for primary mental health care is defined by the various disciplines that make up the partnership, the effectiveness of the teamwork and the exchange of knowledge among collaborators.
- ∞ The literature greatly helps to define the necessary and enabling individual and team characteristics that promote effective collaborative mental health care.
- ∞ A range of professional groups participates in primary mental health care, each offering a unique perspective and enhancing consumer outcomes.
- ∞ Some jurisdictions have created new positions on the collaborative mental health care team (e.g., link workers). Professionals from many disciplines can fill these positions (e.g., nurses, social workers).
- ∞ Exchange of knowledge among partners is a central feature of effective collaborative mental health care. Environments conducive to this exchange are needed (e.g., face-to-face meetings, time). Joint education and training should be promoted.

Chapter 7:

COLLABORATIVE STRUCTURES

KEY MESSAGES

- *Organizational supports at the practice and system levels are required to sustain collaborative care.*
- *Clinical pathways and processes need to be well defined within primary care and at the intersection of primary health care and specialty mental health services to ensure effective and efficient treatment.*
- *Clinical team roles and functions require definition; leadership or coordination must be clearly separated from clinical and professional responsibilities, and supported by appropriate protocols, and team and job descriptions.*
- *Useful tools include electronic health records; consumer registers or recall systems; treatment guidelines and screening tests; service protocols or interagency agreements; and integrated administrative procedures, including reception, appointment processing and charting.*
- *Physical space issues include having suitable space in the primary care area for mental health workers to work, common waiting rooms and reception, and joint staff rooms.*

Structures and tools integral to collaborative models support the delivery of care. Structures are inherent in the organizations within which collaborative care occurs and may be formal or informal. For example, formal structures might include service agreements or coordinating centres. Verbal agreements between providers may constitute an informal structure. Tools that may assist in the delivery of collaborative care include such things as information technology, specific referral protocols and instruments or forms that may be used in evaluation of the program. This chapter reviews the structural features of collaboration; measurement of collaboration, integration and satisfaction; devices or practices that facilitate collaboration; and methods of evaluation of collaborative programs.

Numerous organizational themes have been identified at the practice and system levels

Structural Features

Practice-level structures

Structural factors at the practice and system levels that contribute to effective collaborative care have been highlighted in the literature. At the practice level, a series of elements were identified:

- ✎ Practice elements should be adjusted for those participating in primary mental health care (deGruy, 1999; Patterson et al., 1998; Valianti, 2004).
- ✎ Job descriptions should include clear expectations for professionals working together (Herrman et al., 2002).
- ✎ Team members' expertise should be used appropriately, especially when specialists are part of the team (Jenkins and Strathdee, 2000; deGruy, 1999).
- ✎ Team protocols should be developed and used so that roles and functions are defined, leadership or coordination functions are clearly separated from clinical and professional responsibilities, and service objectives are clear (Herrman et al., 2002; Lipkin, 1999).
- ✎ Supportive infrastructure such as a consumer register and information system, recall system, and joint administrative processes should be available (Jenkins and Strathdee, 2000; Mauer/National Council for Community Behavioral Healthcare [NCCBH], 2003; Valianti, 2004).
- ✎ Clinical processes and pathways should be well designed (Jenkins and Strathdee, 2000; Mauer/NCCBH, 2003; Lipkin, 1999), and emphasize early detection (Kates 2002), collaborative working (Patterson et al., 1998) and clear referral protocols (Lipkin, 1999; Kates, 2002). Outcomes should be solution-oriented rather than process-oriented (Mauer/NCCBH, 2003).
- ✎ Treatment guidelines and screening tools should be used (Jenkins and Strathdee, 2000).
- ✎ Joint decision-making processes should be in place (Lipkin, 1999; Davis and Blitz, 1998).
- ✎ Working style should be open door: it should involve spontaneous or as-needed consultations and more formal meetings (Mauer/NCCBH, 2003).
- ✎ Opportunities for staff socializing should be provided (Mauer/NCCBH, 2003; Patterson et al., 1998).
- ✎ The physical space should be suitably blended into the mainstream of the primary care setting (Mauer/NCCBH, 2003)

and allow for the physical proximity of practitioners involved (Patterson et al., 1998).

System-level structures

At the systems level, a series of structural factors were identified from the literature:

- ∞ Mental health workers should be trained to educate and support nonspecialized health workers who work in primary care settings (Jenkins and Strathdee, 2000).
- ∞ Continuing education should be provided for existing providers in collaborative care (Kates, 2002).
- ∞ Future practitioners should be trained in collaborative mental health care (Kates, 2002; Jenkins and Strathdee, 2000; Patterson et al., 1998; Mauer/NCCBH, 2003; Spruill et al., 1998).
- ∞ Collaborative relationships should be promoted among academic faculties, including medicine, psychology, nursing, social work and others (Peek and Heinrich, 1998; Herrman et al., 2002; Patterson et al., 1998).
- ∞ Collaborative relationships among professional organizations should be encouraged so that they can undertake joint projects on collaboration, develop joint statements about collaborative care that build on best practices, and provide joint training and peer-support programs (Herrman et al., 2002).
- ∞ Support by management within the health care organization and system for collaboration is important (Badger and Nolan, 2002; Hart, 1999).
- ∞ Commitment to continuous quality improvement (Jenkins and Strathdee, 2000; Patterson et al., 1998) and program evaluation should be made (Jenkins and Strathdee, 2000; Badger and Nolan, 2002).
- ∞ Policy should support the decentralization of mental health services, integration of mental health and general health care, and collaboration with nonmedical providers (Jenkins and Strathdee, 2000).
- ∞ Recruitment, training and employment of personnel, adequate supply of medicines and a network of facilities, including transportation, data collection and research should be funded (Jenkins and Strathdee, 2000).
- ∞ Countries or regions should establish a department of mental health (Jenkins and Strathdee, 2000).

- ✎ Countries need to develop national policies on mental health, setting out goals and mechanisms for the integration of primary–secondary mental health care (Jenkins and Strathdee, 2000).
- ✎ Systematic strategic planning should be conducted to align primary and mental health care (Jenkins and Strathdee, 2000; Kates, 2002).
- ✎ In developing countries, essential medicines for treating mental illnesses should be provided in primary care settings (Jenkins and Strathdee, 2000).

Conceptualizing Collaborative Interaction

Understanding which collaborative strategies are associated with successful outcomes for consumers is vital to demonstrating the validity of collaborative services in primary care and to improving services. Because of the number of players involved, collaboration is a complex rather than a simple process: interactions occur in time and space, not only between the collaborators and the consumer, but also among the team members. Understanding this complexity is difficult, but necessary to determine causal relationships between variables of collaboration.

Before any measurement of collaboration can occur, the collaborative program must be clearly conceptualized in practical or theoretical terms, or both. For example, Millward and Jeffries (2001) created a tool to measure teamwork for use in the development of health care teams. They presented a cognitive motivational model of team effectiveness that incorporated the idea of a shared mental model, and meta-cognitive and motivational aspects of team functioning. This model suggests that a team must develop a strong knowledge of itself — its roles, objectives, strengths and weaknesses — to develop a capacity for self-regulation. Self-regulation implies a process of reflection and review of practices, followed by correction, refinement and further development. Two aspects of team motivation, which is inherent in this process, are articulated: identity and potency. Identity is related to the team member's pride in being part of the team, and deriving self-concept and self-esteem from the team's success. Potency is defined as the collective belief in the success and overall effectiveness of the team.

This cognitive approach to understanding teamwork is preferable to that of earlier models that focused on identifying and changing behaviours, which had limited impact (Millward and Jeffries, 2001). Behavioural models are limited because behaviour is specific to a task, situation, team and individual team members. Examining the cognitive elements helps identify which variables of the collaboration are constant

Collaboration is complex and dynamic, and therefore requires detailed study

The theory of collaboration must be conceptualized before any measurements can occur

in different situations and on which variables long-term interventions can be based (Millward and Jeffries, 2001).

Akhavain et al. (1999) also present a theoretical framework for the functioning of psychiatric interdisciplinary treatment teams that is based on systems theory. Teamwork requires being able to combine assertiveness with cooperativeness, being true to individual principles while working on a common goal, and balancing autonomy and togetherness. Differentiation of self refers to the ability to express oneself and the ability to maintain what is different about oneself when cooperating with others in a system of care. System or chronic anxiety occurs when uncertainty exists in oneself and in the system — the more trust and confidence a team member has in being respected, accepted and valued by other members, the less chronic anxiety there is in the system. Low levels of anxiety, higher levels of differentiation and greater emotional maturity of members of the team raise the level of collaboration and productivity. High-quality outcomes for consumers become the common goal of team members. Their collaboration around that goal depends on the unique contributions of each member. Equal importance given to these contributions means equal value assigned, thus supporting each of the team members and the overall work of the team. Members share responsibility for care through collaboration. Higher quality of collaboration positively influences the quality of care and the quality of achieved outcomes.

Sicotte et al. (2002) used an input-intervention-outcome model to develop the analytical framework of interdisciplinary collaboration in their study of Quebec community health care centres. Their model is based on organizational-theory research on work groups and self-managed work teams. Three types of factors may explain the impact of collaborative behaviours on work groups. Two variables related to the groups' working environment were depicted as input into the model: the characteristics of program managers (e.g., their discipline, level of study, years of management experience) and the structure of the program (e.g., activities to formalize care and assessment of the quality of care, the size of the professional workforce, budget). Intragroup processes constituted the interventions and were affected by six factors:

1. Beliefs in the benefits associated with interdisciplinary collaboration.
2. Level of social integration within the group.
3. Level of conflicts associated with interdisciplinary collaboration.
4. Agreement with disciplinary logic.
5. Agreement with interdisciplinary logic.
6. Characteristics of the design of the work group.

The output side of the model, representing the intensity of the interdisciplinary collaboration, had two elements, interdisciplinary coordination and care-sharing activities. Also added to this model was a mediating variable, the nature of the task that moderates the effects of the process factors on the work group's performance.

Pirkis et al. (2001) contrast the conceptual model of the Australian Public and Private Partnerships in Mental Health Project, or Partnership Project, with an input-intervention-outcome framework. This framework is a simple evaluation model in which the input is the consumer in need, the intervention is the collaborative program, and the outcome is the individual benefits and change in status of the consumer. They developed a logic model to capture the interaction taking place between private psychiatrists and public mental health services in the project, with the model supporting the development of specific program objectives and criteria for their success. The collaborative work involved a "sophisticated set of refinements to an already-complex system ... [and should] be understood as a process of structural reform where each step has the potential to activate processes that will impact upon providers and ultimately be of benefit to consumers and carers" (p. 641). In the more elaborate conceptual model of the Partnership Project, the authors highlighted five effects of collaboration:

1. Structural changes.
2. Activation of potential causal mechanisms.
3. Care coordination, consumer access, quality of care, and the like.
4. Changes related to total system reform.
5. Consumer and carer satisfaction and health outcomes.

These attempts to conceptualize collaborative care within a theoretical perspective are important because they attempt to capture the nature of collaboration. While there is no consensus about a preferred theoretical model, those who consider collaboration in terms of its content and links between behaviours have begun to clarify which collaborative elements to measure, how to design valid and reliable measures, and how to interpret the findings.

Measuring Collaboration

Examples of how to measure collaboration in primary care are now emerging, including some that specifically deal with primary mental health care. Common to these studies is the recognition of the multi-dimensional nature of collaboration. Since this field of research is still in its formative stages, studies have unique measurement instruments or approaches and unique views of which aspects of collaboration are worth measuring. These aspects of collaboration have been measured:

- ∞ Frequency of collaboration: collaboration measured with a checklist of collaborative activities and a self-report inventory completed by therapists after the third therapy session with each consumer (Brucker and Shields, 2003).
- ∞ Interdisciplinary collaboration: collaboration initially constructed from a conceptual framework that describes interdisciplinary care and from existing scales that measure the coordination of the interdisciplinary work group in hospital settings. Two factors emerged in the analyses (Sicotte et al., 2002):
 - Care-sharing activities: an 11-item scale focusing on care activities shared among different groups of professionals.
 - Interdisciplinary coordination: a seven-item scale focusing on work routines that facilitate coordination between various groups of professionals.
- ∞ Collaborative strength: measurement of the care patterns and the interpersonal texture of the collaborative relationship (Gerdes et al., 2001). Three factors emerged in the analyses:
 - Relationship quality: consisting of the primary care provider's satisfaction with the mental health provider, perceived access, use of different consultation modes, description of communication with the mental health service provider, types of communication during different modes of care, and timeliness of the mental health consult.
 - Primary care-provider attributes for and attitudes to managing mental health conditions: including primary care providers' personal preference to treat mental health problems, training in diagnosis and treatment of mental illness, self-report rating of ability to treat mental illness and frequency of attending continuing medical education on mental illness and health.

A variety of measures for evaluating collaboration are emerging

- Frequency of collaboration of primary and mental health care: including reported frequency of mental health referral and consultation by primary care providers.
- ✎ Operational integration: involvement of key indicators of operational integration between psychiatry for older consumers and other disciplines, and social services that focus on care activities with consumers (Reilly et al., 2003). A number of factors were associated with integration in practice:
 - The presence of a specialist service.
 - Several outreach activities, including provision of training and advice about early recognition and management of mental health problems to home care and primary health care professionals, and consultants' participation in regular clinical meetings with general practitioners.
 - Shared set of written policies and procedures.
- ✎ Team motivation: motivation shared by team members measured by the Team Survey instrument, which has two important aspects (Millward and Jeffries, 2001):
 - Identity: identity of individual team members is affected by whether the person is proud to be part of the team and derives self-concept and self-esteem from the team's success.
 - Potency: the collective belief that the team can succeed and be effective globally.
- ✎ Collaborative values: team members' assessments of progress towards expressing values consistent with an effective team over time (Cashman et al., 2004).
- ✎ Decision-making in health care teams: decision-making affected by two types of team working processes (Cook et al., 2001):
 - Augmentation of information instrumental to supporting effective consumer-related decision-making.
 - Enhanced support for decision-making, especially for problem-solving.
- ✎ Satisfaction: measurement of the degree to which family physicians, mental health team members and psychiatrists are satisfied with various aspects of a collaborative care mental health program, including adjustments made by practices to accommodate mental health teams, services provided, communication and supports for providers (Farrar et al., 2001).

Evaluating and Monitoring Collaborative Care

Evans and Lloyd (1998) provide a brief, but useful discussion of the difference between research and an audit of primary mental health care. Research is used to determine what best practice is. It is a complex, lengthy, costly process that produces results that are often difficult to implement in real practice. Audits, on the other hand, evaluate how close a practice is to best practice and offers a way of exploring care in the consumer group of a practice, rather than simply relying on research findings based on other populations or different settings. The authors note the availability of a number of audit tools at the time of writing and encourage local ownership of the audit process to ensure that audit findings are applied to future changes in practice.

Pirkis et al. (2001) provide an informative review of the work of Knapp (1995) in their article evaluating the Australian Partnership Project. Knapp identified three key factors required for evaluating collaborative initiatives:

- Ensuring that the perspective of all players in the collaboration is represented in the evaluation.
- Being specific about what is being measured in the evaluation, including processes, impacts and outcomes.
- Attributing effects to causes, which is often difficult because collaborative programs are multi-faceted and operate in complex systems.

Pirkis et al. (2001) also provide advice for dealing with these issues about evaluation:

- Evaluation should be strongly conceptualized. Every attempt should be made to capture the complexity of the collaborative program and the linkages that may assist with the attribution of cause and effect. Use of logic models is recommended.
- Evaluation should include detailed descriptions of the elements of the collaborative program (e.g., structural characteristics, formal and informal collaborative mechanisms, pathways to care, experience of consumers, carers and providers) because different players see the interaction in different ways.
- Evaluation should include comparative analyses of the extent to which collaborative arrangements improve the experience of consumers, families and providers. Also discussion of supportive factors and barriers should be highlighted.

Ensuring collaborative programs are evaluated can build the evidence base

Information technology can facilitate collaboration

- Evaluation should be conducted with constructive skepticism, and should be wary of the hype that comes with collaboration and be open to positive and negative effects at multiple levels.
- Evaluation should be anchored at the level of consumers and families to ensure a balanced approach that examines service and system benefits at the ground level.
- Evaluation should also be collaborative. It should involve input from all players to incorporate as many perspectives as possible. This requires adequate time and willingness to share control.

Information Technology and Other Practices Assisting Collaboration

A variety of devices and practices support collaboration. Documentation and information systems, hand-held computers for information mastery and use of practice guidelines, recall systems for care management, work environment factors and development or use of service protocols are some of the issues raised in the literature reviewed.

Documentation methods

Mauer/NCCBH (2003) discuss how documentation methods for behavioural health care in primary care settings may vary, depending on the business model used to integrate mental health staff into a primary care practice. If the clinician is employed in the primary care practice, the mental health documentation becomes part of the medical chart. Mauer/NCCBH suggest that it be put into a separate segment of the chart to facilitate quick access to these notes and to protect this sensitive information from inadvertent release. Other employment models have an impact on the documentation issue: when the mental health clinician works under the direction of a physician (the so-called staff-rental model), the documentation is part of the medical chart, whereas when mental health staff are employees of the mental health agency working in the primary care setting, the documentation remains in the mental health system (which could be a significant barrier to the integration of care within the primary care setting).

Mauer/NCCBH (2003) add that there is consistent agreement that documentation should be brief and immediate. This is likely to be challenging for mental health providers who traditionally keep long notes in their documentation. Primary care practitioners, in the fast-paced environment in which they operate, require short and easily accessible notes.

Electronic medical record systems

Two studies mention the use of electronic medical record systems in collaborative care programs. Rollman et al. (2003) found that use of the electronic medical record greatly facilitated the interaction among team members managing consumer care in a study of collaborative care of panic and generalized panic disorders. In the case of the U.S. Veteran's Administration who invested considerably in information technology, the electronic medical record is used in their innovative depression care programs (Hedrick et al., 2003). In Canada, a current national initiative to develop electronic records includes an integrated record that would capture all types of health care information, including mental health information (Canada Health Infoway, 2004). This development would be of incredible value to all health care practitioners and would benefit all consumers' health outcomes, including outcomes of collaborative mental health care.

Consumer-held health record

A consumer-held mental health record, an alternate approach to documentation, was tested in a cluster randomized control trial for consumers with schizophrenia (Lester et al., 2003). This research was conducted to see if consumer-held records should become a routine part of shared care for all consumers with schizophrenia in Birmingham, emulating a similar practice for the management of other chronic diseases such as diabetes. In such a record, consumers hold all or some of the information related to the course and care of their illness. The findings showed that although consumers were able to retain their records, which key workers used regularly, there was no demonstrable effect on primary outcomes. However, consumers favoured the consumer-held record as a communication tool, especially for communication between the consumer and the key worker because it served as a reminder and a mechanism for recording their thoughts before their visit.

Use of computers for information mastery

Technology can help family physicians practising mental health care cope with all the information they need. In responding to the demands of offering mental health care in the primary care setting, primary care providers are challenged by the quick pace of service in that setting and the level of knowledge required to deal with a wide range of mental health illnesses. Waters (2003), in an aptly titled article "No one can do it alone anymore: information mastery, collaborative care and the future of family medicine," compares the tools of information mastery used in

family practice with those of collaborative care. Information mastery is evidence-based medicine delivered through doctors' hand-held computers that enables doctors to bring the best scientific evidence to bear on any problem (Waters, 2003). This access to a wide range of the latest information enhances the clinical value of the doctor–consumer encounter and gives the doctor a sense of mastery and effectiveness. Similarly, Waters argues, collaborative care is like information mastery, adding new information and perspectives to the encounter, integrating multiple resources into care, and helping the consumer use the resources to optimize his or her health: “Collaborative care is the behavioral science equivalent of Information Mastery; it does for the doctor in the psychosocial realm what IM [information mastery] does for the doctor in the medical realm. It strengthens the doctor in the area of depth in the same way IM supports the breadth. Each is an important addition to the armamentarium of the family doctor if practice is to remain optimal, viable and interesting. No one can do it alone anymore — and that should be seen as an invitation to expand our horizons, rather than as an admission of failure” (p. 341).

Case registers

The use of case registers as a care monitoring tool within the context of collaborative care has been raised. In Great Britain and Europe, where psychiatric case registers have existed for many years, authors like Jenkins and Strathdee (2000) and Mauer/NCCBH (2003) suggest that joint case registers between mental health programs and primary care, coupled with regular joint review of case plans, can be an effective means of integrating primary and secondary care. Such registers provide prompts for recalling or contacting consumers about their care. Some depression clinical trials studying this element of collaborative care suggest this tool should be included in the depression care model (Craske et al., 2002; Feinman et al., 2000; Oxman et al., 2002).

Work environment

Work environment is a significant issue for mental health workers in primary care settings. As Farrar et al. (2001) found in their study of an integrated shared mental health care program, inadequate workspace caused dissatisfaction with the program among mental health counsellors and psychiatrists. This study did not reveal what was inadequate about the workspace. Mauer/NCCBH (2003) also noted that organizations integrating mental health services into primary care settings need to be aware of the allocation of physical space and support resources because these can be barriers or incentives to implementation.

The ideal is to locate mental health staff in the same primary care area where the doctors work, to support open-door interactions among them; to have behavioural consultations in the medical examining rooms and the same kind of clerical support available to all professionals; and to have common access to all facilities, and a common waiting room and reception area for all consumers.

Service protocols

Ricketts et al. (2003) examined the use of service protocols to support collaboration between primary and secondary mental health care in England. They found that effective development of service protocols was associated with a high level of management support, a single project manager and access to a range of stakeholders for the review of draft protocols. Effective dissemination depended on face-to-face contact with clinicians, training and managerial interventions. A significant barrier to implementation in the system studied was the ambitious, constant overall agenda for change in mental health and primary care services. Of the types of protocols introduced in this study, the depression protocol was the most popular, but little impact of the protocols on clinical practice was reported.

Chapter Summary

A number of collaborative practice and system level structures support collaborative mental health care — from ensuring that the roles and functions of team members are well defined to developing national policies on mental health that establish a mechanism for integrating mental health into primary health care.

Collaborative mental health care must be measured and evaluated to define best practices and adjust processes to improve services. The relative infancy and complexity of this field makes research and evaluation difficult. First, clear conceptualization of a theoretical model is needed — one that will lead to the development and use of reliable measures for effective program monitoring and evaluation.

Information technology can greatly assist the process of collaboration, from instant electronic client-file sharing to e-health records to care registers that offer prompts so that consumers may easily be recalled or contacted about their care.

CONCLUSION

The promise of collaborative mental health care is improved treatment and outcomes for anyone who experiences mental illness. The sustained interest of researchers and practitioners is producing new insights into the types of collaborative mental health care approaches that will make a difference.

The CCMHI Framework for Collaborative Mental Health Care (Gagné, 2005) provides an effective lens through which to view the growing literature about collaborative mental health care. The more than 300 published documents included in this literature review speak to the many key elements defined in the CCMHI Framework.

What follows recapitulates some of the highlights of this annotated bibliography that are relevant to each portion of the CCMHI Framework:

- ∞ Policy is necessary to ensure that health care systems systematically define and incorporate collaborative care.
- ∞ A number of contextual factors for the development of primary mental health care policy were identified in the literature: service delivery, structures, access, financing, monitoring, quality assurance, training and education, privacy protection laws, consumer issues, government agency communications, and national funding.
- ∞ Collaborative care needs to build an evidence base through research. Early research, however, was limited. New research methods and broader outcome measures must be explored.
- ∞ Funding plans must be engineered to benefit the entire system, rather than particular groups of professionals, to encourage the implementation of new care prototypes that are more effective and satisfying than usual care. Payment mechanisms that can be adapted to offer these incentives do exist.
- ∞ Community needs are central to the development of collaborative care programs. These programs should conduct or use current needs-assessment information and use practical strategies to develop collaborative practices.
- ∞ Consumer centredness is predicated on the concept that consumers can and should be actively involved in all aspects of their health care, including identifying issues of concern; making informed treatment choices; and contributing to the design, implementation and evaluation of programs.

- ❧ A number of strategies may strengthen the consumer voice: listening to consumers, raising awareness and declaring differences, encouraging a different kind of power, forming coalitions and valuing dialogue, and preparing to be enriched and enriching.
- ❧ Consumer centredness also means adapting collaborative care to suit the needs of special consumer populations: for example, consumers with serious mental illness or concurrent disorders; and rural populations, seniors, and children and adolescents with mental illness.
- ❧ The rationale for integrating primary and mental health care is a frequent subject of the literature. Collaborative mental health care benefits consumers, providers, and the system at large.
- ❧ A number of frameworks and models have been developed to review that growing literature (e.g., frameworks by Strosahl, Blount, Goetz, Katon and Paxton). Many of the models focus on the level and type of need, both physical and mental, of consumers.
- ❧ The knowledge base for models of collaborative care continues to grow. Models are evolving. Some of these models involve consultation–liaison and management of care for depression.
- ❧ These frameworks and models share common goals: to increase understanding about the integration of discrete disciplinary approaches, to improve services for common mental disorders, and to produce better health outcomes.
- ❧ Teamwork is a functional approach to collaborative care that brings many professionals together in partnership with consumers, families and caregivers.
- ❧ The literature is rich in its description of effective teamwork strategies, including some interactive and ideological tools.
- ❧ Effective communication and clear definitions of roles in multidisciplinary teams are a central theme. Being aware of the differences between the various disciplines involved can greatly contribute to clear communications and expectations among team members.
- ❧ The literature documents the involvement of professionals from many disciplines in collaborative mental health care and their potential roles on the teams. For example, team members may be psychologists, physicians, psychiatrists, pharmacists, social workers, nurses, occupational therapists, dietitians, clergy, and consumers as peer-support workers.

- ∞ Models have evolved to include new positions (e.g., link workers) to facilitate the integration of mental health and primary health care. These positions can be filled by professionals from various disciplines.
- ∞ A number of practice- and system-level collaborative structures support effective collaborative mental health care.
- ∞ Examples of practice-level collaborative structures include job descriptions with clear expectations, leadership and coordination functions separate from clinical and professional responsibilities, and well-designed clinical processes and pathways.
- ∞ System-level structures include continuing education for providers, training future professionals in collaborative mental health care, and evaluating designs and methods.
- ∞ A number of useful tools (e.g., electronic health records, consumer registers or recall systems), administrative processes (e.g., treatment guidelines and screening tests, service protocols or interagency agreements), and integrated administrative procedures (e.g., reception, appointment processing and charting) facilitate the collaborative process.

Synthesis of current findings and advancements in the research about collaborative mental health care require active and ongoing debate, a challenge made more exciting by the interdisciplinary nature of collaborative care. Truly, the best opportunity to meet the mental health needs of consumers in a holistic and meaningful way is for all partners to join in the caring process, particularly in the primary care setting. Consumers and families must take centre stage and assume responsibility for their own personal health and well-being. They must direct health care professionals' response to mental illness to enhance the recovery process. Health care professionals need to bring their knowledge and expertise to bear on these illnesses in creative, effective ways that embrace consumers' goals and propel them into improved health.

The growing body of knowledge documented in the professional literature discussed in this annotated bibliography and literature review provides a starting point that should inspire collaborative care practitioners to continue their dedicated efforts to improve the mental health of people around the world.

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ARTICLE SUMMARIES

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Abrahams S, Udwin O. An evaluation of a primary care-based child clinical psychology service. *Child and Adolescent Mental Health*. 2002 Sep;7(3):107-13. <Abstract>

Abrahams and Udwin (2002) evaluate a primary care-based clinical-psychology service for children in London, England. The purpose of the program was to provide psychological treatment for children who experience emotional or behavioural problems and their families, and consultation and liaison with primary health care teams. The authors compare the characteristics of referrals to and the clinical outcomes for the program with those of local secondary-level mental health services for children, and present their perceptions of the referral agents. Overall, they found that this type of program is useful for responding to a wide range of mental health problems among children and adolescents in a primary care setting.

Akhavain P, Amaral D, Murphy M, Uehlinger KC. Collaborative practice: a nursing perspective of the psychiatric interdisciplinary treatment team. *Holist Nurs Pract*. 1999 Jan;13(2):1-11. <PubMed>

Akhavain et al. (1999) present a theoretical framework describing the dynamic process that occurs in a work system such as a primary care mental health team. Related to the dynamic process of team functioning is the way this work process affects the person receiving care. As a framework for understanding the interdisciplinary collaboration in the mental health team, the authors present the principles of Bowen's family systems theory that focus on relationships. In particular, they discuss two important principles: differentiation of self and chronic anxiety in the system. Differentiation of self involves the ability to express oneself and to maintain what is different about oneself when cooperating with others in a system. Bowen's

theory defines collaboration as working in a system that means giving of, but not giving up of oneself. The skills required include being able to combine assertiveness with cooperativeness, being true to individual principles while working on a common goal, and balancing autonomy and togetherness. Favourable patient outcomes are the common goal that unites the team members, each of whom make unique contributions to the service delivered. As long as these contributions are considered equal in importance and in value, positive collaboration results. Collaboration, in turn, allows shared responsibility. The overall quality of the collaboration has a direct impact on both the quality of patient care and patient outcomes.

Albrecht PC, Gorman E, Aiken F. The promises and perils of interprofessional education: a student's view. *Canadian Social Work*. 2004 Autumn;6(1):9-23.

Albrecht et al. (2004) provide a student's perspective on the promises and perils of interprofessional education through their review of interprofessional education across the globe and in Canada, and of specific interprofessional education efforts at the University of Toronto (1999–2001). They discuss the importance of interprofessional education for health science students, the difficulties in implementing interprofessional education, and the importance of social work in interprofessional education. Their discussion of barriers helps explain why interprofessional education is not the norm at all universities. Practical reasons include conflicting schedules that make it difficult to get students from many faculties together at one time, departments that are reluctant to give up curricular time for interprofessional education when students are already overburdened with demands, and a lack of funding and faculty time for curricular planning. The authors recommend

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research into the effect of interprofessional education on effecting a positive change in student behaviour.

Alexopoulos GS, PROSPECT Group. Interventions for depressed elderly primary care patients [editorial]. *Int J Geriatr Psychiatry*. 2001 Jun;16(6):553-9. <PubMed>

Alexopoulos and the PROSPECT Group (2001) discuss reasons for treating depression of the elderly in primary care settings and the consequences of mismanaging depression in primary care patients. The authors review the challenges of research, focusing on primary care patients. Early efforts that centred on physician education as the key to improving care have not improved physician behaviour or patient outcomes. Treatment guidelines may be useful only for influencing the process of care and clinical outcomes, the latter varying with physician adherence to the guidelines. Research into specific interventions, including the use of computerized tools and face-to-face contact with specialists, has attempted to reduce barriers to the recognition and treatment of depression.

Alkin T, Tunca Z, Yemez B, Gogus A. Training course for primary care physicians and medical students in the management of depression [poster presentation]. *European Neuropsychopharmacology*. 1996 Apr;6(Suppl 1):S1/23-S1/24.

Alkin et al. (1996) discuss a training course about the management of depression given to primary care physicians and medical students in Turkey. In a half-day session with a pre- and post-test design, students and physicians were given a teaching package consisting of an instructional videotape, didactic slides and pocketbooks that focused on the recognition, pharmacological treatment and general clinical management of depression. Students and physicians concurred in their opinions about the cause of depression, their personal interest in mental health problems, their beliefs in the treatment of mental disorders and their self-evaluation about

the effectiveness of the management of such disorders. The study did not assess the long-term success of the education program.

American Association of Community Psychiatrists. Position statement on interface and integration with primary care providers (Approved October 10, 2002.). Dallas, TX: AACP; 2002. Available from: <http://www.comm.psych.pitt.edu/finds/PCPMenu.html> OR <http://www.comm.psych.pitt.edu/finds/primarycare.pdf>

The American Association of Community Psychiatrists (2002) identify a number of training principles to guide the achievement of the goals of integrated primary mental health care:

- ✎ Psychiatrists and other mental health professionals who work in community-based settings must become aware of the clinical culture of primary care and the types of psychiatric disorders encountered in those settings.
- ✎ Behavioural health programs need to train most of their providers to understand how to collaborate and communicate most effectively with their primary care colleagues, especially in the care of persons with severe and persistent mental illness.
- ✎ These same programs should identify and train specific clinicians who can more directly collaborate and consult with primary care providers, either through a co-location consultation model or in a more systematic behavioural health integration program.

Anderson GL, Lovejoy DW. Predoctoral training in collaborative primary care: an exam room built for two. *Professional Psychology: Research and Practice*. 2000 Dec;31(6):692-7.

Anderson and Lovejoy (2000) describe a collaborative practicum experience for family medicine residents and predoctoral psychology students in an outpatient clinic in Virginia. They identify incentives that may convince a busy primary care practice to provide practicum

placements: for example, having the medical resident in the practice for an extra day a week to see patients and to help nursing staff manage urgent requests and difficult cases. The authors describe a few of the instruments used as part of the evaluation of the program, such as the Physician Belief Scale, which is a reliable self-report tool designed to measure primary care physicians' beliefs about the psychosocial aspects of patient care, and the Oetting/Michaels Anchored Ratings for Therapists, which covers assessment and intervention skills.

Anfinson TJ, Bona JR. A health services perspective on delivery of psychiatric services in primary care including internal medicine. Med Clin North Am. 2001 May;85(3):597-616. <PubMed>

Anfinson and Bona (2001) examine the implications of recent advances in the pathophysiology and treatment of psychiatric disorders for internal medicine. Useful as a brief primer, this overview article describes the mental health needs and emerging best practices in primary mental health care. A review of current models of delivering integrated health care is structured according to the hierarchy of psychiatric interventions in primary care: usual care by the primary care provider, usual care with psychiatric consultation, development of primary care psychiatric screening instruments, development of evidence-based treatment guidelines, enhancing dissemination and implementation of the guidelines, and development of collaborative models of care.

Anthony WA. A recovery-oriented service system: setting some system level standards. Psychiatr Rehabil J. 2000 Fall;24(2):159-68.

Anthony (2000) presents a set of system-level standards for a recovery-oriented mental health service system. Based on input from mental health consumers about their experience of recovering from a mental illness, service systems have begun to acknowledge recovery and to reorient service delivery so that it better affirms

the possibility of recovery for people who experience mental illness. Anthony identifies assumptions about the recovery process that may be used to guide the development of the service system, defines the services essential to a recovery-oriented system, details the characteristics of such a system, and provides an overview of system-level research.

Appleton PL, Hammond-Rowley S. Addressing the population burden of child and adolescent mental health problems: a primary care model. Child and Adolescent Mental Health. 2000 Feb;5(1):9-16. <Abstract>

Appleton and Hammond-Rowley (2000) present an ecologically based primary care model for child and adolescent mental health care designed to reduce the burden of these conditions on the population in Wales. In this model, mental health specialists working in primary care settings would follow specific population objectives focused on the particular needs of a particular community, rather than provide a secondary care service for a larger geographical area (specialist-liaison attachment). The supporting infrastructure would assign specialists to all primary care service bases within a small geographic area — all general physicians' practices and schools for the target age groups. Collaboration among professionals in the small area would be fostered. Forthcoming evaluation of the program is also described.

Araya R, Rojas G, Fritsch R, Gaete J, Rojas M, Simon G, Peters TJ. Treating depression in primary care in low-income women in Santiago, Chile: a randomised controlled trial. Lancet. 2003 Mar 22;361(9362):995-100. <PubMed>

Araya et al. (2003) investigated treatment of depression in primary care for low-income women in Chile in a randomized control trial. Results of a stepped-care program, a three-month multi-component initiative led by a nonmedical health worker, were compared with

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those for usual primary care. Measures were taken at baseline, and at three and six months. Findings revealed that a large number of women completed the outcome assessments and that there were substantial group differences for all outcome measures in favour of the stepped program.

Arthur AJ, Jagger C, Lindsay J, Matthews RJ. Evaluating a mental health assessment for older people with depressive symptoms in general practice: a randomised controlled trial. Br J Gen Pract. 2002 Mar;52(476):202-7. <PubMed>

Arthur et al. (2002) present the findings of a randomized trial investigating the effective management of care for elderly people with minor depression in England. In this study, a community mental health team provided follow-up assessment or usual care for participants who scored above a specified threshold on a health check administered to all people over 75 years of age in a large general practice. The findings indicated that the intervention did not effectively improve outcomes for the seniors, although these findings may have been confounded by restrictions on further follow-up by the community team. The funding agency could limit further follow-up to that provided by the patient's general practitioner after the assessment. Arthur et al. recommend that specialty mental health professionals train primary care practitioners to care for depressed older patients within primary care settings.

Atkin K, Lunt N. The role of the practice nurse in primary health care: managing and supervising the practice nurse resource. J Nurs Manag. 1996 Mar;4(2):85-92. <PubMed>

Atkin and Lunt (1996) examine the management and supervision of practice nurses in primary care to determine how nurses, general practitioners and the staff who have responsibility for managing and planning community nursing services perceive the practice nurses' role. The nature of the role, the principles of supervision, the accountability and

responsibility in the work, the need for and role of education and training, the relationship of practice nursing to other types of community nursing, and the perceived benefits of practice nursing to patients are explored. Different stakeholders in the study raised different issues about practice nurses, emphasizing their unique priorities and backgrounds. The practice nurses themselves wanted to see their role expanded in the future, and more emotional and administrative support from their employing general practitioner; saw no problems with the level of clinical supervision; and were not interested in the more general management issues of primary care. Similarly, general practitioners were not concerned about clinical supervision issues, but did raise concerns about managerial and administrative responsibilities, and were open to outside support for the implementation of formal employer–employee relationships with the practice nurses. Purchasing and funding agencies were interested in developing effective and integrated primary health care services, and in ensuring adequate education for practice nurses and the equitable distribution of this nursing resource.

Badger F, Nolan P. General practitioners' perceptions of community psychiatric nurses in primary care. J Psychiatr Ment Health Nurs. 1999 Dec;6(6):453-9. <PubMed>

Badger and Nolan (1999) explore general practitioners' perceptions of community psychiatric nurses. These nurses have worked with psychiatrists and former mental hospital patients in the community in primary care in central England since the 1950s. These community psychiatric nurses became professionals in the 1970s, expanding their role into primary health care, providing counselling, therapy and knowledge about mental health to people experiencing emotional problems. This study revealed that the general practitioners surveyed held favourable views about community psychiatric nurses and believed their role to be important. The authors describe a range of possible linkages between these nurses

and primary care practices: they have been based in primary and secondary (mental health) care, having regular daily, weekly or monthly contact; they hold occasional clinical sessions in primary care; or they attend practice meetings or caseload review meetings. The authors note that insufficient research exists to indicate which of these models is best practice.

Badger F, Nolan P. What have we learned and where do we go from here? In: Nolan P, Badger F, editors. Promoting collaboration in primary mental health care. Cheltenham: Nelson Thornes; 2002. p. 248-64.

In chapter 16 of their book *Promoting collaboration in primary mental health care*, Badger and Nolan (2002) concisely discuss the key collaborative care issues evident in a series of collaborative programs, highlighting the foundations, essential elements, modes and outcomes of collaboration. They outline a model for productive collaboration comprising people-centred and organization-centred components. The three elements of the people-centred component are service user focus, individual characteristics of providers and professional competencies; and those of the organization-centred component, organizational climate, training and education, and policy context.

Badger L, Robinson H, Farley T. Management of mental disorders in rural primary care: a proposal for integrated psychosocial services. J Fam Pract. 1999 Oct;48(10):813-8. <PubMed>

Badger et al. (1999) propose an integrated care model that would include the delivery of psychosocial services in primary care settings in rural communities. Citing the challenges facing rural primary care practitioners, the authors illustrate the advantages of having a psychosocial expert available to rural primary care practitioners and the community itself to respond to the needs of rural residents with mental illness. Since rural residents do not see their issues as psychiatric and wish more holistic

responses, suitable candidates for these positions are social workers who are well qualified to provide case management. Badger et al. further suggest that primary care physicians could provide leadership for building this new capacity in their communities.

Badger LW, Ackerson B, Buttell F, Rand EH. The case for integration of social work psychosocial services into rural primary care practice. Health Soc Work. 1997 Feb;22(1):20-9. <PubMed>

Badger et al. (1997) present the case for collaboration between social workers and rural primary care physicians about health and mental health care. The study investigated the perceptions of rural primary care physicians about the quality of their past experience with social workers, the acceptability of integrating social work services into their practices, and their assessment of the breadth and type of services that social workers might offer in that setting. The authors note that social work and primary care are similar in their emphasis on the continuity of care and the need for comprehensive health and mental health care. Medical social work, one of the oldest subspecialties, dating back to the late 1800s, has always emphasized the need to pay close attention to the effect of the interplay of social forces and conditions on the health of consumers. However, since the role of medical social workers has not always been clear, the study attempted to identify the social work services that physicians value. The findings showed that doctors (30 per cent, or 27/91) who expressed an interest in collaborative care arrangements differed from the other 60 per cent of responding doctors in practice characteristics, attitudes toward social workers and endorsement of social work roles. These doctors treated significantly more patients, had the lowest proportion of patients over 65 years of age and endorsed as useful a significantly larger number of social work activities. Such activities included those of counsellor, patient educator, financial assistant, facilitator of transitions and case manager.

Baldwin C. Community pharmacy 2009: would you believe it? Chemist and Druggist (England). 1999 Nov 6;252:26, 28.

Baldwin (1999) speculates about the role of pharmacists in primary care in Britain in the year 2009 when the introduction of primary care groups and re-engineered social care would allow pharmacists to become partners in the planning and delivery of health care. Their participation would be possible on two fronts — their knowledge about medicines and their interpersonal skills in their work with patients and doctors. In addition, pharmacists have business, strategic and planning skills relevant to the development of primary care. Through their practices, they offer health promotion and education as an integral member of the local health continuum, and often have space available to offer walk-in centres and clinics.

Barnes D, Carpenter J, Bailey D. Partnerships with service users in interprofessional education for community mental health: a case study. J Interprof Care. 2000 May;14(2):189-200. <Abstract>

Barnes et al. (2000) present an informative case study of the involvement of people who experience mental health challenges (whom they call users) in an interprofessional education program for community mental health. Both users and providers were involved in the development, delivery and evaluation of a post-graduate program offered in England, which has supported user involvement for well over a decade. The authors describe the evolution of user involvement models during that time from the consumerist approaches of the early 1990s to a dominant concern with empowerment in the mid 1990s to, most recently, the growth of stakeholders as partners. "Partnership as a concept acknowledges differences in power without demanding equality. Instead it requires a negotiated agreement about roles and responsibilities and an understanding of where power is located....What is important is that the user's voice is heard, their [sic] perspective is valued and their [sic] views have influence" (p.

190). An extensive, insightful list of user-defined outcomes for interprofessional education indicates what content should be covered in education programs that promote collaborative care and what people should expect from that care. Partnerships involving culture, values, roles and responsibilities are discussed. Overall, the authors conclude that there is good evidence that these partnerships add value to the process of interprofessional education.

Barrett G, Greenwood R, Ross K. Integrating interprofessional education into 10 health and social care programmes. J Interprof Care. 2003 Aug;17(3):293-301. <PubMed>

Barrett et al. (2003) report on the introduction of interprofessional modules into ten prequalifying (undergraduate) professional programs at the University of West England in 2000. Implementation was grounded in a new policy in England calling for the collaboration of education and practice agencies. The authors provide a good description of the processes used to develop the new program and curriculum that could be useful to other groups considering this type of change. In addition, a number of challenges confronted during the implementation are reviewed in detail: creating interprofessional student groups when numbers of students are unevenly split across professional groups, developing and selecting appropriate scenarios, assembling the faculty team to deliver the modules, providing resources for interprofessional learning sources and student support, integrating the students' educational experience, and facilitating the delivery of interprofessional modules. Some adjustments in response to preliminary evaluations are also presented.

Bartels SJ, Coakley EH, Zubritsky C, Ware JH, Miles KM, Arian PA, Chen H, Oslin DW, Llorente MD, Costantino G, Quijano L, McIntyre JS, Linkins KW, Oxman TE, Maxwell J, Levkoff SE; PRISM-E Investigators. Improving access to geriatric mental health services: a randomized trial comparing treatment engagement with integrated versus enhanced referral care for depression, anxiety, and at-risk alcohol use. *Am J Psychiatry*. 2004 Aug;161(8):1455-62. <PubMed>

Bartels et al. (2004) conducted a randomized control trial known as the PRISM-E that compared engagement with treatment in two models of mental health care for older patients. In the first model, patients were referred to specialized mental health services, and the cost and transportation were facilitated in the referral process. In the second model, patients were referred to mental health services that were integrated with primary care. Engagement in treatment was greater (e.g., greater number of visits, more timely visits from first point of contact) for those patients in the second model of care. The distance between the mental health services and the primary care setting was a significant indicator of the level of engagement.

Bashir K, Blizard B, Bosanquet A, Bosanquet N, Mann A, Jenkins R. The evaluation of a mental health facilitator in general practice: effects on recognition, management, and outcome of mental illness. *Br J Gen Pract*. 2000 Aug;50(457):626-9. <PubMed>

Bashir et al. (2000) examine the placement of a mental health facilitator in general practice to see whether such facilitation affected the recognition, management and outcome of mental illness. Facilitation had previously been used for physical, but not mental illness. A facilitator establishes personal contact with a local practice, encouraging good practices and better service organization. In this instance, the facilitators were not specialists. They visited six practices over a period of 18 months, providing guidelines and organizing training activities. These practices

were compared with six controls. Recognition, management, the use of medical interventions and investigations, and patient outcomes at four months were assessed before and after the intervention. The facilitator improved physicians' recognition of psychiatric illness, but had no discernable effect on management or patient outcomes. The study showed it was possible to train generic facilitators to take on the mental health role, but the absence of effects on treatment and outcome suggests the need for further development of this approach.

Bateman H, Bailey P, McLellan H. Of rocks and safe channels: learning to navigate as an interprofessional team. *J Interprof Care*. 2003 May;17(2):141-50. <PubMed>

Bateman et al. (2003) used an ethnographic approach to study the establishment of an interdisciplinary primary medical team in England. Five principles of team development were used as guidance: hiring professionals with relevant expertise and experience outside of primary care; using a flat management style; encouraging team members to be curious, and supporting them with encouragement and tools for learning; encouraging team members to use particular skills and expertise to enhance patient care; and establishing respectful and responsible relationships with patients so that patients could play a genuine part in the evolution of the health care services and the health care team. A number of challenges that arose during the first year of operation were discussed.

Bazon Center for Mental Health Law. Get it together: how to integrate physical and mental health care for people with serious mental disorders. Washington, DC: The Center; 2004. Executive summary available from: <http://www.bazon.org/issues/general/publications/getittogether/execsumm.htm> OR <http://www.bazon.org/issues/general/publications/getittogether/execsummary.pdf>

The comprehensive report of the Bazon Center for Mental Health Law (2004) discusses how to

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integrate physical and mental health care for people with serious mental illness. Although the main focus is on the care of adults with serious mental illness, the care of children with serious behavioural problems is also discussed. The review of the literature focuses on conditions that are comorbid with mental illness. A framework of the barriers to integration is used to analyse U.S. service delivery models for integration of behavioural and physical health care. Contracting models are discussed and policy issues are covered in detail.

Bellman L. Evaluation of a multi-professional mentoring scheme in primary health care [research report]. J Interprof Care. 2003 Nov;17(4):402-3. <PubMed>

Bellman (2003) describes a mentoring program for primary care health professionals and administrative staff that encouraged experienced persons to share their knowledge and skills, provided support and encouragement between persons identifying professional development needs and creating a plan to meet those needs, and developed a multi-professional learning environment. Mentors were trained and attended regular multi-professional action learning sessions. Participants were able to select their mentors and receive six 1 1/2-hour mentoring sessions. Evaluation elements included an examination of the personal experience of the mentoring scheme, identification of the outcomes of participating in the scheme and the changes or developments in the scheme. The results for 52 people, selected in a purposive sample to reflect the range of disciplines involved in the program, showed that both mentors and mentees found that the learning experiences were enlightening and empowering, demonstrated support for personal and professional challenges, enhanced collaborative practices, and engendered commitment to the evolving scheme.

Berardi D, Menchetti M, Dragani A, Fava C, Leggieri G, Ferrari G. The Bologna Primary Care Liaison Service: first year evaluation. Community Ment Health J. 2002 Dec;38(6):439-45. <PubMed>

Berardi et al. (2002) discuss the first-year evaluation of the Bologna Primary Care Liaison Service. Italy's national policy requires that community mental health centres, which provide first-level care, offer consultation-liaison services to primary care physicians in their catchment areas. Over one-third of the general practices participated in the first year. Overall, primary care and mental health care networks are well distributed in the country, but not well coordinated. The Bologna Primary Care Liaison Service, which was staffed by two psychiatrists and one psychologist, and was open two days a week, received referrals from local general practices. It provided diagnostic assessment, shared care interventions and consultation-liaison activities between the psychiatrists and general practitioners for the management of cases and educational activities. Overall, the service was well received, and patients and general practitioners found it effective.

Bindman J, Goldberg D, Chisholm D, Amponsah S, Shetty G, Brown J. Primary and secondary care for mental illness: impact of a link worker service on admission rates and costs. Journal of Mental Health. 2001 Dec;10(6):637-44. Abstract available from: <http://taylorandfrancis.metapress.com/openurl.asp?genre=article&eissn=1360-0567&volume=10&issue=6&spage=637>

Bindman et al. (2001) studied the impact of a link-worker service on admission rates and costs for primary and secondary mental health care. This study contrasted a primary care mental health program with a comparable traditional service in a neighbouring and similar community in London, England. Service activity and costs were measured at baseline and over two years' follow-up as the intervention service developed. The intervention service resulted from the

reorganization of an existing community mental health team that appointed link workers to relate to the specific general practitioners that the team served. These link workers remained members of the multi-disciplinary team and were supervised by the team manager. Their role was flexibly defined. They were able to build relationships with the general practitioners and respond to the needs of these local practices for coordination and facilitation of referrals. Each worker was assigned a caseload of patients from the mental health services, registered with their linked primary care practices. Patients were seen in the team setting, the practice or other settings. The results showed that the link-worker program did not affect the use of inpatient beds or costs over the study period. The activity review showed that the link workers were primarily involved in the management of a caseload; a significant minority of the observed consultations had a liaison function. The link-worker program did not increase the proportion of patients with common mental disorders under the care of the mental health service, meaning that there was no loss of focus on people with serious mental illness, a typical fear of establishing these linkage services and a finding of a previous study. A major challenge of the study was the lack of reliable information systems to measure service activity and track costs.

Birleson P, Luk ES, Mileskin C. Better mental health services for young people: responsibility, partnerships and projects. Aust N Z J Psychiatry. 2001 Feb;35(1):36-44. <PubMed>

Birleson et al. (2001) favour early treatment of psychosis in the development of separate mental health programs for youth 12 to 25 years of age. After reviewing the status of current services and considering better linkages with adult mental health care, the authors argue that adolescent psychiatry is best linked with child psychiatry to improve services to young adults 18-to-25 years of age. Factors considered in the discussion about keeping the field unified include developmental factors, psychopathology

and care, and prevention. The authors also discuss clinical competencies and professional training, enumerate the linkages between child-adolescent and adult mental health care, and make recommendations for improving adult, youth and child mental health services.

Blashki G, Hickie IB, Davenport TA. Providing psychological treatments in general practice: how will it work? Med J Aust. 2003 Jul 7;179(1):23-5. <PubMed> <FullText>

Blashki et al. (2003) review the current Australian program in which general practitioners deliver mental health care within the overall program to improve community access to psychological treatments and to specialist mental health care. Those doctors who are already suitably trained and participating in the Better Outcomes in Mental Health Care initiative funded by the Australian government are eligible for reimbursement for focused psychological treatments under a new schedule of Medicare benefits established in 2002. The authors note the immediate need to offer continuing education to practitioners, and to alter undergraduate and graduate programs to prepare doctors to assume these treatment roles in the community. The authors present a list of focused psychological strategies from the Medicare Benefits Schedule, and the key requirements for training and educating providers of focused psychological strategies in general practitioner programs, as detailed by the Royal College of General Practitioners. These standards mandate a 20-hour face-to-face program developed in consultation with general practitioners, consumers, carers and other mental health professionals, and delivered by trainers with clearly stated qualifications. The program must also have clear, stated measurable learning outcomes and the content must include at least four focused psychological strategies, relevant case studies, demonstration of techniques, guidance for scripting and rehearsal, and discussion of closure issues and of the Medicare Benefits Schedule and documentation.

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Blatt SD, Saletsky RD, Meguid V, Church CC, O'Hara MT, Haller-Peck SM, Anderson JM. A comprehensive, multidisciplinary approach to providing health care for children in out-of-home care. *Child Welfare*. 1997 Mar-Apr;76(2):331-47. <PubMed>

Blatt et al. (1997) describe an innovative multi-disciplinary program called ENHANCE, or Excellence in Health Care for Abused and Neglected Children, that provides primary health care for children in foster care in one county in New York State. All children who enter foster care are initially assessed after the child case worker and the foster parents complete an information package. The ENHANCE team, consisting of pediatricians, a clinical child psychologist, a developmental specialist, a pediatric nurse practitioner, a registered nurse and the Department of Social Service liaison, review the material one week before each child's first comprehensive visit. This first visit is designed to coordinate the services of different providers and disciplines. Similar to those reported in the literature, the health profiles of children seen in this program include a cluster of problems directly related to abuse and neglect, failure to thrive, developmental delays, sexual abuse, and the lack of consistent medical care such as delayed immunization. The team determines and delivers appropriate treatment. The authors conclude that a multidisciplinary team approach is an effective means of providing comprehensive care to children who are at risk for multiple and complex physical, developmental and mental health problems.

Blount A. Integrated primary care: organizing the evidence. *Families, Systems & Health*. 2003 Summer;21(2):121-33.

Blount (2003) provides a conceptual framework for understanding the accumulated, but piecemeal evidence supporting collaborative care. He uses the framework to classify 63 collaborative care models obtained through a literature search and generates categories that distinguish different aspects of the relationship between mental health and medical services in

collaborative settings to provide a more coherent view of the available research. The framework also centres on the relationship of services to the populations. Blount found that the majority of studies were about co-location, or nontargeted or targeted models.

Blount A, editor. Integrated primary care: the future of medical and mental health collaboration. New York: Norton; 1998a.

The comprehensive Integrated primary care: the future of medical and mental health collaboration, edited by Blount (1998a), describes the future of medical and mental health collaboration. With contributions from experienced practitioners and administrators of integrated programs, this book demonstrates the successful development and implementation of these programs and argues for their utility. Central to this volume is a description of how to achieve meaningful service integration that goes beyond the co-location of services. In their descriptions of tried or operating programs, contributors provide a wealth of information about the possibilities and the pitfalls of integrated primary care.

Blount A. Introduction. In: Blount A, editor. Integrated primary care: the future of medical and mental health collaboration. New York: Norton; 1998b. p. xi-xiv.

Blount (1998b) introduces his approach to integrated primary care in the opening pages of his book. He provides a definition of the term "integrated primary care" — the unification of medical and mental health care in a primary health care setting — taking a holistic approach to problems of consumers. The focus of the book is outlined, emphasizing the current best practices in integrated primary care.

Blount A. Introduction to integrated primary care. In: Blount A, editor. Integrated primary care: the future of medical and mental health collaboration. New York: Norton; 1998c. p. 1-43.

In Chapter 1 of *Integrated primary care: the future of medical and mental health collaboration*, Blount (1998c) describes integrated primary care from the perspective of both providers and consumers, and explains why integrated care is better for people with mental health problems treated in primary care settings. Also discussed are why mental health services should be integrated into primary care practice, what it takes to build a successful team, how to start a pilot program and how to organize integrated care in the office setting.

Borrill C, Carletta J, Carter AJ, Dawson JF, Garrod S, Rees A, Richards A, Shapiro D, West M. The effectiveness of health care teams in the National Health Service. (UK): University of Aston; Universities of Glasgow and Edinburgh; University of Leeds; 2000. Available from: <http://homepages.inf.ed.ac.uk/jeanc/DOH-final-report.pdf>

Borrill et al. (2000) conducted a study of the benefits of collaborative care with a sample of 400 health care teams involved in primary, secondary and community health care. In their examination of the features of teams that affected the benefits of patients and the professionals themselves, they found that primary teams had clear objectives and high levels of participation; emphasized quality and support for innovation; and provided effective patient care, organization and interdependent working. A high degree of communication, coupled with regular meetings, resulted in higher levels of effectiveness and a greater likelihood of new and improved ways of delivering patient care among effective teams. These teams had members whose own health was good and who were willing to stay in their jobs.

Bower P. Primary care mental health workers: models of working and evidence of effectiveness. Br J Gen Pract. 2002 Nov;52(484):926-33. <PubMed>

In a review of different models of mental health care, Bower (2002) suggests four relevant dimensions that should be considered in the creation of positions for primary mental health care workers in England: the types of patients these workers will manage; the degree to which the workers will work autonomously or as part of a system of care; the stage in the trajectory of the illness at which they will intervene; and the nature of the role, either in clinical interventions or in broader nonclinical tasks, in the organization and monitoring of care. From a review of the evidence of interventions that work at primary, secondary and tertiary levels of care, Bower suggests that problem-solving therapy, group psychoeducation, self-help and some models of collaborative care might be highly relevant to these workers.

Bower P, Byford S, Sibbald B, Ward E, King M, Lloyd M, Gabbay M. Randomised controlled trial of non-directive counselling, cognitive-behaviour therapy, and usual general practitioner care for patients with depression. II: cost effectiveness. BMJ. 2000 Dec 2;321(7273):1389-92. <PubMed> <FullText>

In a randomized control trial, Bower et al. (2000) compared the effectiveness of care for depressed patients by general practitioners with two psychological therapies available in primary care. Therapists provided up to 12 sessions of nondirective counselling or cognitive behaviour therapy in the enhanced care arms of the study. Results showed that both types of counselling reduced depressive symptoms to a greater extent than usual care at four months, but no differences were found at 12 months. There were also no significant differences in direct costs, production losses or societal costs between the three treatments at four or 12 months.

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Bower P, Garralda E, Kramer T, Harrington R, Sibbald B. The treatment of child and adolescent mental health problems in primary care: a systematic review. *Fam Pract.* 2001 Aug;18(4):373-82. <PubMed>

In their systematic review of mental health treatment of children and adolescents in primary care, Bower et al. (2001) examine its clinical effectiveness and cost-effectiveness. The authors discuss three models of child and adolescent mental health services: increased management by primary care and community professionals; management by specialist mental health professionals working in primary care; and the consultation and liaison with specialists supporting the management by primary care professionals, rather than having sole responsibility for individual cases. Overall, the authors found that the quality of studies was variable and that no studies examined the cost-effectiveness of the health care services. Preliminary evidence, they concluded, indicates that the treatment provided by specialist staff working in primary care is effective and that some educational interventions seem to improve primary care practitioners' skills and confidence. However, few studies did controlled evaluations, and few reported changes in practitioner behaviour or patient health outcomes. The authors outline a significant program for future research.

Bower P, Gask L. The changing nature of consultation-liaison in primary care: bridging the gap between research and practice. *Gen Hosp Psychiatry.* 2002 Mar-Apr;24(2):63-70. <PubMed>

Bower and Gask (2002) discuss the gap between research and practice in the use of consultation-liaison in primary care. The authors, who have extensive knowledge of the field (Bower has a particular expertise in systematic overviews about primary mental health care issues), explore the gap between the traditional consultation-liaison model of care that is often implemented in real practice and the complex models of care that have evolved through formalized research

studies (e.g., the depression care model). They suggest that these approaches use different mechanisms of change to achieve their goals of improved care. They argue that the traditional consultation-liaison model focuses on the relationship between professionals, whereas disease management-based models highlight the development of effective systems of care. However, the focus of effectiveness may not be sufficient for widespread application in the real world; stronger, better-quality relationships may be required to disseminate and implement models from research contexts in routine care settings.

Bower P, Jerrim S, Gask L. Primary care mental health workers: role expectations, conflict and ambiguity. *Health Soc Care Community.* 2004 Jul;12(4):336-45. <PubMed>

Bower et al. (2004) examine the new role of mental health worker in primary care settings in England. Using a case-study approach, they investigated existing pilot roles for primary mental health care workers, staff expectations of this role and issues relating to current roles in primary mental health care raised by the introduction of this new position. From qualitative interviews with 46 managers and clinicians from primary care and specialist mental health care positions, Bower et al. found that almost all existing positions were exclusively related to clinical work, whereas the new position was expected to be much broader in scope and to fill gaps in current service provision. They also found that, among some respondents, disagreement and ambiguity existed about the nature of the new workers' role in client work and the work undertaken by other professions such as counsellors, nurses and psychologists. Both findings underscore the potential for role conflict in the implementation of this new position.

Bower P, Richards D, Lovell K. The clinical and cost-effectiveness of self-help treatments for anxiety and depressive disorders in primary care: a systematic review. Br J Gen Pract. 2001 Oct;51(471):838-45. <PubMed>

In a systematic review of eight research studies, Bower et al. (2001) examine the clinical and cost-effectiveness of self-help treatment for anxiety and depressive disorders. While a majority of the studies suggested that self-help (written interventions based primarily on behavioural principles) produced some positive outcomes, methodological weaknesses of the studies and their small numbers prevented more certain conclusions. Long-term effectiveness and costing information were not available for any of the studies.

Bower P, Rowland N, Hardy R. The clinical effectiveness of counselling in primary care: a systematic review and meta-analysis. Psychol Med. 2003 Feb;33(2):203-15. <PubMed>

Bower et al. (2003) present a systematic review and meta-analysis of the clinical effectiveness of counselling in primary care, updating an earlier Cochrane review. Including seven studies in their analysis, Bower et al. tested the hypothesis that counsellors' treatment in primary care is more effective than the usual care provided by doctors or alternative mental health treatment. Overall, the review concluded that primary care counselling may be associated with modest improvements in outcomes in the short-term for people with common mental disorders. A lack of data about treatments such as antidepressants or cognitive behaviour therapy makes comparisons difficult, but the authors suggest that preliminary findings indicate no differences between these treatments and primary care counselling.

Bower P, Rowland N, Mellor Clark J, Heywood P, Godfrey C, Hardy R. Effectiveness and cost effectiveness of counselling in primary care. Cochrane Database Syst Rev. 2002;(1):CD001025. <PubMed>

This Cochrane review was conducted to examine the effectiveness and cost-effectiveness of counseling for psychological problems in comparison to usual general practitioner care, medication or other psychological therapies. This is an update of an earlier review. The authors reviewed cost and outcome data in randomized controlled trials, controlled clinical trials and controlled patient preference trials of counseling interventions in primary care. Seven trials met the review criteria and were included in this report. Counseling was found to be clinically effective when compared with usual care in the short-term but not long-term. Four studies provided costing information and revealed total costs for counseling to be similar to that of usual care over the long-term. The overall conclusion was that counseling offered immediate benefits to consumers who are more likely to feel better and be more satisfied than those who received usual care from their general practitioner. However there is no evidence to show that counseling is better than usual care over the long-term.

Bower P, Sibbald B. On-site mental health workers in primary care: effects on professional practice. Cochrane Database Syst Rev. 1999;(4):CD000532. <PubMed>

Bower and Sibbald (1999) completed a Cochrane review of on-site mental health workers to determine the level of evidence supporting this role in primary mental health care. They reviewed randomized trials, controlled before-and-after studies, and interrupted-time-series analyses of mental health care replacement models (mental health workers replacing primary care providers as providers of care) or consultation-liaison models (mental health workers collaborating with or supporting primary care providers managing patients with mental health problems).

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The outcomes included primary care provider behaviours such as diagnosis, prescribing and referral. A total of 38 studies were included in the review, which covered 460 primary care workers and more than 3880 patients, with these results:

- ✎ Moderate evidence that replacement model mental health workers achieved significant short-term reductions in primary care practitioners' prescribing and mental health referral, without lasting effects.
- ✎ Less consistent evidence of reduced consultation rates.
- ✎ No indirect effects on prescribing behaviour for the wider population and no consistent pattern to the impact of referrals.
- ✎ Some evidence that mental health workers in the consultation–liaison model had a direct effect on the prescribing behaviour of primary care practitioners when used as part of multi-faceted interventions.
- ✎ Only a few studies of the indirect effects of such interventions, but these studies failed to provide evidence that direct effects were generalizable to the wider population or endured after the removal of the consultation–liaison intervention.

Overall, Bower and Sibbald concluded that the existing evidence does not support the hypothesis that adding mental health workers to primary care organizations in replacement models causes significant or enduring changes in primary care practitioners' behaviour. Consultation–liaison interventions may cause changes in primary care providers' prescribing behaviour, but these are short-term and limited to the care of patients the mental health worker sees. The authors recommend longer-term studies to assess the degree to which changes persist over time.

Bradley S, Kramer T, Garralda ME, Bower P, Macdonald W, Sibbald B, Harrington R. Child and adolescent mental health interface work with primary services: a survey of NHS Provider Trusts. *Child and Adolescent Mental Health*. 2003 Nov;8(4):170-6. <Abstract>

Bradley et al. (2003) surveyed National Health Service Provider Trusts providing child and adolescent mental health services in England to examine predictors of the working relationship between secondary and primary levels of care. At the secondary level, one role of child and adolescent mental health services is to work with primary care professionals to support child mental health care offered in primary care (defined as general practice, social and education services). The study findings revealed that a large number of child and adolescent mental health services offer joint training or education to primary care professionals, but fewer than one-third responding to the survey have formalized joint programs of any type. The three types of initiatives mental health services reported were consultation, mental health clinics in primary care (often referred to as "shifted outpatient clinics"), and joint casework with general practice services. About the same number reported plans to establish positions for primary mental health workers. The results also suggest that this joint work develops in those trusts with larger, more specialized child and adolescent mental health programs. Although the authors recommend research into the efficacy of the three approaches, they note that the ability of mental health clinics in primary care (i.e., shifted outpatient clinics) to reach large numbers of children is limited, so consultation or joint casework seems to offer a better opportunity to develop general practice professionals' skills to identify and manage children and adolescents with mental health problems.

Bray JH, Rogers JC. Linking psychologists and family physicians for collaborative practice. *Professional Psychology: Research and Practice*. 1995 Apr;26(2):132-8.

Bray and Rogers (1995) describe a pilot project that linked psychologists and physicians in the treatment of people with alcohol and drug problems in rural settings. Ten pairs of professionals trained on two occasions, six months apart. Pairs began working together after the first training session, during which they developed collaboration and linkage plans. Eight pairs implemented and carried out their plans to some degree. The findings revealed that the most successful pairs seemed to have previous experience working with each other, worked in close physical proximity to each other and had one or both of the members making special efforts to effect collaboration.

Brown GK, Bruce ML, Pearson JL. High-risk management guidelines for elderly suicidal patients in primary care settings. *Int J Geriatr Psychiatry*. 2001 Jun;16(6):593-601. <PubMed>

Brown et al. (2001) outline guidelines for dealing with suicidal elderly patients, determining the level of risk of suicide with a structured approach, and developing and implementing crisis-intervention strategies and ongoing management procedures for use in primary care settings with suicidal patients. The Prevention of Suicide in Primary Care Elderly: Collaborative Trial (PROSPECT) developed a new set of high-risk management guidelines, building on earlier work in the United States, for use by depression health specialists, psychiatrists and other research staff associated with the PROSPECT study, as well as for other primary care providers. An appendix to the paper contains a High-Risk Management Protocol Form (see p. 601).

Brown JB, Lent B, Stirling A, Takhar J, Bishop J. Caring for seriously mentally ill patients. Qualitative study of family physicians' experiences. *Can Fam Physician*. 2002 May;48:915-20. <PubMed> <FullText> OR <FullText>

Brown et al. (2002) explore family physicians' experiences with a shared model of care for people with serious mental illness. The findings of qualitative interviews of 11 full-time family physicians in London, Ontario, reflected three topics: the contribution that these physicians saw themselves making to the shared care arrangement, the challenges they faced in participating in shared care and their overall expectations of the model. Overall, these doctors were interested in serving people with mental illness living in the community; the doctors believed that they offered a holistic approach to care that would benefit these people. They also noted the importance of more exposure to this client group. Some had experienced collaborative relationships that had good communication, backup, access and feedback. Their identified barriers included the absence of these features, and the fragmentation of care and lack of accountability.

Brownhill S, Wilhelm K, Eliovson G, Waterhouse M. 'For men only'. A mental health prompt list in primary care. *Aust Fam Physician*. 2003 Jun;32(6):443-50. <PubMed>

Brownhill et al. (2003) tested a screening instrument specifically designed to detect symptoms of depression in men seen in primary care. This short prompt list was useful for those male consumers who needed to be asked about issues relating to depression. Practitioners found that the tool provided extra information about the consumers they were seeing, helped them to build rapport and made the job of assessment easier.

B

Brucker PS, Shields CG. Collaboration between mental and medical healthcare providers in an integrated primary care medical setting. Families, Systems & Health. 2003 Summer;21(2):181-91.

Brucker and Shields (2003) quantified the collaboration between medical providers and therapists in an integrated primary care setting with a collaborative activities checklist and a self-report inventory. The checklist revealed that therapists and primary care providers collaborated at least once out of every four therapy sessions; the self-report, three out of every four sessions. The authors could not explain these differences. Therapists were the primary initiators of collaborative contacts, and the main reason for collaboration was a discussion of psychosocial issues. The authors provide a list of research issues about measuring collaboration.

Budin J, Boslaugh S, Beckett E, Winiarski MG. Utilization of psychiatric services integrated with primary care by persons of color with HIV in the inner city. Community Ment Health J. 2004 Aug;40(4):365-78. <PubMed>

Budin et al. (2004) identify the patterns of use of psychiatric services integrated with primary care by persons of colour who are HIV-positive in New York City, noting the paucity of information about their psychiatric needs and use of services. The authors collected data for 93 persons seen over a two-year period by working on-site at a primary care centre in an integrated program with a psychiatrist and certified social workers trained as psychotherapists. The program involved rapid referral from medical staff to the mental health workers, a unified medical chart used by all providers, interdisciplinary case conferences, frequent hallway consultations, and weekly cultural in-service training. Budin et al. found that Hispanics were more likely than African Americans to receive psychotropic prescriptions; similarly, patients with HIV were more likely than those with AIDS to receive these medications. High-use patients (defined as patients with six or more visits) comprised almost

28 per cent of the patients, but used 67 per cent of the services. A wide range of psychiatric diagnoses were found, suggesting the need for a broad range of treatment responses.

Burley HJ. Shared care: what do family physicians want from psychiatrists? CPA Bulletin de l'APC. 2002 Dec;29-31. <Fulltext>

In his article, Burley (2002) summarizes family physicians' needs when participating in shared care with psychiatrists. Foremost, what these physicians want is access, communication and respectful relationships with psychiatrists. Family physicians want face-to-face relationships with psychiatrists that are characterized by collegiality, respect for their skills and knowledge, and understanding of the work environment that shapes their interaction with patients. Family physicians need opportunities to discuss cases with psychiatrists to get their advice about patient care, to provide an update on ongoing care or to get direct assistance with more complicated cases. A frequent complaint is psychiatrists' lack of availability for consultation in primary care practices, which in turn results in overuse of emergency facilities when crises develop. Family physicians also call for improved communication: reports about patients referred to specialist care and about emergency room visits and hospitalizations; more frequent telephone consultations; joint charting; lunchtime seminars; and continuing education courses.

Burns BJ, Phillips SD, Wagner HR, Barth RP, Kolko DJ, Campbell Y, Landsverk J. Mental health need and access to mental health services by youths involved with child welfare: a national survey. J Am Acad Child Adolesc Psychiatry. 2004 Aug;43(8):960-70. <PubMed>

Burns et al. (2004) examine the mental health needs of youths involved in child welfare and their access to mental health services. Using data from the U.S. National Survey on Child and Adolescent Well Being, these researchers found that nearly half of the youths (2 to 14 years of

age) with completed child welfare investigations had clinically significant emotional or behavioural problems. Higher scores of mental health need, as defined by a clinical range score on the Child Behavior Checklist, meant that these children were more likely to have received mental health care during the previous 12 months; however, only one-quarter of the children in the sample actually received any specialty mental health services during that time. The authors emphasize the need for routine screening for mental health problems and increased access to mental health services to further evaluate and treat children in the child welfare system.

Buszewicz M. Mental health teamwork in primary care. *International Review of Psychiatry*. 1998 May;10(2):119-22.

Buszewicz (1998) presents the potential advantages of mental health teamwork in primary care. Opportunities include sharing background and management information about patients; deciding on appropriate referrals and selection of team members; providing opportunities for staff to learn from each other; increasing skills for dealing with mental health problems and knowledge about appropriate resources, including the voluntary sector; and providing support for participants. Buszewicz also presents barriers to team work, most of which are common to working on any type of team, for example, dealing with interpersonal differences; fear of change; intra- and inter-professional rivalries and misunderstandings; differences in power, income and status; different conceptual approaches; and different lines of accountability. Identified aspects of mental health work that act as barriers include long team meetings that place too much emphasis on mental health problems; and the hierarchical structures of the medical tradition that result in general practitioners and psychiatrists seeing themselves as the de facto team leader, despite evidence that effective teams have flat rather than hierarchical structures.

Byng R, Jones R. Mental Health Link: the development and formative evaluation of a complex intervention to improve shared care for patients with long-term mental illness. *J Eval Clin Pract*. 2004 Feb;10(1):27-36. <PubMed>

Byng and Jones (2004) document a quality improvement program called the Mental Health Link that is designed to bring professionals together to develop a local program of shared care based on local needs, skills and interests. This program also supports the development of practice systems. Byng and Jones describe the iterative design used to generate such a model of care in southeast London, England, a process that may be useful in other communities.

Byng R, Jones R, Leese M, Hamilton B, McCrone P, Craig T. Exploratory cluster randomised controlled trial of shared care development for long-term mental illness. *Br J Gen Pract*. 2004 Apr;54(501):259-66. <PubMed>

Byng et al. (2004) conducted a cluster randomized controlled trial of the development of shared care for people with long-term mental illness. General practices were randomized into service development as usual or into the Mental Health Link program, a quality improvement intervention focused on creating shared-care approaches among groups of professionals operating in a local area. Results showed that there were no significant differences in patients' perceptions of unmet need, satisfaction or general health. Patients in the intervention group had fewer psychiatric relapses than control patients given similar care. Intervention practitioners were more satisfied, and services improved in the intervention group. While improvements in service development did not translate directly into documented improvements in care, findings of the study suggest that the intervention improved informal shared care, as was evident in better linkages between professionals.

B

Caan W. Mind the gap! Research in primary mental health care [editorial]. *Journal of Mental Health*. 1998 Jun;7(3):217-21.

Although Caan's editorial dates back to 1998, the key topics about researching primary mental health care remain salient today: for example, quantity, quality and credibility. Caan also briefly mentions international developments.

Callahan CM. Quality improvement research on late life depression in primary care. *Med Care*. 2001 Aug;39(8):772-84. <PubMed>

In his comprehensive review of the research about quality improvement in late-life depression, Callahan (2001) examines the use of educational and quality-improvement interventions to improve the recognition and treatment of depression in primary care settings. He succinctly captures four overall themes in this statement: "1) the outcome of major depression in the usual care of primary care is typically poor; this is particularly true of late life depression; 2) informational support provided to primary care physicians is necessary but insufficient to improve outcomes of late life depression in primary care; achieving guideline-level therapy requires substantial participation of an informed and motivated patient working in concert with a health care team and health care system designed to care for chronic conditions; 3) up to 30 per cent of older primary care patients will fail to respond to excellent guideline-level therapy provided in primary care; and 4) the latest quality improvement efforts focus not only on the clinical skills of primary care physicians but also on patient's self-care and on innovative strategies to improve the system of care" (p. 772).

Callahan EJ. The future of psychology in family medicine. *Journal of Clinical Psychology in Medical Settings*. 1997 Jun;4(2):155-66.

Callahan (1997) documents the integral role of psychology and other behavioural sciences in family medicine since its inception. Psychology

has shaped the clinical training of family physicians, assisted with its research agenda and its deployment, and helped create integrated systems of care. Callahan suggests that involving psychologists in collaborative care provides important alternatives to pharmacological and medical interventions to common presenting problems. Increased screening for common mental health issues is only effective if a range of treatments that includes psychological treatment is available.

Canada Health Infoway / Inforoute Santé du Canada. c2004. Available from: <http://www.infoway-inforoute.ca>

Canada Health Infoway Inc. is an independent, not-for-profit organization whose members are the country's 14 Deputy Ministers of Health. The mandate of the organization, created in 2001, is to deliver electronic record solutions to provincial and territorial healthcare systems.

Cape J, Parham A. Relationship between practice counselling and referral to outpatient psychiatry and clinical psychology. *Br J Gen Pract*. 1998 Aug;48(433):1477-80. <PubMed>

In their investigation of the relationship between practice counselling and referral to secondary types of care, Cape and Parham (1998) hypothesized that counselling in general practice would reduce the use of secondary care. For one year, they monitored referrals to secondary care through routine information systems in the main hospital departments serving the Borough of Islington in London, England. They compared referral rates for practices with and without a practice-based counsellor. Their findings showed mixed results: referrals to clinical psychologists increased for practices with a counsellor, whereas referrals to outpatient psychiatry stayed the same for both groups. This finding was contrary to the hypothesis that counselling reduced the use of specialty mental health care.

Cashman S, Reidy P, Cody K, Lemay C. Developing and measuring progress toward collaborative, integrated, interdisciplinary health care teams. *J Interprof Care*. 2004 May;18(2):183-96. <PubMed>

Cashman et al. (2004) investigated an intervention to enhance the functioning of an interdisciplinary health care team in a primary care setting. They used the System for the Multiple Level Observation of Groups (SYMLOG) tool to highlight the changes in team functioning over the course of the study and compared the team's values to those of an optimally effective team. The authors provide useful information about institutional, organizational, and team-related supports and barriers that affect the development of collaborative integrated teams.

Chisholm P, LeMoine D. A shared mental health care model. *Can Nurse*. 2002 Oct;98(9):22-4. <PubMed>

Chisholm and LeMoine (2002) describe a shared care model developed in Nova Scotia and funded through the federal Health Transition Fund. This model is based in the community and is focused on maintaining connections with community agencies that offer other services that mental health consumers use. A mental health–liaison worker liaises with these agencies to discuss consumers' issues, to provide assessments when needed and to refer consumers for additional care. Mental health staff provide direct service to both consumers and agencies.

Churchill R, McGuire H. Developments in the evidence base in primary care psychiatry. *International Review of Psychiatry*. 1998 May;10(2):143-7.

Churchill and McGuire (1998) review developments in the evidence base for primary care psychiatry. They discuss the challenges primary care physicians face trying to keep abreast of emerging evidence. The authors also examine the use of randomized control trials, their strengths and weaknesses, the role of the Cochrane Collaboration and the Cochrane

Collaboration Depression, Anxiety and Neurosis Review Group Controlled Trial Register, systematic reviews relevant to primary care psychiatry, and efforts to improve dissemination of research evidence and its application in primary care in England.

Chur-Hansen A, Todd E, Koopowitz L. Description and evaluation of an up-skilling workshop for rural and remote mental health practitioners in South Australia. *Australas Psychiatry*. 2004 Sep;12(3):273-7. <PubMed>

Chur-Hansen et al. (2004) report on a joint training program designed to enhance the psychiatric skills of medical and nursing staff in the rural and remote communities of South Australia. The authors found that participants welcomed the opportunity to work collaboratively with colleagues during the training and recommended that all professional stakeholders be included in future training. Participants found the information about the pharmacological management and neurobiology of mental illness difficult to absorb (each of these units was delivered in a 30-minute module). Overall, participants gained knowledge and were satisfied with the training. Longer-term evaluation is required to determine the duration of the knowledge gain.

Cockburn K, Bernard P. Child and adolescent mental health within primary care: a study of general practitioners' perceptions. *Child and Adolescent Mental Health*. 2004 Feb;9(1):21-4. <Abstract>

Cockburn and Bernard (2004) studied general practitioners' perceptions of child and adolescent mental health within primary care in one health authority area in England. Using a mailed questionnaire, the researchers asked general practitioners about their relevant training experiences, skills and competence in child and adolescent mental health practice in primary care; knowledge of key areas and levels of interest in this type of practice; knowledge about local specialist services for children and

adolescents; and training needs. Half or more of respondents rated their own competence in dealing with mental health issues as less than satisfactory across three age groups, and believed themselves to be least prepared to deal with these issues in preschoolers. These doctors perceived their skill deficits to be greatest when dealing with disruptive behaviour and eating disorders. Again, a majority of respondents were less than satisfied with their knowledge of the nature and course of mental health problems, and of the treatment or management of children and adolescents with these problems. Training needs were numerous: the top three requests were for training in the appropriate use of psychotropic medications, in treatment or management and in dealing with mental health problems in adolescence.

Colombo A, Bendelow G, Fulford B, Williams S. Evaluating the influence of implicit models of mental disorder on processes of shared decision making within community-based multi-disciplinary teams. *Soc Sci Med.* 2003 Apr;56(7):1557-70. <PubMed>

In their qualitative study, Colombo et al. (2003) evaluated the influence of implicit models of a mental disorder on the processes of shared decision-making within community-based mental health teams. Qualitative methods were used to gather data from five distinct groups operating within the community-based multi-disciplinary teams (i.e., psychiatrists, community psychiatric nurses, approved social workers, patients and family members) who were asked to react to a standardized case vignette of a person with schizophrenia. The results showed each group implicitly supported a complex range of model dimensions about the nature of schizophrenia, the appropriateness of treatment and care, and the rights and obligations of the groups towards one another. The different power relationships explicated showed that existing work structures and practices generate conflict and misunderstanding, and restrict choices for patients and practitioners. The authors emphasized the need for an approach

that supports a common team identity, sharing resources and a defined and accepted role for consumer participation in care decisions.

Cook A, Davis J, Vanclay L. Shared learning in practice placements for health and social work students in East London: a feasibility study. *J Interprof Care.* 2001 May;15(2):185-90. <PubMed>

Cook et al. (2001) explore the feasibility of creating shared learning opportunities through practice placements in community settings. The trial involved placing students of social work, community nursing, and occupational therapy in general practitioner practices and primary care settings in east London, England. One challenge was to ascertain whether the professional and academic abilities of students from the participating programs were comparable for all placements. A second challenge was to identify and engage suitable supervisors to oversee these multi-disciplinary placements. Overall support for the pilot project was considerable, but the developers faced significant organizational challenges when bringing students from different professional courses together. Although support for shared practice learning is widespread, many stakeholders have reservations about the practicality of such initiatives. However, keeping such projects on the periphery of professional training and education will retard the progress of normalizing collaborative care.

Cook G, Gerrish K, Clarke C. Decision-making in teams: issues arising from two UK evaluations. *J Interprof Care.* 2001 May;15(2):141-51. <PubMed>

Cook et al. (2001) examined decision-making in health care teams, using data from two evaluation studies conducted in England. The authors evaluated decisions about client care and enhanced support for decision-making within the teams that supported creative problem-solving. Team members' decisions were influenced by the team's working arrangements; delivery of care evolved from a crisis-response

to a more proactive client-focused approach to care. The authors concluded that respect for team decision-making enhances the strengths of interdisciplinary teams.

Cook S, Howe A. Engaging people with enduring psychotic conditions in primary mental health care and occupational therapy. *British Journal of Occupational Therapy*. 2003 Jun;66(6):236-46.

Cook and Howe (2003) designed and tested a new model of service to improve the social functioning of people with enduring psychotic conditions. Occupational therapy within primary care was an integral part of the program. Using a case-study design, Cook and Howe examined such outcomes as engagement, clinical and social outcomes, and cost consequences. Their findings suggested that primary care expanded to include occupational therapy and case management is both feasible and effective for working with this group of people.

Cooper LA, Brown C, Vu HT, Palenchar DR, Gonzales JJ, Ford DE, Powe NR. Primary care patients' opinions regarding the importance of various aspects of care for depression. *Gen Hosp Psychiatry*. 2000 May-Jun;22(3):163-73. <PubMed>

Cooper et al. (2000) discuss their innovative instrument to measure primary care patients' attitudes toward and ratings of depression care. People with mild-to-major depression recruited for the study participated in focus groups to detail their perceptions of the most important elements of care for depression. These elements were then included in a questionnaire that asked subjects to rank their importance. Two versions of an instrument were constructed, based on the analyses of the most important elements of care for people with depression: a 30-item and 16-item version called the Patient Attitudes and Ratings of Care for Depression, or PARC-D, questionnaire. With this patient-centred approach to instrument development, this study

produced a tool that may improve collaborative care for persons with depression.

Corney RH. Social work involvement in primary care settings and mental health centres: A survey in England and Wales. *Journal of Mental Health*. 1995 Jul;4(3):275-80. Abstract available from: <http://taylorandfrancis.metapress.com/openurl.asp?genre=article&eissn=1360-0567&volume=4&issue=3&spage=275>

Corney (1995) surveyed the involvement of social workers in general practice and community health centres in England and Wales. The survey findings (response rate, 88 per cent) indicated that 70 per cent of general practices had one or more collaborative arrangements for social work (either an attachment scheme that involved the social worker working in the primary care setting while still being employed by the social work agency, or a liaison scheme that involved primary care providers consulting with a social worker in the social work agency), and another 5 per cent were planning such a linkage. Fifty-six per cent of the authorities had formal liaisons between general practitioners and social workers. Thirty-eight per cent of authorities had no scheme for liaisons with social workers; 38 per cent had either an attachment or liaison scheme and 24 per cent had both types. Such arrangements were much more common in country councils (rural) than in metropolitan city boroughs or in boroughs in London. The specialties of the social workers were also examined: in the 60 authorities with social work schemes, 24 indicated that social workers were generic and took all types of referrals. In 32 authorities, the social worker specialized in mental health work. Social workers were based in or attached to 76 per cent of the community health centres of over 70 per cent of the authorities. The remaining centres indicated that they had social worker liaison schemes in place. Comparing these results with those of previous surveys, Corney notes that the number of attachments and liaison schemes waned in the 1980s when funding was reduced; however, social work links were viewed as important to

the provision of primary health care in the two countries.

Coyne JC, Brown G, Datto C, Bruce ML, Schulberg HC, Katz I. The benefits of a broader perspective in case-finding for disease management of depression: early lessons from the PROSPECT Study. *Int J Geriatr Psychiatry*. 2001 Jun;16(6):570-6. <PubMed>

Coyne et al. (2001) used the screening data of the Prevention of Suicide in Primary Care Elderly-Collaborative Trial, or PROSPECT, study to determine the effect of including additional patients who were taking psychotropic medications or had a history of depression. The original study included only those who met diagnostic criteria for major depression, minor depression or dysthymic disorder for scientific and clinical reasons. However, Coyne et al. wished to evaluate the need for a supplemental intervention program to recognize the chronic, recurrent nature of depression, and the recurrent episodes, intermittent symptoms and remissions associated with depression across the adult age span. Their results showed that additional cases could be identified if the criteria were widened, suggesting that more comprehensive approaches to depression management should consider people who are already taking psychotropic medication, are symptomatic and have a history of depression, and have current syndromal depression.

Coyne JC, Thompson R. Psychologists entering primary care: Manhattan cannot be bought for \$24 worth of beads. *Clinical Psychology: Science and Practice*. 2003 Spring;10(1):102-8. <Abstract>

Coyne and Thompson (2003) emphasize that psychologists are best involved in primary care, not as frontline workers, but as those responsible for the design, supervision and evaluation of augmented collaborative services. In their commentary about the usual cost-offset evidence that argues for brief therapy

or psychotherapy in primary care, Coyne and Thompson note that one of the original sources making this assertion was never published and another key study found no cost-offsets from therapy. They argue that cost-offset is a poor measure of the value of psychologists' potential contributions to the outcomes of health care.

Craske MG, Roy-Byrne P, Stein MB, Donald-Sherbourne C, Bystritsky A, Katon W, Sullivan G. Treating panic disorder in primary care: a collaborative care intervention. *Gen Hosp Psychiatry*. 2002 May-Jun;24(3):148-55. <PubMed>

Craske et al. (2002) describe a model for the collaborative treatment of panic disorder in primary care. Cognitive behavioural therapy and medications are used for treatment delivered by the primary care physician and behavioural therapist; the psychiatrist provides direct consultation to the patient, if needed, and consults with the primary care physician about medication. Flexibility in treatment was maintained to accommodate the preferences of the people in need of care. The therapist provided face-to-face and telephone follow-up sessions over the course of the year. The authors describe collaborative care treatment for panic disorder, and note that a treatment manual is available upon request. This model was to be studied further for its effectiveness and costs.

Crawford MJ, Prince M, Menezes P, Mann AH. The recognition and treatment of depression in older people in primary care. *Int J Geriatr Psychiatry*. 1998 Mar;13(3):172-6. <PubMed>

Crawford et al. (1998) conducted a cross-sectional study to determine general practitioners' awareness of depression in older patients and the characteristics of those patients least likely to be recognized and treated. A total of 510 English participants who were registered with 28 general practitioners in 13 practices were included in the study. The authors found that doctors were aware of 51 per cent of the 70 people with depression. Those least likely to be identified included men, and people who were

married, had high levels of physical handicap, had a visual impairment and were poorly educated. Twelve patients were treated with psychotropic medication or referred to needed services.

Crews C, Batal H, Elasy T, Casper E, Mehler PS. Primary care for those with severe and persistent mental illness. *West J Med.* 1998 Oct;169(4):245-50. <PubMed>

Crews et al. (1998) describe the primary care clinics established in a partnership of a public mental health outpatient service and a major medical centre in Denver, Colorado. The clinics were staffed by internists who were deemed the most appropriate medical personnel to respond to the types of medical conditions typical of people who have a mental illness. The delivery of primary care to people referred by the mental health program was done in partnership with case managers and psychiatrists from the mental health program, although the actual provision of service was done in two half-day sessions per week in community health settings. The authors report the preliminary patient outcomes after 6 months of operation and thoroughly discuss the factors influencing the delivery of primary medical care to people with severe mental illness.

Davis TF, Blitz G. Forming a multidisciplinary team. In: Blount A, editor. *Integrated primary care: the future of medical and mental health collaboration.* New York: Norton; 1998. p. 228-46.

Davis and Blitz (1998) use an analytic narrative to tell the story of their experience forming a multi-disciplinary primary mental health team. They describe the concepts and principles they learned: team members' shared goals, missions and expected outcomes; membership in the team and one's professional community, and the ability to function in the so-called foreign culture of other professional communities while maintaining one's professional identity; status, roles and responsibilities, namely members of the team contributing knowledge, skills and wisdom from each discipline, resolution

of conflicts, and enhanced performance of the team; joint decision-making based on the multiple disciplines represented on the team; and development of a common language, practices, experiences and a shared team voice over time.

Daw J. New rule will change the psychologist physician relationship. *Monitor on Psychology [serial on the Internet].* 2001 April;32(4):[about 7 p.]. <FullText> Available from: <http://www.apa.org/monitor/apr01/physicians.html>

In a discussion of the new rules of the Accreditation Council for Graduate Medical Education, Daw (2001) explores the issue of training in collaborative care involving psychology and medicine. After July 1, 2001, the Council required that all residency programs develop pilot programs to meet several core competency requirements that promote an integrated collaborative approach to care. To provide effective and cost-efficient service, all types of residents were to learn teamwork skills and were to partner with other professionals. The rules also stated that upon graduation, residents must demonstrate knowledge of established emerging biomedical, clinical and cognate sciences, and apply this knowledge to patient care. These features would be assessed through accreditation processes. Similarly, the American Psychology Association was developing a model curriculum for training psychologists in collaborative care.

Dea RA. The integration of primary care and behavioral healthcare in Northern California Kaiser-Permanente. *Psychiatr Q.* 2000 Spring;71(1):17-29. <PubMed>

Dea (2000) describes the integration of primary and mental health care in the Kaiser-Permanente managed-care organization in Northern California. The author provides a useful overview of the essential elements of collaborative care, including reasons for and principles of collaboration, needs assessment questions, and structural elements.

D

De Alba I, Samet JH, Saitz R. Burden of medical illness in drug- and alcohol-dependent persons without primary care. *Am J Addict.* 2004 Jan-Feb;13(1):33-45. <PubMed>

De Alba et al. (2004) assessed the burden of medical illness, identified the dependence characteristics of patient and substance abuse that are associated with poor physical health, and compared measures of the burden of illness in a population of drug- and alcohol-dependent persons who lacked primary care. The sample was obtained through an urban in-patient detoxification unit. The factors associated with poor health were female sex, problems with hallucinogens, heroin, other opiates, living alone, having medical insurance, and older age. The authors concluded that addicted persons have a significant burden of medical illness.

DeBar LL, Clarke GN, O'Connor E, Nichols GA. Treated prevalence, incidence, and pharmacotherapy of child and adolescent mood disorders in an HMO. *Ment Health Serv Res.* 2001 Jun;3(2):73-89. <PubMed>

DeBar et al. (2001) examined the treated prevalence, incidence and pharmacotherapy of child and adolescent mood disorders in a managed-care setting. The purpose of the study was to identify what proportion of all youth treated for mental health problems is treated for depression. The report also examined the setting in which youth are seen (primary and specialty medical care versus specialty mental health), the rate and type of pharmacotherapy they received, and the association of youth mood disorders with use of health care services in these settings. General prevalence patterns across age and sex, although somewhat lower, paralleled those reported in epidemiological studies. Primary care providers initially identified a significant proportion of youth with mood disorders. Antidepressant medications were used more often by youth identified with a mood disorder in the medical setting than by youth identified in specialty mental health settings. The authors note that few alternative

treatments other than pharmacotherapy are available within primary care and that persons with uncomplicated cases are not referred to specialty care for treatment and are more likely to be treated with drug therapy, thus resulting in the higher rates. The authors conclude that their study provided important information about the pattern of care for youth within the managed-care sector, evaluated the role of both medical and mental health services in the identification and treatment of youth with mood disorders, demonstrated the use of electronic medical record databases for data collection, described clinical practices in real world settings, and illustrated that youth with mood disorders were having their treatment needs met in an appropriate way. The authors recommended further research into pharmacotherapy for youth, especially the adequate dosage and duration of medication, other types or combinations of treatment, when indicated, in primary and specialty medical care, and specialty mental health care settings; treatments available in nonmedical settings; and efforts to increase the quality of services delivered and their impact on outcomes for youth.

deGruy FV 3rd. The primary care provider's view. *New Dir Ment Health Serv.* 1999 Spring;(81):33-9. <PubMed>

DeGruy (1999) presents the perspective of the primary care provider on mental health problems and mental health care, and discusses opportunities for collaboration with mental health providers. Six characteristics of the impact of primary care practice on mental health care are succinctly described:

1. Practice pace is fast; visits are short; and many problems are handled concurrently, since interruptions a normal part of getting the job done.
2. Many patients have behavioural issues that require a broad range of responses from the primary care provider and consultants. It is not feasible or effective to deal with behavioural issues as separate diagnostic

entities; these are integral to the delivery of primary care.

3. Many mental health issues do not fit into the *Diagnosics and Statistics Manual* nosology, but still require attention.
4. Primary care physicians contend with a large set of competing demands, and screening for undetected mental disorders is not always a priority.
5. Some people will not accept a mental health referral or refuse to acknowledge that theirs is a mental health problem that requires a response within primary care.
6. Some degree of invisible mental health care exists in primary care. Some problems are treated indirectly along with the presenting condition.

DeGruy notes that primary care and mental health practitioners need to make such adjustments for successful collaboration as having immediate access, sharing medical information, making mental health consultants available for proactive consultations, expanding the expertise of mental health consultants to include the mental health implications of chronic illnesses, and adjusting local deployment of mental health resources so that distribution is more rational and includes people in primary care settings.

Dewa CS, Hoch JS, Goering P. Using financial incentives to promote shared mental health care. *Can J Psychiatry*. 2001 Aug;46(6):488-95. <PubMed> <FullText>

Dewa et al. (2001) review primary care remuneration schemes, and associated financial incentives and their implications for shared care. Risk-sharing, the entity bearing the costs and the extent of these costs, is one key element of any reimbursement strategy. Whoever bears the costs has incentive to control them. Risk sharing can be the responsibility of the payers, providers or some combination of the two. Remuneration schemes are either prospective or retrospective; capitation arrangements fall into the former category and fee-for-service, into the latter. Incentives and disincentives associated with each

of these schemes encourage or detract from the involvement of primary care practitioners in collaborative care.

Dickey B, Normand SL, Weiss RD, Drake RE, Azeni H. Medical morbidity, mental illness, and substance use disorders. *Psychiatr Serv*. 2002 Jul;53(7):861-7. <PubMed> <FullText>

Dickey et al. (2002) examine medical morbidity, mental illness and substance abuse disorders to determine whether certain medical disorders are more prevalent among adults with serious mental illness and whether comorbid substance abuse disorder increases the prevalence beyond the effects of mental illness alone. In a large sample of 26,332 Medicaid patients 18 to 64 years of age, 11,185 had been treated for severe mental illness. The study findings showed that people treated for severe mental illness had significantly higher age- and sex-adjusted risk of medical disorders. Those with concurrent disorders had the highest risk of five of the disorders studied. These findings suggested that substance abuse disorders are important risk factors and require early identification; integration of the treatment of medical disorders and severe mental illness should be a high priority; and specialized disease self-management techniques should be developed.

Dietrich AJ, Oxman TE, Williams JW Jr, Kroenke K, Schulberg HC, Bruce M, Barry SL. Going to scale: re-engineering systems for primary care treatment of depression. *Ann Fam Med*. 2004 Jul-Aug;2(4):301-4. <PubMed>

Dietrich et al. (2004) report the preliminary findings of their randomized controlled trial about the Re-Engineering Systems for Primary Care Treatment of Depression model. The study involved subsequent evaluations of the sustainability and dissemination of this chronic care model, and detailed the strategy for changing practice implemented in participating practices. The four-step process, based on innovations theory, involved engagement,

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capacity-building within the health care organization, capacity-building through preparation of primary care clinicians and practices to provide systematic depression management and ongoing support to reinforce practice changes. The authors described this study as the first to link a randomized controlled trial to subsequent dissemination of the model.

Dixon L, Postrado L, Delahanty J, Fischer PJ, Lehman A. The association of medical comorbidity in schizophrenia with poor physical and mental health. *J Nerv Ment Dis.* 1999 Aug;187(8):496-502. <PubMed>

Dixon et al. (1999) studied people with schizophrenia to determine the prevalence of medical comorbidities, and the association of medical comorbidity with physical and mental health status. The results of a survey of a sample of 719 persons participating in the Patient Outcome Research Team study showed that a majority had one medical problem. Reports of problems with eyesight, blood pressure and teeth were most common. In comparison, those persons with a number of current medical problems were perceived to have worse physical health status, more severe psychosis and depression, and greater likelihood of a history of attempted suicide.

Dobmeyer AC, Rowan AB, Etherage JR, Wilson RJ. Training psychology interns in primary behavioral health care. *Professional Psychology: Research and Practice.* 2003 Dec;34(6):586-94.

Dobmeyer et al. (2003) argue for an intensive training program for predoctoral psychological interns in primary behavioural health care. The authors review the evidence and suggest which competencies should be included in the training: generalist psychology, health psychology, interdisciplinary team functioning and skills specific to primary care. Their description of the training rotation highlights the aspects of care that psychology interns must significantly adjust to if they are to conform to the style and culture of the primary care setting. These aspects are

also summarized in a one-page table, complete with corrective actions.

Dobscha SK, Ganzini L. A program for teaching psychiatric residents to provide integrated psychiatric and primary medical care. *Psychiatr Serv.* 2001 Dec;52(12):1651-3. <PubMed> <FullText>

Dobscha and Ganzini (2001) describe the results of the first year of a program for psychiatric residents in collaborative care. During their second or third year of post-graduate work, residents enter the Psychiatry Primary Medical Centre (PPMC) and remain there until the end of their residencies. The PPMC is organized so that psychiatric and medical residents work collaboratively side-by-side, supervised by psychiatric and medical preceptors. Residents spend half a day a week in ambulatory care medical clinics. They also attend conferences on medical issues and the intersection of primary and secondary care. Patients enrolled in the program must have at least one psychiatric disorder and often have some medical conditions; however, those with a severe medical condition are excluded. Overall, the program was successful in its first year of operation: seven residents delivered integrated care to 34 patients during 174 visits of longer than normal duration. Patients were very satisfied with the care provided and liked seeing one provider. Faculty enjoyed teaching within this program and the residents were satisfied with the combined supervision they received. The authors note that the program could be adapted for nonteaching medical and mental health settings, and suggest adapting the approach for training case managers, nurse practitioners and medical assistants.

Dodds S, Blaney NT, Nuehring EM, Blakley T, Lizzotte J-M, Potter JE, O’Sullivan MJ. Integrating mental health services into primary care for HIV-infected pregnant and non-pregnant women: Whole Life-a theoretically derived model for clinical care and outcomes assessment. Gen Hosp Psychiatry. 2000 Jul-Aug;22(4):251-60. <PubMed>

Dodds et al. (2000) report on the theoretical model they developed for the integration of mental health services into primary care for HIV-infected pregnant and nonpregnant women. Called the Whole Life program, it was designed to be implemented by the Miami School of Medicine in the departments of psychiatry, and obstetrics and gynecology. The model, derived in part from a conceptual framework for studying health, illness and stress, posits specific-effect pathways, and allows delivery of clinical care (actual integration at the staff and system levels) and patient outcomes research. A dominant feature of the program is the in-depth life-assessment protocol done during the first two clinic visits by two types of professionals. A service plan results and the assessment data form the clinical record and the research data.

Dodds S, Nuehring EM, Blaney NT, Blakley T, Lizzotte JM, Lopez M, Potter JE, O’Sullivan MJ. Integrating mental health services into primary HIV care for women: the Whole Life project. Public Health Rep. 2004 Jan-Feb;119(1):48-59. <PubMed>

Dodds et al. (2004) describe the conceptual framework of the Whole Life project, integration and implementation strategies, effects of integration, and lessons learned. Comprehensive integration goes well beyond the typical integration of physical and behavioural health care. The program is a women-centred service system that integrates support services for mental health, substance abuse and trauma with primary care for HIV, specialty gynecological and obstetrical services, psychosocial counselling, case management for entitlements, and

concrete support for daily living. Integration of the program expanded during the project. Because of the changes the project wrought in organizational structures, service delivery and the provider’s conceptualization of health for HIV-infected women, the project was continued beyond the demonstration funding period.

Douglas S, Machin T. A model for setting up interdisciplinary collaborative working in groups: lessons from an experience of action learning. J Psychiatr Ment Health Nurs. 2004 Apr;11(2):189-93. <PubMed>

Douglas and Machin (2004) quantitatively evaluate the experience of professional group members involved in action learning and suggest a model for establishing interdisciplinary collaborative working in groups. An action-learning set is defined as a way of addressing organizational change through persons working together on each other’s problems, and as a means of personal development and learning. In this instance, the action-learning set was established with personnel from both primary and mental health care investigating the potential for change. The process of the learning set — specifically the qualitative experience of the professional group members — was the focus of study. While the actual learning set was stopped after only two sessions (due to the illness of the project leader), the process data obtained through interviews with participants were analyzed for common topics:

- ∞ Project momentum.
- ∞ Support (that of both the person involved and the managers).
- ∞ Power (the organizational status of participants and the amount of autonomy they have in their jobs).
- ∞ Context (issues that influence the group in the larger context).
- ∞ Group life (the composition of the group, its orientation to the task and the way this influenced momentum).
- ∞ Barriers (unsuitability of the learning set for the task, ability of members to focus on the group work).

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The model identifies project momentum as the key concept, with the other elements flowing from it. Support, power, context and group life — all had the potential to influence project momentum in either positive or negative ways. The model may be useful as a tool to initiate specific kinds of projects involving collaborative groups.

Druss BG. The mental health/primary care interface in the United States: history, structure, and context. *Gen Hosp Psychiatry*. 2002 Jul-Aug;24(4):197-202. <PubMed>

In a discussion of the history, structure and context of the intersection of mental health care and primary care in the United States, Druss (2002) provides a broad perspective on the treatment of mental disorders in medical settings and the medical care of people with serious mental illness. The historical section traces the cycle of growth and retrenchment of primary care medicine in the 20th century, and the parallel development of care for mental illness. Druss reviews four core features of primary care — first contact, longitudinality, comprehensiveness and coordination — and makes suggestions for improving the integration of primary care and specialized mental health care.

Druss BG, Rohrbaugh RM, Miller, CL, Rosenheck RA. Integrated medical care for patients with serious psychiatric illness: a randomized trial. *Arch Gen Psychiatry*. 2001 Sep;58(9):861-8. <PubMed>

In a randomized control trial, Druss et al. (2001) studied the provision of integrated primary care mental health in a Veterans Affairs program in the United States. For all but two measures, persons in the integrated program experienced more positive outcomes than those in the usual care group. No differences in mental health symptoms or total costs of care were found. Access to and continuity of care improved for those in the integrated program who had primary medical care and case management.

Druss BG, Rosenheck RA, Desai MM, Perlin JB. Quality of preventive medical care for patients with mental disorders. *Med Care*. 2002 Feb;40(2):129-36. <PubMed>

Druss et al. (2002) compared the quality of preventive services for people with and without mental or substance use disorders in a national sample (n=113,505) of medical outpatients. They checked for eight types of preventive services: measures of immunization (2 services), cancer screening (4 services), and tobacco screening and counselling (2 services). Rates of preventive services were compared for veterans with psychiatric disorders or substance abuse disorders, and for those with both or neither disorders, adjusted for health status, demographics, and facility-level characteristics. The findings revealed that the study population received 64 per cent of the eight procedures for which they were eligible. Those receiving the lowest level of preventive services (58 per cent) were persons with concurrent disorders.

Dwight-Johnson M, Unützer J, Sherbourne C, Tang L, Wells KB. Can quality improvement programs for depression in primary care address patient preferences for treatment? *Med Care*. 2001 Sep;39(9):934-44. <PubMed>

Dwight-Johnson et al. (2001) studied a quality improvement intervention for primary care designed to accommodate the choices of patients and providers. They hypothesized that quality-improvement interventions would increase the proportion of patients entering depression treatment compared with those choosing usual care. The findings suggested that quality-improvement interventions that support patient choice could improve participation and receipt of preferred treatments. Those people preferring counselling may require additional interventions to engage in treatment.

Emmanuel JS, McGee A, Ukoumunne OC, Tyrer P. A randomised controlled trial of enhanced key-worker liaison psychiatry in general practice. *Soc Psychiatry Psychiatr Epidemiol.* 2003 Jun;37(6):261-6. <PubMed>

Emmanuel et al. (2003) conducted a pilot randomized control trial to evaluate the effectiveness of an enhanced key-worker program in London, England. All patients from four general practices who were still in touch with the service over a ten-month period were eligible for participation. Practices were allocated to either normal care or care enhanced by a key-worker liaison through a constrained randomized procedure. The enhanced service encouraged key workers to improve communication between primary and secondary care. Symptoms and social functioning were measured at baseline and after 6 months. A total of 43 patients were measured at baseline and 34, reassessed at the later date. Clinical outcomes did not differ between the two groups, but self-rated measures of social function improved significantly for the key-worker intervention compared with those for normal care. Costs were slightly higher for the enhanced care. Only 21 per cent of primary care practices altered their services during the study, and less than half of the key workers thought that they had involved the primary care team more in the care of the patients. Without additional resources, enhanced key-worker liaison for psychiatry in primary and secondary care has limited benefits.

Evans P, Lloyd K. Auditing the primary care of mental disorders. *International Review of Psychiatry.* 1998 May;10(2):127-9.

In their brief report, Evans and Lloyd (1998) contrast the researching and auditing of primary mental health care. Whereas the purpose of research is to define best practice, the purpose of audits or evaluations is to determine how closely actual practice aligns with best practice. The authors identified a few audit tools such as the Exeter Depression Audit Package for use in evaluation studies.

Eve JD. Sustainable practice: how practice development frameworks can influence team work, team culture and philosophy of practice. *J Nurs Manag.* 2004 Mar;12(2):124-30. <PubMed>

In a British study of eight residential rehabilitation and recovery mental health teams over a four-year period, Eve (2004) explores practice-development frameworks as a means of influencing team work, team culture and philosophy of practice. Great Britain has significant experience with team-delivered health care, in particular with mental health care. Through an accreditation program, teams worked with other teams to examine the core functions of their service (the practice framework), both individually and contextually. They developed a shared practice-development philosophy and system-wide goals to improve practice so that it would make a real difference in people's lives. Team learning was chosen to achieve these new goals. Typically, team learning evolves through four discrete phases, from fragmented learning, during which teams gain some understanding of the practice situation and some individual learning takes place; to the most advanced phase of continuous learning, in which collective team learning, central to the team practice and culture, occurs. After two years, the teams created a council of stakeholders (including nurses from the teams, service users, preregistration students and representatives from the local university) whose purpose was to monitor, commission and advise the eight teams about practice-development issues. The author suggests that use of a practice-development framework shifts the energy often used to maintain the status quo into the creation of positive change within clinical practice. Such change has a positive, sophisticated impact on clinicians, the health care environment and the consumers themselves, and gives all those involved in the service a feeling of ownership over the transition and change.

Farrar S, Kates N, Crustolo AM, Nikolaou L. Integrated model for mental health care. Are health care providers satisfied with it? Can Fam Physician. 2001 Dec;47:2483-8. <PubMed> <FullText>

Farrar et al. (2001) examine providers' satisfaction within a well-known Canadian integrated model of shared mental health care in primary practice. The authors used three mailed surveys to solicit input from participating family physicians, mental health counsellors and psychiatrists. Each questionnaire comprised 30 questions, which were customized for each profession and scored with a Likert scale. Overall satisfaction with the program was high for all three groups. Counsellors and psychiatrists were pleased to be accepted by primary care practices, and physicians were very satisfied with the team's work and the benefits to patients. Only two points of low satisfaction were recorded: work space for the mental health team members and linkages with the mental health system.

Feinman JA, Cardillo D, Palmer J, Mitchel M. Development of a model for the detection and treatment of depression in primary care. Psychiatr Q. 2000 Spring;71(1):59-78. <PubMed>

Feinman et al. (2000) summarize the development and implementation of a depression program in a large health management organization in the northeastern United States. Program components included the introduction of a screening tool and protocol; specification of the target population; new role responsibilities for the nurse educator, supported by a protocol for patient follow-up and telephone support; a database to track treatment progress; training for primary care staff; and collaboration with mental health specialists. The authors also discuss barriers to full implementation throughout the organization, such as obtaining the support of key people, both inside and outside the care system; competing with other initiatives, requiring adjustment of priorities for resource allocation; and realigning implementation plans

to be less ambitious in light of economic realities facing the overall organization.

Felker BL, Barnes RF, Greenberg DM, Chaney EF, Shores MM, Gillespie-Gateley L, Buike MK, Morton CE. Preliminary outcomes from an integrated mental health primary care team. Psychiatr Serv. 2004 Apr;55(4):442-4. <PubMed> <FullText>

Felker et al. (2004) present the preliminary outcomes of a study to evaluate the effect of an integrated mental health primary care team in a Veterans Affairs internal medicine primary care clinic. In the first year of operation, the rate of referrals to specialty services declined. The mean number of appointments with the team for evaluation and stabilization was 2.5 in the first year. The inclusion of a chaplain on the team made the integration of spiritual issues into assessment and treatment options available to consumers. Overall, the preliminary results indicate that response to the implementation of this team is favourable.

Finley PR, Rens HR, Gess S, Louie C. Case management of depression by clinical pharmacists in a primary care setting. Formulary (USA). 1999 Oct;34(10):864-66, 869-70.

Finley et al. (1999) describe an interdisciplinary model to improve the pharmacotherapeutic management of patients with depression treated in a primary care setting at Kaiser Permanente of Northern California. Clinical pharmacists provided case management for patients supervised by physicians from the departments of psychiatry and internal medicine. The pharmacists offered patients enhanced contact, patient education and follow-up. The goal was to see whether these enhancements would result in patients receiving appropriate antidepressant therapy, completing adequate courses of therapy and perhaps using fewer health care resources. In their report of the preliminary findings of the randomized control trial, the authors found that patients required relatively low maintenance

doses of medications. The authors concluded that the success of the program may largely depend on the training and motivation of the pharmacists involved. Since all had experience in the mental health field, they had intake interviewing skills, and the ability to establish therapeutic rapport and to determine the need for psychiatric referrals.

Firth MT, Dyer M, Marsden H, Savage D. Developing a social perspective in mental health services in primary care. *J Interprof Care*. 2003 Aug;17(3):251-61. <PubMed>

Firth et al. (2003) reflect on a service pioneered by a small group of mental health social workers in England that has been reshaped as health policy and administrative structures have changed over the last decade. The social work team is based in a general practitioner setting, and team members have additional sessional responsibilities at 11 other work sites. The team reports to a steering committee and is overseen by the primary care trust's strategic mental health task group. Recent work to reform the team has focused on the specific definition of what constitutes a suitable client. This definition has been developed from a guide that lists the psychological, interpersonal and material or environmental problems commonly presented (with attached therapies and specialist services when the need is specific) and a supporting case identifier that consists of nine very brief referral examples, three each that indicate a consumer's suitability for primary care, secondary care and other care. Overall, the authors note the importance of diverse professional and nonprofessional team members to the development of the service to date. Social work in primary health care is not simply a transfer of skills from secondary care, but more a shift of identity. "The process is akin to 'specialization' — the development of a new variety of mental health worker, not merely the reapplication of what in secondary care has been largely bio-medical and psychological practices... Social models of mental life focus more on the interplay between pressure from the environment and internal reactions to stress, and

on the systemic 'fall-out' of these on family, other relationships, work and similar" (pp.259–260).

Firth MT, Dyer M, Marsden H, Savage D, Mohamad H. Non-statutory mental health social work in primary care: a chance for renewal? *British Journal of Social Work*. 2004 Mar;34(2):145-63.

Firth et al. (2004) document the characteristics of their primary care social work practice with clientele who have mainly complex needs and common mental disorders. The authors stress that the purpose of the study was to explore the therapeutic content of social workers' direct and indirect work. In their retrospective analysis of 120 files, the authors found new data derived directly from practice, including direct versus indirect work, managing the context and process, and therapeutic social work as a contextual practice. The authors suggest that these dimensions of social work should be reinforced in education and training, and stressed in service and professional development activities.

Fischer LR, Wei F, Solberg LI, Rush WA, Heinrich RL. Treatment of elderly and other adult patients for depression in primary care. *J Am Geriatr Soc*. 2003 Nov;51(11):1554-62. <PubMed>

Fischer et al. (2003) studied whether depression in older and younger patients in primary care clinics was treated differently. Using administrative data, the authors enrolled adult patients (19 to 93 years of age) from nine primary care clinics owned by a health maintenance organization in the American Midwest. The findings suggested a tendency for older people with depression to be underserved, although no differences between young and old subjects by age, number of depressive symptoms, antidepressant treatment or recommendations for a follow-up appointment were found. Older people were asked less frequently about suicide risk, were referred less frequently to a mental health therapist, and were asked less often

whether they were depressed or had a problem with alcohol.

Fitzpatrick NK, Shah S, Walker N, Nourmand S, Tyrer PJ, Barnes TR, Higgitt A, Hemingway H. The determinants and effect of shared care on patient outcomes and psychiatric admissions — an inner city primary care cohort study. Soc Psychiatry Psychiatr Epidemiol. 2004 Feb;39(2):154-63. <PubMed>

Fitzpatrick et al. (2004) report the findings of their inner city study of levels of shared care for people with serious mental illness and the effects of this care on patient outcomes and psychiatric admissions. Shared care was measured by the patients' general practitioners and reflected the involvement of primary care and secondary mental health care providers. High levels of shared care resulted in patients' greater satisfaction with the care and higher social functioning at baseline. Patients having higher levels of care at follow-up had better mental health scores than those having lower levels of care, but this effect disappeared after adjustments for age, sex and psychiatric diagnosis. Higher levels of shared care had a limited effect on clinical, social or general health outcomes over a year.

Flaherty LT, Garrison EG, Waxman R, Uris PF, Keys SG, Glass-Siegel M, Weist MD. Optimizing the roles of school mental health professionals. J Sch Health. 1998 Dec;68(10):420-4. <PubMed>

Flaherty et al. (1998) discuss the outcome of shifting primary mental health care from community health centres and private offices to schools. They examine the disciplines that may participate in interdisciplinary mental health teams that operate in educational settings, including primary care nurses and psychiatrists, and highlight the importance of interdisciplinary collaboration, barriers, ways of overcoming barriers, and the way such teams operate in school settings.

Freeman G, Weaver T, Low J, de Jonge E, Crawford M. Promoting continuity of care for people with severe mental illness whose needs span primary, secondary and social care: a multi-method investigation of relevant mechanisms and contexts. October 2001, revised June 2002. [London]: National Co-ordinating Centre for NHS Service Delivery and Organisation R & D (NCCSDO); 2002. Available from: http://www.sdo.lshtm.ac.uk/pdf/coc_mentalillness_freeman.pdf

In a report for the National Co-ordinating Council of the National Co-ordinating Centre for NHS Service Delivery and Organisation R & D, Freeman et al. (2002) examine the continuity of care for people with severe mental illness, a top priority of the Council. The aim of the study was to discover and understand mechanisms that enhance the continuity of care for people with severe mental illness, and to comment on the contexts in which these mechanisms operate. The study included a systematic literature review, four field-case studies and a consensus enquiry (a restricted Delphi exercise) that involved researchers, managers, consumers and their families. The results indicate that research about the experience of continuity of care for consumers and those that care for them is scarce. Limited evidence shows the importance of flexible responses to people's needs: professionals need to be able to step outside traditional limits to act in enabling and advocacy roles. The results of the Delphi study emphasize the need to bridge the boundary between primary and specialist mental health care.

Freeth D, Reeves S. Learning to work together: using the presage, process, product (3P) model to highlight decisions and possibilities. J Interprof Care. 2004 Feb;18(1):43-56. <PubMed>

Freeth and Reeves (2004) examine educational opportunities that promote collaborative working using the systems-form presage-process-product (3P) model of learning and teaching. Their aim was to untangle the web of

influences on learning to work together and to promote critical awareness and better informed, timely decisions about professional practice and patient care. Working from the assumption that interprofessional education is the starting point for training in collaborative practice, Freeth and Reeves examined the 3P model in general and in detail for factors affecting learning experiences that enhance collaborative practice. This model is a very useful planning tool for shaping collaborative courses.

Friedli K, King MB. Psychological treatments and their evaluation. *International Review of Psychiatry*. 1998 May;10(2):123-6.

Friedli and King (1998) consider psychological treatments and their evaluation in the primary care setting. They note that general practice-based behavioural professionals offer a wide and increasing variety of treatments, that people often prefer psychological treatments to drug treatment and that most people like to be dealt with in primary care rather than in secondary care settings. In their review, the authors categorize the major studies of psychological treatments offered in general practice in the United Kingdom as brief counselling, cognitive behavioural therapy, problem-solving therapy and combination studies.

Friedli K, King MB, Lloyd M. The economics of employing a counsellor in general practice: analysis of data from a randomised controlled trial. *Br J Gen Pract*. 2000 Apr;50(453):276-83. <PubMed>

Friedli et al. (2000) investigate the direct and indirect costs of nondirective counselling within general practice in their prospective randomized controlled trial. They found no differences in clinical outcomes between counselling and routine general practice care. Cost analysis showed that direct costs for the counsellor group was higher at three months than routine general practitioner care, but during the subsequent six months, the direct costs of routine care was more expensive. Total costs over the nine months

showed that the counsellor group again became more expensive (but not significantly so, because of indirect costs). The authors concluded that counselling is not more clinically effective and the direct plus indirect costs of counselling are not significantly more expensive than those for general practice care over a nine-month period.

Friedmann PD, Alexander JA, Jin L, D'Aunno TA. On-site primary care and mental health services in outpatient drug abuse treatment units. *J Behav Health Serv Res*. 1999 Feb;26(1):80-94. <PubMed>

In their study, Friedmann et al. (1999) examined the impact of the provision of health services on health outcomes for clients treated for drug abuse. Subjects were drawn from a U.S. national survey of 597 outpatient drug abuse-treatment units. The key study variables examined were organizational characteristics and the degree of on-site provision of primary health care and mental health care. More primary care services were provided by programs that were accredited methadone programs. Units with more clients with concurrent disorders provided more on-site mental health services, but fewer HIV or AIDS treatment services. Units affiliated with mental health centres provided more integrated mental health services, but no health services. The authors concluded that an emphasis on quality improvement across the treatment system would increase the reliability of clients' access to health services.

Friedmann PD, D'Aunno TA, Jin L, Alexander JA. Medical and psychosocial services in drug abuse treatment: do stronger linkages promote client utilization? *Health Serv Res*. 2000 Jun;35(2):443-65. <PubMed>

Friedmann et al. (2000) tested whether linkage mechanisms such as on-site service delivery, external arrangements, case management, and transportation assistance increased the use of medical and psychosocial services in outpatient drug treatment units. Surveys were conducted with administrative and clinical personnel from

597 drug abuse programs. On-site delivery of care and transportation assistance were closely associated with higher use of ancillary services. Most external arrangements were informal referral agreements or ad hoc referrals. Unlike the findings of other clinical studies, case management was weakly associated with the level of ancillary service use, which may reflect the usefulness of case management in naturalistic settings in which its application may lack standardization and rigor. Transportation assistance was also found to be an important linkage mechanism.

Friedmann PD, Zhang Z, Hendrickson J, Stein MD, Gerstein DR. Effect of primary medical care on addiction and medical severity in substance abuse treatment programs. *J Gen Intern Med.* 2003 Jan;18(1):1-8. <PubMed>

Friedmann et al. (2003) report the effect of on-site primary medical care for persons in drug treatment programs through secondary analyses of a prospective cohort study of people admitted to 52 U.S. drug treatment programs. The findings revealed that persons treated in programs with on-site primary medical care had significantly less severe addiction at the time of the 12-month follow-up appointment than people who attended programs with no such service. On-site medical care, however, did not significantly influence medical severity at the time of the follow-up appointment. Off-site referrals did not exert any discernable effects on the severity of either addiction or medical problems. Further research is needed to explain how on-site medical care improves addiction outcomes.

Fritz GK. Promoting effective collaboration between pediatricians and child and adolescent psychiatrists. *Pediatr Ann.* 2003 Jun;32(6):383, 387-9. <PubMed>

Fritz (2003) describes the elements of effective collaboration between pediatricians, and child and adolescent psychiatrists. Although this relationship has been discussed in the literature at least once a decade for more than 70 years,

Fritz notes four factors that continue to challenge this collaboration: the distinct developmental histories of each specialty; differences in world views, styles and interests; significant differences in models of practice; and the unrealistic expectations that each discipline may have of the other. Fritz's recommendations are similar to those for other types of collaborative care: acknowledging, accepting and respecting the differences between these professions; building strong individual relationships with partners; paying attention to the type and style of communication, adjusting practices, as needed; and providing new opportunities for joint research.

Fuller J, Edwards J, Martinez L, Edwards B, Reid K. Collaboration and local networks for rural and remote primary mental healthcare in South Australia. *Health Soc Care Community.* 2004 Jan;12(1):75-84. <PubMed>

Fuller et al. (2004) summarize the process of establishing an integrated primary mental health care plan for the most remote region of South Australia. Problems related to rural service delivery were revealed through extensive consultations with stakeholders. Improvement strategies were devised to deal with these problems. Particular attention was paid to the boundaries between different service providers to reduce inflexibility and service gaps. Interagency task groups were established to support collaboration; networking groups to support local human service workers; and a regional mental health coordinator to support service partnerships.

Gale F, Vostanis P. The primary mental health worker within child and adolescent mental health services. *Clinical Child Psychology and Psychiatry.* 2003 Apr;8(2):227-40.

Gale and Vostanis (2003) studied the implementation of the role of the primary mental health care worker within child and adolescent mental health services in one area of England. A team of 13 workers developed a full range of

duties for this position, including consultation, liaison, direct work and training. The team, which was part of the child–adolescent (secondary level) service, reached out to primary care providers and worked within primary care settings. The authors provide a useful discussion of the challenges in the implementation of this new role, such as the need for experience and skill in consultation and supervision; provision of clinical supervision for these workers; maintenance of connections to specialty care; navigation of the intersection of primary and specialty services; and clarification of care pathways, referral protocols and methods of working together with a variety of professionals.

Gallo JJ, Coyne JC. The challenge of depression in late life: bridging science and service in primary care [comment, editorial]. JAMA. 2000 Sep 27;284(12):1570-2. <PubMed>

Gallo and Coyne (2000) argue that traditional treatment models that work in specialized mental health settings need to be adapted to the realities of primary care. It is insufficient to simply place mental health providers in primary care settings; team work is needed. Real change is more likely to occur when the training experiences of family practitioners are integrated with those of mental health specialists. To improve the treatment of mental illness in community settings, the therapeutic role of the family physician needs to be strengthened.

Garralda E. Child and adolescent psychiatry in general practice. Aust N Z J Psychiatry. 2001 Jun;35(3):308-14. <PubMed>

Garralda (2001) reviews the literature to examine the role of general practitioners and primary care staff in response to child and adolescent psychiatric disorders. Although children and adolescents with obvious psychological or behavioural problems are usually identified and properly referred, there is a need to diagnose and treat those whose psychiatric disorders are associated with somatic problems. Garralda discusses psychiatric treatment in primary care,

in particular, shifting approaches from in-patient to outpatient and consultation–liaison services, and new models to enhance the delivery of primary mental health care. Suggested areas for development include improved medical undergraduate teaching and post-graduate training, specific child and adolescent psychiatric interventions suitable for use in primary care settings, enhanced specialist programming within primary care, focused protocols for specialized referrals, health promotion clinics in primary care, and the primary care team's provision of appropriate information and education about children's mental health.

Garralda E. Needs of special groups: children. International Review of Psychiatry. 1998 May;10(2):134-5.

In a concise, informative discussion of the mental health needs of children, Garralda (1998) presents a cogent argument for the role of primary care in meeting these needs. Her argument includes increasing recognition of problems and illnesses, opportunities for establishing consultation–liaison programs and the skills of primary care practitioners needed to respond to children's mental health problems.

Gask L, Rogers A. Bridging the gap: mapping a new generation of primary mental health care research [editorial]. Journal of Mental Health. 1998 Nov;7(6):539-41.

Gask and Rogers (1998) set out a new agenda for research in primary mental health care in their 1998 editorial. Citing the rapidly changing policy and practice in the United Kingdom, they document the agenda that the National Primary Care Research and Development Centre (<http://www.npcrdc.man.ac.uk>) is to adopt. Four questions guide their discussion: What is the most appropriate way of defining, recognizing and responding to mental health problems? What is primary care? Who provides primary mental health care? and What constitutes effective primary mental health care practice?

Gask L, Sibbald B, Creed F. Evaluating models of working at the interface between mental health services and primary care. *Br J Psychiatry*. 1997 Jan;170(1):6-11. <PubMed>

In their review article, Gask et al. (1997) explore the feasibility of evaluating innovative models of collaborative care between primary care and secondary mental health services. They examine the cost-effectiveness of a number of methodological issues, highlighting the need to look at costs from multiple perspectives, including those of the consumer, the primary and secondary sectors, and the health system as a whole. Gask et al. call for comparative studies of different models of collaborative care and the development of the necessary research tools.

Gerdes JL, Yuen EJ, Wood GC, Frey CM. Assessing collaboration with mental health providers: the primary care perspective. *Families, Systems & Health*. 2001 Winter;19(4):429-43.

Gerdes et al. (2001) report their assessment of the strength of collaboration in a primary mental health care model within an integrated health care system in central Pennsylvania. They had two goals for the study: first, to create a way to specify and measure the strength of collaboration in an integrated health care system, and second, to clarify the relative contribution of specific organizational and provider variables identified as moderating factors. The authors separately surveyed the site directors and primary care providers of a health care system that comprised three hospitals, 96 owned primary care sites, several network primary care sites, and a wide range of staff and networked model behavioural health care services. The study included 72 primary health care sites (54 owned and 18 network sites) that had at least 200 health care plan members each, and one to 16 primary care providers on staff. Factor analysis of the primary care providers' responses used to characterize the strength of collaboration revealed that the quality of the relationship, the attributes and attitudes of the primary care provider, and the frequency of

collaboration, together accounted for 54 per cent of the variation in the strength of collaboration. Multivariate analysis demonstrated that having on-site mental health providers, a family practice specialty and employment in the same integrated health care system improves the quality and frequency of collaboration. Family practice specialty and site size are associated with positive provider attitudes and attributes. Key variables affecting the quality of integrated services include the strength and frequency of the collaboration, the type of provider specialty, site size, staff versus network employment and accessibility of mental health services.

Getler AA, Joseph RC, Grunebaum J, Grunebaum H, Eder G. Innovations in primary care mental health. *Families, Systems & Health*. 2001 Winter;19(4):459-66.

Getler et al. (2001) describe the Primary Care Behavioral Health Service established at the Cambridge Health Alliance/Harvard Medical School. This program was designed to integrate ambulatory medicine and psychiatry, and standardize operational practices. The authors provide an overview of the features, rewards and challenges of the service, clinical staff, consulting clinicians, behavioural medicine clinicians, social workers, couples and family clinicians.

Glasby J, Lester H. Cases for change in mental health: partnership working in mental health services. *J Interprof Care*. 2004 Feb;18(1):7-16. <PubMed>

Glasby and Lester (2004) review the current state of knowledge about partnerships between health and social care in the United Kingdom's adult mental health services. Examining 43 documents from a broader literature review about such partnerships, the authors discuss the rationale for successful partnerships, potential barriers and next steps; and implications for current health and social care policy in the United Kingdom.

Goetz RR. The primary care-mental health interface. *New Dir Ment Health Serv.* 1999 Spring;(81):17-24. <PubMed>

Goetz (1999) discusses the intersection of primary and mental health care (in a managed-care environment) through an examination of different practice models. He provides a framework, explored through case studies, to map the issues according to the type of problem (i.e., clinical, administrative or financial) and the different participants' views (the patient, provider, agency or system). Goetz argues that understanding the different models of care can set the stage for collaboration and that collaborative partners need to develop a common language to avoid misunderstandings.

Goldberg D. Training general practitioners in mental health skills. *International Review of Psychiatry.* 1998 May;10(2):102-5. <Abstract>

Goldberg (1998) discusses training in mental health skills for general practitioners. Topics include teaching family doctors communication skills, teaching the management of somatization, following user-friendly treatment guidelines for the management of common mental health issues in primary care, combining guidelines with feedback from consulting professionals within the primary care setting, and identifying the contributions of other primary care staff to patient care and various other treatment methods.

Goldman HH, Ganju V, Drake RE, Gorman P, Hogan M, Hyde PS, Morgan O. Policy implications for implementing evidence-based practices. *Psychiatr Serv.* 2001 Dec;52(12):1591-7. <PubMed> <FullText>

Goldman et al. (2001) discuss, in-depth, the policy implications of implementing evidence-based practices, particularly in specialized public-sector mental health programs. They discuss concepts of accountability, quality and evidence-based practices as a means to both these ends. Barriers and incentives for the possible application of mental health programs

to primary mental health care are reviewed. Their section on the infrastructures needed to support system change details a number of potentially useful approaches taken in evidence-based practice centres across the United States.

Goscha RJ, Rapp CA. The Kansas Excellence in Client-Centered Supervision Program: design and initial results. *Community Ment Health J.* 2003 Dec;39(6):511-22. <PubMed>

Using an organizational definition of a client-centred approach, Goscha and Rapp (2003) assessed a program designed to provide multiple supports, including training, to program supervisors to improve outcomes in community support services. The authors also provided first-year results that showed the overall performance of teams whose supervisors were enrolled in the program increased by 40 per cent while the performance of the rest of the teams in the same state remained stable. Three teams met or exceeded their goals, five others had improved performance but had yet to reach their goals and two teams showed no improvement.

Gow T, MacNiven M. Providing mental health services to Aboriginal peoples through collaborative mental health: a situation report. *Mississauga, ON: Canadian Collaborative Mental Health Initiative. Working paper 2005.*

In their paper for the Canadian Collaborative Mental Health Initiative, Gow and MacNiven (working paper) explore collaborative care for First Nations' people. The delivery of health care for aboriginal people must be culturally competent and firmly grounded in their beliefs if it is to be effective and meaningful. Collaborative care is compatible with the holistic health model of the medicine wheel commonly used in aboriginal approaches to health care.

G

Gray R, Parr AM, Plummer S, Sandford T, Ritter S, Mundt-Leach R, Goldberg D, Gournay K. A national survey of practice nurse involvement in mental health interventions. J Adv Nurs. 1999 Oct;30(4):901-6. <PubMed>

Gray et al. (1999) report the results of a national survey of a random sample of 1500 practice nurses involved in primary care mental health interventions in the United Kingdom. Their response rate was 54 per cent. The results indicated that practice nurses play a significant role in the assessment and treatment of mental health problems. Most frequently, they are responsible for the administration of depot antipsychotics and for screening for depression. However, these nurses do not frequently monitor patients for the side-effects of medication and have a poor understanding of the issues associated with the treatment of depression. Consistent with the recommendations of other studies, the authors point out the need to improve the education and training of practice nurses in mental health.

Grazier KL, Hegedus AM, Carli T, Neal D, Reynolds K. Integration of behavioral and physical health care for a Medicaid population through a public-public partnership. Psychiatr Serv. 2003 Nov;54(11):1508-12. <PubMed> <FullText>

Describing a unique integrated mental health, substance abuse, and primary and specialty health care program for Medicaid, low income, and indigent consumers in one Michigan county, Grazier et al. (2003) note the absence of published guidelines for the design and operation of integrated systems. They discuss a number of key issues affecting the establishment of their program that may be of interest to others wishing to establish an integrated system of care. For example, they explain how multiple, competing stakeholders designed a governance structure, created a legal entity, shared financial risk, allocated funds, coordinated information, monitored quality and provided cost-sensitive high-quality care; and how health policy makers

used integration to build on the successes of interdisciplinary cooperation and collaboration. The partners were the State government, county government and university health care provider, and a Medicaid-managed health care plan. Of critical importance is placing the values shared among these organizations ahead of their shared resources and financial risk. The State government was instrumental as advocate and facilitator throughout the process. In the authors' assessment, the integration of mental health and substance abuse services with primary mental health care offers considerable promise as a method of improving the quality of health outcomes, especially for people with chronic illnesses.

Griffith JL. The importance of nondichotomized thinking. In: Blount A, editor. Integrated primary care: the future of medical and mental health collaboration. New York: Norton; 1998. p. 44-62.

Griffith (1998) outlines the role of primary care mental health treatment in the care of people with physical illnesses, and provides a useful summary of the research about the role of psychosocial factors in the cause and course of physical illness. He argues cogently for a new way of responding to and thinking about people's health needs. He discusses the traditional dichotomized body-mind paradigms underlying medicine and the inadequacy of this dichotomized thinking for the integration of mental and physical care.

Hahn SR. Behavioral science curricula for general internal medicine: leading the fearful and preaching to the converted [abstract]. European Psychiatry. 1997;12(Suppl 2):129s.

Hahn (1997) reports on a program to teach psychosocial skills to general practitioners within a primary care medical education program. Three approaches are briefly described: a curriculum based on professional actors acting in patient scenarios about combined psychopathological family and medical problems; a series of four

additional curricular elements, a Balint group, supervised interviewing, multi-disciplinary case management, and a two-year seminar series on psychopathology, psychotherapeutic interventions and doctor–patient relationships; and a combined medical psychiatry residency program.

Hales A, Karshmer J, Montes-Sandoval L, Fiszbein A. Preparing for prescriptive privileges: a CNS-physician collaborative model. Expanding the scope of the psychiatric-mental health clinical nurse specialist. Clin Nurse Spec. 1998 Mar;12(2):73-80. <PubMed>

Hales et al. (1998) discuss a collaborative model involving psychiatrists and psychiatric–mental health clinical nurse specialists. Because clinical nurse specialists had recently secured prescribing privileges, the goal of this collaborative program was to develop the skills and knowledge they needed to manage patients’ medication, and increase the scope of their practice. The training model had two components: the interactive mentor–preceptee experience in which clinical nurse specialists met weekly with the psychiatrist to see patients jointly, review medications and make appropriate adjustments; and the more formal case presentation given by the clinical nurse specialists to the psychiatrist to generate review and discussion that would increase the clinical nurse specialists’ knowledge of medicines, costs associated with them, dosages, side effects and other management issues. Expansion of the clinical nurse specialists’ role requires attention to local and systems issues so that other professions understand, accept and embrace the potential of this expanded role and its possible benefits for patients. The authors mention some barriers to this program, such as the medical community’s negative attitudes to sharing prescribing privileges, psychologists’ competition for the same type of role expansion, and consumers’ lack of knowledge about this kind of role.

Haque MS, Nolan P, Dyke R, Khan I. The work and values of mental health nurses observed. J Psychiatr Ment Health Nurs. 2002 Dec;9(6):673-80. <PubMed>

Haque et al. (2002) examine the work of community mental health nurses working at the intersection of primary and secondary care in England. A small sample of 30 nurses answered a 39-item questionnaire designed to explore their perception of their role and the degree to which they were able to carry it out. The results indicated that the nurses were enthusiastic about their role and the possibility of its expansion in the primary care setting. However, they were concerned about how other health professionals would view this role, deficiencies in their own therapeutic skills and the level of support they were receiving. The authors recommended that nurses educate other health professionals and service users about their role; spend more time with service users, especially people with complex problems; and work towards increasing the appreciation of the work the nurses do and its added value for the people they treat.

Harmon K, Carr VJ, Lewin TJ. Comparison of integrated and consultation-liaison models for providing mental health care in general practice in New South Wales, Australia. J Adv Nurs. 2000 Dec;32(6):1459-66. <PubMed>

Harmon et al. (2000) compared consultation–liaison and integrated primary mental health care programs in New South Wales Australia. They compared the range and severity of psychiatric problems, levels of general practitioner and psychiatrist involvement, and patterns of care. Mental health nurses worked as part of a regional community mental health team under the supervision of the psychiatrist. The nurses were expected to accept patient referrals and provide clinical assessment, consultation and feedback about diagnosis and treatment; provide short-term counselling or psychotherapy, when indicated, for those patients whose general practitioner was unable or unwilling to provide this care; provide case management in partnership with the general

practitioners; and liaise with general practice, the mental health program and other services. The integrated program treated a broader range of diagnostic groups with higher levels of disability, including higher rates of mood and psychotic disorders, and lower rates of adjustment disorders. Overall, the service was well received: general practitioners deemed it accessible and acceptable.

Hart C. Keeping teams together. *Nurs Times*. 1999 Sep 15-21;95(37):48-9. <PubMed>

Hart (1999) presents a brief overview of issues relating to the operation of effective community mental health teams. Conditions required to operate an effective team are discussed, as are the need for boundaries, appropriate workload, structural enhancements, benefits, management challenges and stress control. Hart's depiction of the elements required to create a culture of openness and shared experience is useful: for example, working in an open-plan team space, having an ongoing training program, developing and maintaining a clear team philosophy and focus, having agreed-upon criteria for entry to and exit from the service, getting feedback and reviewing work with consumers in team forums, receiving group supervision, involving the team in policy-making, and developing some control of the work.

Health Disparities Collaboratives. [2005] Available from: <http://www.healthdisparities.net>

The goal of the Health Disparities Collaboratives in the United States was to change primary health care practices to improve the health care provided to all citizens and to eliminate disparities in that care. The Asthma and Depression Collaborative started in March 2000 had 40 participating health care centres. A number of practical tools for the care of depression were developed and made available on the World Wide Web, such as clinical service, community, decision support, delivery system design, organization of health care and self-management.

Hedrick SC, Chaney EF, Felker B, Liu CF, Hasenberg N, Heagerty P, Buchanan J, Bagala R, Greenberg D, Paden G, Fihn SD, Katon W. Effectiveness of collaborative care depression treatment in Veterans' Affairs primary care. *J Gen Intern Med*. 2003 Jan;18(1):9-16. <PubMed>

Hedrick et al. (2003) compare collaborative and consultation–liaison care within a Veterans Affairs primary care clinic in the northwest United States. The collaborative care model used was based on a chronic-illness model that involves a multi-disciplinary team assisting the primary care provider in the delivery of evidence-based treatment. The two models were compared for effects on the severity of depression symptoms, health status and satisfaction with care. Collaborative care produced greater improvements in depressive symptoms than consultation–liaison care from baseline to three months, but no significant differences at nine months. More people in collaborative care received medications and cognitive behavioural therapy. Mental health status improved and was sustained for those in the collaborative care stream over the nine months.

Heldring M. Integrated primary health care for women. In: Blount A, editor. *Integrated primary care: the future of medical and mental health collaboration*. New York: Norton; 1998. p. 247-60.

Heldring (1998) promotes integrated primary health care for women in her chapter in Blount's *Integrated primary care: the future of medical and mental health collaboration*. She argues for a holistic approach beyond that of the biomedical model to understand women's health issues, including their mental health. She highlights the current increased focus on women's health, clinical health issues that women face, the social impact of women's health problems, multi-disciplinary health care and a few case examples.

Henkel V, Mergl R, Coyne JC, Kohnen R, Moller HJ, Hegerl U. Screening for depression in primary care: will one or two items suffice? Eur Arch Psychiatry Clin Neurosci. 2004 Aug;254(4):215-23. <PubMed>

Henkel et al. (2004) focus on the sustainability of depression screening in routine primary care. While shorter instruments have been developed in recent years, it is still difficult to get primary care practitioners to administer the screening tools with patients and to follow up on positive screening results. This study investigated the psychometric properties of single items and two-item combinations of the WHO-5 Well Being Index, and compared the characteristics obtained to those of the original version of the index and another two-item screening test. A total of 431 primary care patients participated in the study. The results showed that the single-item screening questions were inadequate. The two-item combination of the WHO-5 index was more effective than the longer screening instrument. The authors suggest that screening reduced to two questions offers the potential advantage of increasing the detection of depression among primary care patients.

Herrman H, Trauer T, Warnock J; Professional Liaison Committee (Australia) Project Team. The roles and relationships of psychiatrists and other service providers in mental health services. Aust N Z J Psychiatry. 2002 Feb;36(1):75-80. <PubMed>

Herrman et al. (2002) acknowledge the growing need for an expanded concept of team work among professionals, carers, self-help groups, nongovernmental agencies and statutory authorities providing mental health services. The authors outline a project undertaken by the Royal Australian and New Zealand College of Psychiatrists Professional Liaison Committee (Australia) of the Board of Professionals and Community Relations to examine the problems psychiatrists face in professional relationships. The goal of the project was to make recommendations to their college about training, maintenance of professional standards,

leadership and management. Most of the paper discusses the obstacles to effective teamwork and collaboration. The authors encourage all professions involved in mental health care to develop an understanding of teamwork issues and formulate similar recommendations for education, professional organizations, workplaces and government to advance collaborative working in mental health care.

Hickie I, Groom G. Primary care-led mental health service reform: an outline of the Better Outcomes in Mental Health Care initiative. Australas Psychiatry. 2002 Dec;10(4):376-82. <Abstract>

Hickie and Groom (2002) document the key features of recent primary care-driven mental health reforms in Australia. They provide system-level information about how national primary mental health care evolved, and describe the structures and processes used in this important initiative in a country challenged by rural and remote delivery issues. They also highlight the essentials of the Better Outcomes in Mental Health Care initiative, the benefits of a primary care-based mental health system and priorities for such a system.

Hoffman HL, Castro-Donlan CA, Johnson VM, Church DR. The Massachusetts HIV, hepatitis, addiction services integration (HHASI) experience: responding to the comprehensive needs of individuals with co-occurring risks and conditions. Public Health Rep. 2004 Jan-Feb;119(1):25-31. <PubMed>

Hoffman et al. (2004) describe a state-wide program to evaluate the opportunities for integrating HIV/AIDS programs with substance abuse treatment programs in Massachusetts. The program was done on a one-year planning grant from the federal Substance Abuse and Mental Health Services Administration and was later expanded to include viral hepatitis programming. Among the outcomes were the development of a strategic plan, joint procurement initiatives and an ongoing

commitment to sustain efforts to integrate bureaus. This report emphasizes the need for local, state and federal incentives to support collaborative care that provides greater efficiency, and improved communication and coordination among clients, providers and government funders.

Holleman WL, Bray JH, Davis L, Holleman MC. Innovative ways to address the mental health and medical needs of marginalized patients: collaborations between family physicians, family therapists, and family psychologists. *Am J Orthopsychiatry*. 2004 Jul;74(3):242-52. <PubMed>

Holleman et al. (2004) implemented a collaborative program for homeless people participating in a transitional living centre in Texas. Multi-disciplinary professional teams (almost all of whom worked in the program part-time) worked on four program components that were designed to respond to the complex range of problems facing these homeless people. Over the course of the 12 to 18 months that they were at the living centre, the participants (families and single mothers) took part in a variety of activities, beginning with addictions treatment, if indicated. These four components comprised the program:

1. A psychosocial support group for people with chronic illnesses and disabilities that encouraged clients to take a more active role in their health care, and provided education and support.
2. Building Better Families, an innovative program that helped people recognize the patterns of behaviour in their families of origin and understand how these patterns affected their current family and relationships.
3. The Collaborative Medication Management program in which family physicians and therapists worked with participants to help them understand the appropriate use of the medications they required.
4. A family coaching program in which physicians and therapists worked with

families in their home environment to facilitate links to the services they required.

Together, these collaborative programs provided a number of benefits for consumers, including identification and referral of persons who might benefit from individual or family counselling or medical treatment; comprehensive treatment planning for those with somatic symptoms; increased willingness to receive psychological treatment; expression of clients' emotional, spiritual and social needs; and development of a range of coping skills and techniques. Caregiver benefits have ranged from increased team effectiveness to stress management related to their profession to overall increased satisfaction with work.

Hollifield M. Building new bridges in primary care [editorial]. *Gen Hosp Psychiatry*. 2004 Jul-Aug;26(4):253-5. <PubMed>

Hollifield (2004) discusses a number of barriers to the use of mental health services by people of Chinese origin. One example is an explanatory model of illness that portrays people treated for mental health problems as mad and that identifies common symptoms, such as those for depression, as problems related to family discord, social pressure, poor physical health and adverse life events, rather than to mental health. Other barriers are the belief that help should be sought only for life distress when the behaviour is evident to or affects other people, and when there are language barriers and the need for confidentiality about personal mental health problems in a close-knit community. A rational mistrust of authority, especially amongst those who have experienced war or political oppression, also prevents many people of Chinese origin from using mental health services. A key example of this is the experience of the Chinese Cultural Revolution, when symptoms of depression were often construed as criticism of the government and resulted in arrest or punishment. Hollifield proposes a new model of collaborative mental health care for all immigrants that would embrace more holistic approaches to illness (other than the

mind–body dualism), a model that sanctions a strong relationship between the patient and the doctor, and offers programs and outreach in their communities.

Horder J. Interprofessional collaboration and interprofessional education [editorial]. *Br J Gen Pract.* 2004 Apr;54(501):243-5. <PubMed>

Horder (2004) underscores the need for interprofessional education to prepare professionals of many disciplines for the demands and expectations of collaborative care. Drawing on the United Kingdom's substantial history of interprofessional education (some 25 years), he describes two fundamental beliefs: first, that better communication and teamwork between different types of professionals and agencies will likely benefit not only patients, clients and carers, but also the professionals themselves; and second, that interprofessional education can contribute to the development of these aspects of their work by combating ignorance, prejudice and tribalism, thus increasing understanding, respect and mutual support. Horder points to the need for two kinds of evidence: the need for better collaboration that benefits patients, clients and professionals; and the need for full evaluation of interprofessional education that examines university-based programs for their impact on changing attitudes and work-based endeavours for their ability to improve quality of care. He makes several recommendations for interprofessional education that supports collaborative care:

- ⌘ More evaluations, especially those that relate different educational methods or programs, through collaboration, to consumer benefit.
- ⌘ Training and accreditation of interprofessional teachers.
- ⌘ More experiments that introduce interprofessional modules into educational programs to counter early negative stereotyping.
- ⌘ More initiatives involving workplace learning in which practitioners work together on real

clinical issues or on improving a service that is of interest to them and their patients.

Howard M, Trim K, Woodward C, Dolovich L, Sellors C, Kaczorowski J, Sellors J. Collaboration between community pharmacists and family physicians: lessons learned from the Seniors Medication Assessment Research Trial. *J Am Pharm Assoc (Wash DC).* 2003 Sep;43(5):566-72. <PubMed>

Howard et al. (2003) conducted a qualitative study of specially trained pharmacists with an expanded role and physicians working in a collaborative program to optimize drug therapy for elderly patients. The goal of the study was to learn about the program and identify obstacles to implementation, program shortcomings and strategies to surmount these problems. Physicians and pharmacists differed in their perceptions of appropriate activities that pharmacists with an expanded role should undertake. The pharmacists viewed the project as an opportunity to take on an expanded role, whereas physicians valued the information they received from the pharmacists about adherence and use of nonprescription medicines, but did not agree that pharmacists should counsel patients. Targeting patients for the program also proved to be a problem: inclusion criteria were broad and many did not require intense intervention by the pharmacists. The lack of a suitable compensation mechanism for pharmacists was also noted. The authors recommend clarifying the roles of pharmacist and physician when these professionals work together, targeting appropriate candidates for such a program, streamlining ways to deliver recommendations, and developing appropriate compensation mechanisms for pharmacists.

Hull SA, Jones C, Tissier JM, Eldridge S, Maclaren D. Relationship style between GPs and community mental health teams affects referral rates. *Br J Gen Pract.* 2002 Feb;52(475):101-7. <PubMed>

Hull et al. (2002) examine the effects of relationship style on the referral rates of general practitioners and community mental health teams. Relationship style was characterized as consultation–liaison (regular face-to-face contact and casework discussion four to six times weekly), and categories of some contact (regular telephone contact and ability to meet the team, if required) or no contact (receiving information from the team only by letter and occasional telephone contact). The consultation–style relationship was associated with the mental health team's increased referral rates for people with serious mental illness for both short- and long-term work. In those practices that had in-house psychological services, referral rates to psychiatric outpatient services were lower.

Hunkeler EM, Meresman JF, Hargreaves WA, Fireman B, Berman WH, Kirsch AJ, Groebe J, Hurt SW, Braden P, Getzell M, Feigenbaum PA, Peng T, Salzer M. Efficacy of nurse telehealth care and peer support in augmenting treatment of depression in primary care. *Arch Fam Med.* 2000 Aug;9(8):700-8. <PubMed> <FullText>

In their randomized control study, Hunkeler et al. (2000) examined the efficacy of nurse telehealth care and peer support for augmenting treatment of depression in primary care. The rationale for the study was to improve the treatment of depression. The trial compared usual care, telehealth care and telehealth care plus peer support. Assessments were conducted at baseline, six weeks and six months. A total of 302 patients from two managed-care adult primary care clinics were involved. In the telehealth care intervention, primary care nurses provided emotional support and focused behavioural interventions in ten 6-minute calls over four months. Peer-support interventions involved

trained health care plan members who had recovered from depression contacting patients by telephone and in person. The results showed a 50 per cent improvement in the depression rating scales of those patients who received telehealth care with or without peer support at six weeks and six months, and greater symptom reduction at six months. Peer support added to telehealth care did not improve primary outcomes. Telehealth care improved mental functioning and patient satisfaction. Overall, clinical outcomes for antidepressant drug treatment and patient satisfaction improved with telehealth care. This model could be easily implemented in a busy primary care practice.

Hyvönen S, Nikkonen M. Primary health care practitioners' tools for mental health care. *J Psychiatr Ment Health Nurs.* 2004 Oct;11(5):514-24. <PubMed>

In their small qualitative study, done in a regional Finnish health care system, Hyvönen and Nikkonen (2004) delineated the primary care provider's perspective about effective mental health care. They interviewed doctors and nurses to collect information about the types of mental health tools and the ways in which they are used. Using content analysis, the authors defined a set of tools, which they characterized as the practitioner him- or herself, ideological, interactive, technical and informative. Most central to effective mental health care were the interactive tools and the practitioner. The authors also discuss the educational implications of their findings.

Jackson-Bowers E, Holmwood C, Wade V. Allied health professionals providing psychological treatments in general practice settings. What options are there? *Aust Fam Physician.* 2002 Dec;31(12):1119-21. <PubMed> <FullText> OR <FullText>

Australia's initiative Better Outcomes in Mental Health provides incentives for general practitioners to refer their patients for time-limited psychological treatment. Jackson-Bowers

et al. (2002) discuss this engagement of allied health professionals in the delivery of this service in the general practice setting, the advantages and disadvantages of outsourcing this service, the need to monitor the overall system so that states do not retract previously offered services because of the addition of this new service and the need to locate this new service within the primary care setting. The authors review confidentiality ethics as a key factor in interprofessional interaction and the need for allied practitioner support.

Jacobson L, Churchill R, Donovan C, Garralda E, Fay J; Adolescent Working Party, Royal College of General Practitioners. Tackling teenage turmoil: primary care recognition and management of mental ill health during adolescence. *Fam Pract.* 2002 Aug;19(4):401-9. <PubMed> <FullText>

Jacobson et al. (2002) examine methods of recognizing and managing mental illness during adolescence, and improving its treatment in primary care. Using local (United Kingdom) and international information, they discuss how general practitioners can identify, care for and manage these issues. The paper includes a good discussion of the interrelationship of mental health problems with other health behaviours and risk factors, and stresses biomedical, individual and contextual factors that should be considered in the assessment and diagnosis of mental health issues. The authors present several barriers to the provision of optimal care, such as the lack of definition of teenage distress, of training in adolescent health for general practitioners, of a research base, of resources and of first-hand information from teenagers themselves who might provide useful insights, based on their own experience.

Jacobson N, Greenley D. What is recovery? A conceptual model and explication. *Psychiatr Serv.* 2001 Apr;52(4):482-5. <PubMed> <FullText>

Jacobson and Greenley (2001) describe a conceptual model of recovery that has two key dimensions, internal and external conditions that contribute to a person's recovery from mental illness. Internal conditions such as hope, healing, empowerment and connection are experienced by people who describe themselves as being in recovery. External conditions such as implementation of the principle of human rights, a positive culture of healing and recovery-oriented services facilitate recovery. The model links these abstract concepts to specific strategies that systems, agencies and people may use to support the recovery process.

Jenkins GC. Collaborative care in the United Kingdom. *Prim Care.* 1999 Jun;26(2):411-22. <PubMed>

Using data from the first nationwide survey, Jenkins (1999) documents the growing use of counselling in general practices in the United Kingdom, and discusses the counsellors and their patients. Jenkins challenges the idea of building an evidence base for counselling in general practice, highlighting the shortcomings of randomized controlled trials applied to psychological treatments.

Jenkins GC. Promoting and measuring behavioral health services in family medical practices in the United Kingdom [commentary]. *Families, Systems & Health.* 2002 Winter;20(4):399-415.

In a descriptive overview of the history of the Counselling in Primary Care Trust and the development of the Clinical Outcomes in Routine Evaluations (CORE) system in England, Jenkins (2002) provides an overview of the tensions and debates about the use of counselling in primary care, and insight into what constitutes acceptable evidence for the demonstration of best practices. The CORE system was created to

provide practice-based evidence for counselling in primary care settings. Preliminary results of its application are presented here, although a more thorough presentation of these findings is available (see Mellor-Clark et al., 2001).

Jenkins R. Mental health and primary care-implications for policy. *International Review of Psychiatry*. 1998 May;10(2):158-60.

Jenkins (1998), from the WHO Collaborating Centre in London, England, provides a high systems-level discussion of mental health and primary care policy issues. She provides a broad international perspective on primary mental health care. Interesting are the examples of approaches taken by developing countries where integrated mental health and primary care is innovative and unencumbered by the many issues faced by countries with sophisticated fragmented health care systems that have implemented similar programs. Overall, Jenkins highlights the need to build capacity in primary care systems across the globe to respond to the high demand for the treatment of common mental disorders.

Jenkins R, Strathdee G. The integration of mental health care with primary care. *Int J Law Psychiatry*. 2000 May-Aug;23(3-4):277-91. <PubMed>

In their comprehensive article about the integration of mental health care with primary care, Jenkins and Strathdee (2000) provide insight into the approaches of developing countries that do not have enough general or specialist physicians. The capacity of nonspecialized workers, including primary health care workers, nurses, medical assistants and doctors, to provide general mental health care needs to be developed. The authors point out that mental health services should be decentralized, and mental health care capacity integrated within general health care services. Also vital is the expansion of the role of mental health professionals in training and supporting nonspecialized workers.

Judd F, Davis J, Hodgins G, Scopelliti J, Agin B, Hulbert C. Rural integrated primary care psychiatry programme: a systems approach to education, training and service integration. *Australas Psychiatry*. 2004 Mar;12(1):42-7. <PubMed>

Judd et al. (2004) describe their innovative developmental approach to shared care programming in rural Australia. Through integration of current separate mental health training initiatives, this team crafted a system-wide program that provided mental health services using a stepped collaborative-care model and increased the number of people with mental health problems treated. Goals of the model were to educate and support general practitioners in their practice of mental health care, and to improve specialist mental health treatment of people in the region. The training resulted in the development of a common language and common approaches to mental health care across general practices, and improved use of available resources. A future goal for the program is to continue the dissemination of evidence-based interventions within this rural area.

Kaas MJ, Dehn D, Dahl D, Frank K, Markley J, Hebert P. A view of prescriptive practice collaboration: perspectives of psychiatric-mental health clinical nurse specialists and psychiatrists. *Arch Psychiatr Nurs*. 2000 Oct;14(5):222-34. <PubMed>

Although many states require collaborative prescribing agreements between clinical nurse specialists and psychiatrists, little research has been done on the nature of this collaboration in the United States. Kaas et al. (2000) explore the perspectives of clinical nurse specialists and psychiatrists about collaborative prescribing practices. Thirty-one matched pairs of clinical nurse specialists and psychiatrists participated in the authors' small 1998 study in Minnesota. Their findings revealed that clinical nurse specialists and psychiatrists had a high level of satisfaction with the collaborative approach. Among the

characteristics of this collaboration identified as important were good communication, shared goals for patient outcomes, trust, shared professional values and respect for clinical competency. Psychiatrists identified sharing the workload as a major benefit, whereas clinical nurse specialists appreciated the opportunity for increased personal growth and job satisfaction. Both shared positive perceptions of the impact of the approach on the quality of patients' outcomes.

Kanapaux W. The road to integrated care: commitment is the key. Tennessee CMHC demonstrates promise of co-located behavioral and primary care. Behav Healthc Tomorrow. 2004 Apr;13(2):10-2, 15-6. <PubMed>

Kanapaux (2004) describes the Cherokee Health Systems, a unique community mental health centre in Tennessee, as a model of the way integration of primary care and mental health care can work in the public sector. Cherokee provides a complete community health system that has moved well beyond its original mental health mandate as a community mental health centre; it has 18 service locations, all but three of which have co-located primary behavioural health care. Cultural elements and reimbursement issues relevant to the American context are discussed briefly. Other community mental health centres may learn about the delivery of integrated mental health care from the Cherokee experience.

Kates N. Shared mental health care. The way ahead [Article in English, French] [editorial]. Can Fam Physician. 2002 May;48:853-5, 859-61. <PubMed> <FullText> OR (En) <FullText> (Fr)

In his brief editorial about primary mental health care, Kates (2002) examines new models of collaboration. Highlighting the relationships between family physicians and psychiatrists, he summarizes the key elements required for collaboration. These elements include

strengthening personal contacts between family physicians, psychiatrists and other mental health professionals; improving communication and access to mental health services; emphasizing early detection; providing consumers with telephone backup by psychiatrists; providing continuing education using innovative approaches, including practice-based models, the Internet and simple educational aids such as drug information sheets; training future practitioners; integrating mental health and primary care planning processes better; integrating mental health services within primary care more frequently; and providing new roles for family physicians within mental health service programs.

Kates N, Craven M, Atkinson M, el-Guebaly N. How psychiatrists view their relationships with family physicians. CPA Bulletin de l'APC 2001 Mar;13-15. <FullText>

Kates et al. (2001) report on how psychiatrists view their relationship with family physicians. Questions probing the relationship between family physicians and psychiatrists were included in a larger questionnaire sent to every member of the Canadian Psychiatric Association Research Network in 2000. Psychiatrists rated collaboration highly, although there was wide variation in the time spent on such contacts. Telephone contact was the most frequent form of linkage with family physicians. Results also confirmed that obstacles such as the lack of funding and time constraints prevent greater collaboration. More recent graduates who were exposed to collaborative approaches in their training demonstrated a greater commitment to collaboration. The authors recommended a number of actions:

- ∞ Joint educational or clinical rounds with psychiatrists and family doctors need to be held.
- ∞ Regular communication between psychiatrists and family doctors by telephone is required after a consultation with patients or changes in patients' treatment, or before their discharge.

- Concise, short written communications with family physicians need to emphasize the treatment plan and include the future role of the psychiatrist.
- Shared care training should continue as part of medical education.
- Service planning and funding should consider collaborative models for implementation.

Kates N, Crustolo AM, Farrar S, Nikolaou L. Counsellors in primary care: benefits and lessons learned. *Can J Psychiatry*. 2002a Nov;47(9):857-62. <PubMed>

Kates et al. (2002a) describe the participation of counsellors in a Canadian collaborative model of care, their activities and the evaluation of the program. The program itself brings psychiatrists and counsellors into the office of 87 family physicians in 36 practices in Hamilton, an urban centre of 460,000 people. Counsellors see patients who have depression, anxiety, and family problems (they accept all who are referred). The yearly average of new cases is 161. In a majority of cases (more than 70 per cent), significant improvement is achieved. The professional designations of the counsellors comprise registered nurses (25 per cent), social workers with a master's degree (50 per cent), social workers with a bachelor's degree (15 per cent), PhD psychologists (2 per cent) and other (8 per cent). Overall, the availability of counsellors in primary care settings has increased people's access to mental health care, and those receiving this care are very satisfied. The collaborative nature of the overall program is cited as a reason for these positive outcomes. All partners, including the family physicians, have had a role in designing and modifying the program since its inception. A full-time coordinating team provides support to the family practices and the professionals in the program, and deals with all coordination issues and problems. The authors note three important lessons:

1. The approach creates opportunities for increasing the detection of mental health

problems and initiating treatment at an earlier stage of illness.

2. Provision of mental health care in primary care settings complements, but does not replace, secondary-level mental health services such as outpatient clinics.
3. The practice treats different people than traditional secondary mental health care because there are no specific criteria for intake or treatment.

Kates N, Crustolo AM, Farrar S, Nikolaou L, Ackerman S, Brown S. Mental health care and nutrition. Integrating specialist services into primary care. *Can Fam Physician*. 2002b Dec;48:1898-903. <PubMed> <FullText>

Kates et al. (2002b) report on the involvement of dietitians in their collaborative care model in Hamilton, Ontario. The overall details of this program are described elsewhere (see Kates et al., 2002a). The nutrition component of this program involves a dietitian visiting each family practice from three hours to three days per week, depending on the practice size. Since dietitians may work in six to eight practices over the course of one week, they are usually assigned to practices in the same geographic area to minimize travel time. The dietitians assess patients referred by the family physicians and initiate treatment or an education program, according to individual need. They also provide the doctors and other staff with consultation, training, education or other resources, as requested. This model provides many lessons about successful integration of specialists into primary care offices.

Katon WJ. The Institute of Medicine "Chasm" report: implications for depression collaborative care models. *Gen Hosp Psychiatry*. 2003 Jul-Aug;25(4):222-9. <PubMed>

Katon (2003) contributes a very useful summary of depression research that begins with the U.S. Institute of Medicine's recent report on improving the overall health care system. The health care

system is depicted as a series of levels onto which Katon maps the barriers to depression care and related findings of collaborative care studies. Also discussed are the prevalence rates of mental disorders in primary care, the direct medical and indirect costs for people with mental illness, the impact of mental illness in patients with chronic physical illness, and evidence of the lack of quality of care for depressive disorders. Research-proven models for depression care are summarized and presented according to the system-level framework. Katon also presents a number of directions for future research.

Katon WJ, Ludman EJ. Improving services for women with depression in primary care settings. *Psychology of Women Quarterly*. 2003 Jun;27(2):114-20.

Katon and Ludman (2003) discuss care for women with depression in primary care settings. They systematically review the related issues of health care use among people with depressive disorders, barriers to treatment in primary care, the various intervention models, similarities in effective trials, cost-effective use of psychiatric services and relapse prevention, emphasizing special consideration of women's needs throughout.

Kerwick S, Tylee A. Continuing medical education in primary care psychiatry. Comparing the needs and wants of general practitioners. *International Review of Psychiatry*. 1998 May;10(2):106-9.

Kerwick and Tylee (1998) discuss the continuing medical education (CME) needs of primary care psychiatrists in the United Kingdom. They note that the approach to CME has changed recently: expectations have become more circumspect, more responsive to the learner's needs and more accepting that practice premises are a suitable place for learning; that training in multi-disciplinary environments is underused; and that education must have clear objectives and aims. They highlight a number of specific education and training needs in primary care psychiatry, based on the following facts:

- ✎ Undergraduate education in psychiatry places almost exclusive emphasis on serious mental illnesses.
- ✎ Psychiatric rotations for general practitioners are in hospitals, and fewer than 50 per cent of doctors choose a psychiatric rotation.
- ✎ In recent surveys, general practitioners report that their vocational training is of minimal help when they deal with the mental health issues confronting their primary care patients.
- ✎ Most general practitioners have not taken part in approved education or training so that they can fulfill their role in the delivery of primary mental health care.

Although some progress has been made across the country, the authors report that no coordinated education or training program has yet been created to help general practitioners carry out their mental health care role.

Kirchner JE, Cody M, Thrush CR, Sullivan G, Rapp CG. Identifying factors critical to implementation of integrated mental health services in rural VA community-based outpatient clinics. *J Behav Health Serv Res*. 2004 Jan-Mar;31(1):13-25. <PubMed>

In their study of implementing integrated primary mental health and addictions care in two rural settings, Kirchner et al. (2004) found that a number of factors interact and influence successful uptake of service innovations in collaborative care. They found that internal change leadership needs to be sustained during the implementation of a new model of care. Staff attitudes and beliefs about the care provided and new care providers in the clinic were influential. Organizational factors of interest included clear definitions of roles and reporting relationships. Awareness of and response to community needs was also important.

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Kisely S, Horton-Hausknecht J, Miller K, Mascall C, Tait A, Wong P, Bostwick R. Increased collaboration between primary care and psychiatric services. A survey of general practitioners' views and referrals. Aust Fam Physician. 2002 Jun;31(6):587-9. <PubMed> <FullText>

Kisely et al. (2002) evaluate the primary care partnership between a local mental health service and the division of general practice in the inner city of Perth, Australia. This partnership included a memorandum of understanding to streamline referrals, a consultation–liaison service and a Balint group. The findings revealed an overall awareness of the consultation–liaison service, high use of the duty officer as the first point of contact for consultation–liaison and use of referral forms. The partnership improved general practitioner's self-reported skills for the management of mental health problems and referral behaviour.

Korda H. Stakeholders speak — integrating behavioral health and primary care for treatment of depression: a scan of stakeholder experts. Submitted to the Office of Managed Care, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. Rockville, MD: National Council for Community Behavioral Healthcare; [June 2002]. Available from: <http://www.nccbh.org/html/learn/PCI/pci-stakeholder.htm>

Korda (2002) surveyed stakeholder experts about the issues of integrating behavioural health and primary care for the treatment of depression in the United States. Best practices for the treatment of depression have been identified previous to this review. Many groups' interest in the widespread implementation of depression programs is growing. Korda asked purchasers, managed-care plan providers, care providers, and national consumers and consultants about financial and other leverage points that might improve the integration or coordination of mental health care and its quality within primary

care settings. The review discusses a large number of key themes and findings, ranging from defining the concept of integration to consumer involvement.

Kramer T, Garralda ME. Child and adolescent mental health problems in primary care. Advances in Psychiatric Treatment. 2000 Jul;6(4):287-94. <FullText>

Kramer and Garralda (2000) provide an overview of the mental health problems of children and adolescents seen in primary care. They reviewed such topics as prevalence, pattern and detection of problems, consultation and perception of need, referral to specialist mental health services, and interventions. They described two collaborative programs: the shifted outpatient clinic (where psychiatrists operate clinics within primary care) and the consultation–liaison model.

Kushner K, Diamond R, Beasley JW, Mundt M, Plane MB, Robbins K. Primary care physicians' experience with mental health consultation. Psychiatr Serv. 2001 Jun;52(6):838-40. <PubMed> <FullText>

In a study of 684 primary care physicians' experience with mental health consultation in Wisconsin, Kushner et al. (2001) found that the majority had only moderate access to mental health professionals, even less if their patients had public or no insurance. Those physicians working in group practices that included at least one mental health professional reported greater, but not optimal access to care. Community size did not affect access, which may reflect the effectiveness of the mental health system in Wisconsin. Physicians preferred to make referrals to, rather than consult with, mental health professionals, but the authors gave no reasons for this finding. They speculate whether physicians preferred referrals because they lack the time, the qualifications or the confidence to treat people with mental illness. Lack of reimbursement may also play a role.

Lacey I. The role of the child primary mental health worker. *J Adv Nurs.* 1999 Jul;30(1):220-8. <PubMed>

Lacey (1999) discusses the role of the child primary mental health worker, another innovative position being mandated in English mental health policy. This study surveyed mental health trusts to determine how many child mental health workers had been hired and how these trusts were being staffed. Of 169 trusts surveyed, 98 indicated that 22 child mental health services had this new position and 42 others were planning to establish one. On average, these workers spent 35 per cent of their time in primary care consulting with and training health professionals rather than directly caring for children and families. Many of the positions were filled by advanced practice nurses.

Lankshear AJ. Coping with conflict and confusing agendas in multidisciplinary community mental health teams. *J Psychiatr Ment Health Nurs.* 2003 Aug;10(4):457-64. <PubMed>

Lankshear (2003) identifies a number of strategies that six mental health teams in the north of England used to manage problems caused by the disparity between the stated and agreed purposes of the teams, and their actual patterns of referrals for people with serious mental illness. To avoid having their funding withdrawn, the six teams increased referrals in a number of ways. Lankshear's case study provides a multi-professional rather than uni-professional view of interdisciplinary working. Six strategies emerged:

1. Isolation: In response to the rising number of referrals for acute work, a few teams restructured so that only some team members, usually the community psychiatric nurses, managed the extra cases. This effectively isolated these professionals from the rest of the team.
2. Homogenization: All members of a team increased their caseloads, seeing it as their

responsibility to respond as an integrated unit.

3. Fraternalization: Workload tensions were resolved among team members, even though formal protocols and agreements may not have permitted this. Members believed it important to offer support as valued colleagues and friends.
4. Negotiation: Some teams managed the extra workload by having all members participate in a defined rotation of work assignments and cases.
5. Manipulation: Some teams engaged in game-playing and selective screening. This was most evident when cases were transferred to workers after the intake assessment.
6. Demarcation: The social workers on the team defined clear boundaries for themselves to preserve their professional identities as social workers. This was not in response to the referral situation, but to the physical location in a hospital where the team had to work. For example, social workers objected to having the team office next to the electroconvulsive therapy suite.

Larivaara P, Taanila A. Towards interprofessional family-oriented teamwork in primary services: the evaluation of an education programme. *J Interprof Care.* 2004 May;18(2):153-63. <PubMed>

Larivaara and Taanila (2004) discuss a two-year training program for professionals working in primary services (health, social welfare, schools, daycare) in Finland. The goal of the program was to provide workers with the skills that they need to work with families in interprofessional teams and to develop new models for serving families. Interprofessional family work is defined as professionals from different organizations working with families to prevent problems, treat illnesses and care for clients within a primary service system. The training program focused on training participants to cooperate with other professionals, families and communities and providing appropriate resources to do

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the work; encouraging creative and innovative approaches to helping people; enhancing cooperation among professionals in private and public organizations; and enhancing professional competencies. Contact instruction, independent study and a variety of other learning methods were used to deliver the training. A total of 76 participants from 13 professions participated. Working methods and job satisfaction improved over the course of the training. The authors found that participants increasingly valued collaborative practice and that client- and family-oriented working methods also helped families use their own resources for solving problems. The element of practice included in the program fostered genuine change, not only in the practical skills of those trained, but also in the theoretical framework on which the program was based.

Lean ME, Pajonk FG. Patients on atypical antipsychotic drugs: another high-risk group for type 2 diabetes. *Diabetes Care*. 2003 May;26(5):1597-605. <PubMed> <FullText>

Lean and Pajonk (2003) examine the relationship between the use of antipsychotic drugs and the risk of type 2 diabetes for people with schizophrenia because persons younger than 40 years who take antipsychotic medication are an unrecognized group with a high risk of developing diabetes. The authors explore a number of explanatory hypotheses about disease mechanisms and highlight the requirements of people with psychoses who need to change their diet and lifestyle to ameliorate weight gain and diabetes. In particular, Lean and Pajonk recommend ongoing collaboration between psychiatric and diabetology teams for the management of these comorbid health conditions. Active collaborative management can potentially reduce or minimize the high risk of cardiovascular disease for persons with schizophrenia.

Lee J, Gask L, Roland M, Donnan S. Primary care led commissioning of mental health services: lessons from total purchasing. *Journal of Mental Health*. 2002 Aug;11(4):431-9.

Lee et al. (2002) conducted a study of Total Purchasing and Extended Fundholding sites in England for the National Health Service. Their purpose was to identify the lessons that could be learned from the 1990s organizational experiment that funded secondary services for general practitioners, including mental health. Lee et al. found improved communication and working relationships between primary care and secondary mental health care providers. Indeed, the number of mental health providers working in the primary care settings increased. Increased collaboration with social care was not as evident, and consumer involvement was lacking. The authors discuss this information in the context of the most recent reorganization of local health care, namely, in the context of primary care groups and trusts.

Lester H, Allan T, Wilson S, Jowett S, Roberts L. A cluster randomised controlled trial of patient-held medical records for people with schizophrenia receiving shared care. *Br J Gen Pract*. 2003 Mar;53(488):197-203. <PubMed>

Lester et al. (2003) conducted a randomized controlled trial to determine whether patient-held medical records were as effective for people with schizophrenia receiving shared care, as they are for other chronic care populations. These records, retained by the patients, contain all or some information related to the course and care of their illness, and are commonly used in the management of some chronic physical illnesses. A total of 201 patients from 74 general practices and six community mental health localities participated in the trial. The majority of patients retained and used the records over a 12-month period. Patients were satisfied with the records as a communication tool, but the use of these records did not affect primary outcomes. The

authors did not recommend the use of this type of record-keeping for routine shared care.

Lester H, Glasby J, Tylee A. Integrated primary mental health care: threat or opportunity in the new NHS? Br J Gen Pract. 2004 Apr;54(501):285-91. <PubMed>

Lester et al. (2004), in their discussion paper about the opportunity for integrated primary mental health care in the new National Health Service in England, argue that interprofessional education is a vital underpinning of such a program. Noting evidence that points to the challenge of changing practice and the impact on outcomes, they call for more flexible and innovative approaches to education. The learner-centred approaches to education that they frequently recommend involve general practitioners teaching each other. The authors suggest that interprofessional education is also required to teach practitioners about one another's settings, paradigms and styles of working to promote a culture of collaboration and respect. Lester et al. recommend the participation of those who use these programs so that the learning reflects what people in need of service want and need rather than what professionals think consumers want and need.

Lester H, Tritter JQ, England E. Satisfaction with primary care: the perspectives of people with schizophrenia. Fam Pract. 2003 Oct;20(5):508-13. <PubMed>

In their study of satisfaction with primary care for people with schizophrenia, Lester et al. (2003) interviewed 45 people receiving shared care within the North Birmingham Mental Health Trust to collect data about user perspectives. Five themes that reflect important elements of the primary care experience emerged from the data: the exceptional potential of the consultation itself, the importance of aspects of the organization of primary care, the construction of the user in the doctor-patient relationship, the influence of stereotypes on general practitioners' behaviour, and the importance of hope for recovery. The findings

showed that satisfaction was multi-dimensional. Of particular importance to participants' satisfaction with medical encounters were the health care providers' interpersonal skills and the offer of hope for recovery from schizophrenia. The authors commented that the involvement of mental health consumers in primary care depends on issues that cannot be mandated, such as providers' understanding of and respect for consumers, and asking for their views. Lester et al. recommended that future training of doctors emphasize the importance of treating people with schizophrenia as rational partners in the caring process; in other words, reframing schizophrenia for doctors as "an illness with turning points where a form of recovery is possible."

Lichtenberg PA, MacNeill SE. Streamlining assessments and treatments for geriatric mental health in medical rehabilitation. Rehabilitation Psychology. 2003 Feb;48(1):56-60.

Lichtenberg and MacNeill (2003) describe new tools that they created to increase the efficiency and retain the effectiveness of rehabilitation psychologists working with older adults. For example, they describe their 12-week interdisciplinary training program for the geriatric team and list the modules used in the program.

Lin EH, Katon W, Von Korff M, Tang L, Williams JW Jr, Kroenke K, Hunkeler E, Harpole L, Hegel M, Areal P, Hoffing M, Della Penna R, Langston C, Unützer J; IMPACT Investigators. Effect of improving depression care on pain and functional outcomes among older adults with arthritis: a randomized controlled trial. JAMA. 2003 Nov 12;290(18):2428-9. <PubMed>

Lin et al. (2003) report the outcome of their study of collaborative care for 1,001 adults with both depression and arthritis. In contrast to usual care, collaborative care interventions that included management of depression by a

psychiatrist or primary care expert who educated participants to identify their preferred mode of treatment (antidepressant medication or brief psychotherapy) improved arthritis pain and functional outcomes over a 12-month period.

Lipkin M Jr. Psychiatry and primary care: two cultures divided by a common cause. *New Dir Ment Health Serv.* 1999 Spring;(81):7-15. <PubMed>

Exploring how the relationship between primary care and psychiatry can be reconciled through effective partnerships, Lipkin (1999) reviews traditional barriers and tensions between the two professions. These include differences in methods of dealing with mental illnesses, practice characteristics and access problems. Lipkin's guidelines for building effective relationships include caring about colleagues; being polite and cordial; practising intense, active listening skills; developing personal relationships; understanding colleagues' work world through training and placements; negotiating differences; understanding the reasons for contact; agreeing on roles, responsibilities, and modes and frequency of contact; avoiding the use of jargon; consulting on key decisions; having communication strategies for patients, families and staff; communicating in writing; expressing gratitude for referrals or consultations; and returning the favour of referral or consultation.

Lorenz AD, Mauksch LB, Gawinski BA. Models of collaboration. *Prim Care.* 1999 Jun;26(2):401-10. <PubMed>

Lorenz et al. (1999) cover a number of important issues in their discussion of models of collaboration, especially the underpinning paradigms of the mind-body split in medicine. Most useful is their list of key ingredients for effective collaboration such as relationship, common purpose, recognition of different paradigms, communication, location of service, and business arrangements. They also provide suggestions for getting started.

Lovell K, Richards DA, Bower P. Improving access to primary mental health care: uncontrolled evaluation of a pilot self-help clinic. *Br J Gen Pract.* 2003 Feb;53(487):133-5. <PubMed>

Lovell et al. (2003) examine the feasibility, acceptability, efficiency and effectiveness of a fast-track self-help primary care clinic. In this pilot project, people were referred by primary care staff or self-referred, and were accepted into the clinic if they had a general practitioner's diagnosis of mild depression or anxiety and were 16 years of age. The clinic operated one day per week; provided a 30-minute assessment by a nurse therapist, followed by monthly 15-minute follow-up sessions to monitor progress. People received individually tailored self-help programs that were supported by the therapist. The study showed that a self-help clinic is feasible, acceptable to patients and efficient. Effectiveness was difficult to assess in this uncontrolled study.

Luoma JB, Martin CE, Pearson JL. Contact with mental health and primary care providers before suicide: a review of the evidence. *Am J Psychiatry.* 2002 Jun;159(6):909-16. <PubMed> <FullText>

Luoma et al. (2002) review 40 studies about suicide that included information about rates of contact that the persons who died had with primary care and mental health professionals. Findings revealed that these people commonly made contact with primary care providers before their suicide; in particular, older people contacted their doctors within one month of their death. Luoma et al. concluded that primary care may be an appropriate setting for suicide intervention for those who do make contact with primary care providers and, conversely, that alternate approaches may be required to reach those, in particular, young men, who are less likely to be treated in primary or mental health care facilities.

Lyles JS, Hodges A, Collins C, Lein C, Given CW, Given B, D’Mello D, Osborn GG, Goddeeris J, Gardiner JC, Smith RC. Using nurse practitioners to implement an intervention in primary care for high-utilizing patients with medically unexplained symptoms. *Gen Hosp Psychiatry*. 2003 Mar-Apr;25(2):63-73. <PubMed>

Lyles et al. (2003) report the development of a multi-dimensional treatment protocol for patients with medically unexplained symptoms in primary care. The intervention focused on pharmacological management, cognitive behavioural principles, the provider–patient relationship and treatment of comorbid medical diseases. Instead of physicians, nurse practitioners delivered the interventions because their biopsychosocially oriented education is conducive to effective management of patients with medically unexplained symptoms and also because they are known to deal effectively with medical and psychological problems. The study of the program, conducted in a health management organization (HMO), involved 101 people in the treatment group treated by nurse practitioners and 102 controls in the usual care group. Nurse practitioners were able to implement the program, but required start-up training and ongoing support to manage difficult, resistant patients and to establish strong communication links with the HMO. Both nurse practitioners and primary care physicians assessed the program favourably. Primary care physicians welcomed the nurse practitioners’ assistance with the care of difficult patients and the improvements that they witnessed in their patients enrolled in the trial. The administration’s assessment was also favourable: hiring nurse practitioners was seen as favourable to both the HMO and the project, and patients praised the HMO generously for supporting it. The authors suggest that this model could be useful for expanding collaborative care for this demanding group of patients.

McAllister M, Walsh K. Different voices: reviewing and revising the politics of working with consumers in mental health. *Int J Ment Health Nurs*. 2004 Mar;13(1):22-32. <PubMed>

McAllister and Walsh (2004) provide a very useful discussion of the politics of working with consumers in mental health care, including primary mental health care. Using the concept known as the politics of difference, the authors show that the objective of this work is to understand, explain and critique how differences such as sex or race reduce the ability of dominant groups to speak on behalf of minorities. These theories of difference require movement beyond dichotomous thinking (e.g., we/them, black/white, consumers/providers) toward the recognition of diversity and the reformulation of ways of knowing. The authors elaborate some of the tensions involved in applying the theories of difference to consumer partnerships in mental health care: avoiding separation and fragmentation in working groups, while resisting the tendency to consistency and conformity; and attempting to create more participatory processes, while acknowledging the authority inherent in the provider’s role. They suggest a number of strategies for balancing these tensions.

McBride L, Pilkington L, Murray PJ, Whitfield D. Collaborative counselor and medical training at a family practice residency program: a sharing of the experience. *Family Journal: Counseling and Therapy for Couples and Families*. 2000 Jul;8(3):287-92.

McBride et al. (2000) assessed a collaborative-systems approach to treatment in a family practice residency program that involved counsellors in training, medical students and family medicine residents. The authors presented the perspectives of each of the participants: their initial impressions, their impressions about the content and the process of the training model, and the benefits and their struggles with the experience. Most revealing were their discussions about how the experience

changed their view of training: each was positive about being involved directly in collaborative care. The supervisor summarized the experience this way: “the synergism of different disciplines becomes much more powerful than one discipline’s healing by itself” (p. 292).

McCabe S, Macnee CL. Weaving a new safety net of mental health care in rural America: a model of integrated practice. *Issues Ment Health Nurs.* 2002 Apr-May;23(3):263-78.

<PubMed>

To integrate and strengthen consumers’ informal support systems into a more formal system of care for mental illness, McCabe and Macnee (2002) propose that advanced practice nursing services be introduced in rural communities. They note that expanding the role of advanced practice psychiatric nursing fits with the needs of rural patients and is best modelled with integrated care. Their useful discussion of what integration is and is not culminates in this formal definition: “Integration in health care can be defined as a progressive coordination and blending of the totality of care, the process of care, to create holistic services to achieve optimal health” (p. 270). Application of this definition in rural settings specifically means the provision of holistic care, physical and behavioural health care that incorporates essential services in a full, practical, meaningful manner. The authors propose four components to this integration model of care: physicality, structurality (including interpersonal relationships, communication between staff and providers, provider mix, and information management), provider roles and recipient-of-care roles. In this model, integration is a process that occurs along a continuum from no to complete integration. Three stages in the integrated advanced practice nursing model are discussed:

1. The parallel stage: shared space or location, but no significant interaction between providers.
2. The overlapping stage: the same space and face-to-face interaction of providers, but

independent functions for mental or physical care.

3. The synthesized stage: the location and structure of care undifferentiated for the type of health problem, care that comes to the patient and occurs simultaneously.

McCann TV, Baker H. Models of mental health nurse-general practitioner liaison: promoting continuity of care. *J Adv Nurs.* 2003 Mar;41(5):471-9. <PubMed>

McCann and Baker (2003) describe an Australian liaison model of care that involved mental health nurses and general practitioners. The authors identify three reasons for nurses to collaborate with general practitioners. First, a greater proportion of people with mental illness are encountered in primary care than in mental health care. Second, general practitioners are better equipped than nurses to diagnose medical illness. Third, clients are assumed to benefit from greater continuity of care when these professionals collaborate. Using qualitative methods, including interviews and observational data, the study identified two models of collaboration used by community mental health nurses and analyzed the effect of these models on the continuity of care. In the first model, the shared-care model, the community nurse had close contact with the general practitioner throughout the patient’s acute-care episode. In the second model, a specialist–liaison model, the nurse, as part of the community mental health team, assumed overall responsibility for the patient during the acute-care episode and had intermittent contact with the doctor. The findings suggested that the shared-care model resulted in greater personal and organizational continuity of care because the nurse and doctor were required to work together as a team. The specialist–liaison model encouraged only personal continuity of care between the nurse and the patient.

McCrone P, Fitzpatrick NK, Mathieson E, Chisholm D, Nourmand S. Economic implications of shared care arrangements. A primary care based study of patients in an inner city sample. Soc Psychiatry Psychiatr Epidemiol. 2004 Jul;39(7):553-9. <PubMed>

McCrone et al. (2004) discuss the economic implications of shared-care arrangements, focusing on an inner-city sample of persons with serious mental illness in a primary care setting. The authors begin their unique study by examining the different levels of shared care, their impact on service use and costs, and their cost-effectiveness. Using the Shared Care Assessment Schedule to measure shared care between professionals, McCrone et al. compared low, medium and high levels of shared care. They found that people with serious mental illness requiring medium or high levels of shared care from primary and secondary care professionals are likely to incur higher costs for care than those requiring low levels of care. Policy makers need to reconcile these higher costs with the improvement in patient outcomes that result from shared care and with their deterioration in the absence of such care.

McDaniel SH. Collaboration between psychologists and family physicians: implementing the biopsychosocial model. Professional Psychology: Research and Practice. 1995 Apr;26(2):117-22.

McDaniel (1995) reviews the theories supporting the psychologist–medical provider interaction and proposes the use of the biopsychosocial model as the underpinning paradigm. Highlighted were the types of support these professionals provide each other through collaboration:

- ∞ Physician to psychologist: Physicians are an important source of referrals for psychologists. Physicians can help patients adjust to their psychological treatment by being positive about it, reducing their fears, increasing their motivation to change and paving the way for successful connections.

Physicians can provide psychologists with information about a patient's disease process.

- ∞ Psychologist to physician: Psychologists pay particular attention to the psychosocial aspects of an illness. Their involvement helps physicians attend to all relevant levels of the system, especially in complex conditions. Psychologists help physicians understand the psychological and interpersonal aspects of the patient's symptoms. Psychologists provide a way out of the somatic fixation and biopsychosocial treatment, and support physicians doing emotionally taxing work.

Macdonald W, Bradley S, Bower P, Kramer T, Sibbald B, Garralda E, Harrington R. Primary mental health workers in child and adolescent mental health services. J Adv Nurs. 2004 Apr;46(1):78-87. <PubMed>

Macdonald et al. (2004) examine the new role of the primary child and adolescent mental health worker in the English health care system that was mandated in the latest round of health care reform policy. This position was designed to promote effective collaboration between primary and specialist care through the provision of clinical mental health care in primary care settings, and to build the skills and confidence of primary care providers. In their review of the implementation of this role in six health authorities in England, the authors found three models of organization: outreach from specialty care to primary care, primary care–based implementation and team approaches. Each model had advantages and disadvantages related to referral rates to specialty care and the development of effective relationships with primary care providers. Accommodation and effective integration of the primary care mental health workers and the degree to which they provided direct patient care, as opposed to consultation or liaison, created tension at all sites. The authors conclude that successful implementation of these new positions requires planning with all stakeholders before

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implementation, clear goals for these and related staff positions, and a long-term perspective on service development.

Macmillan HL, Patterson CJ, Wathen CN. Screening for depression in primary care: recommendation statement from the Canadian Task Force on Preventive Health Care. CMAJ. 2005 Jan 4;172(1):33-5. <PubMed> <FullText>

The latest recommendations from the Canadian Task Force on Prevention Health Care about screening for depression in primary care follow the work of a similar task force in the United States. The Canadian Task Force recommends that screening for depression in adults be done in primary care settings where resources are available to provide treatment and follow-up. Where such services are not available, the Task Force recommends that physicians advocate for the implementation of systems to provide linked screening for depression and treatment services in primary care settings.

Malcolm H. A primary mental health-care model for rural Australia: outcomes for doctors and the community. Aust J Rural Health. 2000 Jun;8(3):167-72. <PubMed>

In a rural Australian study, Malcolm (2000) documents the effects of a collaborative model of care on doctors and the community. A salaried psychiatric nurse was employed to work in general practices and fulfill a number of functions, for example, to provide direct patient care; improve primary care staff skills, including general practitioners' counselling skills; educate service providers, community groups and other people about mental illness and available services; and research the prevalence of mental illness in the area. Doctors experienced a small, but defined increase in confidence in their diagnosis and treatment of patients' depression, including diagnoses for the elderly, and treatment of adults, children and adolescents. Overall, counselling skills improved and the need for referral to specialist services decreased.

Doctors indicated a preference for the informal consultations facilitated by the psychiatric nurse. Community effects were favourable: community awareness about depression increased and the community supported the program when its funding was at risk.

Malcolm H. Primary mental health-care model in rural Tasmania: outcomes for patients. Aust J Rural Health. 2002 Feb;10(1):20-5. <PubMed>

Malcolm (2002) reports the effects on patients of a rural collaborative model implemented in Tasmania. Having a psychiatric nurse available in local general practices increased the volume of people with mental health issues served. Over three years, the nurse saw an average of two or three new patients per week. Almost 20 per cent of these new cases (n=316) were people younger than 25 years of age. Depression was the most common diagnosis, although the range of diagnoses reflected the range of common mental health problems dealt with most frequently in primary care. To overcome barriers to access to care because of the stigma of mental illness in rural communities, self-referrals were accepted and supported. Having a local worker was thought to increase the access to and acceptability of care because people who are depressed often lack the motivation to initiate a visit to the doctor or to travel great distances for psychiatric care. Malcolm concluded that this approach to collaborative care in rural communities is inexpensive and suitable for application in other communities.

Mann A, Tylee A. Evaluation of change in primary care practice. International Review of Psychiatry. 1998 May;10(2):148-53.

Mann and Tylee (1998) discuss a range of measurements useful for evaluating change in the primary care of patients with mental disorders. This practical article may be useful to researchers, practitioners, teachers and students examining the changes in practitioners' attitudes and behaviour as outcomes for primary mental health care. The authors highlight the usefulness

of practice-based statistics, evaluation of prescriptions and suicide rates, and quantitative and qualitative measures for evaluating change in primary care.

Mann AH, Blizard R, Murray J, Smith JA, Botega N, MacDonald E, Wilkinson G. An evaluation of practice nurses working with general practitioners to treat people with depression. *Br J Gen Pract.* 1998 Jan;48(426):875-9. <PubMed>

In two naturalistic random allocation studies that ran concurrently over four months, Mann et al. (1998) evaluated the extended role of practice nurses in the improvement of the outcome of depression. The first study examined practice nurses' use of a standardized psychiatric assessment and feedback of information to the general practitioner. The second study evaluated this same approach combined with nurse-assisted follow-up care. Training practice nurses to work with general practitioners to assess patients and provide follow-up care was associated with excellent outcomes for both the intervention and control groups. Although no additional benefits for people receiving the nurse intervention were found, the authors concluded that the brief training for the nurses produced a shift in attitudes and management of care that had a beneficial impact on patient outcomes.

Mann AH, Tylee A, Jenkins R. Editorial comment [editorial]. *International Review of Psychiatry.* 1998 May;10(2):101.

In their brief editorial, Mann et al. (1998) comment on the shift in the approach to and execution of primary mental health care research in England. They attribute the shift to the changing policy and practice environment, from one driven by secondary care to one driven by primary care. Describing the dynamics of this change, Mann et al. note the influence of new policies and organization of the health care system and make some recommendations for future research in this field.

Marion LN, Braun S, Anderson D, McDevitt J, Noyes M, Snyder M. Center for Integrated Health Care: primary and mental health care for people with severe and persistent mental illnesses. *J Nurs Educ.* 2004 Feb;43(2):71-4. <PubMed>

In an "academic practice exemplar," Marion et al. (2004) discuss their innovative Center for Integrated Health Care, which focuses on the primary health care needs of people with serious mental illness. They describe how the centre was established and detail the integrated program collaboration. The goals of the centre are the delivery of quality health care to members of the psychosocial rehabilitation program; teaching and learning evidence-based integrated primary and mental health care; and generating new knowledge in an active joint research program to improve the health of people with severe mental illness. The Faculty of Nursing of the University of Chicago offers the program in partnership with the psychosocial rehabilitation centre called Thresholds. Being an academic nursing centre, funding sustainability is an ongoing challenge to which the faculty respond through a continuous strategic planning process.

Marshall EJ, Deehan A. Needs of special groups: drug and alcohol problems. *International Review of Psychiatry.* 1998 May;10(2):136-8.

Marshall and Deehan (1998) provide an overview of the medical needs of people who have problems with alcohol and drug abuse. They review epidemiological evidence that shows that abusers have significant primary mental health care needs. They document brief interventions for alcohol abuse in primary care, possible drug treatments in that setting, and the attitudinal barriers of physicians dealing with either type of problem. They highlight three factors (as detailed in the original Maudsley Alcohol Pilot Project of the 1970s) that explain why primary care fails to adequately deal with alcohol and drug abusers: the uncertainty about whether the professional has a responsibility to deal with these problems (role legitimacy), the lack

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of training to deal with these problems (role adequacy) and the uncertainty about where to turn for help with patient issues (role support).

Martin CM. Making a case for transdisciplinarity [Article in English, French]. Can Fam Physician. 2003 Jul;49:905-8. <PubMed> <FullText> (En) <FullText> (Fr)

Writing from the perspective of the Canadian family physician, Martin (2003) identifies transdisciplinarity as a means of providing family medicine and primary care with intellectual leadership and an appropriate research base. She defines transdisciplinarity as various research disciplines coming together to develop complex primary care reforms, and as the integration and translation of various types of knowledge. This approach to the construction of transdisciplinary research includes the development of an intellectual foundation for multiple ways of knowing; a system of values that is open, participatory, respectful and focused on the real world; the use of practical and integrative research methods and rules for synthesizing and translating knowledge; and the development of transdisciplinary roles for practitioners.

Matalon A, Nahmani T, Rabin S, Maoz B, Hart J. A short-term intervention in a multidisciplinary referral clinic for primary care frequent attenders: description of the model, patient characteristics and their use of medical resources. Fam Pract. 2002 Jun;19(3):251-6. <PubMed> <FullText>

Matalon et al. (2002) report on an innovative short-term intervention involving a multidisciplinary referral clinic for high users of primary care services. The clinic was created to alleviate the burden that the high-volume demands of people with somatic and other mental health problems place on general practices. The clinic was staffed by a family physician trained in psychotherapy and a medical social worker. A senior psychiatrist provided supervision. The study focused on the first 40 clients of the clinic who completed mental health-screening

questionnaires and a functional health assessment. Clients' use of medical resources was determined from a chart review for the year before and after their first encounter at the clinic. In addition to drug therapy and psychological treatment, the intervention involved a biopsychosocial consultation that used a unique narrative technique. The integrative approach of the clinic was acceptable to the people treated, and met the needs of the referring physicians and the cost-reduction needs of the health management organization. Average yearly costs were reduced from US\$4035 to US\$1161 the year after the referral.

Mauer BJ; National Council for Community Behavioral Healthcare. Background paper: behavioral health/primary care integration models, competencies, and infrastructure. Rockville, MD: NCCBH; May 2003. Available from: <http://www.nccbh.org/who/industry/Primary%20Care%20Integration/PrimaryCareDiscPaper.pdf>

In their comprehensive seminal background paper on models of integrated behavioural-health primary care, competencies and infrastructure for the National Council for Community Behavioral Healthcare (NCCBH), Mauer and the NCCBH (2003) discuss many features of integrated care, including the reasons for pursuing integration; systemic barriers; principles for integration; definitions of integration; a model for clinical integration; and current evidence for care of depression, financial issues, and collaboration tools.

Mauer BJ; National Council for Community Behavioral Healthcare. Behavioral health/primary care integration: environmental assessment tool state level policy and financing. Rockville, MD: NCCBH; April 2004. Available from: <http://www.nccbh.org/HTML/LEARN/PCI/PCI-Enviro-Assess.pdf>

Mauer and the National Council for Community Behavioral Healthcare (2004) prepared an environmental assessment tool for use at the

state level to determine the appropriateness of policy and financing for collaborative care. The tool examines the organizational and contractual arrangements for Medicaid-funded behavioural health care and state-level behavioural programs, including structure, use of state funds, intergovernmental coordination, program administration and local funding, and other financing details. This tool is designed for use by working groups planning collaborative care programs. The overall goal for the tool is to provide detailed information about the multiple forces that affect collaborative care in the clinical setting.

Mayall E, Oathamshaw S, Lovell K, Pusey H. Development and piloting of a multidisciplinary training course for detecting and managing depression in the older person. *J Psychiatr Ment Health Nurs.* 2004 Apr;11(2):165-71. <PubMed>

Mayall et al. (2004) provide an overview of a multi-disciplinary training course for the detection and management of depression in older people. In keeping with national policy in the United Kingdom, the program was intentionally designed to appeal to multiple disciplines and agencies, including primary care practitioners and mental health professionals. The program comprised three 1-day workshops and four consecutive courses. Evaluation of the training program with pre- and post-testing revealed significant differences in participants' knowledge about depression in older people, and in their confidence in detecting and managing depression.

Meadows GN. Overcoming barriers to reintegration of patients with schizophrenia: developing a best-practice model for discharge from specialist care. *Med J Aust.* 2003 May 5;178 Suppl:S53-6. <PubMed> <FullText>

Meadows (2003) focuses on a new program, the Consultation and Liaison in Primary-care Psychiatry Program, which is designed to

facilitate the transfer of people with severe medical illness from specialty care to general practice in Australia. This program encourages general practitioners to manage the care of people who have schizophrenia through a combined set of practices that include the recognition of the early warning signs of relapse, called "relapse signatures," and drills for each person that general practitioners use to monitor and manage relapses. Consultation and liaison are achieved through the mental health agency psychiatrist's regular visits to the general practices and through semi-annual or annual reviews of all transferred cases. Of particular use are the relapse signatures and drills for application in settings in which such shared-care models are not operating.

Mellor-Clark J, Connell J, Barkham M, Cummins P. Counselling outcomes in primary health care: a CORE system data profile. *European Journal of Psychotherapy, Counselling & Health.* 2001 Apr;4(1):65-86. <Abstract>

Mellor-Clark et al. (2001) discuss the need for evidence that supports counselling in primary care as an evidence-based practice. This need for evidence was fuelled by the emergence of policy demanding enhanced service quality throughout the English health care system. The authors report the outcome of their feasibility study of the Clinical Outcomes in Routine Evaluation, or CORE, system, a standardized approach to profiling patients and outcomes in primary care counselling practice. The study findings suggested that routine monitoring and profiling are possible and that counselling has the potential to alleviate distress for a wide range of problems seen in primary care. Mellor-Clark et al. also discuss the implications of their findings for the national policy initiative.

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Mellor-Clark J, Simms-Ellis R, Burton M; Royal College of General Practitioners. National survey of counsellors working in primary care: evidence of growing professionalisation? [London]: Royal College of General Practitioners; April 2001.

Mellor-Clark et al. (2001) report on an updated national survey of counsellors working in primary care in the United Kingdom, specifically, prevalence figures for counselling in primary care and detailed profiles of practice counsellors' qualifications, experience and working practices. Analysis of the 1031 usable questionnaires received revealed that the majority of counsellors held diploma-level qualifications; an additional 31 per cent had an additional first or master's degree. Almost all reported that they were clinically supervised. Overall, the authors conclude that the vast majority of counsellors are adequately trained and supervised, and meet the national standards for good practice.

Mildred H, Brann P, Luk ESL, Fisher S. Collaboration between general practitioners and a child and adolescent mental health service. Aust Fam Physician. 2000 Feb;29(2):177-81. <PubMed>

Mildred et al. (2000) report on a pilot project to develop a collaborative working relationship between a child and adolescent mental health service, and general practitioners in Australia. The two primary objectives of the project were to change the policies and culture within the mental health service to make it more aware and inclusive of general practitioners, and to provide general practitioners with an accredited training package about common mental health problems. Surveys done before and after the project, and interviews revealed increased communication between the service and general practitioners, and radical improvement in general practitioners' perceptions of the helpfulness of the child and adolescent mental health service. Actual instances of shared care increased as a result of these efforts.

Miles ML, Goetz RR. Gatekeeping and authorization. New Dir Ment Health Serv. 1999 Spring;(81):65-73. <PubMed>

Miles and Goetz (1999) examine the issues of gatekeeping and authorization in managed health care in the United States. Increasingly, these managed-care techniques are used to control costs in public health care. The authors discuss the increased expectation that primary care physicians will recognize, diagnose and treat mental illness.

Millar E, Garland C, Ross F, Kendrick T, Burns T. Practice nurses and the care of patients receiving depot neuroleptic treatment: views on training, confidence and use of structured assessment. J Adv Nurs. 1999 Jun;29(6):1454-61. <PubMed>

Millar et al. (1999) looked specifically at practice nurses' views about the delivery of depot medication treatment. They interviewed 39 nurses who were part of a randomized control study that investigated the effectiveness of training and structured assessment on the clinical and social outcomes of patients receiving maintenance depot antipsychotic medications. Findings revealed that a majority of the nurses worked with scant referral information and without service protocols. In spite of training that increased their knowledge of mental illness, these nurses demonstrated a lack of confidence and inadequate knowledge to manage the medication. The authors, like others, recommended increased training and enhanced clinical supervision.

Miller C. Special needs of persons with SPMI: ensuring that persons with serious and persistent and mental illness obtain primary health care [PowerPoint presentation]. Talbott, TN: Cherokee Health Systems; [2004]. Available from: <http://www.nccbh.org/html/learn/PCI/04conf/C1/C1-Miller.pdf>

In his presentation, Miller (2004) documents the special needs of people with serious mental illness for integrated primary and mental health

care, and describes the well-known Cherokee Health System in Tennessee. Cherokee offers integrated community care clinics with traditional outpatient behavioural services, in addition to primary and dental care. System-wide, this program treats 40,000 people, for a total of 260,000 annual visits for all types of services. The author provides an excellent review of the barriers that the population with serious mental illness faces when trying to access primary care, including barriers attributable to mental illness and systemic barriers.

Miller CL, Druss BG, Dombrowski EA, Rosenheck RA. Barriers to primary medical care among patients at a community mental health center. *Psychiatr Serv.* 2003 Aug;54(8):1158-60. <PubMed> <FullText>

In their study, Miller et al. (2003) examined barriers to primary medical care for 59 people with chronic mental health conditions who attended a community health centre. The authors evaluated access to primary mental health care using the Primary Care Assessment Tool that measured four features of primary care: care provided at first contact, ongoing care, comprehensiveness of care and coordination of care. Findings revealed that the study participants had significantly lower scores on all four domains than the general population, resulting in poorer quality of primary medical care. The authors recommended an integrated care approach that combines mental health and primary medical care for people with chronic mental illness.

Miller CL, Druss BG, Rohrbaugh RM. Using qualitative methods to distill the active ingredients of a multifaceted intervention. *Psychiatr Serv.* 2003 Apr;54(4):568-71. <PubMed> <FullText>

Miller et al. (2003) examine the process of care in an integrated primary health care clinic for veterans with major psychiatric disorders. They focused on the usefulness of qualitative methods (focus groups) for teasing out influential elements in the multi-faceted interventions

these patients received. Content analyses revealed three themes: patients had difficulties in their previous attempts to obtain primary care; the clinic's resources were available and flexibly organized to increase access to care; and organizational restructuring allowed for enhanced communication among different professionals working in the clinic, which in turn improved patient care.

Millward LJ, Jeffries N. The team survey: a tool for health care team development. *J Adv Nurs.* 2001 Jul;35(2):276-87. <PubMed>

Millward and Jeffries (2001) review their use of the Team Survey[®] with a range of health care teams in a large National Health Service trust in Great Britain. The instrument is based on a cognitive-motivational model of team effectiveness. Results suggest that the instrument is psychometrically sound, but the factors affecting team effectiveness that emerged are somewhat different than those suggested by the theory, indicating that construct validity of the instrument needed further testing over a range of samples. Overall, the study recommends a framework for health care team development that focuses on developing cognitions (shared mental models) and meta-cognitions (such as self-regulation) through training, rather than on behavioural-based and context-specific approaches to understanding teamwork.

Mulsant BH, Alexopoulos GS, Reynolds CF 3rd, Katz IR, Abrams R, Oslin D, Schulberg HC; PROSPECT Study Group. Pharmacological treatment of depression in older primary care patients: the PROSPECT algorithm. *Int J Geriatr Psychiatry.* 2001 Jun;16(6):585-92. <PubMed>

Mulsant et al. (2001) discuss the Prevention of Suicide in Primary care Elderly-Collaborative Trial, called the PROSPECT trial. This trial has demonstrated the effective collaboration between clinicians trained at the master's level and primary care physicians working to improve the management of and outcome for older

patients with depression. The authors outline the algorithm that was developed to guide the clinicians trained at the master's level. The algorithm favours the use of medicine because it is more practical in a primary care setting. Psychotherapy is reserved for those patients who do not tolerate the medications. However, clinicians do provide psychoeducation, ongoing monitoring, and support to patients and families as part of their clinical intervention.

Murray J, Jenkins R. Prevention of mental illness in primary care. *International Review of Psychiatry*. 1998 May;10(2):154-7.

Murray and Jenkins (1998) explore prevention of mental illness and promotion of mental health in primary care, and primary care teams' implementation of these approaches in the United Kingdom. The authors provide a good overview of how the primary care is well positioned to respond to people experiencing life transitions or crises: to recognize persons at risk and to support them with a range of health promotion activities. Murray and Jenkins highlight the need for training in mental health interventions, protocols to guide response and recognition of problems.

Mynors-Wallis LM, Gath DH, Day A, Baker F. Randomised controlled trial of problem solving treatment, antidepressant medication, and combined treatment for major depression in primary care. *BMJ*. 2000 Jan 1;320(7226):26-30. <PubMed> <FullText>

In a randomized control trial, Mynors-Wallis et al. (2000) investigated problem-solving treatment, antidepressant medication and combined treatment for major depression in primary care. The trial used fewer therapy sessions than previous trials to investigate the cost-effectiveness of these treatments. All groups improved over 12 weeks. No differences were found between research general practitioners or research practice nurses delivering problem-solving treatment. The combined treatment of

medication and therapy was no more effective than either treatment alone.

Nolan P, Badger F, editors. *Promoting collaboration in primary mental health care*. Cheltenham: Nelson Thornes; 2002a.

Promoting collaboration in primary mental health care, by Nolan and Badger (2002a), documents many perspectives on primary mental health care in Britain. In their opening and closing chapters, the editors provide an excellent overview of the issues salient to collaborative care. Other perspectives include those of service users (the British equivalent of the term "consumers") and special populations such as people with eating disorders, serious mental illness, personality disorders and perinatal mental illness; children; illicit drug users; people with depression; people committing suicide and parasuicide; and older adults. One chapter examines the promotion of mental health.

Nolan P, Badger F. In search of collaboration and partnership. In: Nolan P, Badger F, editors. *Promoting collaboration in primary mental health care*. Cheltenham: Nelson Thornes; 2002b. p. 3-19.

Nolan and Badger (2002b) provide a concise review of collaborative mental health care in Britain, its background and national context. They cover a number of topics, including the evolution of the National Health Service, primary care developments, need for mental health services, fit of mental health services into primary care, promotion efforts, barriers and challenges.

Nolan P, Badger F. Preface. In: Nolan P, Badger F, editors. *Promoting collaboration in primary mental health care*. Cheltenham: Nelson Thornes; 2002c. p. xi-v.

Nolan and Badger (2002c), in the Preface to their edited volume about promoting collaboration in primary mental health care, review a number of related issues. The overall political context has changed: participation is now the given approach to shaping all aspects of health care

in the British context. Failure to realize this potential may doom health care to stagnation. In their overview of recent trends in health care, the authors promote a bottom-up approach to understanding collaboration in everyday practices through direct accounts from front-line practitioners. Nolan and Badger analyze the main themes of the papers in the volume, such as the importance of professionals being confident in their own roles, having the appropriate skills to carry out the required work, being ready to respect and acknowledge the expertise of others, and being able to build relationships with different agencies and professionals. The authors also provide an interpretative framework for the conditions necessary for collaboration.

Nolan P, Murray E, Dallender J. Practice nurses' perceptions of services for clients with psychological problems in primary care. *Int J Nurs Stud.* 1999 Apr;36(2):97-104. <PubMed>

Nolan et al. (1999) surveyed a small sample of 200 practice nurses (response rate of 52 per cent) to identify the types of mental health problems they encounter in primary care, the interventions they provide and the skills they use. The findings showed that practice nurses deal with a wide range of mild-to-severe mental health issues, that a majority of patients can self-refer themselves to the practice nurse, and that a little more than half of the practice nurses are permitted to refer people directly to other health professionals. Nurses expressed feelings of being unprepared to deal with mental health work. They were somewhat reluctant to get too involved in this work because they feared that problems beyond their expertise would arise. Lack of positive interprofessional relationships and a lack of educational support were highlighted as major barriers.

Northwest Territories Medical Association, Northwest Territories Registered Nurses Association. The provision of health care in the Northwest Territories (NWT): a joint statement on health care reform in the NWT, September 1998. *Canadian Journal of Rural Medicine.* 2000 Winter;5(1):12-7. <FullText>

The Northwest Territories Medical Association and the Northwest Territories Registered Nurses Association (2000) produced a joint statement about health care reform in the Northwest Territories in 1998. Their vision for reform called for a consistent collaborative model of primary health care that includes collaborative practice and accountability. They defined the roles of the nurse practitioner and physician in the collaborative practice model, and included recommendations for education, collaboration and governance.

Norton D, Measday J, Grenfell R, Mackay C, Teed A, Macdonald C. GP-pharmacist liaison: a rural case study. *Aust Fam Physician.* 2003 Mar;32(3):191-2. <PubMed> <FullText> OR <FullText>

Norton et al. (2003) report on an Australian study of a rural general practitioner-pharmacist liaison project. The goal of the project was to breakdown barriers within a specific geographic area. A total of 33 pharmacists and 48 general practitioners who worked full-time in the area were surveyed to identify core health care activities common to both, and to identify barriers to and potential for better cooperation. Six areas of common interest were studied: medication use, polypharmacy, drug-seeking behaviour, specific-disease counselling, primary health care and health promotion. Respondents were asked to rank the categories of interest and the issues defined in each category. Overall, both groups indicated an interest in working cooperatively. They shared a high interest in medication use and polypharmacy, and indicated that the supply of medication was the most important issue. Barriers identified included time constraints, lack of a workforce

and face-to-face contact time between the two professionals, greater need for clinical education of pharmacists in rural areas, general practitioners' lack of understanding about the roles and responsibilities of pharmacists, and lack of a structured meeting place and time. The local division responded to these findings by developing a series of activities to promote future collaboration: for example, combined educational events for the two groups, structured discussion groups, a local pharmacy group, a weekly fax sent to all pharmacists, appointment of a pharmacist to the division staff, local work groups and consumer education.

Nutting PA, Rost K, Dickinson M, Werner JJ, Dickinson P, Smith JL, Gallovic B. Barriers to initiating depression treatment in primary care practice. *J Gen Intern Med.* 2002 Feb;17(2):103-11. <PubMed>

Nutting et al. (2002) examine barriers to the initiation of treatment of acute-phase depression in primary care practice. Their study focused on 66 patients in a randomized control trial who did not engage in treatment. Qualitative methods were used to develop a checklist of barriers to care, as determined by physicians and nurse care managers. The primary care physician then completed the checklist for each of the 66 patients. Physicians assigned the highest ratings to patient-centred barriers (76 per cent); physician-centred barriers accounted for a much smaller proportion (15 per cent), followed by system barriers (9 per cent). Patient-centred factors included such things as resistance to diagnosis or treatment, noncompliance with visits and psychosocial problems. Physician-centred factors included judgments that overruled the guideline, whereas the most dominant system barrier was the management of the person's medication by a mental health specialist outside of the practice. The study concluded that failure-to-treat is not simply a matter of a physician's poor performance; it is a much more complex process than is usually appreciated.

Oishi SM, Shoai R, Katon W, Callahan C, Unützer J; IMPACT Investigators (Improving Mood: Promoting Access to Collaborative Treatment Investigators). Impacting late life depression: integrating a depression intervention into primary care. *Psychiatr Q.* 2003 Spring;74(1):75-89. <PubMed>

Oishi et al. (2003) conducted a qualitative study of managers of depression care involved in the Improving Mood: Promoting Access to Collaborative Treatment, or IMPACT, trial in the United States. The purpose of the study was to document collaborative care interventions for late-life depression during the introduction of the model into real primary care settings. Through two focus groups and follow-up interviews with 11 of the 16 managers of depression care, Oishi et al. reviewed key elements of the model. Among the factors deemed effective support for patient care were the psychiatrist's supervision of and liaison with the primary care provider, computerized patient tracking, weekly team meetings, and outcome assessment tools. Integration was facilitated by such things as the details of the protocols, environmental set-up, training and interpersonal factors. Research factors that should be preserved in applications after the trial included case finding, intervention length and caseload, documentation, support for the positions of managers of depression care and psychiatric consultation.

Ólafsdóttir M, Marcusson J, Skoog I. Mental disorders among elderly people in primary care: the Linköping study. *Acta Psychiatr Scand.* 2001 Jul;104(1):12-8. <PubMed>

Ólafsdóttir et al. (2001) conducted a study to determine the prevalence of mental disorders among older Swedish patients in primary care and to compare diagnoses derived from psychiatric interviews with those found in the medical records. An overall prevalence of 33 per cent of mental disorders was found in a sample population of 350 patients 70 years of age and older. Of these patients, 49 per cent had a diagnosis of a psychiatric illness in their

case records and 17 to 38 per cent received psychiatric treatment. Psychiatric symptoms were found during psychiatric interviews among those who had no recorded mental disorder. Those with mental disorders were more often female, had more visits with a doctor and more diagnoses noted in their medical records, and were prescribed more drugs. The authors conclude that overall, the detection rate of psychiatric disorders in the elderly patients was low and that detection and treatment in primary care must be improved.

O'Malley SS, Rounsaville BJ, Farren C, Namkoong K, Wu R, Robinson J, O'Connor PG. Initial and maintenance naltrexone treatment for alcohol dependence using primary care vs specialty care: a nested sequence of 3 randomized trials. Arch Intern Med. 2003 Jul 28;163(14):1695-704. <PubMed>

In their study, O'Malley et al. (2003) compared initial and maintenance treatment with naltrexone for alcohol dependence in primary and specialty care settings. Traditionally, this drug is used in combination with cognitive behavioural therapy in addictions programs to treat people with alcohol dependence. This study compared the effectiveness of a primary care model of counselling and naltrexone treatment to this traditional model for ten weeks. A second study was then done to determine whether continued use of naltrexone for an additional six months would effectively maintain the initial response to short-term treatment and primary care monitoring or cognitive behavioural therapy. Both methods proved to be effective over the short-term. Results of the maintenance trials illustrated that either approach may optimize long-term response. This type of treatment is therefore possible in primary care settings and could potentially increase access to such treatment by people who are unwilling to go into specialty treatment programs, but are willing to be treated in a primary care setting.

Osher FC. Co-occurring addictive and mental disorders. In: Manderscheid RW, Henderson MJ, editors. Mental health, United States, 2000. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Administration, Center for Mental Health Services; [2001]. Report No.: SMA01-3537. Available from: <http://www.mentalhealth.samhsa.gov/publications/allpubs/SMA01-3537/chapter10.asp>

In his comprehensive review of concurrent disorders in the U.S. Department of Health and Human Services' report, Mental health, United States, 2000, Osher (2001) examines these disorders in terms of their epidemiology, outcomes in traditional systems, evidence-based treatment, principles of care, and barriers and solutions. He noted that people with concurrent disorders have broad needs for primary care and behavioural health treatment. Therefore to meet these needs, they require a range of services, from those totally integrated to those with a single focus. Osher highlights the State of New York's generic model of locus of care for concurrent disorders.

Oxman TE, Dietrich AJ, Schulberg HC. The depression care manager and mental health specialist as collaborators within primary care. Am J Geriatr Psychiatry. 2003 Sep-Oct;11(5):507-16. <PubMed>

In a comprehensive review of four American trial studies of depression involving elderly people, Oxman et al. (2003) examine in detail system changes in the care for depression involving case managers or mental health specialists within primary care. The synopsis of the four studies provides the reader with quick, but thorough access to this growing body of information about the treatment of depression and the role of collaborative models of care. Overall, the studies suggest that older people are more likely to respond to collaborative treatment within primary care settings than care in mental health programs. Better outcomes than usual care seem

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to result from system changes that incorporate multi-faceted approaches to treatment. Results of these studies support the use of managers for depression care in primary care settings, and a supervisory and consultative role for specialist mental health professionals.

Oxman TE, Dietrich AJ, Williams JW Jr, Kroenke K. A three-component model for reengineering systems for the treatment of depression in primary care. *Psychosomatics*. 2002 Nov-Dec;43(6):441-50. <PubMed>

Oxman et al. (2002) developed a three-component model to investigate the transference of tested depression treatment programs to real primary care practice settings. Their model had three components: prepared practice, care management, and enhanced mental health support provided by mental health specialists. The model focused on a series of routines (processes for diagnosis and treatment, with a timeline) and new definitions of responsibility, including those for a telephone-care manager. A measure of the diagnosis and severity of depression was used to facilitate communication between the workers and treatment decisions.

Pace TM, Chaney JM, Mullins LL, Olson RA. Psychological consultation with primary care physicians: obstacles and opportunities in the medical setting. *Professional Psychology: Research and Practice*. 1995 Apr;26(2):123-31.

Pace et al. (1995) present an integrated behavioural-systems model for effective psychological consultation with primary care physicians. This approach blends systems theory with a practical focus on measurable outcomes, multi-level interventions and the benefits of interdisciplinary or transdisciplinary team approaches. The model promotes simultaneous targeting of actions at different levels of the systems involved, namely, those of the patient, family, physician and other professionals. The psychologist examines the definition of the problem, proposed solutions and their effects

on each subsystem. Five steps are required to provide this system assessment:

1. Evaluation of the reasons for the referral and the physician–patient relationship.
2. Assessment of the therapeutic relationship.
3. Development of this relationship.
4. Evaluation of the larger system (e.g., more distal levels of care giving) and its potential impact on the problem.
5. Education of the physician and other health care subsystems about specific, practical and empirically-based intervention strategies.

Papa PA, Rector C, Stone C. Interdisciplinary collaborative training for school-based health professionals. *J Sch Health*. 1998 Dec;68(10):415-9. <PubMed>

Papa et al. (1998) describe various training initiatives that focus on training for interdisciplinary teams that work in school-based health centres across the United States. They profile two projects — the California State University Interprofessional Collaboration Training Project and the Catholic University of America School Nurse Practitioner Program — briefly review the evaluation of the two programs and provide implications for academic institutions. The authors conclude that collaborative training for physicians and nurses can help improve the delivery of health care to students and enhance response to community needs.

Parthasarathy S, Mertens J, Moore C, Weisner C. Utilization and cost impact of integrating substance abuse treatment and primary care. *Med Care*. 2003 Mar;41(3):357-67. <PubMed>

In a randomized control study, Parthasarathy et al. (2003) compared the utilization and health care costs associated with the integrated treatment of medical and substance abuse and those associated with independent medical care. Results for an integrated care model used in an outpatient chemical-dependency recovery program were compared with those for a separate independent care model delivering

medical care in the health management organization's primary care clinics. Measures were taken at baseline and at 12 months. Across the whole sample, no statistically significant differences were found between the two groups over time. The subgroup of patients with substance abuse-related medical conditions in the integrated care group had significant decreases in hospitalization rates, in-patient days and emergency room use. Their total medical costs for each month in the study declined. For those with substance abuse-related medical problems in the independent care group, there was a downward trend in in-patient days and emergency room costs, but no significant decrease in total medical costs. The overall findings did not support the use of integrated treatment for all groups of patients.

Patterson J, Bischoff RJ, McIntosh-Koontz L. Training issues in integrated care. In: Blount A, editor. Integrated primary care: the future of medical and mental health collaboration. New York: Norton; 1998. p. 261-84.

Patterson et al. (1998) describe training medical and behavioural students in an integrated setting. At the time, the program was unique; the challenges faced during its establishment have been documented elsewhere. The authors develop their basic premise that the practice and training models clinicians experience during training strongly influence their practice strategies. They also discuss the dynamic interchange between their ongoing efforts to examine, change and evaluate integrated care models and their efforts to design the training course. They conclude that flexibility is required early in the process to be able to move forward.

Paxton R, Shrubbs S, Griffiths H, Cameron L, Maunder L. Tiered approach: matching mental health services to needs. Journal of Mental Health. 2000 Apr;9(2):137-44.

Paxton et al. (2000) developed a tiered approach designed to match mental health services to needs in a system-wide project in Northumberland, England. Their framework

balances the needs of people with severe mental disorders and the larger number of people with less disabling, but perhaps equally distressing mental health problems. The authors describe the framework, its intended benefits and current problems, and the progress of its implementation and evaluation.

Peek CJ, Heinrich RL. Integrating primary care and mental health in a health care organization: from pilot to mainstream. In: Blount A, editor. Integrated primary care: the future of medical and mental health collaboration. New York: Norton; 1998. p. 167-202.

Peek and Heinrich (1998) describe the cultural changes that occur in organizations in which integrated care is practised for a long period of time. They highlight the transition of integrated care from the pilot stage to full implementation in a larger health care program. The perspective of management is well articulated in this discussion.

Petersen I. Comprehensive integrated primary mental health care for South Africa. Pipedream or possibility? Soc Sci Med. 2000 Aug 1;51(3):321-34. <PubMed>

In her overview of recent changes in the delivery of primary mental health care in South Africa, Petersen (2000) expresses concern that these changes will not ensure comprehensive integrated primary mental health care as planned. For truly integrated care to emerge, a shift to more comprehensive care that includes mental health is needed. She discusses existing barriers to including mental health care in her examination of one subdistrict of care, and suggests four factors for a restructured system of care: support for emotional labour, health promotion, empowerment of service users and provision of care that accounts for the patient's subjectivity about illness.

Petersen I. Training for transformation: reorientating primary health care nurses for the provision of mental health care in South Africa. *J Adv Nurs*. 1999 Oct;30(4):907-15. <PubMed>

Petersen (1999) studied the use of a mental health training program in the reorientation of primary health care nurses in South Africa. Recent changes in that country prompted an ambitious agenda to adopt a model of community mental health care integrated into the primary health care system. A necessary underpinning of this change is training primary health care personnel. A reorientation program was developed that included the role of the primary care health nurse within the district mental health system, review of the narrow scope of the psychiatric approach to the identification and management of mental health problems at the primary level of care, nursing ideology and its subsumption into the medical system, culturally congruent care, a framework for assessing problems from the perspective of comprehensive care, and skills for comprehensive care that cover the care relationship and the process of comprehensive care. Using a quasi-experimental time-series qualitative and quantitative research design, Petersen found that personality and contextual factors had mediating effects on the nurses' ability to deliver comprehensive mental health care. She identified the need for the change program to offer reorientation to all health care personnel so that all stakeholders embrace the shifts in the care paradigm equally, including service users (e.g., recognizing that there are models other than the biomedical for explaining illness). She also highlights the need to change the current delivery (e.g., the time and way that clinics are offered, nurses practising in clinics outside their home communities) and management systems to give nurses more power and status as primary care practitioners within the system and to empower them to deliver direct care to people.

Pignone MP, Gaynes BN, Rushton JL, Burchell CM, Orleans CT, Mulrow CD, Lohr KN. Screening for depression in adults: a summary of the evidence for the U.S. Preventive Services Task Force. *Ann Intern Med*. 2002 May 21;136(10):765-76. <PubMed> <FullText>

In their brief article, Pignone et al. (2002) summarize the research evidence that supports the U.S. Preventative Services Task Force's recommendation that adults be screened for depression in primary care. This evidence was drawn from a search of MEDLINE (January 1994 through August 2001) for publications dealing with depression or depressive disorders and screening instruments, and searched for older articles by looking in the second edition of the Guide to Clinical Preventive services, recent systemic reviews and focused searches of MEDLINE from 1966 to 1994. Two reviewers determined the eligibility of articles for inclusion, and a single reviewer abstracted the relevant data from these articles and created data tables that the second reviewer checked for accuracy against the original articles. Overall, good evidence was found to support the recommendation that adults be screened for depression. The diagnostic accuracy of depression-screening instruments for adults had 80 to 90 per cent sensitivity and 70 to 85 per cent specificity.

Pincus HA. The future of behavioral health and primary care: drowning in the mainstream or left on the bank? *Psychosomatics*. 2003 Jan-Feb;44(1):1-11. <PubMed>

Pincus (2003) begins his review of collaborative care by asking why mental disorders and psychosocial problems are viewed so differently from other issues routinely managed in primary care. He discusses the characteristics of mental conditions that set them apart from other illnesses and the barriers that stand in the way of collaborative care. Looking to the future, Pincus illustrates a number of trends in the health care system that may have a significant impact

on collaborative care. He proposes an overall framework for the delivery of mental health care across the continuum of primary and specialty care that would be useful to discussions of roles, levels of care and client groups in local health care systems.

Pirkis J, Herrman H, Schweitzer I, Yung A, Grigg M, Burgess P. Evaluating complex, collaborative programmes: the Partnership Project as a case study. *Aust N Z J Psychiatry*. 2001 Oct;35(5):639-46. <PubMed>

Pirkis et al. (2001) present a detailed evaluation of the Australian Partnership Project, a demonstration project designed to increase collaborative care between private psychiatrists and primary health care in Melbourne. The authors discuss such theoretical and practical issues as the levels of collaboration, evaluating programs to deal with poor linkages and features of useful evaluations. They offer a detailed model that may be useful for the evaluation of other collaborative programs.

Pirkis J, Livingston J, Herrman H, Schweitzer I, Gill L, Morley B, Grigg M, Tanaghow A, Yung A, Trauer T, Burgess P. Improving collaboration between private psychiatrists, the public mental health sector and general practitioners: evaluation of the Partnership Project. *Aust N Z J Psychiatry*. 2004 Mar;38(3):125-34. <PubMed>

The aim of the Partnership Project in Australia (September 2000 to August 2002) was to improve links between public mental health services and private psychiatrists, and to improve outcomes for consumers 18 years of age or older who lived in an area of Melbourne with a high per capita coverage by private psychiatrists, but few shared-care arrangements. Pirkis et al. (2004) describe two components of the project. The first was the Linkage Unit, designed to improve service delivery for individual consumers and promote the system-level and cultural change necessary to sustain collaboration between the public and private sectors. The second

was the expanded-roles component, the trial item numbers used for participating private psychiatrists' billing for activities other than direct patient care. The Linkage Unit facilitated 224 episodes of collaborative care, many of which resulted in positive outcomes for patients, providers and carers. At the systems level, the Linkage Unit influenced procedural changes and raised awareness of collaboration. Thirty-two psychiatrists took on expanded roles and billed a total of \$78,032 (Australian dollars) over the two-year study period. Most of this expanded-role activity was supervision, which accounted for 80 per cent of the psychiatrists' total hours and costs. Overall, the project successfully improved collaborative care and increased opportunities for supervision and training. Its costs and benefits warrant further exploration.

Pollack DA. The mental health provider's view. *New Dir Ment Health Serv*. 1999 Spring;(81):25-32. <PubMed>

Pollack (1999) highlights the issues associated with an integrated primary mental health care system that develops effective consultation relationships with primary care. The advantages and differences between primary and mental health spheres are explored, and opportunities for collaborative care identified. Communication issues within an integrated program are explored: for example, sharing patient information is necessary, confidentiality is of less concern since information flows internally, communication needs to be timely and efficient, and the format of notes should be similar to that for primary care notes. Pollack also stresses avoiding over bureaucratization of communication and the consultation partnership because of the resultant potential micromanagement of one professional by another that, in turn, diminishes the value and meaning of their communication.

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Pollin I, DeLeon PH. Integrated health delivery systems: psychology's potential role [news]. Professional Psychology: Research and Practice. 1996 Apr;27(2):107-8.

Pollin and DeLeon (1996) discuss the psychologist's role in a medical crisis-counselling model of integrated health delivery. In essence, medical crisis counselling is brief focused therapy done in the primary care setting and has a positive, long-term effect on the way the consumer, family and system manage illness. The authors note two distinct advantages of this therapy. First, the patient benefits not only from having the therapy added to the medical treatment, but also from having psychosocial supports provided as part of the medical treatment package. Second, this type of treatment often involves families, providing them with support when needed and creating positive opportunities for them to be caregivers to the patient. Pollin and DeLeon also highlight the need for an ongoing alliance between physicians and psychologists throughout the entire treatment course, beginning with early assessment, especially when pharmacotherapy is indicated.

Price D, Beck A, Nimmer C, Bensen S. The treatment of anxiety disorders in a primary care HMO setting. Psychiatr Q. 2000 Spring;71(1):31-45. <PubMed>

Price et al. (2000) summarize their adaptation of an integrated primary mental health care model to the treatment of anxiety disorders in a health management organization. They then present the results of the intervention for a cohort of people with generalized anxiety disorder and clinically significant anxiety secondary to major depressive disorder. Compared with those in usual care, patients receiving the intervention had significantly reduced symptoms of anxiety at six months and were more satisfied with care. The integrated model provided successful treatment for people with anxiety in the primary care setting.

Quirk MP, Simon G, Todd J, Horst T, Crosier M, Ekorenrud B, Goepfert R, Baker N, Steinfeld B, Rosenberg M, Strosahl K. A look to the past, directions for the future. Psychiatr Q. 2000 Spring;71(1):79-95. <PubMed>

Quirk et al. (2000) describe the history of a well-known approach to American primary care mental health, the Group Health Cooperative. They present their information in answer to a series of key questions: Why should primary care and behavioural health be integrated? What has been done so far and how well has it worked? What is the idealized picture of integration in the future? How can we get from here to there and what will help or hinder the effort? Why make these efforts? This comprehensive discussion comments on a number of key points about collaboration, including consumer involvement, funding, cultural change within primary care, structural decision-support tools, and outstanding issues that require attention if integration is to proceed.

Qureshi NA, Al-Ghamdy YS, Al-Haddad NS, Abdelgadir MH, Tawfik MH. Integration of mental health care into primary care: preliminary observations of continuing implementation phase. Saudi Med J. 2001 Oct;22(10):899-906. <PubMed>

Qureshi et al. (2001) present the preliminary findings of a project designed to integrate mental health care into primary care in Saudi Arabia. The authors detail the intensive short-term psychiatric training program for medical and paramedical staff that successfully prepared the first three groups of health personnel to deliver the integrated program. The authors recommend that this program be the top training agenda in their country.

Raue PJ, Alexopoulos GS, Bruce ML, Klimstra S, Mulsant BH, Gallo JJ. The systematic assessment of depressed elderly primary care patients. *Int J Geriatr Psychiatry*. 2001 Jun;16(6):560-9. <PubMed>

Raue et al. (2001) discuss the process of assessment selection used in primary care studies. Points of tension in studies of primary care treatment of depressed older people involve limited time and space, and the burden they place on older people. Assessments in the course of such research must balance obtaining clinically meaningful information against these factors. Assessments of older people must also consider suicidality, hopelessness, substance abuse, functional disability, anxiety, medical comorbidity, cognitive functioning, social support, service use and satisfaction with service. Suggested approaches are framed in the context of the PROSPECT, or Prevention Suicide in Primary Care Elderly: Collaborative Trial, study in which these authors were involved.

Raymond J, Kirkwood H, Looi J. Commitment and collaboration for excellence in older persons' mental health: the ACT experience. *Australas Psychiatry*. 2004 Jun;12(2):130-3. <PubMed>

Raymond et al. (2004) detail the development of a seniors' mental health service in the capital region of Australia. They describe the evolution of a consultation–liaison model of service initially offered by two professionals into a multi-disciplinary comprehensive collaborative model. System activities, such as strategic planning to obtain sustainable funding for the service, training and education, the participation of other community partners in a protocol working group, joint meetings and seminars, contributed to the overall development of the service, which was linked into the local system of care. Other important contributing factors discussed were consistent leadership, incentives such as employee-recognition awards, learning from other areas that had implemented such services, and development of a related academic department.

Reeves S. A systematic review of the effects of interprofessional education on staff involved in the care of adults with mental health problems. *J Psychiatr Ment Health Nurs*. 2001 Dec;8(6):533-42. <PubMed>

In a systematic review of the effects of interprofessional education on staff involved in the care of adults with mental health problems, Reeves (2001) found a lack of rigorous evidence. Of the 1529 articles originally found, based on very broad inclusion criteria in an initial search of three databases, the author examined 67 articles and found 19 papers that qualified for discussion. Many of these studies examined the use of small-group learning activities, including seminar-based discussions, group problem-solving and role playing. Using a variety of statistical methods to analyze the data from the eligible studies, Reeves found that overall the quality of evidence about the effects of interprofessional education was low. Solid effort is needed to build an evidence base for interprofessional education.

Reilly S, Challis D, Burns A, Hughes J. Does integration really make a difference? A comparison of old age psychiatry services in England and Northern Ireland. *Int J Geriatr Psychiatry*. 2003 Oct;18(10):887-93. <PubMed>

In a comparative study of old-age psychiatry programs, Reilly et al. (2003) examined the effect of integrated service structures on the integration of care in England and Northern Ireland. Northern Ireland has a highly structured and integrated comprehensive model of health and social care. When the authors solicited psychiatrists' perceptions through mailed surveys, they found that services were indeed more integrated in Northern Ireland, that managerial arrangements and location of staff resulted in more integrated delivery of care in that jurisdiction. Three themes emerged in the seven factors associated with greater integration of health and social care: the provision of specialist service, the provision of outreach activities and shared team policies. The authors

conclude that integrated structures alone will not produce integrated practices.

Reynolds CF III. Meeting the mental health needs of older adults in primary care: how do we get the job done? *Clinical Psychology: Science and Practice*. 2003 Spring;10(1):109-11. <Abstract>

Reynolds (2003) summarizes the findings of a randomized control trial to compare the Prevention of Suicide in Primary Care Elderly: Collaborative Trial, or PROSPECT, model with usual primary care. In the PROSPECT model, managers of depression care in primary care settings oversaw the care of large numbers of older patients, and spent their time managing the depression and teaching patients and families about depression. After four months, use of the PROSPECT model had significantly positive effects on the rates of major depression. The author called for the development of an economically viable model of depression care in primary care.

Richards A, Barkham M, Cahill J, Richards D, Williams C, Heywood P. PHASE: a randomised, controlled trial of supervised self-help cognitive behavioural therapy in primary care. *Br J Gen Pract*. 2003 Oct;53(495):764-70. <PubMed>

Richards et al. (2003) present the results of their randomized control trial of a supervised self-help cognitive behavioural therapy in primary care. Self-help therapies based on cognitive behavioural principles are designed to help people make choices and act to improve their own health and well-being. Since access to psychological treatment is limited in primary care settings, self-help approaches may offer effective alternatives to care. This trial involved people with anxiety or mild depression. The self-help intervention consisted of three appointments, two appointments one week apart and a third, three months later. The clinical outcomes and costs of the self-help intervention were similar to those of usual care, and patients were more

satisfied. This approach to treatment may provide short-term cost-effective clinical benefits for people with mild-to-moderate anxiety and depression.

Richards JC, Ryan P, McCabe MP, Groom G, Hickie IB. Barriers to the effective management of depression in general practice. *Aust N Z J Psychiatry*. 2004 Oct;38(10):795-803. <PubMed>

Richards et al. (2004) studied the effects of prior general practice training in mental health and practice location on general practitioners' attitudes toward depression; self-confidence in dealing with and treating depressed patients; identification of doctor, patient and practice barriers to their effective care in general practice; and self-reported current clinical practice. A mailed questionnaire was used to survey Australian general practitioners; 420 general practitioners responded. Overall findings suggested that general practitioners' prior training in mental health has a positive effect on their attitudes toward depressed patients and on their confidence in and ability to effectively diagnose and manage the common mental disorders they see in their practices.

Ricketts T, Saul C, Newton P, Brooker C. Evaluating the development, implementation and impact of protocols between primary care and specialist mental health services. *Journal of Mental Health*. 2003 Aug;12(4):369-83. Abstract available from: <http://taylorandfrancis.metapress.com/openurl.asp?genre=article&eissn=1360-0567&volume=12&issue=4&page=369>

Ricketts et al. (2003) evaluated the development, implementation and impact of mental health protocols on primary care and specialized mental health services in one health system in England. Three features affected the effective development of the protocols: a high level of management support, a single project manager and the review of draft proposals by a range of stakeholders. Dissemination of the protocols

was successful when contact with clinicians was face-to-face, and supported by training and managerial interventions. Overall, high levels of system change interfered with the implementation of the protocols in this health care system.

Roberts D. Making the connections to aid mental health. *Nurs Times*. 1998 Apr 15-21;94(15):50-2. <PubMed>

Roberts (1998) describes the links between mental health and general nurses, defines liaison nursing and explains the collaborative mental health model from the nursing perspective. Topics briefly reviewed include mental health liaison; education research; supervision; support; and mental health, nursing care, professional and systemic consultation.

Rollman BL, Herbeck Belnap B, Reynolds CF, Schulberg HC, Shear MK. A contemporary protocol to assist primary care physicians in the treatment of panic and generalized anxiety disorders. *Gen Hosp Psychiatry*. 2003 Mar-Apr;25(2):74-82. <PubMed>

Rollman et al. (2003) describe a collaborative stepped-care program for the treatment of anxiety and panic disorder in primary care that was part of a randomized control study done by the U.S. National Institute of Mental Health. The program involved a telephone-based care manager doing timely, patient-specific clinical and case-management tasks. The description of the development of the treatment protocol emphasizes pharmacotherapy, patient education, initiation of drug treatment, treatment decline, treatment monitoring, duration of treatment, failure to respond to treatment and mental health referral. Special concerns are also discussed, including comorbid depression, suicide ideation, managing anxiety and managed care, and the training and supervision of the case manager. The authors note that the effectiveness of this collaborative care strategy for other medical conditions has been demonstrated through randomized controlled trials, but only one other trial

involving anxiety disorder is available. They discussed the challenges of implementing such a program in small primary care practices and those that lack the support of an organized health care system that can absorb start-up costs.

Romanow RJ, Marchildon GP. Psychological services and the future of health care in Canada. *Canadian Psychology*. 2003 Nov;44(4):283-95.

Romanow and Marchildon (2003) discuss a reformed Canadian health care system that extends beyond hospital and physician care to home care, and includes a revamped primary health care system. Psychology has key roles to play in this system, but the extent of its involvement will depend, in part, on decisions made about the precise range of specialized services that will be supported by public funding. For example, if funders favour the provision of home mental health care by psychiatrists, psychiatric nurses and nurse practitioners, there will be little place for specialized psychological services. Reconfiguring membership in the home care team or giving care managers broader discretion to decide on appropriate interventions will create more opportunity for these services. The authors specifically recommend that psychologists become full-fledged members of multi-disciplinary primary health care teams. The provinces and the federal government, through the Health Accord, have already agreed to make this kind of primary care available to 50 per cent of their populations by 2008. The authors note that psychologists are well trained and well positioned to offer their unique perspective on the psychosocial aspects of care within primary care.

Rost K, Nutting P, Smith J, Werner J, Duan N. Improving depression outcomes in community primary care practice: a randomized trial of the quEST intervention. *J Gen Intern Med*. 2001 Mar;16(3):143-9. <PubMed>

Rost et al. (2001) report the findings of their primary care intervention trial to determine

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whether redefining primary care team roles would improve outcomes for people beginning a new round of treatment for major depression. Details of the design of the study are presented in another article (see Rost et al. 2000). A two-stage screening process was used in 12 community primary care practices that employed no on-site mental health professionals. Symptoms of depression improved significantly for the group of people beginning new treatment and especially for those who reported that antidepressant therapy was an acceptable treatment for their condition. Brief intervention training for primary care team members who assumed redefined roles that included treatment of depression effectively improved outcomes for people. Sustaining these redefined roles over time was identified as a challenge.

Rost K, Nutting PA, Smith J, Werner JJ. Designing and implementing a primary care intervention trial to improve the quality and outcome of care for major depression. *Gen Hosp Psychiatry*. 2000 Mar-Apr;22(2):66-77. <PubMed>

Rost et al. (2000) describe how they designed a primary care intervention trial to improve the quality and outcome of care for major depression. A teleconference program was used to train primary care physicians and nurses to deliver effective care in the absence of mental health professionals, since there are not enough of these professionals to staff every primary care practice. In-person training for nurses and office administrative staff was also provided. A detailed budget for the intervention is included. Results of the intervention are described in a separate article (see Rost et al. 2001).

Russell G, Potter L. Mental health issues in primary healthcare. *J Clin Nurs*. 2002 Jan;11(1):118-25. <PubMed>

Russell and Potter (2002) studied mental health issues in primary care to gain insight into professionals' mental health training needs in the United Kingdom. They argue that the mental

health issues facing primary care professionals may differ from those confronting mental health workers in secondary mental health care. Primary care workers may require a discrete set of skills and a special approach to mental health training. Using a series of focus groups and semi-structured interviews involving professionals across disciplines and service users, the authors explored the clinical issues occurring in practices: experiences with depression, eating disorders, anxiety, substance abuse, psychoses and other general mental health issues. Findings indicated the need for basic mental health knowledge and skills for all primary care professionals; improving access to the secondary level of service; and creating protocols for assessment, treatment and referral that are sensitive to local conditions, such as geography, culture, role expectations and conflict. Also noted was the "sense that a paradigm shift was needed to promote practices that truly foster psychological wellbeing" (p. 124). The authors conclude that training for primary care professionals would have to be based on broader measures than those described in the current policy, the National Service Framework for Mental Health.

Rutter D, Manley C, Weaver T, Crawford MJ, Fulop N. Patients or partners? Case studies of user involvement in the planning and delivery of adult mental health services in London. *Soc Sci Med*. 2004 May;58(10):1973-84. <PubMed>

Rutter et al. (2004) undertook a series of case studies about user involvement in planning and delivering adult mental health services in London, England. With increased policy demands for the full involvement of consumers in the delivery of care, investigation of actual involvement is important. Qualitative methods were used to assess the type of involvement in the planning of service delivery in two mental health trusts and the differences in the expectations of the various stakeholders. The results that emerged showed that consumers were participating, but that providers retained control over decision-making and coerced consumers into endorsing existing

trust agendas and management practices. Consumers who sought greater influence, more concrete outcomes and a shift to partnership or power-sharing were disappointed. Advice for improving collaboration in service planning and management was provided.

Ryan-Nicholls KD, Racher FE, Robinson JR. Providers' perceptions of how rural consumers access and use mental health services. J Psychosoc Nurs Ment Health Serv. 2003 Jun;41(6):34-43. <PubMed>

Ryan-Nicholls et al. (2003) studied providers' perceptions of how rural consumers access and use mental health services in rural Manitoba. The authors provide a good review of the challenges of providing rural mental health care and summarize their findings as a number of key topics: for example, communication and team effort, awareness and availability of community resources, access to mental health services in the community, attitudinal barriers, clarification of programs and roles, challenges of discharge planning, legal issues, and referrals and interagency communication.

Saitz R, Horton NJ, Larson MJ, Winter M, Samet JH. Primary medical care and reductions in addiction severity: a prospective cohort study. Addiction. 2005 Jan;100(1):70-8. <PubMed>

In their prospective cohort study of adults enrolled in a randomized control trial to improve linkages with primary care, Saitz et al. (2005) assessed the effects of primary medical care on outcomes for adults with addictions. People in a residential detoxification unit whose substance of choice was alcohol, heroin or cocaine and who had no primary medical care were included in the study. Receipt of medical care was assessed over two years, and the outcomes measured included the severity of alcohol or drug use and any other substance use. Lower odds of drug use or alcohol intoxication were associated with receipt of primary care in the overall sample. For those with alcohol problems, severity of alcohol use was also lower for those who got medical

care. Likewise severity of drug use was lower for those drug users who were medically treated. Overall access to medical care in the integrated model was beneficial to the study participants, supporting the hypothesis that linking addiction and medical care is warranted.

Saitz R, Larson MJ, Horton NJ, Winter M, Samet JH. Linkage with primary medical care in a prospective cohort of adults with addictions in inpatient detoxification: room for improvement. Health Serv Res. 2004 Jun;39(3):587-606. <PubMed>

In a prospective cohort study done in the context of a randomized trial, Saitz et al. (2004) examined the value of linking people in an inpatient detoxification program with primary medical care. Knowing that a substantial number of people with addictions do not seek primary care, the study sought to identify factors associated with primary care linkage after alcohol or drug detoxification. These characteristics were related to making contact with primary care: being a woman, having a social support system to maintain abstinence, not having been recently incarcerated, having had a recent medical appointment with a doctor and having health insurance. Unrelated factors were recent addictions, mental health treatment and health status. The authors recommend that better linkages to primary medical care be created for those least likely to connect with it.

Samet JH, Friedmann P, Saitz R. Benefits of linking primary medical care and substance abuse services: patient, provider, and societal perspectives. Arch Intern Med. 2001 Jan 8;161(1):85-91. <PubMed>

Samet et al. (2001) discuss the linkage and integration of medical, mental health and substance abuse care. Their overview included examination of barriers to such integration, advantages to be gained through integration and published models of care. They provide a good primer for readers wishing to understand more about this type of care.

RS

Samet JH, Larson MJ, Horton NJ, Doyle K, Winter M, Saitz R. Linking alcohol- and drug-dependent adults to primary medical care: a randomized controlled trial of a multi-disciplinary health intervention in a detoxification unit. *Addiction*. 2003 Apr;98(4):509-16. <PubMed>

In a randomized control trial, Samet et al. (2003) assessed how effectively a multi-disciplinary clinic links people in a residential detoxification program with primary medical care. The intervention, done in the detoxification program, consisted of a clinical evaluation of the person's health; linkage to a primary care clinic by a doctor, nurse and social worker; and an off-site referral to a primary care clinic. The primary outcome was having an appointment at the primary health clinic within 12 months. Overall, 69 per cent of those in the intervention group were linked with primary care within the year, as opposed to 53 per cent in the control group. The intervention successfully linked persons with problems with addictions to primary care. The findings were interpreted as a "reachable moment" in the period of addiction care — namely, intercession at the right moment with the right action to get people into primary care.

Saur CD, Harpole LH, Steffens DC, Fulcher CD, Porterfield Y, Haverkamp R, Kivett D, Unützer J. Treating depression in primary care: an innovative role for mental health nurses. *Journal of the American Psychiatric Nurses Association*. 2002 Oct;8(5):159-67. <Abstract>

Saur et al. (2002) use case examples to illustrate a collaborative stepped-care treatment program that involved nurses practising as depression clinical specialists. This approach was particularly effective for treating seniors.

Saxena S, Maulik PK, O'Connell K, Saraceno B. Mental health care in primary and community settings: results from WHO's Project Atlas [editorial]. *Int J Soc Psychiatry*. 2002 Jun;48(2):83-5. <PubMed>

In their editorial, Saxena et al. (2002) summarize the findings of the World Health Organization (WHO) Project Atlas, which examined mental health care in primary and community settings. The project documents the resources available to meet the high need for mental health care in 185 of 191 WHO member states, especially those in developing countries. The information covers available policies, programs, legislation, finance, primary and community facilities, including therapeutic drugs, number of psychiatric beds and mental health professionals, involvement of nongovernmental organizations, information systems and available special programs. Overall, the trend toward deinstitutionalization and the development of primary and community care for people with mental illness present serious challenges for developing countries.

Schaefer J, Davis C. Case management and the chronic care model: a multidisciplinary role. *Lippincotts Case Manag*. 2004 Mar-Apr;9(2):96-103. <PubMed>

Schaefer and Davis (2004) discuss the chronic care model and consider case management through three systems, a health-coaches program in a community health centre, a depression care program in a community health centre and a building-capacity program in an integrated health system, that have implemented the model. The example of depression care captures many of the components of evidence-based practices for the care of people with depression.

Schoenbaum M, Unützer J, McCaffrey D, Duan N, Sherbourne C, Wells KB. The effects of primary care depression treatment on patients' clinical status and employment. Health Serv Res. 2002 Oct;37(5):1145-58. <PubMed>

Schoenbaum et al. (2002) evaluated the effects of depression treatment in primary care on patients' clinical status and employment over six months. This reasonably large randomized control trial included 938 adults with depressive disorder in 46 managed primary care clinics in five states. At six months, patients receiving appropriate care had lower rates of depressive disorder, better mental health-related quality of life and higher rates of employment than those without care. A major strength of this trial was that it was done under naturalistic primary care practice conditions.

Schulberg HC, Bryce C, Chism K, Mulsant BH, Rollman B, Bruce M, Coyne J, Reynolds CF 3rd; PROSPECT Group. Managing late-life depression in primary care practice: a case study of the Health Specialist's role. Int J Geriatr Psychiatry. 2001 Jun;16(6):577-84. <PubMed>

In their randomized control study of older depressed patients at risk of suicide, Schulberg et al. (2001) provided an overview of the health specialist's role activated in the Prevention of Suicide in Primary Care Elderly: Collaborative Trial. They describe the role in detail, and include clinical and case-management tasks designed to provide the primary care physician with timely, specific information and recommendations that may be incorporated into an overall treatment plan. Details about the implementation of this position in a variety of primary care settings may be useful to applications in other real-life settings.

Schwenk TL. Diagnosis of late life depression: the view from primary care. Biol Psychiatry. 2002 Aug 1;52(3):157-63. <PubMed>

Schwenk (2002) summarizes some previous studies and argues for the implementation of new collaborative approaches to delivering mental health care to depressed older patients in primary care settings. The new approaches highlighted include telephone monitoring, nurse-clinician outreach and improved availability of psychiatric consultation in primary care settings.

Scott J, Jennings T, Standart S, Ward R, Goldberg D. The impact of training in problem-based interviewing on the detection and management of psychological problems presenting in primary care. Br J Gen Pract. 1999 Jun;49(443):441-5. <PubMed>

Scott et al. (1999) conducted a control study of the problem-based interviewing (PBI) skills of a small number of general practitioners in England. Ten general practitioners who had received PBI training were matched with ten control general practitioners for age, sex, clinical experience and practice setting. A total of 280 consecutive patients seen at each identified general practice met the study inclusion criteria and consented to participate in the study. The most important findings showed that physicians trained in PBI were better than controls at recognizing and managing their patients' psychological distress. These physicians were able to discern persons with more subtle symptoms measured with standardized instruments, as well as those with more overt disorders. Having PBI training was also associated with greater use of psychotropic medications. Patients were satisfied with the style of interviewing. The authors suggest the PBI training may be an effective method of improving the skills of general practitioners since these skills, maintained over time, have an effect on practice methods. Despite the study's methodological limitations, the evidence about PBI warrants further study in a randomized control trial.

S

Sebuliba D, Vostanis P. Child and adolescent mental health training for primary care staff. *Clinical Child Psychology and Psychiatry*. 2001 Apr;6(2):191-204.

Sebuliba and Vostanis (2001) describe an interagency training program in child and adolescent mental health for primary care staff developed in the United Kingdom. Very useful is the two-phase strategy the authors use to define training needs in the study region: consultation with key senior managers through interviews and questionnaires, and consultation with frontline staff in a workshop. From these consultations emerged the need to develop a local training program for professionals in a given area. Half-day workshops were organized and combined delivery of information and exercises. The bottom-up approach to basic training aimed at the entire staff population was deemed successful, except that few general practitioners were represented among the trainees.

Secker J, Pidd F, Parham A. Mental health training needs of primary health care nurses. *J Clin Nurs*. 1999 Nov;8(6):643-52. <PubMed>

Secker et al. (1999) found that primary care nurses working in London, England, were doing a wide range and increasing volume of mental health work with little preparation and training. The authors identify the nurses' specific training needs: time and space to identify training gaps, training in safe working practices and management of role boundaries, and multi-disciplinary training. Further, they recommended that health care trusts, primary care groups and health authorities clarify which aspects of the nurses' mental health care workloads are appropriate to their role, and develop policies, procedures and training to support their fulfillment of that role.

Secker J, Pidd F, Parham A, Peck E. Mental health in the community: roles, responsibilities and organisation of primary care and specialist services. *J Interprof Care*. 2000 Feb 1;14(1):49-58.

Secker et al. (2000) describe opposing trends affecting community mental health care in the United Kingdom that were inherent in its health policies of the late 1990s. Policy called for a national health service led by primary care that reflects the needs of people with milder mental disorders and specific mental health policies that continue to focus on the delivery of specialist services for those with serious mental illness. These trends are discussed from the perspectives of primary care nurses, general practitioners and community psychiatric nurses. Implications for training are highlighted.

Sederer LI, Ellison J, Keyes C. Guidelines for prescribing psychiatrists in consultative, collaborative, and supervisory relationships. *Psychiatr Serv*. 1998 Sep;49(9):1197-202. <PubMed> <FullText>

Sederer et al. (1998) describe the guidelines for prescribing psychiatrists in consultative, collaborative and supervisory relationships that were developed for the Harvard Risk Management Foundation. The underlining premise of the guidelines is that quality of care can be improved by delineating responsibilities and having clear expectations among providers about communication, documentation, confidentiality, coverage arrangements and handling emergencies. The guidelines are designed to reduce ambiguity in the roles of the involved clinicians, especially in the role of the psychiatrist. In all three types of relationships (consultative, collaborative and supervisory), psychiatrists should complete these four steps:

1. Clarify which other clinicians are involved in the patient's care.
2. Ascertain why they have been asked to assist in this instance.
3. Be open about and prepared to discuss their treatment approach, experiences and

goals, and be willing to deal with problem treatment approaches with other clinicians.

4. Assign communication responsibilities to supervised personnel, as appropriate.

In all instances, the participating clinicians should clarify their expectations about regular communication and have a specific plan for emergencies. Special attention should be paid to patients' preferences for care and disclosure of information.

Shanley E, Jubb M, Latter P. Partnership in Coping: an Australian system of mental health nursing. *J Psychiatr Ment Health Nurs.* 2003 Aug;10(4):431-41. <PubMed>

Shanley et al. (2003) present a new theoretical framework for mental health nursing in Australia called the Partnership in Coping (PIC) system. This framework provides a consumer-centred approach to mental health nursing and a starting point for assigning contributing roles to nurses within a collaborative primary mental health team. The underlying philosophy of the PIC system is that mental illness is episodic. "For most of the time people who experience a mental illness cope well with their lives only occasionally requiring the use of mental health services. It is these occasions when clients may not be using their coping strategies that they become ill. The role of the nurse is to work with clients, helping them to identify and use their coping strategies to deal with these concerns" (p. 434). This framework takes a needs- and strengths-based approach and gives clients a greater role in decision-making about their care. The framework uses the positive aspects of mental health nursing, including its holistic perspective, the length and nature of informal contacts, the ordinariness of relationships with clients, and the nurse's awareness of clients' social and physical environments. At the time the authors wrote the article, the framework was undergoing trial in Western Australia.

Shannon-Jones S, Surridge A, Boden J. Developing an integrated mental health nursing team. *Nurs Stand.* 2003 Mar 19-25;17(27):41-4. <PubMed>

Shannon-Jones et al. (2003) present a rationale for developing an integrated mental health nursing team to provide services in the primary care setting, in keeping with the policies of Wales and England. The authors propose a model of mental health liaison in primary care settings that gives all members of the primary care team access to mental health nursing skills and to specialist knowledge of appropriate services. The policy recommends that the mental health nurse be available to all members of the primary care team and the general public, based on the premise that more than one person's or professional's skills are required to meet the needs of people with mental illness. In the model described in this article, the community psychiatric nurse was linked to three general practices to enhance communication between local services and educate primary care personnel. In turn, the community psychiatric nurse worked with district nurses (the equivalent of public health nurses in Canada) to develop a medication-monitoring clinic, a postpartum depression screening program and a healthy options group.

Sicotte C, D'Amour D, Moreault MP. Interdisciplinary collaboration within Quebec community health care centres. *Soc Sci Med.* 2002 Sep;55(6):991-1003. <PubMed>

Sicotte et al. (2002) examine interdisciplinary collaboration in community health care centres in Quebec. Outlining the considerable history and interdisciplinary philosophy of this model of primary health care, the authors delineate the strong analytical model on which the research was based. They examine the contextual intragroup process, the intensity of interdisciplinary collaboration and the moderating effects of the nature of the task undertaken. Modest levels of interdisciplinary collaboration have been achieved in these health centres. Factors that may prove useful for

improving interdisciplinary collaboration include the simultaneous and contradictory effects of some intragroup process factors: agreement with interdisciplinary and disciplinary logic, social integration with work groups, and conflicts associated with interdisciplinary collaboration. Collaboration within primary care teams is best achieved when the professional disciplinary focus is balanced by strong collaborative values and practices. Intensity of collaboration also seems contingent upon the nature of the clients' illness and associated long-term morbidity. Often the simultaneous presence of multiple pathologies favour the more intense, multi-faceted responses that are available through collaborative approaches to care. Collaborative care is not required by all people or in all contexts.

Sigel P, Leiper R. GP views of their management and referral of psychological problems: a qualitative study. *Psychol Psychother.* 2004 Sep;77(Pt 3):279-95. <PubMed>

Sigel and Leiper (2004) explore general practitioners' views about managing and deciding on referrals for psychological problems. Using grounded theory, the authors formulated a model with five components from data collected during interviews with ten general practitioners from one locality. The model describes how physicians explored psychological problems in the overall context of managing their patient's health issues. Once they reached the perceived end of their capacity to deal with a particular problem, physicians made their decisions about referrals based on the person's suitability for psychological therapy and access to psychological services. Physicians' decisions were influenced by their views of psychological problems and therapies, and by their professional interactions with psychologists. These components were not discrete; they represented a series of interactions between these domains. This study suggests a useful model for understanding how general practitioners work with mental health problems. Also suggested are ways that mental health

specialists might work within existing practices to improve general practitioners' skills, rather than imposing psychiatric or psychological ways of working. The model could be useful for establishing collaborative models within primary care settings where general practitioners are part of the mental health team.

Simon GE, VonKorff M, Rutter C, Wagner E. Randomised trial of monitoring, feedback, and management of care by telephone to improve treatment of depression in primary care. *BMJ.* 2000 Feb 26;320(7234):550-4. <PubMed> <FullText>

Simon et al. (2000) report the results of their randomized control trial of a telephone-based depression care program in primary care. The three treatment arms of the study were traditional care, feedback to the doctors only, and feedback to the doctors plus care management by telephone for the patients, sophisticated treatment recommendations and practice supports by the care manager. Compared with usual care, feedback alone had no significant effect on the treatment received or on patient outcomes. Those in the integrated intervention had a high chance of receiving moderate doses of antidepressant drugs, and having significant improvement in depressive symptoms and a lower probability of major depression at the time of their follow-up appointment. Costs were moderate for the delivery of the telephone support. This integrated approach may be useful because it falls between more intensive depression models and less intensive programs, such as screening, that are not linked to structured interventions.

Simpson S, Corney R, Fitzgerald P, Beecham J. A randomised controlled trial to evaluate the effectiveness and cost-effectiveness of counselling patients with chronic depression. *Health Technol Assess.* 2000;4(36):1-83. <PubMed> <FullText>

Simpson et al. (2000) evaluated the effectiveness and cost-effectiveness of counselling people

with chronic depression in a randomized control trial. They compared counselling for chronic depression with the usual care provided by general practitioners. For this small study (n = 181), actual scores showed overall significant improvement over time, but no difference between groups or between the two types of counselling (cognitive behaviour therapy or psychodynamic counselling) at either six or 12 months. Further visual analysis of the data showed that people with mild or moderate depression improved and ceased to be cases, and that more people in the intervention than the control group had ceased to be cases. Multiple regression analysis, however, demonstrated no significant interactions between groups and initial severity of depression. The inclusion of severely depressed people may have confounded the effects of counselling. Costs were higher during the intervention for the experimental group, reflecting the additional costs for the counsellors. Since these costs were not offset by subsequent reduced use and cost of service, no cost savings were realized at 12 months.

Sokhela NE. The integration of comprehensive psychiatric/mental health care into the primary health system: diagnosis and treatment. *J Adv Nurs.* 1999 Jul;30(1):229-37. <PubMed>

Sokhela (1999) investigated the effectiveness of a program designed to teach primary health care nurses in South Africa how to diagnose and treat common psychiatric conditions, to refer patients whom the nurses could not manage and to evaluate the implementation of these new functions in their practices. Overall, the training program was effective, and the use of record reviews to teach history-taking, diagnosis, pharmacological treatment and referral was acceptable.

Sorohan H, Lester H, Hughes E, Archer L. The role of the practice nurse in primary care mental health: challenges and opportunities. *Primary Care Psychiatry.* 2002 Jun;8(2):41-6. <Abstract> <FullText>

Sorohan et al. (2002) call for the development of education and learning strategies that would increase the skills of practice nurses working in primary care teams. The authors cite studies showing that most practice nurses think themselves ill-equipped to handle the common mental health issues of people often seen in primary care practices. Sorohan et al. recommend that this training focus on ethical practices; knowledge of mental health policy and services; communication; assessment; possibly intervention skills; and understanding what consumers want and need from a primary care practitioner, including hope, mutualism and joint decision-making.

Speer DC, Schneider MG. Mental health needs of older adults and primary care: opportunity for interdisciplinary geriatric team practice. *Clinical Psychology: Science and Practice.* 2003 Spring;10(1):85-101. <Abstract>

Speer and Schneider (2003) examine a range of factors that create opportunities for dealing with the mental health needs of seniors in primary care. They provide a useful literature review about the prevalence, use of services, older adults' use of mental health services and its costs, use of medical services, mind-body interactions, services within primary care, and physician care. Also discussed are two cost-offset meta-analyses, a comparison of traditional and alternative interventions for older people, patient screening, and physician training. The authors suggest roles for nonmedical behavioural professionals in primary care, academic and clinical training requirements, and an integrated, collaborative approach to seniors' mental health care.

Spruill J, Barksdale C, Bush D; Education Directorate, American Psychological Association. Interprofessional health care services in primary care settings: implications for the education and training of psychologists. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA)/Health Resources and Services Administration (HRSA); June 1998. Available from: <http://www.apa.org/ed/samhsapdf.html> OR <http://www.apa.org/ed/samhsa.pdf>

For a joint project of the American Psychological Association, Substance Abuse and Mental Health Services Administration and the Health Resources and Services Administration, Spruill et al. (1998) produced a bibliography, and appropriate education and training guidelines for the participation of psychologists in interprofessional health care services, including treatment for substance abuse and mental health care within managed-care settings. The authors present a set of general principles relevant to all primary health care providers delivering collaborative care that focus on knowledge and skills; educational and training priorities for the four roles (clinical, teaching, research and administration) that psychologists may have in integrated primary care; and principles for interdisciplinary training, complete with supporting references.

Staab JP, Datto CJ, Weinrieb RM, Gariti P, Rynn M, Evans DL. Detection and diagnosis of psychiatric disorders in primary medical care settings. *Med Clin North Am.* 2001 May;85(3):579-96. <PubMed>

In their review article, Staab et al. (2001) discuss the significant advancements in the diagnosis and management of depressive, anxiety and substance-related disorders made in the last decade. Included is information about the use of screening tools for screening and detecting these conditions.

Stark S, Stronach I, Warne T, Skidmore D, Cotton A, Montgomery M. Teamworking in mental health: zones of comfort and challenge [research report]. *Researching Professional Education Research Report Series.* 2000;(17). (London: English National Board for Nursing, Midwifery and Health Visiting; 2001. 151p.)

In an evaluation study, Stark et al. (2001) report on the effectiveness of educational preparation for mental health nursing in multi-professional multi-agency team environments in a range of mental health settings in England. Using a large number of data collection activities, including a national survey of 800 mental health care service users, providers and students, and a national survey of 400 persons, the authors obtained feedback about the findings of an early phase of the study and made a total of 23 recommendations. Relevant to collaborative care were the following recommendations: "1) because teamwork is more effectively caught than taught, provide students with longer clinical placements earlier in their pre-registration programs; 2) place more emphasis on team building skills; 3) promote more collaborative patterns of teamwork, both in clinical and educational settings; 4) combine teamwork focused case studies, educational vignettes and assignments with technical nursing issues and user perspectives; 5) give more consideration to the affective nature of nurses' work, both in terms of stress and in terms of vocational commitment; and 6) give ex-mental health service users greater input in policy, practice and educational contexts."

Stevens L, Kinmonth AL, Peveler R, Thompson C. The Hampshire Depression Project: development and piloting of clinical practice guidelines and education about depression in primary health care. *Med Educ.* 1997 Sep;31(5):375-9. <PubMed>

Stevens et al. (1997) describe the development and pilot application of a comprehensive depression education program for multi-

disciplinary team members in primary care. The program consists of clinical practice guidelines, practice-based seminars and follow-up sessions. The program is designed to be flexible, clinically oriented and relevant to all members. A systematic approach to the access of practices and practice teams, and the organization and process of the seminars was recommended.

Stewart D, Oslin DW. Recognition and treatment of late-life addictions in medical settings. *Journal of Clinical Geropsychology*. 2001 Apr;7(2):145-58.

Stewart and Oslin (2001) discuss three late-life addictions — smoking, excessive alcohol consumption and gambling — and opportunities for the recognition and treatment of these conditions within primary care. As with mental health conditions, seniors tend not to seek treatment for these conditions in specialty programs, suggesting that the optimum location for response is the primary care setting. The authors recommend that behavioural health specialists be introduced into this setting to help develop collaborative treatment for these costly addictions.

Stichler JF. Developing collaborative relationships: balancing professional power in the health care environment. *AWHONN Lifelines*. 1998 Jun/Jul;2(3):53-4. <PubMed>

Stichler (1998) discusses balancing professional power in collaborative relationships. Necessary conditions for collaboration include mutual trust, respect, valuing the contributions and knowledge of others, and working toward common goals. The art of collaboration is learned, and “once learned and demonstrated the resulting synergy cannot be achieved by any other means.” The author provides five strategies for developing collaborative practices:

1. Enhancement of each profession’s knowledge and skills through continuing education.
2. Development of interdisciplinary committees to set patient goals and to discuss roles and responsibilities.
3. Examination of similarities and differences in roles, looking for ways to make unique contributions to patient care and increase understanding of one another’s roles.
4. Development of forums for the open exchange of communication, problem-solving, decision-making and planning.
5. Celebration of success, including the use of collaborative behaviours or practice as examples for others.

Strathdee G. The severely mentally ill: working better with specialist services. *International Review of Psychiatry*. 1998 May;10(2):139-42. <Abstract>

Strathdee (1998) describes methods for developing a program to foster collaboration between primary care and specialized mental health care providers. The author delineates the types of information that assist with the identification of local needs and care pathways, and effective communication strategies and shared care for people with serious mental illness.

Strosahl K. Integrating behavioral health and primary care services: the primary mental health care model. In: Blount A, editor. *Integrated primary care: the future of medical and mental health collaboration*. New York: Norton; 1998. p. 139-66.

Strosahl (1998) comprehensively discusses a primary mental health care model, drawing firm distinctions between this type of care and specialty mental health care. He suggests that the care provided by the mental health specialist practising traditional psychotherapy or family therapy separate from medicine in a primary care setting does not constitute integrated or collaborative care. Strosahl supports the need for mental health professionals who function as mid-level providers on a primary care team. This chapter examines horizontal and vertical integration as templates for integrative primary

care, compares collaborative and integrated care, and discusses levels of care within primary mental health care.

Sturm R, Unützer J, Katon W. Effectiveness research and implications for study design: sample size and statistical power - evaluating the cost-effectiveness of improving care for depression. *Gen Hosp Psychiatry*. 1999 Jul-Aug;21(4):274-83. <PubMed>

Sturm et al. (1999) discuss the use of sample size and statistical power in effectiveness studies. Although efficacy studies have been criticized on a number of fronts, they are able to document differences in clinical outcomes with sample sizes that are well under 100 per group. The emerging emphasis on effectiveness studies requires attention to their sample size and statistical power. Broad outcome measures and costs are influenced by many factors other than the health intervention; moreover, such heterogeneity leads to high variances, even when samples are relatively homogenous. According to the authors' analysis of previous mental health and primary care studies, broad outcome measures such as quality of life require sample sizes in the hundreds per group and costs require sample sizes in the thousands. Sturm et al. advocate for discretion in the use of broader-based outcome measures, the development of new study designs and funding to support such alternatives.

Swartz L, MacGregor H. Integrating services, marginalizing patients: psychiatric patients and primary health care in South Africa. *Transcultural Psychiatry*. 2002 Jun;39(2):155-72.

Swartz and MacGregor (2002) discuss South Africa's experience of implementing integrated primary mental health care. They consider some of the ideological bases for integration, but focus on the needs of persons with serious mental illness. Using case examples, the authors illustrate the failure of current approaches to meet the high level of needs of this group, even those considered stable enough to be cared for

in a primary care setting. This text is richly details working in a poorly resourced post-conflict society.

Tarren-Sweeney M, Carr V. Principles for development of multi-disciplinary, mental health learning modules for undergraduate, postgraduate and continuing education. *Educ Health (Abingdon)*. 2004 Jul;17(2):204-12. <PubMed>

Tarren-Sweeney and Carr (2004) discuss instructional methods and techniques, and principles for developing multi-disciplinary mental health learning modules for undergraduate, graduate and continuing education in Australia. The authors describe a CD-ROM training program about personality disorders designed for professionals and developed with these principles. According to these principles, such products should have these characteristics:

- ✎ Multi-disciplinary application.
- ✎ Adaptability for presentation in multiple education domains.
- ✎ Accessibility for rural and remote practitioners.
- ✎ Combined structured solutions and focused lessons (directed learning), with elements of problem-based learning.
- ✎ Authentic, relevant working problems.
- ✎ Normal, abnormal and cross-cultural manifestations of problems.

Thomas SA, Hargett T. Mental health care: a collaborative, holistic approach. *Holist Nurs Pract*. 1999 Jan;13(2):78-85. <PubMed>

Thomas and Hargett (1999) provide an overview of a collaborative model of mental health care practice known as the Siegal & Thomas HealthCare Group. A partnership between a psychiatric nurse specialist and a psychiatrist, this group practice involved a multi-disciplinary team of professionals providing mental health care to adults, children, families and groups of clients in managed-care networks. The practice roles of the various professionals are discussed, and a few

cases presented to demonstrate the nature and features of this collaborative program.

Thompson C. Managing major depression: improving the interface between psychiatrists and primary care. *International Journal of Psychiatry in Clinical Practice*. 2001 Jun 1;5(Suppl 1):11-18.

Thompson (2001) summarizes research about depression to improve understanding of the intersection of primary and secondary care. Included are a useful summary of the recent primary care audit in the United Kingdom and a review of current practices for delivering treatment of depression in primary care.

Thompson C, Kinmonth AL, Stevens L, Peveler RC, Stevens A, Ostler KJ, Pickering RM, Baker NG, Henson A, Preece J, Cooper D, Campbell MJ. Effects of a clinical-practice guideline and practice-based education on detection and outcome of depression in primary care: Hampshire Depression Project randomised controlled trial. *Lancet*. 2000 Jan 15;355(9199):185-91. <PubMed>

In a randomized controlled study of the Hampshire Depression Project, Thompson et al. (2000) used feedback from participants and expert raters to evaluate the education provided to practice teams. Overall, participants were satisfied with the education program. However, the impact of the program on physicians' ability to diagnose depression or on patient outcomes was minimal.

Trainor J, Pomeroy E, Pape B. A framework for support. 3rd ed. Toronto: Canadian Mental Health Association; 2004. Available from: <http://www.cdha.nshealth.ca/programsandservices/mhstrategicplanning/framework.pdf>

The recently updated A framework for support (third edition), by Trainor et al. (2004), provides a conceptual framework that emphasizes the full involvement of mental health consumers

and families in mental health systems that are community-focused and recovery-oriented. The community resource base highlights the partnerships among four groups (consumers, families, mental health service providers and generic social services) in planning and operating the mental health system. The knowledge resource base, the second key concept in the model, identifies main sources of information and understanding that show how people think about mental illness. This concept untangles the complex individual and social issues faced by mental health consumers. The personal resource base added in this third edition highlights the essential capacities, identified by mental health consumers, for coping with mental illness and emphasizes the meaning of person-centred care.

Twilling LL, Sockell ME, Sommers LS. Collaborative practice in primary care: integrated training for psychologists and physicians. *Professional Psychology: Research and Practice*. 2000 Dec;31(6):685-91.

Twilling et al. (2000) describe an integrated training program for psychologists and physicians. The authors note that the obstacles to collaborative training include differences in theoretical orientation; degrees of training in the physiological, psychological and social influences on illness and well-being; lack of a common language; different styles of patient-provider interaction; and divergent assumptions about the integration of assessment and treatment. They describe, in full, the format of the interaction of paired practitioners (one psychology intern and one medical resident) with the patient, and the procedures for the case review with the attending physician and psychologist. The knowledge and skills needed for cross-training are encouraged at every step, and are captured in the joint curricular objectives formulated for the program. The ultimate focus is on team-building by modelling at the senior level and by experiential learning at the trainee level.

United Kingdom Department of Health. Fast-forwarding primary mental health care: 'gateway' workers. London: Department of Health; October 2002. Available from: <http://www.dh.gov.uk/assetRoot/04/06/11/12/04061112.pdf>

In their report, Fast-forwarding primary mental health care: 'gateway' workers, the Department of Health presents the practice guidelines for the newly introduced position of gateway worker for primary mental health care under the National Health Service plan, called the NHS Plan, in the United Kingdom. This plan called for the implementation of 500 community mental health staff or gateway workers, at both a clinical and strategic level, by 2004. Within a primary care trust, the gateway worker can work as a member of the local service to support assessment and treatment in an actual or impending mental health emergency. At the level of the local implementation team, the gateway worker can support effective planning and integration of services by providing leadership and facilitating local service development.

Unützer J, Katon W, Callahan CM, Williams JW Jr, Hunkeler E, Harpole L, Hoffing M, Della Penna RD, Noel PH, Lin EH, Arean PA, Hegel MT, Tang L, Belin TR, Oishi S, Langston C; IMPACT Investigators. Improving Mood-Promoting Access to Collaborative Treatment. Collaborative care management of late-life depression in the primary care setting: a randomized controlled trial. *JAMA*. 2002 Dec 11;288(22):2836-45. <PubMed>

Unützer et al. (2002) conducted a randomized control trial to determine the effectiveness of the Improving Mood-Promoting Access to Collaborative Treatment (IMPACT) model for the care of late-life depression. The IMPACT model gave patients access to a manager for their depression care who was supported by a primary care physician and a psychiatrist. The manager offered patients education, managed their care, and supported the antidepressant management

offered by the patient's primary care physician or brief psychotherapy for depression. In contrast to patients in the usual care group, those in the IMPACT group had significantly greater symptom reduction, more satisfaction with care, lower severity of depression, less functional impairment and greater quality of life. The IMPACT model also emphasized education and treatment choices for consumers.

Unützer J, Katon W, Williams JW Jr, Callahan CM, Harpole L, Hunkeler EM, Hoffing M, Arean P, Hegel MT, Schoenbaum M, Oishi SM, Langston CA. Improving primary care for depression in late life: the design of a multicenter randomized trial. *Med Care*. 2001 Aug;39(8):785-99. <PubMed>

Unützer et al. (2001) describe in detail the design of their Improving Mood: Promoting Access to Collaborative Treatment trial, or Project IMPACT. This randomized control trial examined later-life depression and compared a collaborative treatment approach with usual care. In the collaborative program, a depression care specialist, who was supervised by a psychiatrist and a primary care expert, supported the patient's regular primary care provider in the treatment of the patient's depression. Patients were treated for up to 12 months with antidepressant medications and problem-solving therapy, according to a stepped protocol. Evaluations were done at baseline, three, six, 12, 18 and 24 months. Cost-effectiveness was examined on an incremental basis, as were specific outcomes, including care for depression, depressive symptoms, health-related quality of life, satisfaction with depression care, health care and patient-time costs, market and nonmarket productivity, and household income. The authors conclude that this model of care for late-life depression is both cost-effective and suitable for implementation in a variety of primary care settings.

U.S. Department of Health and Human Services. Report of a Surgeon General's working meeting on the integration of mental health services and primary health care: 2000 Nov 30 – Dec 1; Atlanta, Georgia. Rockville, MD: US Department of Health and Human Services, Public Health Service, Office of the Surgeon General; 2001. Available from: <http://www.surgeongeneral.gov/library/mentalhealthservices/mentalhealthservices.pdf>

The U.S. Department of Health and Human Services report (2001) summarizes the Surgeon General's meeting about the integration of mental health services with primary health care. In his address to primary care mental health experts, Satcher, then Surgeon General of the United States, noted the concurrent high-level demands on primary care physicians to deal with a broad range of issues and the severe limitations on the time available to take on such additional demands. Satcher identified the emerging opportunity to create collaborative models within primary care practices to meet the mental health needs of the population and encouraged primary care doctors to assume a leadership role in the development of team approaches.

U.S. Preventive Services Task Force. Screening for depression: recommendations and rationale. Rockville, MD: Agency for Healthcare Research and Quality; May 2002a. Available from: <http://www.ahrq.gov/clinic/3rduspstf/depression/depressrr.htm>

In its online summary, the U.S. Preventive Services Task Force (2002a) briefly describes the rationale for its recent recommendation that adults be screened for depression in primary care. Overall, the Task Force concludes that accurate screening tests and effective therapies for depression are available and should be used in primary care. Compared with regular mental health assessment for adults, screening for depression improves outcomes, especially when linked to adequate treatment and follow-up.

U.S. Preventive Services Task Force. Screening for depression: recommendations and rationale. *Ann Intern Med.* 2002b May 21;136(10):760-4. <PubMed> <FullText>

In its statement about depression screening in primary care, the U.S. Preventive Services Task Force (2002b) discusses clinical considerations and scientific evidence, and reviews the recommendations of other similar task forces. Also presented here are the grading scales for the Task Force's recommendations and for the strength of the overall evidence.

Valianti LC. Small project reveals large cultural barriers to integrated care. *Behav Healthc Tomorrow.* 2004 Apr;13(2):19-23. <PubMed>

Valèanti (2004) examines the practice cultural barriers that emerged during the implementation of a shared-care program involving the Providence Community Health Center and The Providence Center (the state's largest community mental health centre) in Rhode Island. In describing the problems that arose and the steps taken to deal with the problems throughout the implementation, the author highlights important actions that are often required during the development of collaborative care. For example, compromise was identified as a key lesson: to achieve the desired the quality of client care, providers had to compromise on the method of providing that care. Of all the professionals involved in the program, behavioural providers had to make the most substantial adjustments in their practice to be able to work in primary care settings and adapt to the quick-paced practice model in operation.

van Os TW, Ormel J, van den Brink RH, Jenner JA, Van der Meer K, Tiemens BG, van der Doorn W, Smit A, van den Brink W. Training primary care physicians improves the management of depression. *Gen Hosp Psychiatry*. 1999 May-Jun;21(3):168-76. <PubMed>

Van Os et al. (1999) examined the effects of a training program on Dutch primary care physicians' ability to recognize mental health problems, and diagnose and treat depression, according to clinical guidelines. In the pretest, 1778 consecutive patients of 17 general practitioners were screened. A stratified sample of 518 patients was interviewed for the presence of depression. Participants were trained in eight 2.5-hour intensive sessions, three of which focused on depression. In the post-test, a new group of patients was screened, and a new stratified sample of patients (n = 498) was interviewed. Primary care practitioners' knowledge of depression had improved significantly; their recognition of mental health problems and the accuracy of their diagnosis of depression improved, but were not statistically significant. More patients received depression care that conformed to the clinical guidelines. The researchers concluded that training could improve depression care.

Van Voorhees BW, Cooper LA, Rost KM, Nutting P, Rubenstein LV, Meredith L, Wang NY, Ford DE. Primary care patients with depression are less accepting of treatment than those seen by mental health specialists. *J Gen Intern Med*. 2003 Dec;18(12):991-1000. <PubMed>

In this cross-sectional study, Van Voorhees et al. (2003) looked for differences in beliefs and attitudes between primary care and specialty care patients during treatment of depression. The question was whether depressed patients treated exclusively in primary care reported less need for care and less acceptability of treatment options than those depressed patients treated in a specialty mental health program. A total

of 881 people with major depression received mental health care in the previous six months and were enrolled in the three of the four quality improvement for depression collaboration studies included in these analyses. Findings showed that the attitudes and beliefs of patients with depression treated exclusively in primary care made them more adverse to care than patients treated by mental health specialists. The authors suggest that these differences in attitudes and beliefs may contribute to the lower-quality depression care observed in comparisons of primary care and specialty mental health providers.

Vines RF, Richards JC, Thomson DM, Brechman-Toussaint M, Kluin M, Vesely L. Clinical psychology in general practice: a cohort study. *Med J Aust*. 2004 Jul 19;181(2):74-7. <PubMed> <FullText>

Vines et al. (2004) present a cohort study of a collaborative care model involving psychologists and general practitioners in Australia. The level of psychological dysfunction of a sample of 276 patients from a total of 11 practices (nine group or urban practices and two single-doctor or rural practices) was measured before and after they had full assessment, case formulation and focused psychological interventions. A normative comparison group comprising people who had not been referred for psychological treatment within the same practices was established. Findings showed that average treatment scores for mental health in the treatment group were significantly improved after the intervention, but the scores for the treatment and the normative group at follow-up were unchanged. Based on these early findings, the authors suggest that this collaborative model of care provides positive gains for patients with common mental disorders.

Walker L, Barker P, Pearson P. The required role of the psychiatric-mental health nurse in primary health-care: an augmented Delphi study. *Nurs Inq.* 2000 Jun;7(2):91-102. <PubMed>

Walker et al. (2000) question the specific need for the community psychiatric nurse in the community or primary health care. The authors conducted an augmented Delphi study and a verification study with service users. In the Delphi study, a panel of experts generated and assigned priorities to the elements of the role of the community psychiatric nurse. What emerged was a strong consensus that a major gap in primary mental health care exists and places a huge burden on general practitioners. Further development of the role of the community psychiatric nurse could effectively deal with this gap. The authors suggested that the position be activated as that of a community mental health nurse consultant to augment the role of the community psychiatric nurse, to offer some direct patient care and to support other members of the primary care health team.

Walker S. Interprofessional work in child and adolescent mental health services. *Emotional and Behavioural Difficulties.* 2003 Aug;8(3):189-204. <Abstract>

Walker (2003) describes the findings of a two-year evaluation of a new multi-disciplinary child and adolescent mental health service in Great Britain. Team members, recruited from three different agencies, were health, education and social work professionals. An operational manager oversaw the team; however, members remained employees of their home agencies. Over a short period of time, the team supported families, and troubled children and adolescents with a mix of therapeutic, practical and activity-based help and advice. In his article, Walker presents the micro details of building a team and the macro issues of developing such a service from the ground up.

Walker Z, Townsend J. Promoting adolescent mental health in primary care: a review of the literature. *J Adolesc.* 1998 Oct;21(5):621-34. <PubMed>

Walker and Townsend (1998) review the literature to test the hypothesis that primary care is a suitable setting in which adolescents' mental health problems can be prevented by early detection and treatment. The authors provide a useful discussion of mental health promotion, such as the concepts of primary and secondary prevention, treatment of adolescents, and application of these within primary care. An insightful overview of the incidence and prevalence of mental health problems among adolescents, this review points to the need for recognition of and screening for mental illness in this group. The authors found only three studies about adolescent screening; these identified a high rate of mental health problems. Although teenagers are generally receptive to attending clinics, these clinics may be attracting those who are not in need of help. As a consequence, extra effort is needed to reach out to those teens not attending clinics within primary care. The authors note the need for research about effective treatments for adolescents and the most cost-effective way to apply these treatments within primary care settings.

Walsh JM, Wheat ME, Freund K. Detection, evaluation, and treatment of eating disorders: the role of the primary care physician. *J Gen Intern Med.* 2000 Aug;15(8):577-90. <PubMed>

Walsh et al. (2000) discuss the role of the primary care physician in the detection, evaluation and treatment of eating disorders. Drawing from a review of the literature from 1994 to 1999, the authors describe the risk factors, and the symptoms and signs of anorexia nervosa and bulimia nervosa. They note the need for treatment by a multi-disciplinary team that includes a primary care physician, nutritionist

and mental health professional. The physician's role on the team is to help determine the need for hospitalization and to manage medical complications.

Weene KA. The psychologist's role in the collaborative process of psychopharmacology. *J Clin Psychol.* 2002 Jun;58(6):617-21. <PubMed>

Weene (2002) discusses the psychologist's role on the primary care team in the administration of psychotropic medications. The proper administration of psychotropic medications requires a team effort for four reasons: the clinical data used to determine the need for such treatment are very subjective; since the drugs take time to work, compliance must be actively encouraged; other systems affected (e.g., schools) must be apprised of the time required to establish the treatment regimen; and active engagement with the current evidence is required to keep up with rapid changes in the science of psychotropic medications and the brain. Weene provides a thorough discussion of how psychologists can contribute to these tasks within the primary care setting, thus leaving physicians to focus on the medical side of care.

Weisner C, Mertens J, Parthasarathy S, Moore C, Lu Y. Integrating primary medical care with addiction treatment: a randomized controlled trial. *JAMA.* 2001 Oct 10;286(14):1715-23. <PubMed>

In a randomized controlled trial, Weisner et al. (2001) examined the differences in treatment outcomes and costs for integrated and independent models of substance abuse and medical care, and for a subgroup of subjects with substance abuse-related medical conditions. Both groups showed improvement on all drug and alcohol measures. There were no group differences in total abstinence rates. Patients with substance abuse-related medical conditions in the integrated care group were more likely to be abstinent than patients in the independent care group, whether their problems were medical or psychiatric. Costs were marginally, but not

significantly higher for the integrated care group and for people with substance abuse-related medical conditions in integrated care than for those in the independent care group. Integrated care for the subgroup was deemed both beneficial and cost-effective.

Wells KB, Kataoka SH, Asarnow JR. Affective disorders in children and adolescents: addressing unmet need in primary care settings. *Biol Psychiatry.* 2001 Jun 15;49(12):1111-20. <PubMed>

Wells et al. (2001) tackle the issue of the unmet needs of children and adolescents with affective disorders. The authors identify primary care as an appropriate setting in which the identification and treatment of these disorders for the younger population could be provided. They review the numerous factors contributing to the low rate of detection of these issues in primary care, including child and family, clinician, practice and health care system factors. The authors suggest potential solutions in the American context, for example, more systematic implementation of programs that provide insurance coverage for all children; stronger parity laws that ensure equity in defined benefits and application of managed-care strategies for all physical and mental disorders; and widespread application of quality improvement programs within primary care settings that promote specialty and primary care collaboration, support the use of care managers to coordinate care, and train providers in developmentally and clinically appropriate principles of care for affective disorders. The authors recommend research into the effective treatment of depression and other affective disorders for children and adolescents.

Wells KB, Sherbourne C, Schoenbaum M, Duan N, Meredith L, Unützer J, Miranda J, Carney MF, Rubenstein LV. Impact of disseminating quality improvement programs for depression in managed primary care: a randomized controlled trial. JAMA. 2000 Jan 12;283(2):212-20. <PubMed>

Wells et al. (2000), in a randomized control trial, compared usual care with one of two programs enhanced with quality improvements. Quality improvements included enhanced resources, either to support management of medication or to provide psychotherapy for depression. The authors hypothesize that the dissemination of quality improvements for the treatment of depression under naturalistic conditions would improve the quality of care and health-related outcomes over the course of a year's follow-up. Results showed that implementation of quality improvement programs that improved care for depression without mandating it had positive effects on the quality of care, mental health outcomes and retention of employment for people with depression over the year. Medical visits, however, did not increase overall.

Ward E, King M, Lloyd M, Bower P, Sibbald B, Farrelly S, Gabbay M, TARRIER N, Addington-Hall J. Randomised controlled trial of non-directive counselling, cognitive-behaviour therapy, and usual general practitioner care for patients with depression. I: clinical effectiveness. BMJ. 2000 Dec 2;321(7273):1383-8. <PubMed> <FullText>

In a randomized control trial, Ward et al. (2000) compared the effectiveness of general practitioner care and two psychological therapies (nondirective counselling and cognitive behaviour therapy) available for patients with depression in primary care. The authors report on clinical-effectiveness outcomes, and Bower et al. (2000) report on cost-effectiveness. Measures were taken at baseline, four and 12 months. All groups improved significantly over time. At four months, persons in the two therapy groups had significantly higher scores on the Beck Depression Inventory than those in usual care, but there

were differences between the therapy groups. No significant differences were found between any of the groups at 12 months. The effects of counselling were evident only over the short-term.

Washington County Mental Health Council. Guiding principles for integration: mental health and primary health care (Adopted December 5, 2002). Seattle, WA: The Council; 2002. Available from: <http://www.nccbh.org/html/learn/PCI/role2.pdf> OR <http://www.wcmhcnet.org/StaticContent/1/Resources/WCMHCGuidingPrinciples.htm>

The Washington County Mental Health Council adopted integration principles in 2002 to steer the development of collaborative programs. Guiding principles for integration: mental health and primary health care presents a rationale for the guidelines, along with suggestions for ways in which these principles may be used. The guidelines identify a number of the dimensions of collaborative care; for example, the ways in which integration can be accomplished (through clinical, structural or financial avenues), desired outcomes, best practices, working with existing community resources, consumer and family involvement, levels of care, and need for clear definitions.

Waters DB. No one can do it alone anymore: information mastery, collaborative care, and the future of family medicine. Families, Systems & Health. 2003 Winter;21(4):339-46.

Waters (2003) presents the engaging thesis that collaborative care is the behavioural-science equivalent of information mastery, a version of the evidence-based medicine used in primary care. This comparative discussion highlights the many advantages of collaborative mental health for primary care: for example, dealing with the anxiety of not knowing, making practitioners more comfortable with mental health issues, changing the nature of the patient visit in positive ways, providing ongoing learning as doctors interact with mental health professionals, replacing frustration and boredom with a sense of possibility and interest when dealing with

patients' often masked mental health issues, and improving the use of referrals to other specialists. Waters also discusses how the benefits of collaborative care can be extended to people who do not have access to such programs:

- ∞ The use of information mastery and collaborative care in training sites should be encouraged to enhance future practitioners' learning. This would expose them to optimal practice that may influence actual care.
- ∞ Medical education needs to embrace change and improvement to propel the profession forward, prompt new ways of thinking and inspire improved ways of practising.
- ∞ Also required is acknowledgement that collaboration and support are the way of the future, and that family medicine is ideally situated to further develop this model of care.

Wilson I, Howell C. Small group peer support for GPs treating mental health problems. Aust Fam Physician. 2004 May;33(5):362-4. <PubMed> <FullText> OR <FullText>

Wilson and Howell (2004) argue for the use of small-group peer support for general practitioners treating mental health problems. Although no specific model was found for the provision of peer support, commonly referred to as supervision in the literature, a number of activities have been tried, including Balint groups, small-group educational activities and teleconferencing. Peer support is thought to allow valuable feedback and sharing among group members with a range of life experiences. As part of the Better Outcomes in Mental Health Care initiative in Australia, the authors established a training program for peer-group facilitators working with groups of general practitioners. In a pilot test, the training manual was modified so that facilitators would have the skills to support small-group learning and the ability to manage personalities within a group, national and state privacy principles applied to group educational activities were reviewed, and the manual was published so that others may use it. The pilot project did result in the establishment

of a number of peer-support groups in South Australia.

Wright NM, Tompkins CN, Oldham NS, Kay DJ. Homelessness and health: what can be done in general practice? J R Soc Med. 2004 Apr;97(4):170-3. <PubMed>

In their overview of the common health issues facing people who are homeless, Wright et al. (2004) present best-practice principles for responses within primary care. They examine problems with drugs, alcohol and mental health, and the opportunity for health promotion. They argue for a "specialized primary care practice" for the homeless group in larger urban centres that would be supported by a dedicated general practice liaison or resettlement worker. This person would assist people with the necessary transitions as they are transferred to a mainstream practice. For those areas with less concentrated numbers of homeless people, the authors propose enhanced mainstream primary care services that use collaborative approaches.

Yeung A, Kung WW, Chung H, Rubenstein G, Roffi P, Mischoulon D, Fava M. Integrating psychiatry and primary care improves acceptability to mental health services among Chinese Americans. Gen Hosp Psychiatry. 2004 Jul-Aug;26(4):256-60. <PubMed>

Yeung et al. (2004) report on the replication of the Bridge Project, a program to enhance collaboration between primary care and mental health services for Chinese Americans in New York City, for Chinese people in Boston. The aim of this collaborative primary care mental health program was to increase referrals for treatment and engagement in treatment within a community health program. There were four elements to the project: training for the general practitioners about common mental health problems to improve their recognition of problems, cultural sensitivity training for the doctors and nurses, assignment of a nurse to act as the bridge worker between primary and behavioural care to overcome any structural barriers, and location of

a liaison psychiatrist in the primary care clinic to provide on-site evaluation and treatment. Overall, these efforts were successful, as was evident from the increased volume of referrals and successful engagement of participants with treatment during the project.

Zeiss AM, Thompson DG. Providing interdisciplinary geriatric team care: what does it really take? *Clinical Psychology: Science and Practice*. 2003 Spring;10(1):115-119.

<Abstract>

Zeiss and Thompson (2003) highlight the role of the psychologist in the delivery of interdisciplinary team-based programs of geriatric care. They provide a good discussion of the elements required for effective teamwork, and contrast multi-disciplinary and interdisciplinary approaches. Their list of basic skills required for psychologists to work as part of an interdisciplinary team is insightful.

Zillich AJ, McDonough RP, Carter BL, Doucette WR. Influential characteristics of physician/pharmacist collaborative relationships. *Ann Pharmacother*. 2004 May;38(5):764-70. Epub 2004 Mar 18. <PubMed>

Zillich et al. (2004) introduce an innovative theoretical model of physician-pharmacist collaborative relationships, based on three groups of relationship characteristics: participant (demographics), context (the practice environment and professional interactions between the physicians and pharmacists) and exchange (the nature of social exchange). The model was tested by means of a questionnaire distributed to a random sample of 1000 primary care physicians in Iowa. The questionnaire, called the Physician/Pharmacist Collaboration Instrument, included the elements of the model and five questions about the physician's collaborative practice with pharmacists. A total of 334 usable questionnaires were returned. Significant predictors in the model were being an internal medicine physician, having professional interactions with a pharmacist and three relationship drivers, defined as role specification, trustworthiness and relationship initiation. Knowing these factors may be useful to

the future involvement of pharmacists in primary care.

Zygowicz KM, Saunders SM. A behavioral health screening measure for use with young adults in primary care settings. *Journal of Clinical Psychology in Medical Settings*. 2003 Jun;10(2):71-7. <Abstract>

Zygowicz and Saunders (2003) evaluated the use of a behavioural health screening measure for young adults in primary care settings. In response to calls for routine mental health assessment of young adults seen in primary care, a self-assessment tool was developed and tested in two studies that examined its utility and effectiveness. The first study was designed to determine the cut-off score for the instrument. This cut-off score was then used in the second study to divide a sample of young adults into two groups, those with and those without a mental illness. Analyses showed that the two groups differed on measures of depression, anxiety and general well-being. The instrument was deemed suitable for use in primary care settings where screening tools need to be easy to administer and quick to complete in a variety of settings. Such tools should minimize disruption to routine clinical practice and yield results that are easy to calculate and interpret.

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