Canadian Collaborative Mental Health Initiative

Initiative canadienne de collaboration en santé mentale

Collaborative Mental Health Care in Primary Health Care: A Review of Canadian Initiatives

Volume I
Analysis of Initiatives

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Canadian Collaborative Mental Health Initiative
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Collaborative Mental Health Care in Primary Health Care: A Review of Canadian Initiatives

Volume I
Analysis of Initiatives

A paper for the
Canadian Collaborative Mental Health Initiative
(Volume I of II)

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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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PREFACE

The current document is **Volume I** of ***Collaborative Mental Health Care in Primary Health Care: A Review of Canadian Initiatives***, a report that supports providers, planners, educators and policy-makers in developing and enhancing collaborative mental health care activities in primary health care.[1]

This document

- **Volume I: Analysis of Initiatives** identifies key themes and trends of collaborative mental health care as they emerged from an analysis of 89 collaborative mental health care initiatives in Canada and links these observations to previous research and best practices.

- **Volume II: Resource Guide** provides a two-page description for 91 Canadian collaborative mental health care initiatives.[2] Each initiative description includes information about funding, sponsoring organization(s), purpose, goals/objectives, collaborative disciplines/ resources, characteristics unique to the local community, barriers, strategies and contact information. These descriptions give readers concrete examples of the inner workings of collaborative initiatives in primary health care and provide them with creative ideas about how to participate in the future of collaborative mental health care in Canada. Volume II also offers complete contact information for individuals involved in collaborative mental health care initiatives.

1 This report builds upon and expands the document created by The College of Family Physicians of Canada and the Canadian Psychiatric Association Shared Mental Health Care in Canada: A Compendium of Current Projects, published in Spring 2002, (Kates and Ackerman, 2002). Available at: http://www.shared-care.ca/pdf/compendium.pdf

2 For a more detailed discussion, refer to Collaborative Mental Health Care in Primary Health Care: A Review of Canadian Initiatives, Volume II: Resource Guide (Pauzé and Gagné, 2005), a report prepared for the CCMHI. Available at: http://www.ccmhi.ca

EXECUTIVE SUMMARY

Throughout the world, the burden of mental illness is high. In fact, according to the World Health Organization (WHO, 2001), mental and behavioural disorders were estimated to account for 12 per cent of the global burden of disease. A 2000 study by Jenkins and Strathdee and a 2004 report by Thornicroft and Tansella found that the greatest opportunity to address the needs of consumers with common mental illnesses resides within primary health care. If mental health care is to be made more accessible, primary and mental health care providers, consumers, families, caregivers, policy-makers, governments and other key stakeholders must re-examine the ways in which mental health care services are provided. Collaborative mental health care is one way of improving mental health promotion and prevention, enhancing access to early detection of illness, and making sure that treatment and recovery from mental illness is an integral part of primary health care.

The Canadian Collaborative Mental Health Initiative (CCMHI) focuses on research and the implementation of collaborative mental health care. Funded through Health Canada's Primary Health Care Transition Fund, the CCMHI is comprised of 12 national organizations that, for the first time, have come together to demonstrate their commitment to addressing the mental health needs of Canadians by:

- Conducting an analysis of the current state of collaborative mental health care;
- Developing toolkits to aid in the implementation of collaborative initiatives; and
- Creating a national charter for collaborative mental health care.

Making mental health care work: New partners New places New hope!

Twelve reports have been commissioned to capture a snapshot of the current issues and trends in collaborative mental health care. A goal of the CCMHI Steering Committee was to provide an accurate baseline of the current state of collaborative care to inform a series of implementation toolkits[3] and a charter that promotes the development of collaborative mental health care in a direction that is consistent with the shared views of CCMHI Steering Committee members.[4]

3 The CCMHI developed a total of 12 toolkits. This includes one general implementation toolkit and eight specialized toolkits for practitioners that tailored to the following populations: geriatric, child and adolescent, ethnocultural, severely mentally ill, rural and isolated, urban and marginalized, substance-use disorders, and Aboriginal. A consumer, family and caregiver toolkit provides practical information for consumers and their families/caregivers about their role in a collaborative mental health care team; an additional toolkit has been developed specifically for First Nations consumers, families and caregivers. The final resource, an education toolkit, was developed to strengthen collaborative care through interprofessional education.

4 The CCMHI developed a Charter for collaborative mental health care. This Charter has two vital components: a set of Principles that create the vision for collaborative care in Canada and a set of Commitments that are actions for all key health care partners working together to enact the Principles. For more information visit: http://www.ccmhi.ca

The document, ***Collaborative Mental Health Care in Primary Health Care: A Review of Canadian Initiatives***, was commissioned to provide a comprehensive analysis of current initiatives. These findings will also provide a foundation for toolkits which are being developed to support the implementation phase and future initiatives. In addition to describing 91 collaborative mental health care initiatives, this report gives an analysis of the findings and a rich discussion of the current collaborative mental health care initiatives in Canada. It is divided into two volumes: ***Volume I: Analysis of Initiatives*** and ***Volume II: Resource Guide***.

This report, ***Volume I: Analysis of Initiatives***, provides a comprehensive analysis of current collaborative mental health care initiatives. This discussion of trends of collaborative mental health care in Canada is based on the analysis of 89 initiatives identified between July 2004 and July 2005.

Key Findings

- Macro-level issues related to policy, legislation, funding regulations and funds are vital to the enhancement of collaborative mental health care practices. A concerted effort must be made to ensure that these fundamentals (macro-level influences) continue to support collaborative activities.
- The most prominent barrier reported by the initiatives relates to funding and remuneration, followed by those related to collaborative structures and systems, and buy-in and human resources, respectively.
- The most prominent solution suggested as a way to overcome the challenges reported by these initiatives relates to collaborative structures, followed by suggestions for further team and skill development, and advocacy, respectively.
- A total 79.8 per cent of initiatives are conducting or have completed some form of service or program evaluation of their collaborative activities. Their evaluations often measure provider/consumer satisfaction, quality of life and various consumer outcomes.
- Most initiatives use a combination of direct and indirect approaches to providing their services (68.5 per cent). Many are looking for strategies that increase consumer access to mental health care specialists. In addition, a number of initiatives aim to enhance the capacity of primary health care providers to confidently manage complex mental health illnesses.
- Most commonly, the providers who are part of the collaborative team include family physicians (94.4 per cent), psychiatrists (84.3 per cent), nurses (62.9 per cent — an additional 27 per cent were registered psychiatric nurses or mental health nurses) and/or social workers (62.9 per cent). However, there is a trend toward including a broader range of primary and mental health care providers, consumers, families and caregivers.
- Involving consumers in all aspects of their care is an important trend that is increasingly recognized and supported by collaborative initiatives. The knowledge and expertise of consumers should not be overlooked during the development, implementation or evaluation stages of collaborative activities.

Conclusion

There are many exciting ways in which health care partners from across Canada are working to improve the delivery of mental health care. Evidence suggests that collaborative activities are gaining momentum, but these efforts must be supported through congruent policies, legislation and funding regulations, if collaborative mental health care initiatives are to continue to grow successfully in primary health care settings. In addition, research, service and program evaluations are the key to identifying and implementing better practices. Collaborative initiatives must consciously enhance the involvement of consumers, families and caregivers in the development, implementation and evaluation of programs. If these goals can be achieved, the integration of mental health care into primary health care settings will be more successful in meeting the needs of each community and, ultimately, improving the mental health and well-being of all Canadians.

INTRODUCTION

Mental illness affects all Canadians: studies have estimated that nearly one in five adults will personally experience a mental illness during a one-year period (Offord et al., 1996; Bland et al., 1988). Even if a person does not have a mental illness, he or she is likely to know a family member, friend, or colleague who does (Health Canada, 2002). Considered a worldwide phenomenon (WHO, 2005), no one is immune to mental illness; it affects people of all ages, cultures, educational, and income levels (Health Canada, 2002). Mental or behavioural disorders represent four of the ten leading causes of disability around the globe (WHO, 2001). The economic costs of mental illness to the national economy are profound, with an estimated $14.4 billion in lost productivity and health care costs (Stephens & Joubert, 2001).

Data from the Canadian Community Health Survey (CHS) Cycle 1.2, on Mental Health and Well-Being, which was conducted in 2002, revealed that, overall in Canada, only 61 per cent of individuals who had a self-reported mental disorder or dependency[5] in their lifetime had consulted a professional for their mental health during their lifetime. Analyses on whether individuals with mental health disorders or dependencies had consulted a professional were broken down into specific health care providers. Family physicians were consulted most frequently (Lesage et al. 2005). This data is consistent with the findings from other developed countries with modern mental health services that suggests that many people seek help first, and perhaps only, from primary health care providers for common mental disorders (Barrett et al., 1988; Blount, 1998); those with more serious mental illness are seen within mental health services.

Interest in collaborative care in primary health care is growing internationally, and is gathering increased support. WHO promotes the treatment of common mental disorders such as depression in primary health care (2003). Jenkins and Strathdee (2000), Saxena et al. (2002), and Thornicroft and Tansella (2004) note that primary health care is the logical site for meeting most (or even all) mental health care needs, particularly in countries that have a low level of resources available. Even richly resourced countries like Canada, with a wider range of specialized mental health care programs, demand treatment of common mental disorders through primary health care settings (Jenkins and Strathdee, 2000). Blount (1998) and Lester, Glasby and Tylee (2004) present convincing arguments that the integration of health and mental health care in primary health care settings is the best option because:

1. Primary health care settings are the predominant locus of treatment for problems that are clearly psychological or psychiatric in nature, such as depression and anxiety.
2. Consumers are more satisfied with their physical and mental health care being integrated in the primary health care setting.
3. Primary health care is a better fit with the typical way a majority of consumers present their undifferentiated mental health problems.

5 Major depressive episode, manic episode, panic disorder, agoraphobia, social phobia, alcohol and drug dependence, gambling, suicide, distress, and eating trouble.

4. With this better fit, there is better adherence by consumers to treatment regimes and, ultimately, better health outcomes.
5. The range of mental health needs that appear in primary health care settings exceeds the capacity and skills of even well-trained primary care physicians, and referral out is a poor alternative. A team approach is also the best way to improve the skills of primary care providers in dealing with the psycho-social aspects of care.
6. Job satisfaction for primary care providers working in integrated settings is enhanced.
7. Over the long term, collaborative care appears to be a break-even or cost-saving approach.

The goal of the CCMHI is to promote and improve access to collaborative mental health care. Collaboration and access to care will help to enhance mental health promotion, illness prevention, reduce the burden of illness, and improve health outcomes and recovery. This document contributes to this goal by examining existing collaborative mental health care initiatives in Canada, discussing trends and linking this information to the evidence — in essence, creating a resource to inform this growing field and assist us in the development of toolkits for practitioners, educators, learners, and consumers, families and caregivers.

The first section of this report reviews the methods employed to identify and gather information on nearly 90 collaborative mental health care initiatives, including key barriers and strategies used by respondents to address these barriers. Six sections based on the framework follow a brief description of the Collaborative Mental Health Care Framework (Gagné, 2005), a conceptual framework employed to frame the discussion. Each section discusses the research findings and trends of collaborative mental health care initiatives in Canada. The first two sections, grouped under "fundamentals," review the macro-level implications of policies, legislation, funding regulations, funds and community resources on collaborative mental health care. The next four sections review trends at the implementation level (that is, accessibility, structures, collaboration and consumer centredness) and relate key findings to previous research and best practices.

METHODOLOGY

The goal of the data collection was to identify a broad cross-section of the collaborative mental health care initiatives that currently exist across Canada. **Participants** in the study were the contacts (e.g., managers, directors, coordinators or other contacts) for collaborative mental health care initiatives. The data (initiative descriptions) were gathered between July 2004 and July 2005 and included three major steps.

Procedure

The qualitative research technique of 'snowball' sampling was used to gather the data. This procedure has been used to reach populations that are difficult to access, using non-random data collection whereby an initial group of participants is asked to make referrals in order to generate additional participants (Henry, 1990).

During *step one*, selected key informants were requested via e-mail, phone and/or mail (in both English and French) to identify key contacts for Canadian collaborative mental health initiatives. Key informants included known experts in collaborative mental health care, experts in mental and primary health care, government representatives and associate members of the 12 CCMHI steering committee organizations. Approximately 850 key informants were initially contacted.

During *step two*, a survey was used to gather the data (i.e., initiative descriptions). This survey was e-mailed and/or mailed to contacts listed in the document, *Shared Mental Health Care in Canada: A Compendium of Current Projects* (Kates and Ackerman, 2002), and new contacts identified by the key informants. This survey was available in English and French. Due to an initial low response rate and feedback from participants suggesting that the survey was too lengthy, the survey was condensed into a letter requesting the same information (revised information request letter). The revised letter was re-sent to key contacts who had not yet responded to the initial surveys. Phone interviews and e-mails were also used to collect missing pieces of information. A total of 57 initiative contacts completed phone interviews.

Measures

The following documents were used to collect the data (copies of the documents are included in Appendix A):

1. Key informant letter
2. Contact letter
3. Survey
4. Revised information request letter
5. Phone interview guide
6. Consent form

During *step three*, a screening process separated the initiatives that would from those that would not be included in the data analysis for Volume I. All collaborative initiatives that involved both primary and mental health care providers and which offered mental health care services to consumers in a primary care setting were included. Those that did not directly provide mental health services to consumers (e.g., educational initiatives, guides, manuals) were excluded.[6] In addition, completed programs/projects and international collaborative mental health care initiatives were not included in the analysis. Of the total 147 potential collaborative initiatives identified during the data analysis period, 37 initiatives did not meet inclusion criteria.

A total of 110 collaborative initiatives met the inclusion criteria, but only 89 completed a survey or phone interview prior to the deadline for submission and were included in the data analyses. A total of 91 initiatives provided written consent to include their completed initiative descriptions in Volume II. An additional five individuals representing collaborative initiatives gave consent by e-mail to include their contact information, but did not provide a completed description for Volume II. Reasons that these individuals were unable to provide a completed description and/or signed consent included the following:

- Lack of time to complete the description;
- The initiative was in a very early planning stage;
- Contacts were unable to get signed consent from board/committee members or directors;
- The contact did not feel comfortable providing a description at the time.

Each initiative description included the following information:

- Sources of funding;
- Sponsoring organizations or individuals;
- Rationale, goals and objectives;
- The approach used to deliver mental health care;
- Service or program evaluation information;
- Health care partners involved on the collaborative team;
- Where the services are provided;
- Special populations primarily served by the initiative;
- Unique characteristics of the initiative's local community;
- Barriers and solutions to implementing and sustaining the initiative; and
- Contact information.

A two-page description of each of the 91 initiative, their contact information and descriptive statistics can be found in Volume II.

6 For a more detailed discussion of educational initiatives and interprofessional education issues, refer to Interprofessional Education Initiatives in Collaborative Mental Health Care (McVicar et al., 2005), a report prepared for the CCMHI. Available at: http://www.ccmhi.ca

Limitations

The methodology used to collect the data had a few limitations. First, although the 'snowball' technique is a widely used and acceptable method for qualitative data collection, its non-randomized nature makes it difficult to generalize the results to the greater population. In addition, the success of this technique is also dependent upon how representative the initial key informants are. Although an attempt was made to identify appropriate key informants, the collaborative initiatives which were ultimately identified during the data collection may not be completely representative of all of the existing collaborative initiatives from across Canada.

Second, due to an initial low response rate and feedback from participants who suggested that the survey used to collect the data was too long, the survey was condensed into a letter requesting the same information. The revised letter was re-sent to the key contacts that had not yet responded to the initial surveys. This change in methodology resulted in the initiative contacts failing to report all of the required information. Ultimately, the change made it challenging to compare each initiative across all variables that were initially requested. As a result, the analysis of the trends of collaborative mental health care is based only on information that was consistently provided by the majority of initiatives. The analysis is not as comprehensive as was initially intended prior to the change in methodology.

Important Note:

The degree to which participants collaborate varies greatly.

Finally, the initiative contacts were allowed to self-identify their collaborative activities. A select few of the initiatives included in the analysis do not offer the majority of their collaborative services within a primary health care context. For example, some of the initiatives provide the majority of their services at the secondary or tertiary care levels, although they may connect with or offer some services at the primary health care level. In addition, the degree to which collaboration between mental and primary health care providers occurs appears to exist on a continuum whereby some initiatives provide collaborative services to a great extent and on a consistent basis, while others do not.

Blount (2003) developed a method of categorizing and describing primary health care programs. Blount identified two dimensions — initiatives exist along these two continuums:

- *types of care*: coordinating, co-located, integrated; and,
- *relationships of services provided to populations served*: targeted versus untargeted, specific versus unspecified care, small versus large scope of implementation.[7]

The initiatives described in this report, were not categorized along any continuum. Contacts were allowed to self-identify and define their work as collaborative. The range of approaches described therein, is indicative of the growth in this field, the lack of consistent terminology, and of a fragmented system — where many will define collaboration as any interdisciplinary interactions.

7 For more detailed discussion on Blount model, refer to Blount (2003) or Pautler K, Gagné MA. Annotated bibliography of collaborative mental health care. Report prepared for the Canadian Collaborative Mental Health Initiative, Mississauga, Ontario, Canada; September 2005. Available at: http://www.ccmhi.ca

Analysis

The analysis of the data was guided by 15 questions. For some of the questions, the Collaborative Mental Health Care Framework (Gagné, 2005) was used as a guide to code the data. Simple descriptive statistics were calculated from the quantitative and qualitative data.

Based on the information collected from the initiative descriptions, the following questions guided the analysis:

1. How many initiatives were identified in each province and territory?
2. From where do collaborative initiatives receive their funding?
3. Where are the services provided?
4. What are the service volumes?
5. What approach is used by the initiatives to deliver their services?
6. Who are the non-health care professionals that support the collaborative team?
7. Who are the health care professionals that support the collaborative team?
8. Which provider(s) assume(s) responsibility or liability for consumer care?
9. What special populations are served by the collaborative initiatives?
10. What are the common methods used for knowledge exchange?
11. How many collaborative initiatives are conducting evaluations?
12. How many of the collaborative initiatives report using information technologies to support their activities?
13. How many short-term and long-term collaborative initiatives have been identified?
14. What are the common barriers or challenges reported by the collaborative initiatives?
15. What are the common strategies or solutions that the collaborative initiatives use to address the challenges they face?

DESCRIPTIVE STATISTICS

The purpose of this section is to report the descriptive statistics for 89 collaborative mental health initiatives. These statistics guide and provide support for the discussion section in order to provide readers with a meaningful overview of ***what Canadian collaborative mental health care initiatives look like.***

1. **How many initiatives were identified in each province and territory?**

Every attempt was made to identify a broad cross-section of collaborative care initiatives in each of Canada's provinces and territories within the data collection period. It is important to note that the initiatives in this report are not exhaustive in scope. Collaborative initiatives are constantly emerging from newly forged relationships. Figure 1 provides a map of Canada, indicating the representation of the initiatives; this information is also summarized in Table 1.

figure 1: Geographical Representation of the 89 Canadian Initiatives included in the Analysis

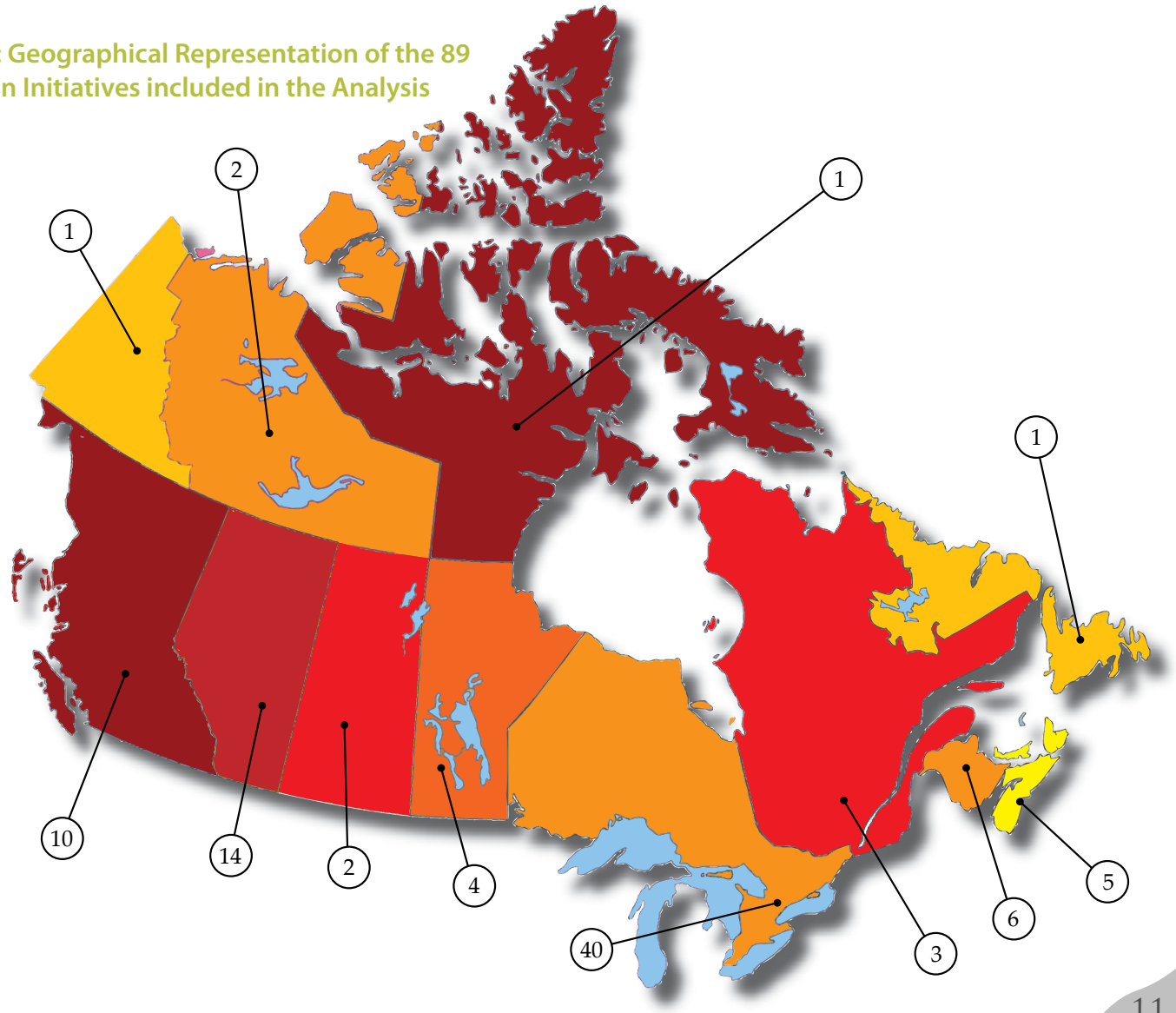


table 1 **Summary of the Regional Representation of Canadian Initiatives**

Region of Canada	Province/Territory	Number of Initiatives that Met the Inclusion Criteria	Number of Initiatives Included in the Analysis
Pacific	British Columbia (BC)	12	10**
Western	Alberta (AB)	18	14
	Saskatchewan (SK)	2	2
	Manitoba (MB)*	3	4**
Central	Ontario (ON)*	49	40
	Quebec (QC)	4	3
Eastern	New Brunswick (NB)	6	6
	Prince Edward Island (PE)	1	0
	Nova Scotia (NS)	5	5
	Newfoundland and Labrador (NL)	1	1
Northern	Yukon (YT)	2	1
	Northwest Territories (NT)	2	2
	Nunavut (NU)	5	1
	TOTAL	110	89

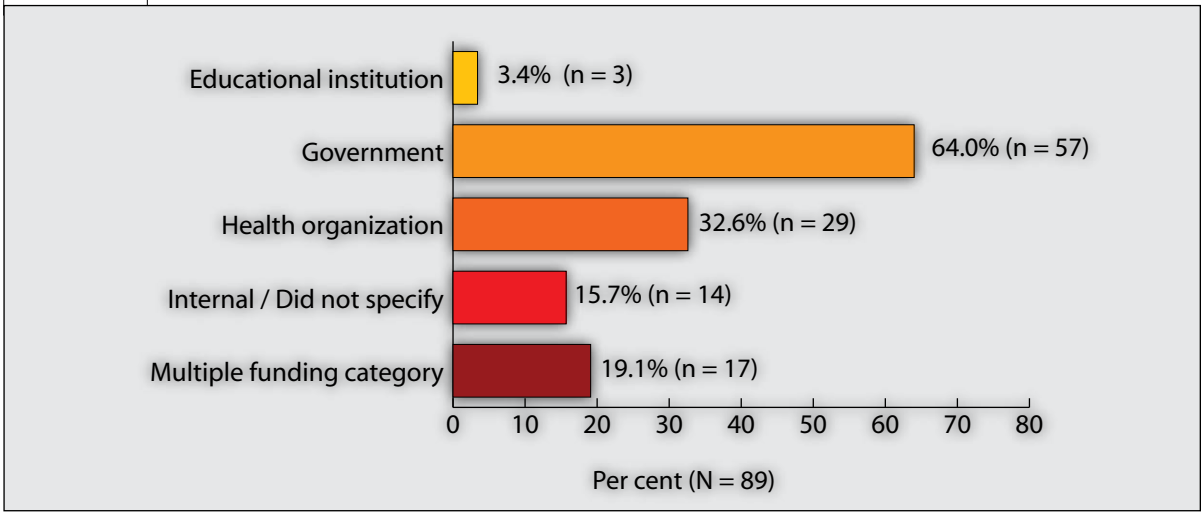
* *Note: Two initiatives (one in MB and another in ON) only provided consent to include their data in the overall analysis and not in Appendix D: Descriptions.*

** *Note: There are two initiatives that provide services to more than one province or territory. One initiative provides services to parts of BC and YT; the initiative is listed under BC. In the second initiative, services are provided by clinicians from MB to parts of NU; the initiative is listed under MB.*

2. From where do collaborative initiatives receive their funding?

A majority of the initiatives received funding from government (Figure 2). Of the initiatives, 19.1 per cent received funding from more than one funding category. Some initiatives received funding from multiple sources within the same funding category. For example, it was possible for an initiative to receive funding from a provincial government and the federal government.

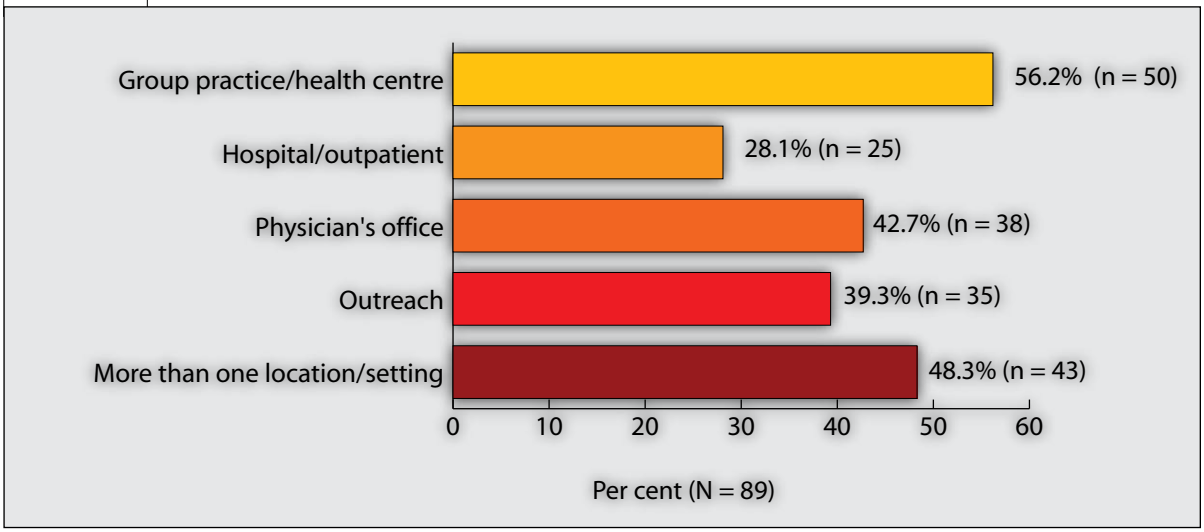
figure 2 **Sources of Funding in Per cent**



3. Where are the services provided?

Participants were requested to indicate the service delivery site(s) (location or setting) where their mental health services are provided (Figure 3). They were asked to note the number and type of site(s). The locations/settings were coded according to group practice/health centre, hospital/outpatient, physician office, or type of outreach. Some examples of the outreach sites included the following: school, home, workplace, shelter, long-term care facility and church. Of the initiatives, 48.3 per cent provided services in more than one type of setting. The majority of participants reported providing services in either group practice/health centre (56.2 per cent) or a physician's office (42.7 per cent). Due to incomplete information, the number of sites could not be analyzed for each type of location/setting.

figure 3 **Location/Setting of Services in Per cent**



4. What are the service volumes?

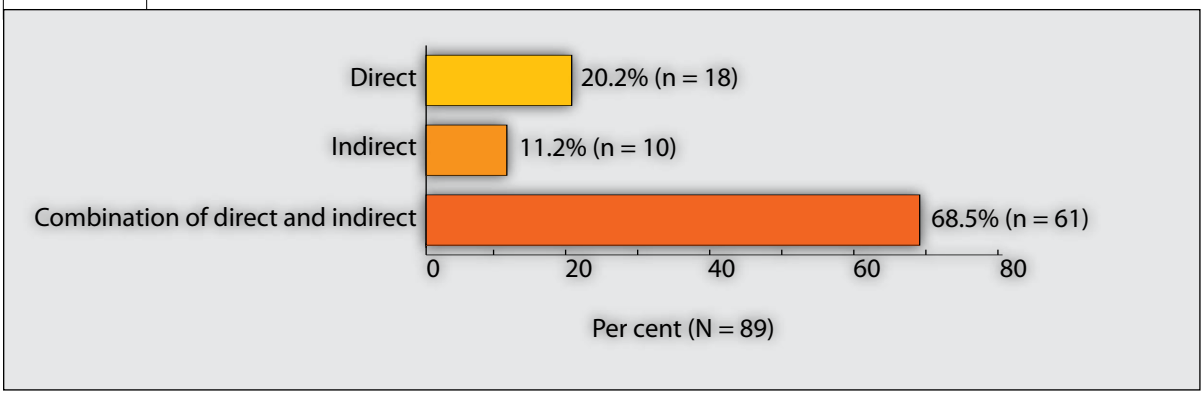
Participants were requested to report their service volumes according to the number of patient or client visits per month. Due to the inconsistencies in the way this information was reported, this analysis was not possible; that is, initiatives record service volumes differently. For example, information was reported on a monthly, biannual and/or annual basis. Some of the data came from completed program evaluations; however, some of the data were only rough estimations or 'best guesses'. Participants reported service volumes for the number of referrals received, and/or the number of patients/clients/consumers seen, and/or the number of follow-up visits that were given. These inconsistencies made it impossible to describe general trends regarding initiative sizes or the range of service volumes.

5. What approach is used by the initiatives to deliver their services?

This information was coded according to the key element of 'accessibility', as defined in the Collaborative Mental Health Care Framework (Gagné, 2005) (Figure 4). Initiatives were coded based on whether they used a:

- *direct approach* - mental health specialists offer their services to consumers in primary health care settings;
- *indirect approach* - a primary health care provider delivers mental health services to consumers while receiving consultative support from a mental health specialist (i.e., the mental health specialist provides indirect mental health care);
- *combination of indirect and direct approaches* - the majority of initiatives use a combination of direct and indirect approaches to providing their services (68.5 per cent).

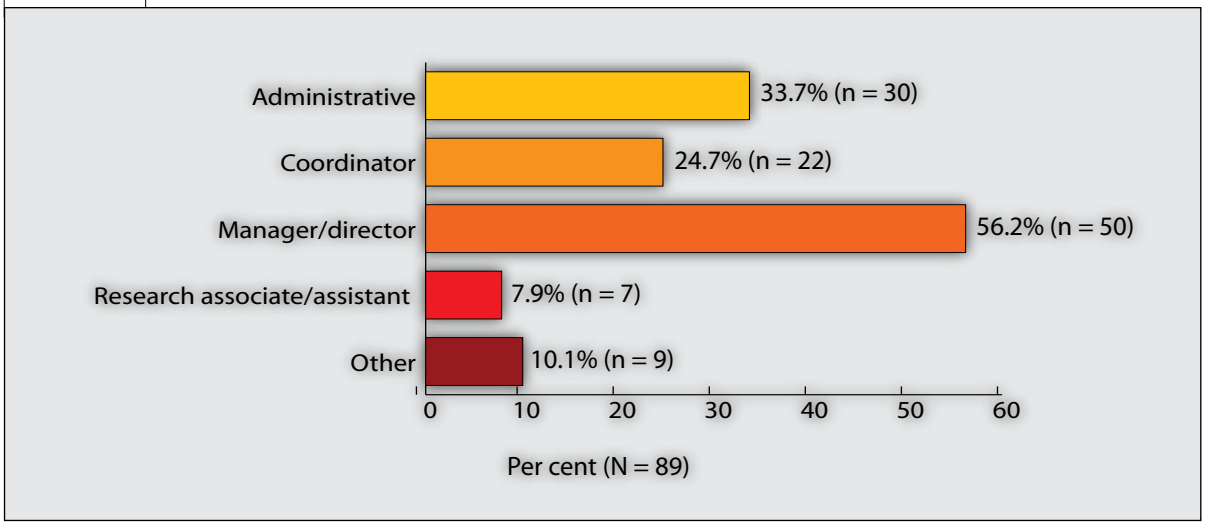
figure 4 **Approaches Used by the Collaborative Initiatives in Per cent**



6. Who are the non-health care professionals that support the collaborative team?

Non-health care professionals that support the collaborative team were grouped into the following categories (based on how the information was reported by the initiative contacts): administrative, coordinator, manager/director, research associate/assistant or other (Figure 5). Other human resources included: health promoter, educator, project evaluator, information technology specialist and policy analyst.

figure 5 **Non-Health Care Professionals that Support the Collaborative Team in Per cent**



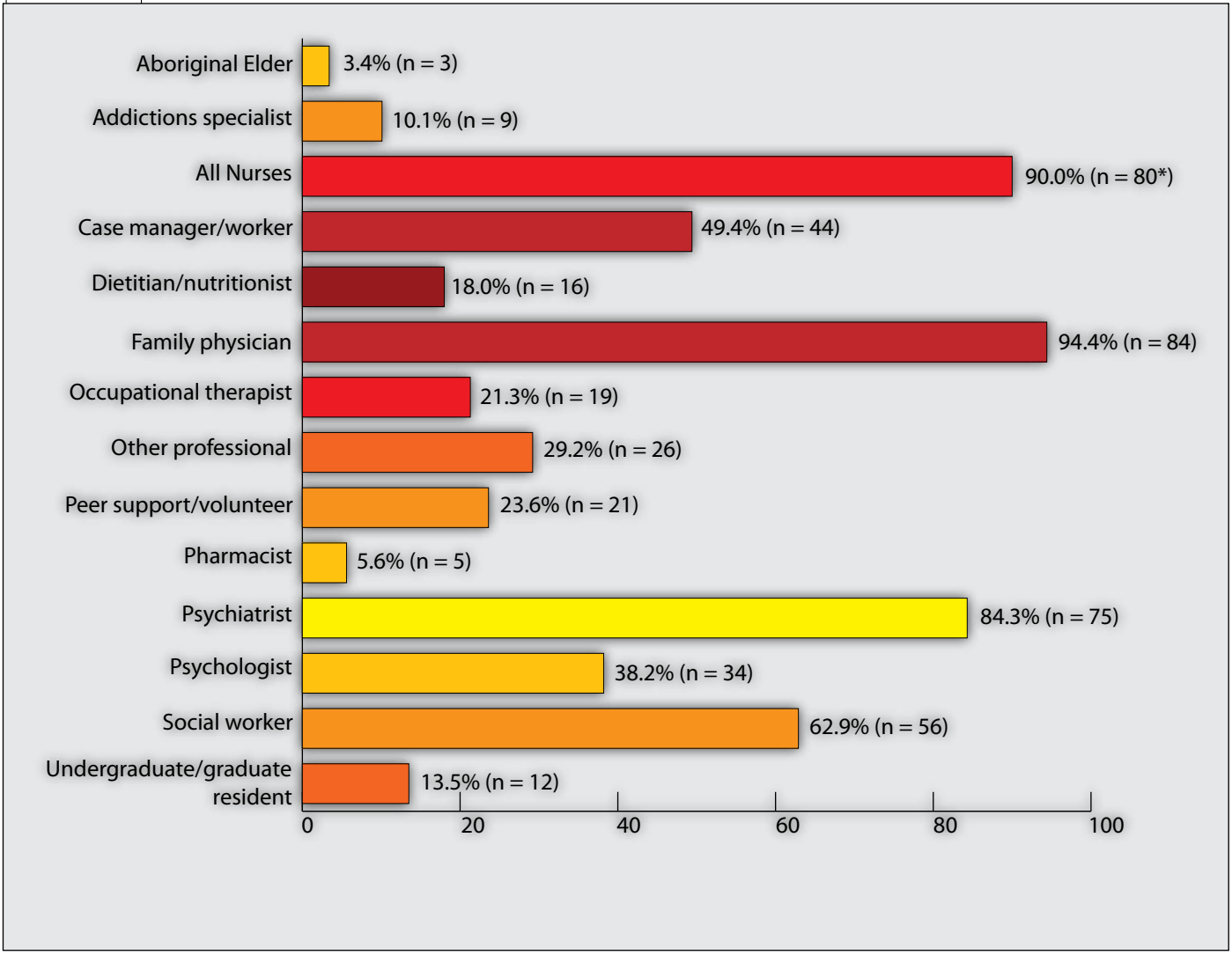
7. Who are the health care professionals that support the collaborative team?

Participants were asked to specify the type of service providers that are involved in their collaborative initiative (Figure 6a). These included: Aboriginal Elders, peer supports/volunteers, dietitians, family physicians, nurses (see Figure 6b for a complete list), occupational therapists, social workers, pharmacists, psychiatrists, psychologists or others. The list of providers for each initiative included those who were and those were not directly employed by the initiative. The categories for the providers were based upon the responses received. For example, several categories of nurses were developed to represent the range of responses. Examples of 'other professional' included: chiropodist, occupational health physician, psychometrist, psychotherapist, neuropsychologist, physiotherapist, speech language pathologist, recreational therapist and rehabilitation therapist.

In order to accurately summarize the different types of nurses reported by the participants, several categories were developed, including: nurse, primary care nurse, registered psychiatric nurse or mental health nurse, public health nurse, registered nurse, nurse-practitioner, licensed practical nurse, regional outreach nurse, and registered practical nurse. These categories are representative of the types of nurses indicated by the participants (see Figure 6b).

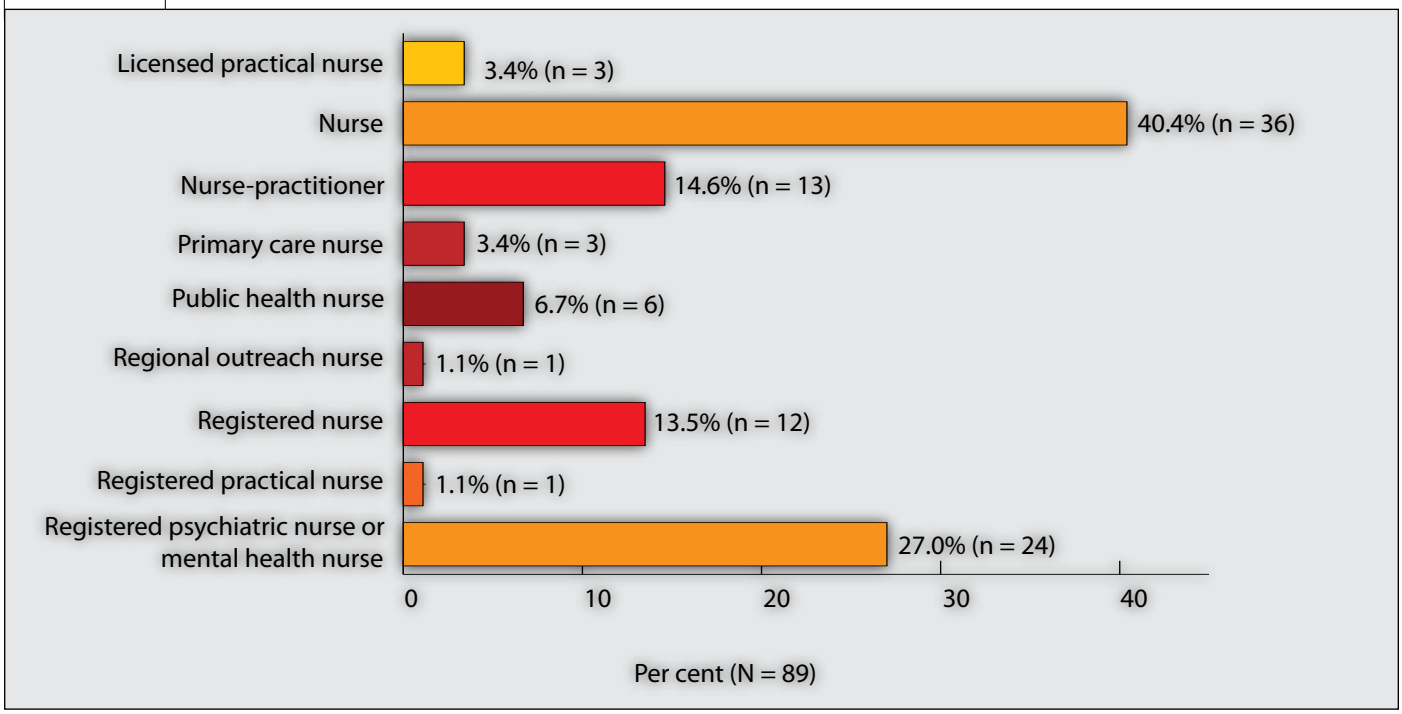
The most common providers listed included: family physicians, psychiatrists, nurses and social workers. Although the initiatives were requested to indicate FTEs (full-time equivalents) where possible, this information was inconsistently reported and was not included in the analyses.

figure 6a **Health Care Professionals that Support the Collaborative Team in Per cent**



* *Note: this number represents all categories of nurses combined. Refer to Figure 6b for a complete breakdown of the nursing categories reported by participants.*

figure 6b **Reported Nursing Categories in Per cent**



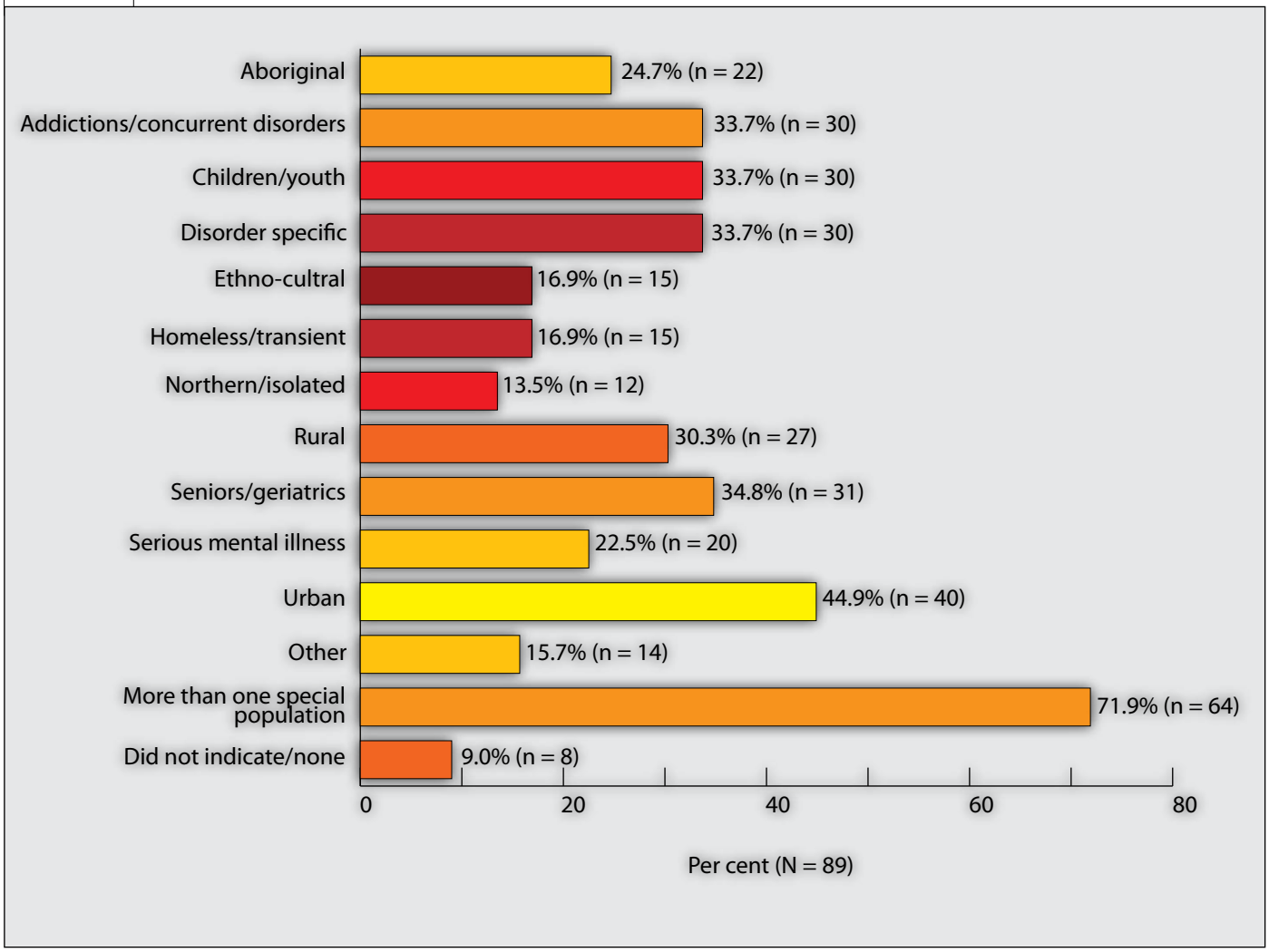
8. Which provider(s) assume(s) responsibility or liability for consumer care?

Participants were requested to indicate who was most responsible or liable for the care provided to the consumers; only 37 of the 89 initiatives provided this information. These participants indicated that responsibility/liability was either shared (22.5 per cent) or not shared (19.1 per cent); 58.4 per cent of the initiatives did not provide this information. When responsibility/liability was not shared, it was held by one of the following: family physician, primary care provider, psychiatrist, general practitioner, health centre or another unspecified practitioner.

9. What special populations are served by the collaborative initiatives?

Participants were requested to identify all of the special populations that they primarily serve. The following populations were identified: Aboriginal, addictions/concurrent disorders, children/youth, disorder-specific, ethno-cultural, homeless/transient, northern/isolated, rural, seniors/geriatrics, serious mental illness, urban and other (Figure 7). The most common special population served was urban (44.9 per cent) and 71.9 per cent of the initiatives serve more than one special population. Examples of 'other' populations included: pregnant women, families, people in crisis and persons with chronic illnesses.

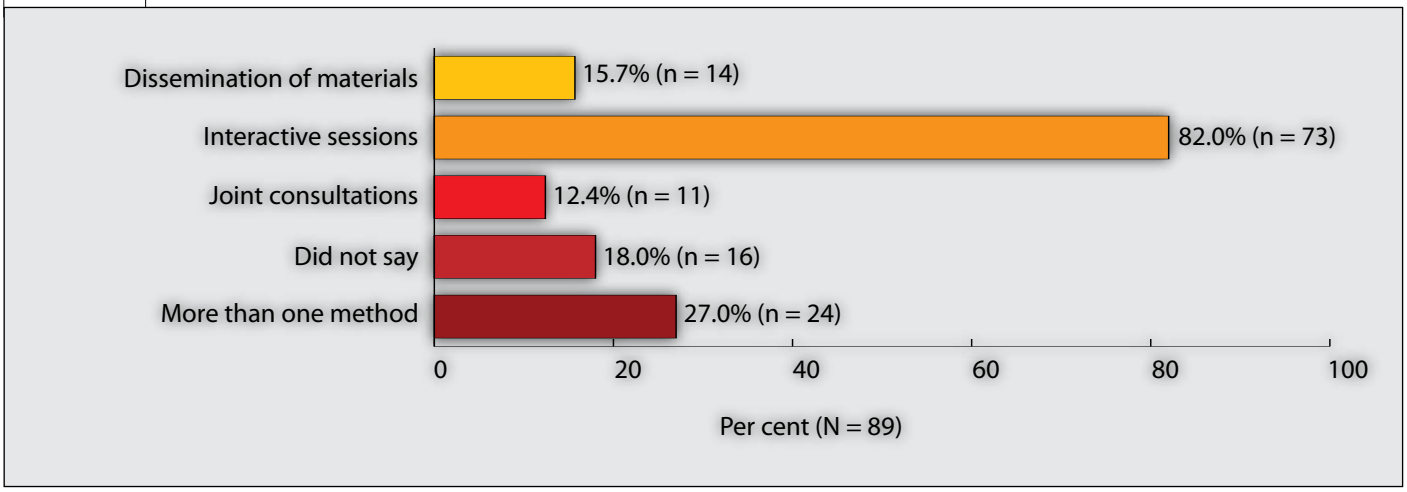
figure 7 **Per cent of Initiatives Serving Special Populations**



10. What are the common methods used for knowledge exchange?

The methods commonly used to facilitate knowledge exchange fell into one of three broad groups: dissemination of materials, interactive sessions or joint consultations (Figure 8). It should be noted that the initiatives were not requested to specifically provide this information. Therefore, it is possible that initiatives use a broader range of methods more often than was reported. The most common method involved interactive sessions, including: weekly/monthly meetings, informal case discussions, educational workshops, conferences, teleconferences or other; 18.0 per cent of the initiatives did not clearly report using any method.

figure 8 **Strategies Used for Knowledge Exchange in Per cent**



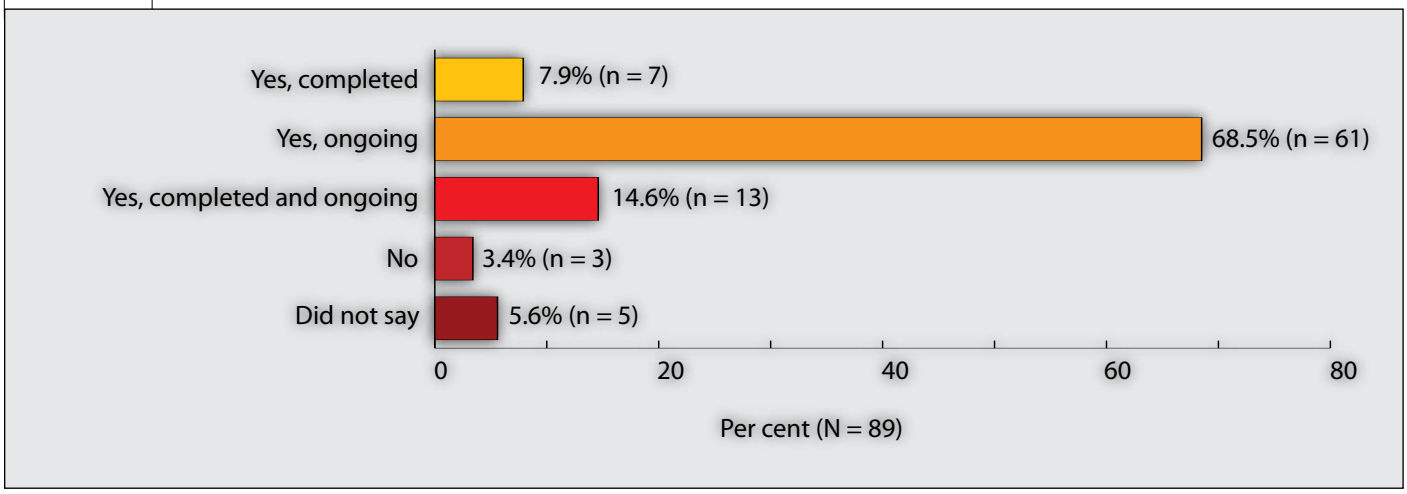
11. How many collaborative initiatives are conducting evaluations?

Participants were requested to identify if they: had completed a program or service evaluation, had not completed an evaluation, or were currently conducting an evaluation (Figure 9). Although the participants that had completed an evaluation were asked to identify what their top three key findings were, this information was not used in the current data analysis because it was inconsistently reported.

Refer to Appendix C for a preliminary examination of evaluation information prevoided by 16 collaborative mental health care initiatives.

In addition, participants were asked to submit any proposed evaluation strategies or completed evaluation results for analyses that were completed prior to January 2004. Researchers of the Continuous Enhancement of Quality Measurement (CEQM) primary care mental health project

figure 9 **Per cent of Initiatives Conducting Service or Program Evaluations**

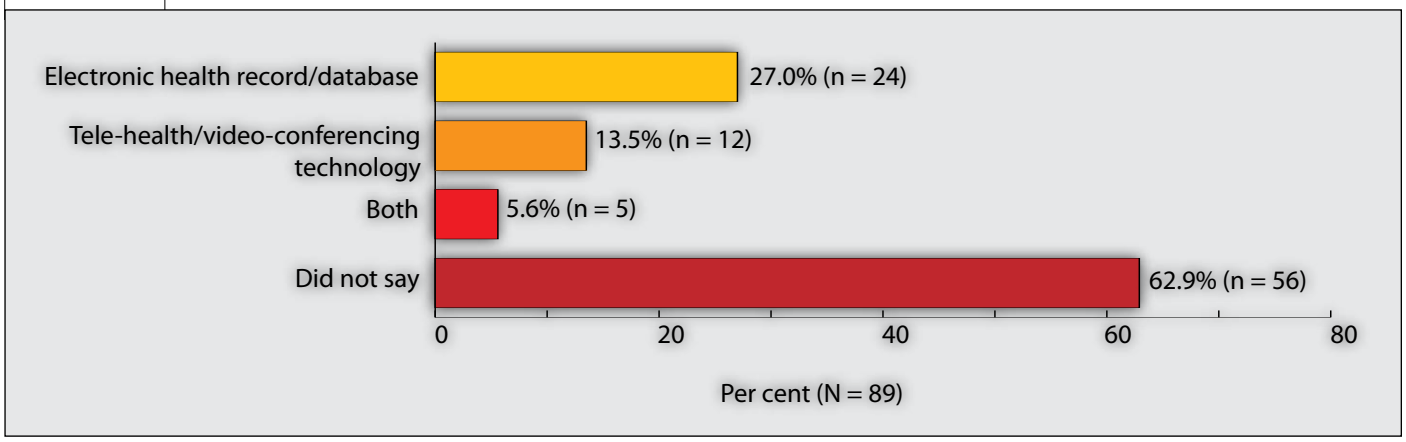


synthesized these data. The CEQM project is a sister project of the CCMHI initiative, from which the present research has sought advice. A total of 16 initiatives provided documentation. Key findings from this analysis are included in Appendix C.

12. How many of the collaborative initiatives report using information technologies to support their activities?

Participants were asked to indicate all of the technologies that were used to support the work of the initiative, including: tele-health, electronic health records, e-mail or other. See Figure 10 for information related to the use of electronic health records/databases and tele-health/ video-conferencing technology.

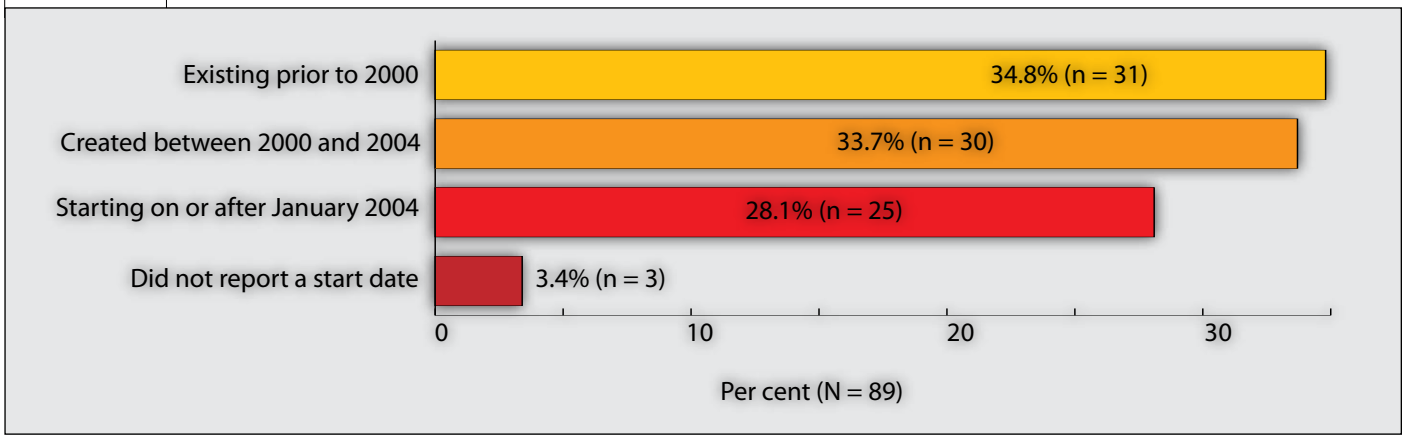
figure 10 **Use of Information Technologies to Support Communication in Per cent**



13. How many short-term and long-term collaborative initiatives have been identified?

This information was coded according to the start and end dates reported by the initiatives. Based on this information, a total of 18 participants reported a specific end date for their activities. Many of these programs are hoping to secure long-term/ongoing funding to sustain their activities. Ongoing initiatives were coded according to those that existed prior to the year 2000 (when the

figure 11 **Per cent of Long-Term Initiatives**

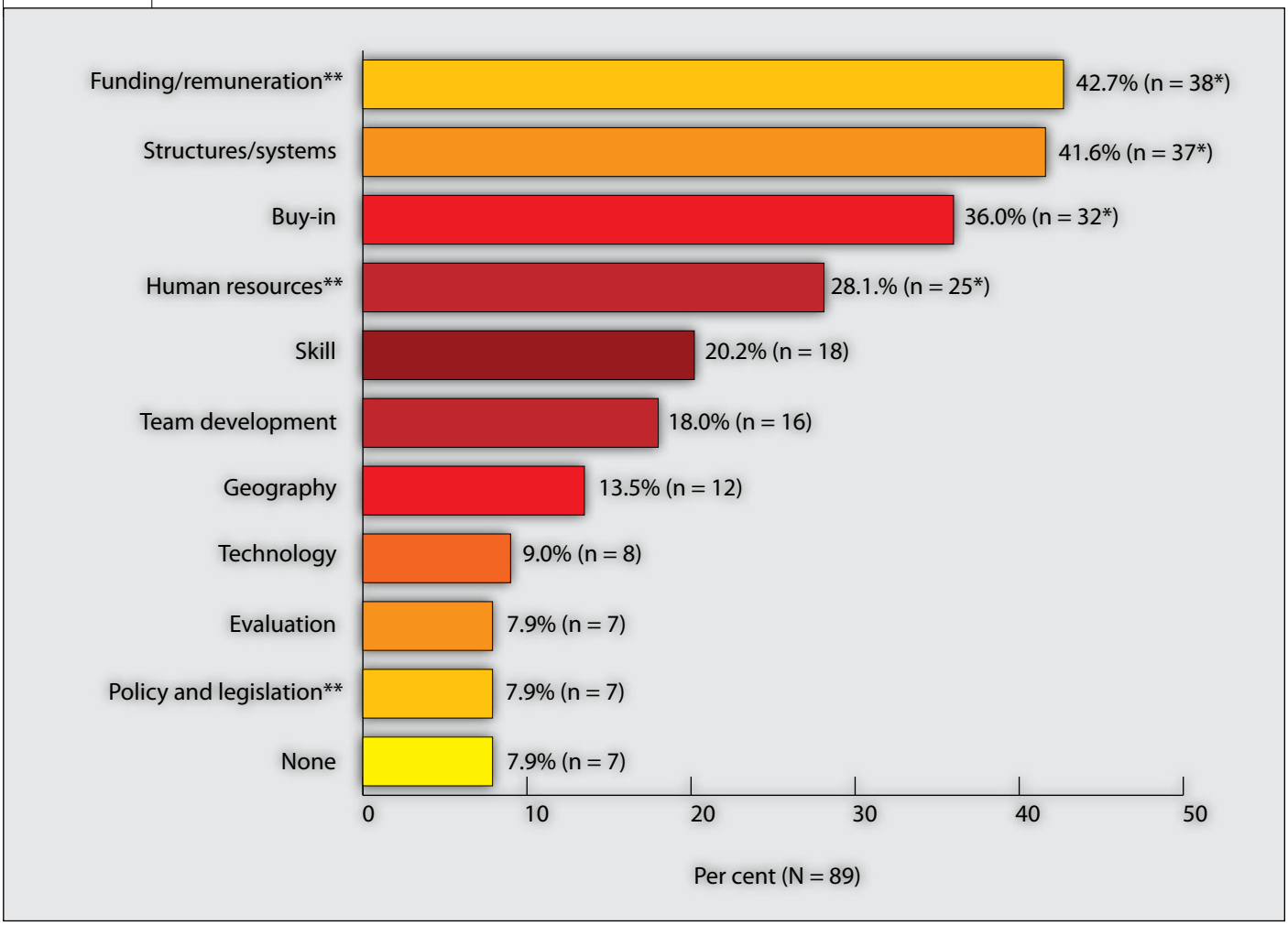


Primary Health Care Transition Fund was implemented); those that were created between the years 2000 and 2004; and those that were created after January 2004 (Figure 11).

14. What are the common barriers or challenges reported by the collaborative initiatives?

Participants were asked to describe briefly the difficulties they encountered in establishing and sustaining their initiative. This information was coded according to the fundamentals (macro-level) and key elements (micro-level) of the Collaborative Mental Health Care Framework (Gagné, 2005). Several categories emerged, including: buy-in, evaluation, funding, geography, policy and legislation, remuneration, human resources, skill, structures/systems, team development and technology. Only 7.9 per cent of the initiatives reported that they did not experience any barriers. This information is summarized in Figure 12. Please refer to Appendix B for examples of each of the barriers that were identified. These barriers are reviewed in the discussion section of this document.

figure 12 **Barriers Encountered by the Collaborative Initiatives in Per cent**

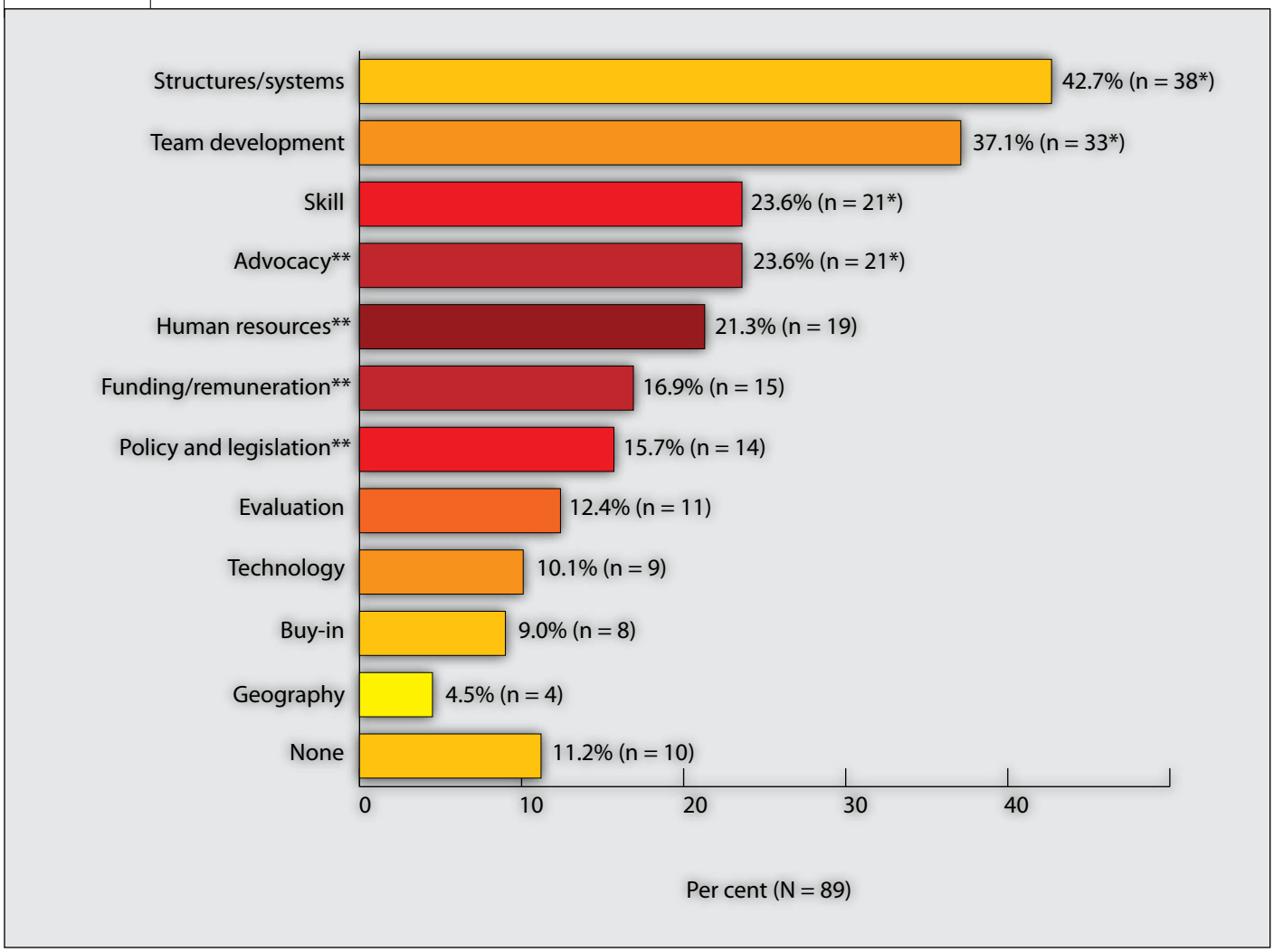


* *Note: indicates the most prominent barriers reported.*
** *Note: indicates macro-level barriers.*

15. What are the common strategies or solutions that the collaborative initiatives use to address the challenges they face?

Participants were asked to describe briefly the strategies they used to overcome the difficulties (barriers) they had experienced. This information was coded according to the fundamentals (macro-level) and key elements (micro-level) of the Collaborative Mental Health Care Framework (Gagné, 2005). Several categories emerged, including: advocacy, buy-in, evaluation, funding, geography, policy and legislation, remuneration, human resources, skill, structures/systems, team development and technology. Only 11.2 per cent of the initiatives reported that they did not use any strategies. This information is summarized in Figure 13. Please refer to Appendix B for examples of each of the strategies that were identified. These strategies are reviewed in the discussion section of this document.

figure 13 **Strategies Used by the Collaborative Initiative to Overcome Barriers in Per cent**



* *Note: indicates the most prominent strategies reported.*
** *Note: indicates macro-level strategies.*

DISCUSSION

The purpose of this section is to highlight the many different ways that collaborative mental health care initiatives endeavour to meet and exceed the goals of consumers; it is not our intention to suggest 'right' or 'wrong' ways to engage in collaborative activities. The consumer goals of collaborative mental health care include: increased access, decreased burden of illness and optimized care.

The Collaborative Mental Health Care Framework (Gagné, 2005) is used to illustrate and examine important trends to providing collaborative mental health care in primary health care related to the fundamentals (macro-level influences) and four key elements (micro-level influences) identified in the Framework. Each section includes the following:

- Description of the fundamentals and key elements;
- Observations, based on the data collection and analysis;
- Examples and quotations from the initiative descriptions;
- Summary of the barriers to implementation of collaborative activities and the strategies used by initiatives to overcome these challenges; and
- Key messages.

The goal of this section is to present trends of collaborative mental health care in a meaningful way, in order to support providers, planners, educators and policy-makers in the development of future collaborative mental health care initiatives.

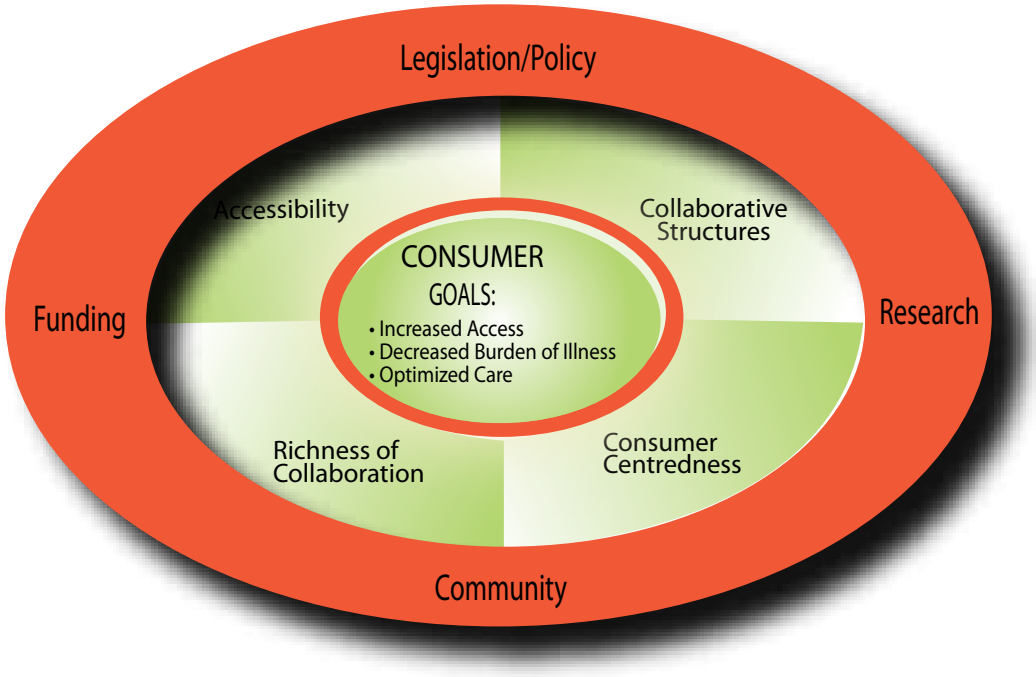
The Collaborative Mental Health Care Framework

figure 14: The Collaborative Mental Health Care Framework

The Collaborative Mental Health Care Framework (Gagné, 2005) is a conceptual framework developed to further an understanding of how collaborative mental health care operates.[8]

8 For a more detailed discussion of the Framework, refer to What is Collaborative Mental Health Care? An Introduction to the Collaborative Mental Health Care Framework (Gagné, 2005), a report prepared for the CCMHI. Available at: http://www.ccmhi.ca

Fundamentals



Collaboration varies across Canada in response to the needs of consumers. Within the Framework, the enabling features of collaborative mental health care are termed "fundamentals" (outer orange ring) and can be defined as the macro-level context for the development and enhancement of collaborative initiatives. Aspects of the operating environment that are fundamental to the success of collaborative initiatives include: regulation, policies, legislation, human resources planning and remuneration, and funding that is consistent with the principles of collaborative mental health care. Other features may include attention to evidence-based research, and the needs of communities, their existing resources and their readiness contribute to the success of collaborative care.

Policies, Legislation, Funding Regulations and Funds

Supportive infrastructure is required to bring collaborative care into the mainstream of health care systems. **Policy**, **legislation** and **regulations** are needed to ensure that health care systems actually define and incorporate collaborative care in a systematic way that responds to the needs of consumers with common mental disorders (Jenkins and Strathdee, 2000).[9] While integration of mental health into primary health care may seem logical, the support of policy-makers and payers is required to ensure long-term sustainability. In mature health care systems, primary and mental health care have historically been separate silos of care (e.g., Kirby, 2004: report #1; Druss, 2002, Institute of Medicine, 2001). Recent reform efforts in these two

Policy and Legislation

Policy and legislation barriers were reported by 7.9 per cent of the initiatives. One initiative related that, "*the information-sharing between organizations was a long process of developing a sharing of information documents and a protocol to inform the client, when signing to participate in the program.*"

"[The] development of a medical directive approved by the hospital administration to allow psychiatric nurses, social workers and psychologists to independently assess patients and open charts and arrange an assessment with a clinic psychiatrist within two weeks" [was one strategy used to overcome policy and legislation barriers].

9 For a more detailed discussion of the funding, policy and legislation issues related to collaborative mental health care in Canada, refer to report six written for the CCMHI: Collaborative Mental Health Care in Primary Health Care Across Canada: A Policy Review (Pawlenko, 2005). Available at: http://www.ccmhi.ca

areas of health have not necessarily resulted in them being combined (Kates, 2002). Focused and deliberate efforts must be made for supportive mental health policy to become the norm (WHO, 2003). In some jurisdictions, this policy process, with a stated emphasis on the integration of primary and mental health care, is well underway (Hickie and Groom, 2002; Lester et al, 2004; Nolan and Badger, 2002; Pawlenko, 2005).

The critical elements for primary mental health care policy (Jenkins, 1998) have been identified. Such policy addresses how care for common mental illnesses will be delivered within a health care system. The details of who will be responsible for assessment, diagnosis and management of these conditions are clearly stated in these policies.[10] Clinical activities are fully supported by quality standards for service inputs, processes and outcomes, and a monitoring process (e.g., regulations) is defined. Workforce development and training needs are identified and the format for commissioning services is detailed. Key aspects of policy may be implemented through legislation and regulations; they may cover such issues as scopes of practice, use of confidential information, liability, professional self-regulation, and division of responsibilities between governments and professional regulatory bodies (Bosco, 2005).

The movement to regionalize and restructure health services has been an attempt to streamline services. However, it has also caused uncertainty about the future for initiatives that have been in existence for some time. There were only 31 initiatives (34.8 per cent) prior to the implementation of the Primary Health Care Transition Fund in 2000, a year that marked the beginning of significant primary health care reform in Canada. Since then, an additional 58 initiatives have been developed.

The number of initiatives varies greatly among provinces and territories. At first glance, it would appear that some provinces have many more collaborative mental health care initiatives than others. Although this is true, there are two important contextual factors to consider: population base and size of the initiative. By population size alone, there is a higher percentage of collaborative mental health care initiatives in the territories and the Maritime provinces. In addition, initiatives vary greatly in their size, skewing the perception that some provinces have more collaborative care than others. In some of the provinces

Human Resources

Another significant barrier to collaboration was related to resources; initiatives reported that the recruitment of an adequate and skilled staff was a challenge (28.1 per cent). One initiative suggested that "*recruiting clinicians to work for the program, due to the unavailability of targeted expertise and a reluctance of clinicians to embrace new and unfamiliar work arrangements*," was a common frustration. Other common challenges, in addition to recruitment, included:

- Finding the proper ratio of mental health specialists to primary health care providers;
- Experiencing a high demand for resources;
- Staffing reductions due to funding cuts;
- Isolation of the initiative;
- Retention of qualified staff; and
- Staff turnover.

10 For a more detailed discussion of the health human resources issues related to collaborative mental health care in Canada, refer to report eight written for the CCMHI: Health Human Resources in Collaborative Mental Health Care (Bosco, 2005). Available at: http://www.ccmhi.ca

and territories, there are provincial or regional collaborative mental health care strategies which cover several smaller private practices, health centres or hospitals.

Other provinces such as Ontario have a number of smaller initiatives that are not necessarily connected to larger regionalized initiatives. For example, there may be a large number of initiatives in Ontario simply by virtue of the lack of regional health authorities in the province. In this situation, each site must manage its own activities without support from a larger network, forcing each individual initiative to function on its own. The initiatives are not necessarily connected to each other, even when they might exist in the same geographical location. When this is the case, it also means that there is quite a bit of diversity among sites in the way services are provided.

In some provinces such as Manitoba or Alberta, health services are regionalized. Several of the initiates that were identified in these provinces represent vast geographical areas or they may include many different health centres, private practices, outreach sites or hospitals in their activities. Often, when this is so, the services that are provided at each site are similar, whereas in areas that are governed by regional services, the initiatives have access to an increased number of potential resources.

Policy alone is insufficient to bring about more collaboration. **Funding** and financial incentives are central issues in the development of collaborative care to be considered at the levels of system funding and payment to providers. Indeed, lack of funding (i.e., for pilot projects with one-time capital and annualized funding) is an often-cited barrier to the development of collaborative care. Health care funding in mature health care systems continues to reflect the structural divisions within medicine and a lack of parity in funding for mental health services, in comparison with that for other medical conditions (U.S. Department of Health and Human Services [USDHHS], 2001). Funding allocations and **remuneration** plans do not typically accommodate holistic approaches to care that may involve more than one provider delivering services to a consumer at one time (e.g., development of integrated team approaches to care). In Canada, fee-for-service remuneration by provincial health care systems is the dominant form of payment for physicians, and few of these jurisdictions allow other approved professionals to bill provincial payment plans for their services. Few schemes provide incentives that support collaboration among various mental health and

Funding and Remuneration

Barriers related to funding and remuneration were the most commonly reported challenges experienced by initiatives (42.7 per cent). Many initiatives said they had a lack of sustained and adequate funding. Eighteen initiatives said that they had received funding for a limited period of time; the majority of these newly established initiatives or pilot projects hope to secure long-term funding arrangements. Rearranging internal structures, such as reorganizing services that already exist so that they function more efficiently, can sometimes alleviate the need for increased funds. This is one strategy that initiatives have used to combat their frustration with the lack of funding. In addition, initiatives report that constantly advocating for funding has helped them secure additional funds, when needed.

"Funding to allow family physicians from fee-for-service sites to be compensated for time spent at retreats, case consultation sessions, etc...[was one solution to the funding barriers experienced by the initiative]."

primary care providers across disciplinary lines (Romanow and Marchildon, 2003; USDHHS, 2001). Without such incentives, sustained participation of providers in collaborative care often becomes untenable, one-time initiatives do not become part of the mainstream, and promising programs are not evaluated.

Understanding the funding elements of collaborative care is lacking. Korda (2002) reported that system stakeholders throughout the United States indicated that they did not know about key concepts of cost (e.g., offsets, parity, differences between financial incentives versus disincentives, health care market forces and market leverage). Among Canadian professionals, a dearth of funding knowledge may be the result of lack of exposure to a variety of funding approaches and domination of fee-for-service payment schemes. Dewa et al. (2001) addressed the need for blended payment schemes (fee-for-service plus incentives) for collaborative care providers in the absence of full-scale change in current Canadian reimbursement schemes.

To truly support collaboration, funding schemes, payment programs and business models must be both flexible and accountable (Quirk et al, 2000; Dea, 2000). However, payers need to wait to see the results of collaborative care and must be willing to "front-load" collaborative systems to reduce the turnover of health care professionals (Enhancing Interdisciplinary Collaboration in Primary Health Care Initiative - EICP) (Nolte and Tremblay, 2005). Financial incentives and funding options can be extremely useful tools for leveraging and reinforcing changes to health care and the behaviour of the practitioners in the organization. New approaches to funding for collaborative care need to accommodate the short- and long-term costs of collaborative care, relative to the gains in health outcomes for consumers.

Funding and Remuneration

A lack of creative or supportive remuneration strategies does not provide incentive for participation in collaborative efforts, and creates further barriers related to the accessibility of services. Initiatives report that they experience difficulty recruiting the necessary providers to their team because of unsupportive funding structures. Fee-for-service remuneration strategies do not support collaborative activities, partly because these arrangements do not allow providers to bill for the time they spent engaging in collaborative activities such as team meetings, educational sessions, consultations or communicating treatment plans to team members. Initiatives identified that creating salaried positions for family physicians, or other providers who are normally paid using fee-for-service structures, was one strategy that had helped them over come challenges related to remuneration.

"Difficulties include the family physicians' unremunerated time spent in traveling to meetings at the hospital and discussing problems and strategies to improve individual patient care."

KEY MESSAGES

Policy, Legislation, Human Resources, Funding Regulations and Funds

- *Provincial, territorial and federal policies and legislation can either facilitate or prevent collaborative services, as is evident in the spread of collaborative initiatives across Canada.*
- *Barriers related to funding and remuneration are the most prominent challenges reported by the initiatives (42.7 per cent).*
- *The recruitment of skilled professionals willing to engage in collaborative care is challenging, according to 28.1 per cent of participants.*
- *Most fee-for-service remuneration strategies do not support or provide incentives for collaborative activities.*

Research and Community

Research is both a starting point and an outcome that is critical to the validation of collaborative care. As with any new approach to care, research can play an important role in legitimizing the new approach as being one that "works" and "works better" than previous/other approaches.

The involvement of many professionals in the delivery of collaborative care and their commitment to consumer involvement in all aspect of this care requires new approaches to research that transcend traditional disciplinary models (Martin, 2003). Gask and Rogers (1998) call for research to begin with a broader view of the paradigms inherent in collaborative care, as well as an expanded definition of primary mental health care, to encompass the full range of community resources beyond those of primary medical care. Such a perspective would support consumers' recovery from mental illness or distress, taking them to a state of wellness and health. Both a focus on evidence-based practice and innovative treatments that go beyond adapting specialized treatment to the primary care setting will be needed. Bridging the gap between research and real life practices, between ideal models and everyday constraints, is also

Evaluations

Seventy-one initiatives are currently conducting, or have conducted, some form of service or program evaluation. Formal evaluations are becoming more common practice. However, guidance needs to be provided on how evaluations should be conducted (e.g., when, by whom, for how long and using which measures). Of the initiatives, 7.9 per cent noted barriers related to evaluations. The most common barriers to conducting formal evaluations, as reported by the initiatives, include a lack of funding, time and/or human resources. On the other hand, conducting evaluations or using information that was generated from these evaluations was one strategy that initiatives used to overcome some barriers to implementing or enhancing their activities (expressed by 12.4 per cent).

vital to understanding collaborative care[11]. Finally, research needs to be recognized for its importance and supported, if this change is to be realized. Funds must be earmarked for this purpose so that common methods and multi-site collaborative approaches can be adopted.

When developing an initiative, it is important to look at the **community's** needs and resources, as well as assessing the readiness of potential providers and consumers to work in collaborative mental health care (Gask and Rogers, 1998; Mauer/National Council on Community Behavioural Healthcare, 2003). Many collaborative mental health care initiatives are aware of the needs and know what available resources exist within the community. Conducting needs assessments, focus groups or questionnaires have helped these initiatives to identify the unique needs of their communities. In addition, strong communication between collaborative initiatives and other community resources has strengthened the ability of health care partners to collectively provide consumers with the care they need and want.

Furthermore, health care partners acknowledge that there are special populations with unique needs. These populations include: addictions/concurrent disorders, ethno-cultural, disorder-specific, homeless, children/adolescent, seniors, Aboriginal, urban, northern/isolated, rural and those with serious mental illnesses. Eighty-one initiatives (91 per cent) reported that they offer specialized services for at least one special population and 64 (or 71.9 per cent) serve at least two populations.

In the hope of supporting the efforts of clinicians, managers, programs and practices interested in providing specialized services, the CCMHI developed implementation toolkits[12] to aid in the development and enhancement of collaborative initiatives in primary health care. These toolkits offer practical advice on all aspects of establishing a successful initiative, from identifying the need to evaluating the project. The toolkits also contain a variety of checklists, work pages and resources. Since resources vary from project to project, the toolkit offers a range of options that bridge the ideal (what could be achieved if funding/resource availability was not an issue) with the realistic (what can be done with available resources).

KEY MESSAGES

Research and Community

- *The purpose of research and conducting service and program evaluations is to build a knowledge base and identify better practices, so that enhanced care can be implemented by collaborative initiatives.*
- *Many initiatives recognize that certain populations have special needs and are developing specialized services to address the needs of their specific communities.*

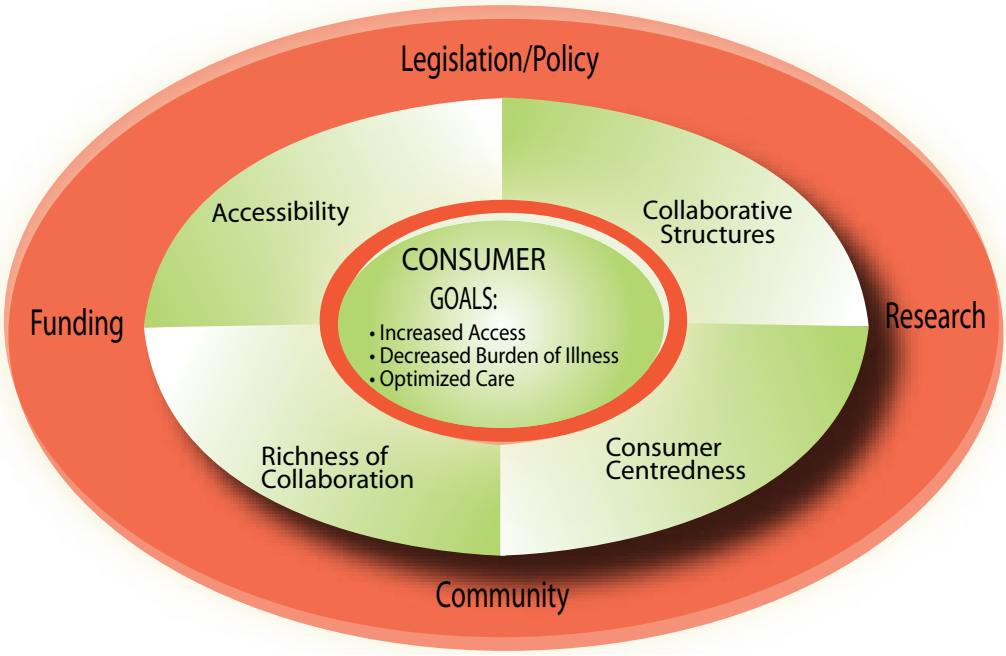
11 For a detailed discussion of the current information available on best practices, refer to report four written for the CCMHI: Better practices in collaborative mental health care: An analysis of the evidence base (Craven and Bland) 2005. Available at: http://www.ccmhi.ca

12 Kates N, Ackerman S, Crustolo AM, Mach M. Collaboration between mental health and primary care services: A planning and implementation toolkit for health care providers and planners. Mississauga, ON: Canadian Collaborative Mental Health Initiative; 2005. Available at: http://www.ccmhi.ca

Key Elements

The Framework (Gagné, 2005) seeks to facilitate an understanding of and appreciation for collaborative mental health care by defining four key elements: (middle green ring)

- Accessibility
- Collaborative structures
- Richness of collaboration
- Consumer centredness



Accessibility, or "bringing the services closer to home," captures the need for providers to offer mental health services in a location that is close to consumers, accessible and offered by the most appropriate provider. This includes accessibility to mental health prevention, promotion, detection, treatment and recovery.

Collaborative initiatives require appropriate and supportive ***structures*** (i.e., ways in which health care partners have agreed to work together) and ***systems*** (i.e., how health care partners will accomplish certain key functions of collaboration). These characteristics are the building blocks for collaboration.

Richness of collaboration is a way to enhance the capacity of primary health care providers to offer mental health care activities, and is supported through educational activities (involving knowledge exchange), inclusion of a range of health care partners and interdisciplinary communication. These characteristics enhance the capacity of all health care partners.

Finally, ***consumer centredness*** is based upon the notion that consumers should be involved as active partners in all aspects of their care, recognizing that the needs of consumers drive collaborative mental health care in primary health care.

The following is a discussion of how these key elements are evident in the range of collaborative initiatives across Canada. The discussion will include a description of each key element, provide examples of the characteristics of each key element, highlight the main themes, trends and observations related to the key elements, and conclude with key messages.

Accessibility: Bringing Services Closer to Home

Improving access to mental health services in primary health care, including mental health prevention, promotion, detection, treatment and recovery, is being accomplished in a number of ways in Canada. Generally, approaches to collaboration fall into two groups: direct and indirect mental health care provision. The size and scope of the initiatives using both approaches varies, but there is a common thread that unites them: a desire to bring about change in a way that facilitates consumers getting the services they need as quickly as possible, in a location that is convenient to them.

In a ***direct approach***, mental health specialists offer their services to consumers in primary health care settings. Such arrangements typically include: special visits by mental health specialist(s); co-location of mental health specialist(s) and primary health care provider(s); or tele-mental health arrangements.

In an ***indirect approach***, a primary health care provider delivers mental health services to consumers, while receiving consultative support from a mental health specialist (i.e., the mental health specialist provides indirect mental health care). Providers may or may not be co-located. Consultative arrangements vary according to the needs of the primary health care provider and typically include support via telephone, e-mail, video-conferencing, face-to-face discussions, and/or joint consultations (involving the mental health specialist, primary health care provider and

Initiative Examples

Direct Approach: In Vancouver, British Columbia, the Geriatric Psychiatry Outreach Team (GPOT), which consists of psychiatrists, registered nurses, social workers and a neuro-psychologist, provides consultation services (i.e., on-site consultation, assessment and on-going follow-up, as needed) to two family practice clinics and one community health centre between one and two half-days per month. The GPOT will also travel to patients' homes to conduct assessments, when appropriate.

the consumer). These support mechanisms may be defined formally (e.g., scheduled contact) or informally (e.g., unscheduled contact), depending on service volumes and the needs of the primary health care provider(s).

Initiative Examples

Indirect Approach: The Collaborative Mental Health Care Network in Ontario consists of a mentoring program that links psychiatrists, general practitioner psychotherapists and social workers (mentors) with family physicians ("mentees") in a collaborative relationship. Family physicians provide mental health care to their patients, while receiving consultative support from their assigned "mentee(s)" by e-mail, fax, telephone or face-to-face, as needed.

General Discussion: Accessibility

The very essence of "increasing access to care" means meeting consumers' mental health needs in a way that complements the way they live their lives and their preferences for care to be delivered in a single setting (Blount, 1998). The fragmented set of mental health services and a compartmentalized medical care system present major challenges for health care practitioners who wish to embrace consumers' demands for more holistic approaches to mental illness and distress. The burden of navigating these services streams has fallen on consumers and families, often at times when they are under considerable stress. Making collaborative care available in primary health care settings brings service "close to home" for consumers and families in a familiar and non- stigmatizing community location. Increased capacity to deal with common mental disorders is needed worldwide (WHO, 2003).

The benefits of this increased accessibility to collaborative mental health care are many. Consumers often present in primary health care settings with problems that are not differentiated as being biological or psychological (Blount, 1998; Peek and Heinrich, 1998). There are also consumers with chronic health conditions who need mental health treatment (Griffith, 1998). Collaborative mental health care has the potential to address many aspects of these problems through the combined expertise and skills of the health care team. By being part of the consumer's community, primary health care also has the greatest potential to implement effective, brief treatments for common mental illnesses and to harness other community and personal resources that support the consumer in receiving care. By seeing consumers on a regular basis, there is an opportunity to know consumers better over a longer period of time, to provide them with care by the same providers, to recognize common mental illnesses as these emerge and to provide prevention and health promotion activities.

Providers and local health care systems also benefit from providing this increased access. By taking the time to address the mental health issues of consumers seen in primary health care settings, health care providers can focus on the functional status of consumers, rather than merely on their symptoms (Nolan and Badger, 2002). Having various professionals participate as part of the collaborative care team shares the responsibility for diagnosis and treatment, increases opportunities for communication, teaching and skill development, and creates more opportunity to respond to a wider range of problems and thus, reduce the burden of illness (Blount, 1998; Dea, 2000; Mauer/National Council for Community Behavioral Healthcare, 2003).

A ***direct approach*** to collaborative mental health care tends to be used by initiatives with smaller teams that report lower service volumes and a small or moderate range of collaborative providers (typically no more than three disciplines). The collaborative team is more likely to include physicians and psychiatrists, although social workers and nurses are becoming more commonly used as mental health specialists. The success of this approach relies on strong referral agreements between the mental health specialists and the primary health care providers. Of the initiatives, 20.2 per cent used a direct approach to collaborative care.

An ***indirect approach*** to collaborative mental health care tends to allow for larger teams, a greater range of collaborative partners and higher service volumes. Coordination of this approach requires strong communication methods (e.g., regular telephone, e-mail or face-to-face support) and well-defined structures and systems (e.g., regular team meetings and the use of an electronic health record). This approach enhances the primary health care provider's capacity to assess, diagnose and treat mental illnesses. Opportunities for knowledge and skill transfer between health care partners (capacity-building) are greatest when using this approach because of the enhanced formal and informal interactions that can occur between team members. Of the initiatives, 11.2 per cent used an indirect approach to collaborative care.

Buy-in

Barriers related to 'buy-in' (or a lack of buy-in) on the part of the provider or consumer, were one of the most significant challenges reported by the initiatives. For example, one initative reported that "*family physicians were initially skeptical regarding the amount of time that they would be investing in a shared-care relationship*." Other concerns related to uncertainty about the effectiveness of collaborative mental health care approaches to improving consumer outcomes or to enhancing the capacity of primary health care providers.

Concerns were greatest about creating buy-in from primary health care providers, especially family physicians. Some initiatives have reported that buy-in increased over time, due to a number of important factors:

- Providers received greater support for necessary resources (e.g. supportive funding structures and protected shared-care time);
- Providers saw marked improvements in consumer outcomes; and
- Providers grew more comfortable and confident in dealing with mental health issues simply by having informal contacts with mental health specialists (e.g. their general awareness increased).

Thirty-six per cent of the initiatives reported that a lack of provider or consumer 'buy-in' was a barrier to implementing collaborative care.

An ***indirect approach*** to collaborative care requires more time and energy on the part of the primary health care provider and is, therefore, less likely to be used if there is a lack of buy-in on the part of the primary health care provider. Not all primary health care providers are able to find the clinical time to see consumers with mental health illnesses, nor are they all interested in increasing their ability to assess, diagnose or treat a variety of mental illnesses.

Since there are unique benefits to using each approach, initiatives are more likely to use a ***combination of direct and indirect approaches*** to delivering their services. This appears to be chosen to better accommodate the needs of consumers, while balancing the needs and availability of the primary health care providers and mental health specialists. The benefits of using a combination of both approaches are: (1) consumers are likely to get quicker access to providers who are equipped to address their mental health needs; (2) primary health care providers become increasingly confident and capable of managing consumers with mental health illnesses; and (3) consumers are more likely to receive ongoing care from a provider or a team of providers who are familiar with their unique needs. Of the initiatives, 68.5 per cent used a combination of direct and indirect approaches to collaborative care. Factors that appear to influence the emphasis placed on a particular approach include:

- The desire of the primary health care provider to build his or her capacity to treat mental illnesses.
- The availability of mental health specialists.
- The availability and buy-in of primary health care providers.
- Financial and other incentives for the participation of providers in collaborative care.
- The unique needs of the population of consumers who are primarily served by the initiative.

Buy-in

When primary health care providers buy in to collaborative mental health care, they are more likely to seek consultative support and value, receiving support from mental health specialists, and they will be more interested in enhancing their own capacity to provide mental health care services (Grazier et al., 2003). An appropriate consultative arrangement, including what type of support, by who it will be offered, and how and when it will be provided, is determined by attempting to match the needs and skills of the mental health specialist(s) and the primary health care provider(s) involved in the initiative. For example, initiatives were able to create buy-in once they,"*received support from champions within the care teams and administrative/ management structures who saw the value in [their] initiative*." From a consumer, family and caregiver perspective, it meant that these individuals had an understanding of the benefits of collaborative care and that they had their concerns answered.

Advocacy, a strategy used by 23.6 per cent of the initiatives, was one method used to overcome barriers related to buy-in.

"[One challenge involved] convincing parents/ guardians that current [collaborative] intervention efforts will have a positive impact further along in the child's development and do not mean that child welfare will be brought in."

Geography

Although geography was a barrier reported by some initiatives, it was not as prevalent (4.5 per cent) as others. However, geography is a significant challenge to initiatives located in rural, northern or isolated areas. The isolation experienced by some providers may prevent the necessary communication with experts or consumers. However, with the development of supportive communication technologies such as video- and tele-conferencing, initiatives report that they are better able to reach out to these communities and providers. In addition, special on-site visits by traveling providers are another effective way to enhance communication and trust between providers and consumers.

"The vastness of the catchment area and the necessity of involving many jurisdictions as partners [was one barrier that] required a more carefully planned process of collaboration."

KEY MESSAGES

Accessibility

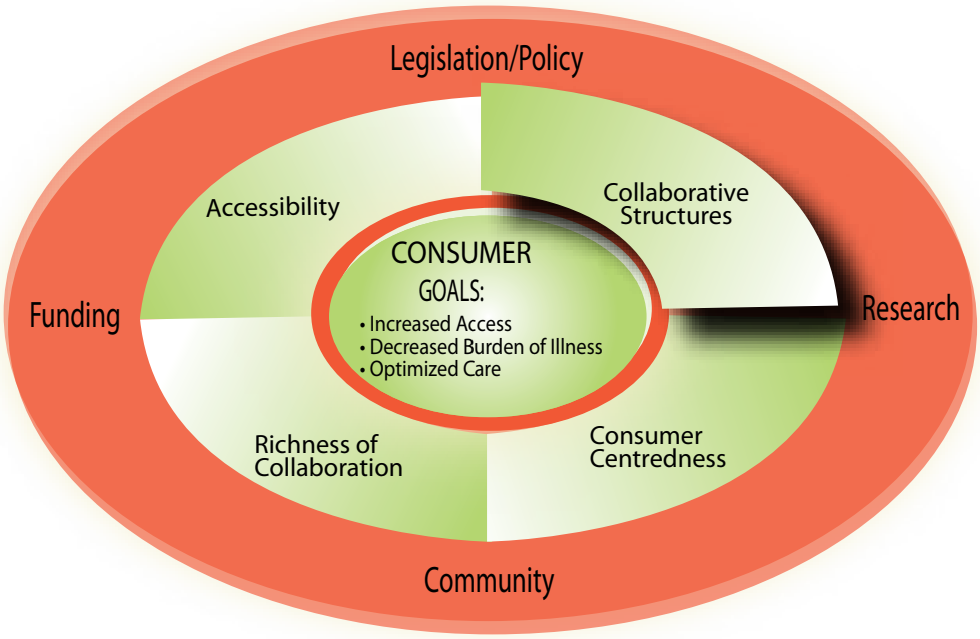
- *Initiatives are more likely to use some combination of direct and indirect approaches to providing their services, since this allows them to maximize the benefits of each approach, in order to meet the needs of consumers and the available mental and primary health care resources.*
- *Some factors that appear to influence which approach or combination of approaches (direct or indirect) will be used by an initiative include:*
  1. *The desire of the primary health care provider to build his or her capacity to treat mental illnesses;*
  2. *The availability of mental health specialists;*
  3. *The availability and buy-in of primary health care providers;*
  4. *Financial and other incentives for the participation of providers in collaborative care; and*
  5. *The unique needs of the population of consumers who are primarily served by the initiative.*
- *Lack of buy-in on the part of providers (especially primary health care providers), consumers, families and/or caregivers is a prominent barrier to collaboration.*

Collaborative Structures: Building Blocks for Collaboration

Successful collaborative mental health care initiatives recognize the need for *structures* and *systems* that support collaboration. The importance of the structure of an initiative cannot be understated, because it serves as the foundation for fundamental systems and operations.

The ***structures*** of collaborative initiatives define the ways in which people work together. They serve as a foundation for the types of interactions and expectations that are formed, as well as the shape of supporting systems. For example, structures help to define how collaborative activities will be financed and evaluated, who will assume liability for consumer care, and what the role of each provider offering care will be. Collaborative initiatives can have both formal and informal structures to support their operation.

Project proposals, contracts and service agreements are often used to define ***formal structures***. Coordinating centres and collaborative networks can be considered



Initiative Examples

Formal Structures: The Hamilton Health Services Organization (HSO) Mental Health and Nutrition Program is administered by a central management team, which is responsible for: allocating resources; recruiting and orienting counsellors and psychiatrists; establishing and maintaining program standards; linking with the funding source; and advocating for the program. In addition, the team provides educational events for the counsellors, psychiatrists and family physicians involved in the program. Relevant references or items of interest are circulated to physicians' practices.

***Informal Structures*:** The Kelsey Trail Health Region does not have a formalized process per se. However, significant efforts have been made to coordinate and integrate primary and mental health care services in the region. The mental health staff is primarily located in the three community hospitals (including mental health nurses, addiction workers, psychologists, mental health therapists and social workers). The mental health staff has access to and communicates with a number of other providers, including family physicians, physiotherapists, nutritionists, exercise therapists and other community resources, as needed.

formal structures that govern the operation of collaborative initiatives.

Many loosely defined operating structures or ***informal structures*** exist within collaborative initiatives and are often based on verbal agreements. These informal structures tend to support the daily nuances involved in managing a collaborative initiative.

Systems of collaborative mental health care develop from the structures of collaborative initiatives and define how to accomplish various key functions of collaborative mental health care (i.e., how to deliver mental health services in primary health care settings in a collaborative fashion). Systems commonly employed include: referral strategies (including referral forms or networks); information technologies (including electronic records, web-based information exchange, tele-conferencing, video-conferencing, e-mail and list serves); and evaluations (standardized measurement tools).

Initiative Example

Systems: A multi-jurisdictional project involving the Yukon Territory and British Columbia has been specifically designed to use information/communication technology to support collaboration, disseminate information and foster sharing best practices among sites serving northern/isolated areas. The project is supported by distance technologies such as video-conferencing, a secure intranet site and e-mail. An electronic health record has recently been added as a means of linking diverse providers and supporting continuity and integration of care.

General Discussion: Collaborative Structures

The delivery of collaborative care requires practice adjustments by all professionals involved and these practice elements must fit within the care setting. Where collaborative care is being delivered in primary care settings, it is the mental health professionals who most often make adjustments, in terms of such things as treatment delivery (brief approaches focused on solutions rather than process), clinical records (integrated with the medical record and more concise notes), shorter appointments (de Gruy, 1999; Patterson et al, 1998; Valienti, 2004). Team protocols help to define roles and functions and to make clear distinctions between leadership or coordination functions and clinical and professional responsibilities (Herrman et al, 2002; Lipkin, 1999). The physical proximity of team providers is important, when it comes to supporting both the formal and informal communication between providers and facilitating joint interaction with consumers (Mauer/NCCBH, 2003; Patterson et al., 1998). Dissatisfaction arises if mental health providers

Structures and Systems

Of the initiatives, 41.6 per cent reported barriers related to the structures and systems of collaborative care. For example, initiatives felt challenged when they developed or implemented new models for collaborative care, and they experienced frustrations when they lacked coordination. It was especially challenging to coordinate activities when the initiative did not have a designated coordinator or manager.

Several initiatives suggested that their team members were very busy and did not always have the time to participate in collaborative activities such as joint consultations, tele-conferences or team meetings. Other issues included acquiring adequate space to conduct assessments and support the initiative's staff.

are located outside the office mainstream and/or in shabby accommodations (Farrar et al, 2001). Technological tools facilitate collaboration; these include electronic medical records, call-back systems and hand-held computers.

Formal structures are essential for larger collaborative initiatives, especially when the collaborative team has many members and service volumes are high. These types of structures are often required to be in place when an initiative seeks funding for a demonstration or research project. Formal structures become increasingly important when smaller initiatives, or those initiatives with small service volumes or fewer team members, attempt to expand their services. Of the initiatives described, 56.2 per cent have a designated director/manager and 24.7 per cent have a coordinator.

Informal structures are more common in smaller collaborative initiatives, when service volumes are low or fewer health care partners collaborate. They are also important when initiatives are first getting started and staff members are working through the challenges of daily operations. One key to success is identifying when and how informal structures should become formal structures, in order to improve the avenues for communication and referrals.

The level of complexity of *systems* can be considered on a continuum, although this is not to suggest that more complex systems are necessarily better. For example, initiatives in northern, isolated or rural locations often rely on systems that support communication among health care partners within a wide geographical area. This support might include the use of information technologies such as tele-mental health, video-conferencing, e-mail and electronic databases.

Structures and Systems

Strategies related to structures and systems were indicated by 42.7 per cent of the initiatives — the most prominent strategy reported. Components of collaborative structures and systems that were identified as important include:

- Developing key partnerships with community resources;
- Having flexible structures that accommodate the needs of the community;
- Having designated planning days or team meetings;
- Providing strong orientations for new team members;
- Working closely with key stakeholders to ensure that the initiative's goals are achieved;
- Developing formal communication strategies;
- Bringing in a coordinator who has clearly defined roles and responsibilities; and
- Reviewing the partnership agreement and recommitting to the purpose, objectives and service delivery methodologies with all of the key stakeholders.

"Increased structure and active mentorship was identified as critical for continued use and effective use [of the initiative] on an ongoing basis…"

As mentioned, 71 of the initiatives reported that they are conducting or have completed some form of formal or informal program or service evaluation. Evaluations were more likely to be conducted in a formal manner by initiatives that were funded on a short-term basis (e.g., pilot or demonstration project). Unfortunately, a total of 7.9 per cent of the initiatives reported barriers related to evaluations. For example, some initiatives said they had collected data that could be used

for formal evaluations, but that they lacked the funding, time and human resources required to compile and evaluate the information.

However, the benefits of conducting evaluations were clearly reported by the initiatives (12.4 per cent). Many used evaluations to size up the current needs of their community, assess how many and what particular resources are required at each location/setting, and provide evidence of the effectiveness of collaborative care. Evaluations often included measures of: provider/consumer satisfaction, quality of life and various consumer outcomes. One initiative stated "*[We]… plan to actively dispel the myth [misconceptions of the efficacy of the model] of reduced [volume] capacity by using our evaluation and anecdotal evidence.*"

Information Technologies

Of all the initiatives, nine per cent reported barriers related to technology. Common factors included: poor working knowledge of the technology used to support the initiative, a lack of confidence in using technologies, and a lack of funding to access or implement the use of information technologies.

Initiatives that were able to implement the use of information technologies reported that these assisted their collaborative activities. Information technologies were a strategy used by 10.1 per cent of initiatives to overcome some of the challenges they experiences.

Of the initiatives, 27 per cent reported using electronic health records or an electronic database, 13.5 per cent use some type of tele-health or video-conferencing technology, and 5.6 per cent use both. Fifty-six initiatives (62.9 per cent) did not specify using any of these types of information technologies.

"[The] establishment of an Internet-based 'Community of Practice' using Share Point software to support communication and collaboration [was one strategy used]."

KEY MESSAGES

Collaborative Structures

- The most common strategies used by initiatives to overcome the barriers or challenges they experienced were related to the structures and systems of collaboration.
- Most initiatives have a director, manager or coordinator.
- The use of information technologies to support collaborative initiatives is a trend that is growing.
- A majority of initiatives conduct formal or informal evaluations, or have done so in the past.
- The value of program and service evaluations should not be overlooked or undervalued. However, more guidance and structures need to be provided, so that evaluations can be used to discern and implement best practices.

Richness of Collaboration: Enhancing the Capacity of Health Care Partners

A central feature of effective collaborative mental health care is the richness of collaboration that exists and is nurtured among health care partners. Prominent characteristics of this element that enhance the capacity of health care providers include: knowledge exchange between providers, an interdisciplinary approach to care and interdisciplinary communication.

Knowledge exchange: Opportunities for health care partners to become acquainted, learn together, share clinical skills and experiences, and inform consumers of care and treatment options, are critical to facilitating knowledge and skill exchange. Knowledge exchange is essential if we are to build the capacity of primary health care providers to offer mental health care services. Collaborative initiatives in Canada have demonstrated numerous ways of facilitating this process, including: formal and informal interactive educational sessions, joint consultations, and educational materials.

An **interdisciplinary approach** to collaborative care means that a range of health care partners (e.g., nurses, social workers, dietitians, family physicians,

Initiative Example

Knowledge Exchange: The Cowie Family Medicine Clinic in Nova Scotia provides an academic teaching environment for family medicine residents and clinic staff (family physicians, nurses, social workers and psychiatrists). Knowledge transfer is enhanced by use of electronic patient records. Weekly rounds are attended by all primary and mental health care staff. There are monthly case discussions between the primary care group and the social workers, as well as three shared-care retreats are held each year.

Initiative Example

Interdisciplinary Approach: Patients of the collaborative mental health program at the Three Bridges Community Health Centre in Vancouver benefit from the involvement and support of the following health care partners: dietitians, family physicians, nurses, occupational therapists, social workers, pharmacists, psychiatrists, psychologists, addiction counsellors, licensed practical nurses and four self-help/advocacy groups.

psychologists, psychiatrists, pharmacists, occupational therapists, peer support workers) work together to provide care. Consumers, families and caregivers are an integral part of the team and, like primary and mental health care providers, they need to have clearly defined roles and to understand the contribution/role of each health care partner involved in the collaboration.

Communication among health care partners is a key component of successful collaborative mental health care. Many initiatives have demonstrated that interdisciplinary communication is enhanced through written/electronic, face-to-face and verbal communications. Formal and informal communication enhances care delivery and is most easily achieved when colleagues work in close physical proximity.

Initiative Example

Interdisciplinary Communication: The Winnipeg Regional Health Authority Shared Mental Health Care Program services 10 different private practice and/or alternate payment clinics in Winnipeg, Manitoba. Communication among family physicians, counsellors (social workers or psychologists), nurses and psychiatrists who support the shared-care program is facilitated by informal and formal education meetings. The following features are included in clients' charts: a psycho-social assessment, a psychiatric consultation summary, and a shared-care closure form.

General Discussion: Knowledge Exchange

At the practice level, collaborative care is advancing at a rapid pace. For many practitioners, learning the lessons of collaboration occurs in daily practice, setting collaborative care apart from other types of medical care because academic medical training centres are not the foremost source of care innovations. This distinction has important implications for the training of future practitioners. Educators and trainers must be in close contact with collaborative programs operating in the field to be able to transfer this knowledge into the curricula being delivered in educational programs (Blount, 1998; Patterson, 1998). Furthermore, collaborative care crosses traditional disciplinary boundaries, creating the need for academic departments to find innovative ways to educate students about collaborative care. A dynamic and close relationship is required between the field and the academic institutions charged with the responsibility of preparing students for collaborative work. For those already in the field, innovative continuing education approaches (e.g., practice-based models, Internet-based programs, simple education aids — Kates, 2002) and more frequent opportunities to share experiences and emerging evaluation evidence in this formative stage are what is needed. Such education is an important lever to widespread endorsement of collaborative care and its long-term sustainability (Nolte and Tremblay, 2005).

While the full range of competencies for collaborative mental health care has yet to be defined (Hoge, Tondora and Marrelli, 2004; Hoge et al., 2004), the need for interdisciplinary teamwork and integration of care have been acknowledged as being fundamental to the renewal of primary health care services (Nolte and Tremblay, 2005).

One purpose of ***knowledge exchange*** in collaborative mental health care is to build the capacity of primary health care providers to offer mental health services to consumers. Although the method

of knowledge and skill exchange used by the initiatives varies, the most commonly reported form of this exchange was interactive sessions (82 per cent). Formal interactive or education sessions occur less frequently, but on a larger scale (e.g., conferences, whole team meetings, retreats). Informal education sessions occur more frequently, but with smaller groups (e.g., lunch-time meetings, when sub-sections of teams meet). Joint consultations between the primary and mental health care providers and the consumer, are also an effective method of enhancing skill transfer, but were reported less frequently by the initiatives (12.4 per cent). Twenty-seven per cent of the initiatives reported using more than one method of knowledge or skill transfer.

Knowledge exchange that targets consumers appears to be focused on developing self-care or self-management behaviours. Providers work with consumers to set treatment goals. In addition, providers may also offer educational opportunities through peer groups or written manuals for consumers to learn more about their mental illness and how they can contribute to managing their illness. Families or caregivers may receive similar support, where knowledge transfer is focused on building the capacity of caregivers to support consumers and/or support groups for caregivers to learn more about their role in the recovery process. Unfortunately, very few of the initiatives reported this information.

Skill

One category of barrier that the initiatives reported was related to skill (20.2 per cent). Initiatives were either concerned that the providers on their team did not have the necessary skills required, or found that providers lacked confidence in their abilities to manage various mental health illnesses. For example, one initiative stated that, *"some physicians are initially not comfortable with assuming their role in maintenance care of patients with psychotic disorders."*

Strategies related to acquiring skills were one of the more commonly reported solutions (23.6 per cent). For example, one initiative stated that, *"above all, the continuation of professional development and education has been essential in overcoming issues related to interdisciplinary care and increasing knowledge of mental health issues and impact on overall health."*

Some initiatives felt that skill training was important enough for them to allocate additional funding resources. Overall, skill development appeared to be an important solution that was used to address many of the different challenges experienced by the initiatives, including frustrations with technology, buy-in, collaborative structures and systems, and team development.

"To address interpretation/application issues, a manual and orientation to the program was designed and delivered to all CHCs [community health centres] and the mental health specialists."

The most common providers that make up a collaborative team include family physicians, nurses, psychiatrists and/or social workers.

The purpose of an ***interdisciplinary approach*** to providing collaborative mental health care is to have a range of health care partners working interdependently to provide coordinated and seamless mental health care to consumers. This approach offers providers the opportunity to gain a greater appreciation of each health care partner's unique skills. There is less likelihood of duplication of services in this case, and ultimately, it offers a more

comprehensive and holistic approach to consumer care. In some initiatives, community programs are viewed as an extension of the core collaborative team; however, their role tends to be less formal and not as well-defined. The providers who are most commonly part of the collaborative team include family physicians (94.4 per cent), nurses (89.9 per cent, 27 per cent of which were registered psychiatric nurses or mental health nurses), psychiatrists (84.3 per cent) and/or social workers (62.9 per cent). However, a broader range of providers, consumers, families and caregivers is increasingly being included as part of the interdisciplinary team.

Interdisciplinary communication enhances the effectiveness of collaborative services. Some of the reported benefits of interdisciplinary communication include a decrease in the duplication of services and more streamlined procedures for the consumer (i.e., so they do not have to tell their story many times to different professionals). Communication between health care partners differs in content, frequency and purpose. For example, communication between primary and mental health care providers can be case-specific, or it may include information about the diagnosis and treatment of common mental illnesses. Providers often meet frequently, either formally or informally, to exchange information that enhances the capacity of primary health care providers to offer appropriate mental health services. Communication between primary and/or mental health care providers and consumers tends to be less frequent, and often focuses on treatment plans or self-care issues.

Team Development

Another category of barrier that initiatives reported related to team development (18 per cent). This included challenges and frustrations with the normal evolution and characteristics of teams, including interpersonal relationship and professional 'turf" issues, misunderstandings and other frustrations based on a lack of coordination or clearly defined roles and responsibilities.

Solutions related to team development were among the most prevalent strategies used by the initiatives to address their challenges (37.1 per cent). For example, one initiative reported that it *"worked on creating an environment where staff feels they can be open and honest about their concerns regarding collaborative efforts."* Some of the other specific strategies used by initiatives include:

- Meetings with all of the team members to learn about their needs
- Frequent and clear communication of the expectations of all team members
- Clarifying roles and responsibilities
- Face-to-face sessions to increase group cohesion and contact between team members
- Involvement of all team members in the planning and implementation of the initiative;
- Fostering positive interactions and greater respect among team members
- Offering orientations for all new team members; and
- Providing the opportunity for team members to give their feedback.

"Issues that often occur when numerous disciplines are involved in a shared learning environment are role diffusion, maintaining a common goal, staff turnover, […] and working within multiple professional disciplines that have unique perspectives to client care."

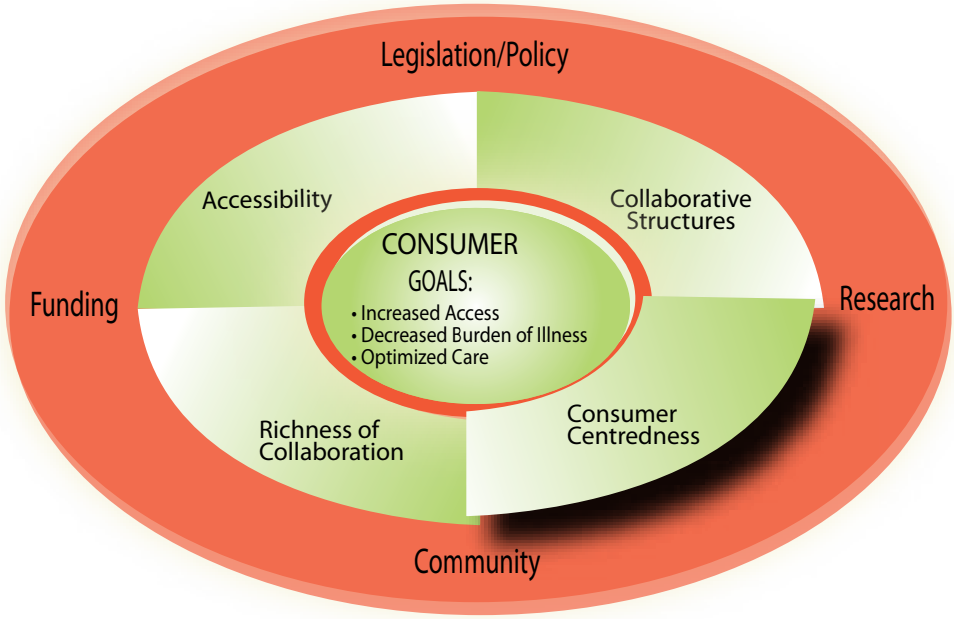
KEY MESSAGES

Knowledge Exchange

- The most common method for knowledge and skill transfer is the use of interactive sessions.
- The providers who are most commonly part of the collaborative team are family physicians, nurses, psychiatrists and social workers. There is a trend to include a broader range of primary and mental health care providers, consumers, families and caregivers.
- One of the most prominent strategies used by the initiatives to address their challenges is team development.

Consumer Centredness: Consumers as Active Partners

The needs of consumers are at the core of collaborative mental health care. Consumer centredness reflects the active involvement of consumers in all aspects of their care. This includes their involvement in the development of initiatives, helping to design their own treatment plans and guiding the evaluation of the initiatives. This key element also reflects programs or initiatives that address the needs of specific groups and, in particular, those that are often underserved or have a high need for both primary and mental health care.



Consumers as active health care partners: A growing number of collaborative mental health care initiatives emphasize the active role of consumers, families and/or caregivers in designing, implementing and sustaining collaborative initiatives. Examples of consumer centredness include: involvement in the initiative's design, operation and evaluation; peer support; adapting health promotion and treatment interventions to the unique needs of consumers; and educating consumers, families and caregivers.

General Discussion: Consumer Centredness

Consumer centredness is based on the idea that all consumers can and should be actively involved in all aspects of health care. A major myth concerning consumers with mental illness is that they have special needs resulting from their illness which impairs their ability to actively participate in "normal life." These beliefs are often acted on and entrenched within health care systems; so as to deny many mental health consumers access to the same range of human rights as citizens not affected by mental illness, according to the Standing Committee on Social Affairs, Science and Technology (2004). The National Association of State Mental Hygiene Program Directors and

Initiative Example

Active Consumers: The Healthy Minds/Healthy Children program in Calgary, Alberta, is supported by parent and youth involvement on the steering committee of the project's parent network (i.e., the Southern Alberta Child and Youth Health Network, or SACYHN). Parents and youth participate in planning and decision-making for SACYHN, which includes the overall direction and advocacy for the network. The steering committee establishes priorities and facilitates their implementation, determines network infrastructure and identifies resource needs. It also involves stakeholders, including families, and designs accountability mechanisms, as well as overseeing process and outcome evaluation.

Strategies

It was difficult to identify clear strategies that were related to consumer centredness. Several general examples were identified:

"Work hard to form relationships with patients."

"Ethno-cultural needs of clients have focused recruitment of mental health service providers who possess language skills reflective of the client base."

"With the Aboriginal community, the approach was to be respectful, wait to be invited, be available and genuinely interested, enter when invited, and no person refused."

"As the family context is all-important in the life of a child, family physicians need the experience of guiding parents, regarding what is the impact of mental illness on the family and how does the family unit cope."

"…[Initiative team members] being part of committees within the community that fosters the extension and possibilities of partnerships and networking opportunities."

"Promoting a health promotion approach to a child's care, with physicians and families, facilitates their acceptance and likelihood of accessing a shared mental health care service."

"The participants in the project development live and work in the community, so we have been able to generate widespread community support. A strong community-based steering committee has helped us interest the health authority and various fund-givers."

the National Technical Assistance Center (Deegan, 2005b) and others in the mental health consumers' movement affirm that all people have the same basic needs for community, companionship, decent and affordable housing, the right to choose the course their lives will take, and the resources to meet these needs. People with mental illness are able to speak for themselves and to participate in their personal health care process, as well as to represent themselves as stakeholders in the health system (Nolan and Badger, 2002).

Collaborative care offers the ideal opportunity to embrace roles for all participants. It allows providers to be trained to work in teams and to share responsibility for care, as well as expertise. It gives consumers a chance to be central to decision-making about their care, benefit from the interdisciplinary care, and be able to assess the quality of services they receive (Nolte and Tremblay, 2005). Consumers are also able to participate in the design, implementation and delivery of collaborative services, sharing their expertise from life experience and speaking to the responses that are most helpful to the very personal and individualized recovery process (e.g., Mowbray et al., 1997; National Association of State Mental Hygiene Program Directors and the National Technical Assistance Center, 2005a).

Barriers

It was difficult to identify barriers that were specific to consumer centredness because there were so few of them, and often, they were associated more generally with other barriers, making them obscure. Several general examples were identified:

"Convincing parents/guardians that current intervention efforts will have a positive impact further along in the child's development and does not mean that 'child welfare' will be brought in [was a challenge]."

"Stigma and ageism [were common barriers]."

"Some stable clients that are using minimal team services are reluctant to participate in the [initiative], as they will be discharged [from the initiative]."

"Building relationship with respect with the Aboriginal community involving elders, a public health nurse, four Bands, crisis workers, families etc… [was one barrier experienced]."

Although involving consumers as active health care partners is a trend that is growing in collaborative mental health care, initiatives across Canada vary considerably in the extent to which they involve consumers of mental health care services (or their families or caregivers) in their care.

Consumer involvement in collaborative care is difficult to assess unless specific and pointed questions are asked regarding all of the potential aspects of consumer centredness. Many initiatives will not explicitly express the many ways that consumers are involved when they are asked to provide a description of their collaborative activities. Through telephone interviews, this information was more evident. For example, many participants responded that their consumers are actively involved in designing their treatment plans — the most common aspect of consumer centredness that was evident among initiatives. However, this information was unlikely to be mentioned in the description of the initiative, as most suggested that it is a common practice and that "everyone should just know needs to be done."

Overall, several main themes summarize the involvement of consumers in collaborative mental health care. Consumers are actively involved in designing their treatment plans. Consumer, family

and caregiver involvement tends to be considered after an initiative has been developed. For example, few initiatives were able to (or decided to) include consumers during the development phase. However, more initiatives are using consumer feedback to make modifications in the initiative's activities. This is accomplished by actively seeking out this information through questionnaires, focus groups or needs assessments.

Further, consumers are more likely to be involved when there is an opportunity for change. That is, initiatives will seek out consumer involvement when funding is available to improve or expand the collaborative initiative. If funding for change or evaluation is not available, initiatives are less likely to request consumer feedback.

Few initiatives have a consumer, family or caregiver represented on the management team, steering committee and/or advisory group. It is unclear why this trend exists. More attention needs to be directed to uncovering the barriers to the involvement of consumers, family and/or caregivers in this aspect of consumer centredness. Finally, many initiatives explicitly report designing their collaborative services to meet the needs of special populations. Ninety-one per cent of initiatives reported that they served one special population, and 71.9 per cent serve at least two.

KEY MESSAGES

Consumer-Centredness

- Consumers, families and caregivers are becoming recognized as important members of the collaborative team. They are more involved in all aspect of the development, implementation, evaluation and governance of collaborative initiatives.
- Initiative contacts need to be asked direct questions about the involvement of consumers, families and caregivers, in order to accurately assess the degree to which these individuals are involved in the initiative's activities.
- The majority of mental health care initiatives serve at least one special population.

CONCLUSION

The participants who provided the valuable descriptions of initiatives used in Volume I of this report continue to work extremely hard to improve the quality and effectiveness of their services. Based on their responses, several key messages can be discerned.

From a macro level, several challenges remain, regarding policy, legislation, funding regulations and funds. Initiatives continue to advocate for policies and legislation to support collaborative activities. In addition, funding regulations and remuneration strategies not only need to be congruent with the goals of collaborative mental health care — they need to provide an incentive for mental and primary health care providers to engage in collaborative activities.

In addition, there is greater emphasis on identifying and implementing best practices that take the unique needs of communities into consideration. It is essential that program and service evaluations be encouraged, in addition to being conducted in a manner that allows the data to be used to identify better practices. Although 79.8 per cent of initiatives reported they are conducting evaluations, more guidance is needed to improve the usefulness of the data that is emerging. Research and evaluations can help to assess and demonstrate the quality, effectiveness and importance of collaborative mental health care activities.

What do collaborative mental health care initiatives look like across Canada? While it is clear that no two initiatives function exactly the same way, several important themes, trends and characteristics were evident and are described in detail in Volume I.

Each initiative attempts to address the unique needs of its community, while at the same time managing the available resources to which it has access. When it comes to accessibility, initiatives are most likely to use a combination of direct and indirect approaches to delivering their services. This means that both mental and primary health care providers deliver mental health services in primary health care settings. It also means that the initiatives are making the most of the benefits available from each approach and tailoring that approach to suit the unique needs of their consumers.

Collaborative structures and systems form the building blocks of collaborative mental health care. Nowhere is this more evident than in the data suggest that initiatives use strategies related to the structures of collaboration as the most common method of overcoming barriers and challenges.

The richness of collaboration among health care partners is definitely growing. Although family physicians, psychiatrists, social workers and nurses are the providers most commonly represented on collaborative teams, there is a growing trend to broadening the range of providers. Creating buy-in on the part of providers and consumers can present an important barrier to implementing and sustaining collaborative activities. Strategies related to advocacy, remuneration strategies and team development have been used to successfully enhance buy-in.

Consumers' goals to increase access to services, improve outcomes and decrease the burden of illness drive collaborative mental health care. Therefore, consumers must be considered valuable members of the collaborative team, with clearly defined roles and responsibilities — just like other

team members. In the long run, consumers need to be involved in all aspects of the initiative, from the development phase, through implementation, and the crucial evaluation phase.

It has become clear that *all* health care partners place high importance on the integration of mental health care into primary health care. Their commitment to providing Canadians with the best mental health care possible is also demonstrated through the creation of the CCMHI and its activities. With the continued identification of better practices, the creation of supportive policies, legislation, funding regulations and funds, the development of toolkits, and the creation of comprehensive resources such as this report, health care partners will be equipped to provide Canadians with the mental health care that they both need and want.

REFERENCES

Barrett JE, Barrett JA, Oxman TE, Gerber PD. The prevalence of psychiatric disorders in a primary care practice. Arch Gen Psychiatry. 1988 Dec;45(12):1100-6. <PubMed>

Bland RC, Newman SC, Orn H. Period prevalence of psychiatric disorders in Edmonton. Acta Psychiatr Scand Suppl. 1988;338:33-42. <PubMed>

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; 1998. p. 1-43.

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

Bosco C. Health human resources in collaborative mental health care. Mississauga, ON: Canadian Collaborative Mental Health Initiative; September 2005. Available at: http://www.ccmhi.ca

Burley J. Initiating and developing a shared care relationship in your community. CPA Bulletin de L'APC. 2003 Apr;35(2):34-6. Available at: http://www.cpa-apc.org/Publications/Archives/Bulletin/2003/april/burley.asp

Craven, M. et Bland, R. Meilleures pratiques pour des soins de santé mentale axés sur la collaboration : Une analyse des données existantes. La revue canadienne de psychiatrie 2006 : 51 (Suppl 1, mai) à paraître.

Dea RA. The integration of primary care and behavioral healthcare in northern California Kaiser-Permanente. Psychiatr Q. 2000 Spring;71(1):17-29. <PubMed>

deGruy FV 3rd. The primary care provider's view. New Dir Ment Health Serv. 1999 Spring;(81):33-9. <PubMed>

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>

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>

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> Available at: http://www.cfpc.ca/cfp/2001/Dec/_pdf/vol47-dec-research-1.pdf

Gagné MA. What is collaborative mental health care? An introduction to the Collaborative Mental Health Care Framework. Mississauga, ON: Canadian Collaborative Mental Health Initiative; June 2005. Available at: http://www.ccmhi.ca

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.

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> Available at: http://ps.psychiatryonline.org/cgi/content/full/54/11/1508

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.

Health Canada. Mental health, mental illness and addiction: overview policies and programs in Canada. A report on mental illness in Canada. Ottawa: Health Canada; October 2002. Available at: http://www.cmha.ca/data/1/rec_docs/171_full_report_mic.pdf

Henry GT. Practical sampling. Newbury Park: Sage Publications; 1990.

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>

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>

Hoge MA, Paris M Jr, Adger H Jr, Collins FL Jr, Finn CV, Fricks L, Gill KJ, Haber J, Hansen M, Ida DJ, Kaplan L, Northey WF Jr, O'Connell MJ, Rosen AL, Taintor Z, Tondora J, Young AS. Workforce competencies in behavioral health: an overview. Adm Policy Ment Health. 2005a May-Jul;32(5-6):593-631. <PubMed>

Hoge MA, Tondora J, Marrelli AF. The fundamentals of workforce competency: implications for behavioral health. Adm Policy Ment Health. 2005b May-Jul;32(5-6):509-31. <PubMed>

Institute of Medicine. Committee on Quality of Health Care in America. Crossing the quality chasm: a new health system for the 21st century. Washington, DC: National Academies Press; 2001. Available at: http://www.nap.edu/openbook/0309072808/html/index.html

Jenkins R. Mental health and primary care-implications for policy. International Review of Psychiatry. 1998 May;10(2):158-60.

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>

Kates N. Shared mental health care. The way ahead [editorial] [Article in English, French]. Can Fam Physician. 2002 May;48:853-5, 859-61. <PubMed>
Available at: www.cfpc.ca/cfp/2002/May/vol48-may-editorials-1.asp

Kates N, Ackerman S, Crustolo AM, Mach M. Collaboration between mental health and primary care services: a planning and implementation toolkit for health care providers and planners. Mississauga, ON: Canadian Collaborative Mental Health Initiative; In press 2005. Available at: http://www.ccmhi.ca

Kates N, Ackerman S, editors. Shared mental health care in Canada: a compendium of current projects. Ottawa: Canadian Psychiatric Association; Mississauga, Ontario, Canada: The College of Family Physicians of Canada Collaborative Working Group on Shared Mental Health Care; Spring 2002. Available at: http://www.shared-care.ca/pdf/compendium.pdf

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>

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/who/industry/Primary%20Care%20Intergration/pci-stakeholder.htm

Lesage A, Vasiliadis HM, Gagné MA, Dudgeon S, Kasman N, Hay H. Prevalence of mental illnesses and related service utilization in Canada: an analysis of the Canadian Community Health Survey. Mississauga, ON: Canadian Collaborative Mental Health Initiative; December 2005.

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>

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>

Martin CM. Making a case for transdisciplinarity [Article in English, French]. Can Fam Physician. 2003 Jul;49:905-8. <PubMed> Available at: http://www.cfpc.ca/cfp/2003/Jul/vol49-jul-resources-3.asp

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/SERVICE/consult/consult-pdf/PrimaryCareDiscPaper.pdf

McVicar J, Deacon D, Curran V, Cornish P. Interprofessional education initiatives in collaborative mental health care. Mississauga, ON: Canadian Collaborative Mental Health Initiative; August 2005. Available at: http://www.ccmhi.ca

Mowbray CT, Moxley DP, Jasper CA, Howell LL, editors. Consumers as providers in psychiatric rehabilitation. Columbia, MD: International Association of Psychosocial Rehabilitation Services; 1997.

National Association of State Mental Hygiene Program Directors and the National Technical Assistance Center. Implementing recovery-based care: tangible guidance for SMHAs. Alexandria, VA: National Association of State Mental Health Program Directors; 2005a. Available at: http://www.nasmhpd.org/spec_e-report_fall04intro.cfm

National Association of State Mental Hygiene Program Directors and the National Technical Assistance Center. Expert panel discusses workforce issues in the face of a recovery-based care transformation. Alexandria, VA: National Association of State Mental Health Program Directors; 2005b. Available at: http://www.nasmhpd.org/spec_e-report_fall04intro.cfm

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; 2002. p. 3-19.

Nolte N, Tremblay M. Enhancing Interdisciplinary Collaboration in Primary Health Care Initiative. Enhancing interdisciplinary collaboration in primary health care in Canada. Ottawa: Enhancing Interdisciplinary Collaboration in Primary Health Care Initiative; 2005. Available at: http://www.eicp-acis.ca/en/resources/pdfs/Enhancing-Interdisciplinary-Collaboration-in-Primary-Health-Care-in-Canada.pdf

Offord DR, Boyle MH, Campbell D, Goering P, Lin E, Wong M, Racine YA. One-year prevalence of psychiatric disorder in Ontarians 15 to 64 years of age. Can J Psychiatry. 1996 Nov;41(9):559-63. <PubMed>

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.

Pautler K, Gagné MA. Annotated bibliography of collaborative mental health care. Mississauga, ON: Canadian Collaborative Mental Health Initiative; September 2005. Available at: http://www.ccmhi.ca

Pauzé E, Gagné MA. Collaborative mental health care in primary health care: a review of Canadian initiatives. Volume II: resource guide. Mississauga, ON: Canadian Collaborative Mental Health Initiative; November 2005. Available at: http://www.ccmhi.ca

Pawlenko N. Collaborative mental health care in primary health care across Canada: a policy review. Mississauga, ON: Canadian Collaborative Mental Health Initiative; June 2005. Available at: http://www.ccmhi.ca

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.

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>

Romanow RJ, Marchildon GP. Psychological services and the future of health care in Canada. Canadian Psychology. 2003 Nov;44(4):283-95.

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>

Standing Senate Committee on Social Affairs, Science and Technology. Mental health, mental illness and addiction: overview of policies and programs in Canada. Interim report. Report 1. Ottawa: Government of Canada; November 2004. (Chair: Michael J.L. Kirby). Available at: http://www.parl.gc.ca/38/1/parlbus/commbus/senate/com-e/soci-e/rep-e/report1/repintnov04vol1-e.pdf

Stephens T, Joubert N. The economic burden of mental health problems in Canada. Chronic Dis Can. 2001;22(1):18-23. <PubMed>

Thornicroft G, Tansella M. Components of a modern mental health service: a pragmatic balance of community and hospital care: overview of systematic evidence. Br J Psychiatry. 2004 Oct;185:283-90. <PubMed> Available at: http://bjp.rcpsych.org/cgi/content/full/185/4/283

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: U.S. 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

Valianti LC. Small project reveals large cultural barriers to integrated care. Behav Healthc Tomorrow. 2004 Apr;13(2):19-23. <PubMed>

World Health Organization. World health report 2001: mental health: new understanding, new hope. Geneva: WHO; 2001. Available at: http://www.who.int/whr/2001/en/index.html OR http://www.who.int/whr/2001/en/whr01_en.pdf

World Health Organization. Mental Health Atlas — 2005 [database]. Geneva: WHO; 2005. Available at: http://www.who.int/mental_health/evidence/atlas/index.htm

World Health Organization. Investing in mental health. Geneva: WHO; 2003. Available at: http://www.who.int/mental_health/media/investing_mnh.pdf

appendixA
DATA COLLECTION TOOLS

A1. Key informant letter

A2. Contact letter

A3. Survey

A4. Revised information request letter

A5. Phone interview guide

A6. Consent form

appendixA

DATA COLLECTION TOOLS

A1. Key informant letter

Canadian Collaborative Mental Health Initiative

Initiative canadienne de collaboration en santé mentale

Dear Colleagues –

We are looking for your assistance in creating a very important resource intended to assist in strengthening collaborative, inter-disciplinary mental health care in Canada.

Funded through the Primary Health Care Transition Fund Project (Health Canada), the Canadian Consortium on Collaborative Mental Health Care is comprised of twelve national organizations, representing community services, consumers, family and self-help groups, dietitians, family physicians, nurses, occupational therapists, pharmacists, psychiatrists, psychologists and social workers from across Canada. The Consortium is working together to improve the mental health and well-being of Canadians by strengthening the relationships and improving collaboration among health care providers, consumers and their families and communities. For more information, please see http://www.shared-care.ca/consortium.shtml.

Our shared vision is of a country where consumers receive the most appropriate service, from the most appropriate provider, when they need it, in a location that is accessible and with the fewest obstacles. Together, the partners will develop a charter to define their inter-relationship(s) and develop strategies to support collaboration among individual health care providers, consumers and community/social services.

One of the **key activities is the development of a *Review of Collaborative Mental Health Care Initiatives in Primary Health Care**** (working title) that demonstrates successful interdisciplinary, collaborative mental health care in primary care. This resource is intended to document the 'state-of-the-art' in collaborative mental health care and to provide a resource tool to assist others in developing their own initiatives. The Review will build upon and broaden the Compendium compiled in 2002 by the Collaborative Working Group on Shared Mental Health Care (to see a copy, go to http://www.shared-care.ca/pdf/compendium.pdf). In this Review, we will include the full range of health professionals, consumers, and providers involved in mental health care.

We are requesting your assistance in identifying the contact person for *Canadian or international initiatives,* that should be included in the 2005 *Review of Collaborative Mental Health Care Initiatives in Primary Health Care* (working title). **Please forward the contact name, a telephone number and/or email and the location of the initiative(s) to *Marie-Anik Gagné*, Project Manager, on or before Friday, September 24, 2004: fax (905) 629-0893 or e-mail mag@cfpc.ca. Please forward this request to any interested parties.**

If you have any questions or comments regarding this initiative, or the Canadian Consortium, please email or call Marie-Anik Gagné, Project Manager, mag@cfpc.ca or (905) 629-0900 ext. 209.

With great appreciation, and thanks in advance for your assistance with this important work, I remain

Sincerely yours,

Scott Dudgeon
Executive Director
Canadian Collaborative Mental Health Initiative

The College of Family Physicians of Canada
2630 Skymark Avenue
Mississauga, ON
L4W 5A4
tel: (905) 629-0900 fax: (905) 629-0893

appendixA

DATA COLLECTION TOOLS

A2. Contact letter

Canadian Collaborative Mental Health Initiative

Initiative canadienne de collaboration en santé mentale

Dear Colleagues –

We are looking for your assistance in creating a very important resource intended to assist in strengthening collaborative, inter-disciplinary mental health care in Canada.

Funded through the Primary Health Care Transition Fund Project (Health Canada), the Canadian Consortium on Collaborative Mental Health Care is comprised of twelve national organizations, representing community services, consumers, family and self-help groups, dietitians, family physicians, nurses, occupational therapists, pharmacists, psychiatrists, psychologists and social workers from across Canada. The Consortium is working together to improve the mental health and well-being of Canadians by strengthening the relationships and improving collaboration among health care providers, consumers and their families and communities. For more information please see http://www.shared-care.ca/consortium.shtml.

Our shared vision is of a country where consumers receive the most appropriate service, from the most appropriate provider, when they need it, in a location that is accessible and with the fewest obstacles. Together, the partners will develop a charter to define their inter-relationship(s) and develop strategies to support collaboration among individual health care providers, consumers and community/social services.

One of the **key activities is the development of a *Review of Collaborative Mental Health Care Initiatives in Primary Health Care*** (working title) that demonstrates successful interdisciplinary, collaborative care in mental health. This resource is intended to document the 'state-of-the-art' in collaborative mental health care and to provide a resource tool to assist others in developing their own initiatives. The Review will build upon and broaden the Compendium compiled in 2002 by the Collaborative Working Group on Shared Mental Health Care, and will include: consumers, family and self-help groups, dietitians, family physicians, nurses, occupational therapists, pharmacists, psychiatrists, psychologists and social workers (to see a copy, go to http://www.shared-care.ca/pdf/compendium.pdf).

Below, please find a **brief survey** that will ensure that your initiative is included in the *Review of Collaborative Mental Health Care Initiatives in Primary Health care*, to be released in 2005. It can be filled out in one of two ways:

1. as an email (ie, completed in the body of the email itself and returned via email) or
2. as a word document, which can be downloaded, completed by word processing and returned via email or fax to (905) 629-0893.

If you have any questions or comments regarding the survey, please email or call Marie-Anik Gagné, Project Manager, mag@cfpc.ca or (905) 629-0900 ext. 209.

We greatly appreciate your assistance in completing this survey and returning it on or before October 22, 2004. The *Review of Collaborative Mental Health Care Initiatives in Primary Health care* will be not only an important record of the state of interdisciplinary mental health care, but an invaluable resource to others hoping to improve mental health care in Canada through enhanced collaboration.

Sincerely,

Marie-Anik Gagné, PhD
Project Manager
Canadian Collaborative Mental Health Initiative

The College of Family Physicians of Canada
2630 Skymark Avenue, Mississauga, ON L4W 5A4
tel: (905) 629-0900 ext. 209, fax: (905) 629-0893

appendixA

DATA COLLECTION TOOLS

A3. Survey

Canadian Collaborative Mental Health Initiative

Initiative canadienne de collaboration en santé mentale

2005 REVIEW OF COLLABORATIVE MENTAL HEALTH CARE INITIATIVES IN PRIMARY HEALTH CARE SURVEY QUESTIONS
Program / Project Title:
Sponsoring organization(s):
Other participating organizations or individuals:
Current Status: ongoing, completed, abandoned (starting date, finish date)
Funding - Source and duration:
Identify the individual or organization responsible for the regulation of funds:
Rationale:
Goals:
Description:
Which of the following populations do you primarily serve? Please check all that apply. ◎ Homeless/Transient ◎ Concurrent Disorders ◎ Children & Youth ◎ Seniors/Geriatrics ◎ Aboriginal ◎ Ethno-Cultural ◎ Northern/Isolated ◎ Rural ◎ Urban ◎ Disorder Specific (e.g., depression) ◎ Serious Mental Illness ◎ Other, please describe:
Identify service delivery site(s) (if applicable). Please note the number of sites, and the type of site (e.g., hospital, community health clinic, private practice, university, others).
Which health care provider assumes liability for patients/clients involved in the collaborative initiative?
Service Volumes: How many client visits per month? _____ How many patients per month? _____

Resources: Type and FTEs of service providers involved, including dietitians, family physicians, nurses, occupational therapists, social workers, pharmacists, psychiatrists, psychologists, self-help or advocacy groups, others.
Please include:

- Collaborative or indirect/external relationships with other service providers, including any of the list immediately above
- Relationship with any primary medical care setting – (if not covered above)
- Relationship with any community-based agency or service – (if not covered above)

Is there something unique to your local setting that played a role in implementing your initiative?

Briefly describe the difficulties encountered in setting up and sustaining this initiative.

Briefly describe the strategies used to overcome difficulties identified above:

Program or Service Evaluation:
Did you evaluate your collaborative mental health care initiative?

- No
- Yes – Ongoing
- Yes - Completed

What were the top 3 key findings?
Where can the evaluation be accessed? (i.e., website, request a hard copy, etc)

Identify planned future developments of your project:
Identify desirable future developments (assuming resources available):

Use of internet-based technology:
What technology is used to support the work of the initiative? Check all that apply:

- Telehealth
- Electronic health record
- Email
- Other, please specify_____

Identify any other significant aspects of the project, or comments:

Contact(s): Including name, organization, address, telephone, fax and email

Were you aware of the publication "Shared Mental Health Care in Canada: A Compendium of Current Projects" (2002) prior to receiving this survey?
____Yes _____No

If yes, was it useful to you in the development of your initiative? ____Yes ____No

Do you have any recommendations or suggestions on ways in which this *Review of Collaborative Mental Health Care Initiatives in Primary care* could be made more useful?

Thank you for completing this survey!
Please complete and return the survey on or before [Insert date] to Enette Pauzé
e-mail: ep@cfpc.ca fax: (905) 629-0893

appendixA

DATA COLLECTION TOOLS

A4. Revised information request letter

Canadian Collaborative Mental Health Initiative

Initiative canadienne de collaboration en santé mentale

IMPORTANT REQUEST!!

Please respond to Enette Pauzé, ep@cfpc.ca fax: (905) 629-0893 as soon as possible.

Dear Colleagues:

A representative from your association/college is a member of the Canadian Collaborative Mental Health Initiative (CCMHI). This Initiative is conducting a national *Review of Collaborative Mental Health Initiatives in Primary Health Care* (working title). We do not wish to miss any key collaborative activities.

Thank you to all of you who responded to our previous requests!

This Review is intended to represent the range of collaborative mental health initiatives in Canada, and to provide a resource tool to assist others in developing their own initiatives. This Review will build upon and broaden the Compendium of Current Projects on Shared Mental Health Care in Canada compiled in 2002 by the Collaborative Working Group on Shared Mental Health Care. The new Review will include initiatives involving consumers, family and self-help groups, community-based services, dietitians, family physicians, nurses, occupational therapists, pharmacists, psychiatrists, psychologists and social workers (to see a copy, go to http://www.shared-care.ca/pdf/compendium.pdf).

Over the past several months, we have been working very hard to contact individuals involved in various collaborative mental health initiatives, in order to collect valuable information about the current state of collaboration.

If you are involved in or are aware of a *collaborative* approach to providing mental health services in a primary care setting (an approach whose purpose is to enhance mental wellbeing and/or to improve the mental health of individuals and their families and involves your discipline and at least one other discipline), we need to hear from you. *If one of your colleagues is better suited to respond, please forward this request to them.*
Please tell us more about your initiative by providing details related to the following:

- **Program / Project Title**
- **Sponsoring organization(s)**
- **Funding** - Source and duration (please also identify the individual or organization responsible for the regulation of funds). Is the funding part of a funding or policy framework encouraging collaborative initiatives, or is it for a more local, *ad hoc* or demonstration initiative?
- **Current Status:** ongoing, completed, abandoned (starting date, finish date)
- **Rationale**
- **Goals**
- **Description,** For example:
  - Identify service delivery site(s) (if applicable). Please note the number of sites and the type of site (e.g., community group or agency, hospital, community health clinic, private practice, university, others).
  - Which service provider(s) assume legal liability for clients/patients involved in the collaborative initiative?
  - Service Volumes: How many client visits per month? How many individual patients per month?
  - Resources: Type and FTEs of service providers directly involved, including self-help or advocacy services, dietitians, family physicians, nurses, occupational therapists, social workers, pharmacists, psychiatrists, psychologists, others. Please include:
    - Collaborative or indirect/external relationships with other service providers, including any of the list immediately above
    - Relationship with any primary medical care setting – (if not covered above)
    - Relationship with any community-based agency or service – (if not covered above)
  - Is there something unique to your local setting that played a role in implementing your initiative?
  - Briefly describe the difficulties encountered in setting up and sustaining this initiative, and any strategies used to overcome these difficulties. Include lessons learned.

- **Special Populations:** Please identify any specific populations that you primarily serve.
  - **Homeless/Transient**
  - **Disorder Specific (e.g., depression)**
  - **Concurrent Disorders**
  - **Children & Youth**
  - **Seniors/Geriatrics**
  - **Aboriginal**
  - **Ethno-Cultural**
  - **Self-help (e.g., group setting)**
  - **Northern/Isolated**
  - **Rural**
  - **Urban**
  - **Other, please describe:**
- **Program or Service Evaluation** (yes, no, ongoing - What were the top 3 key findings?)
- **Planned future developments**
- **Desirable future developments (assuming resources available)**
- **Use of information/communication technology** (e.g., telehealth, electronic health record, email)
- **Any other significant aspects of the project, or comments**
- **Project Contact(s)** (name, address, E-mail, phone and fax numbers)

If you would like to learn more about our national initiative, the CCMHI, please refer to the attached brochure, or visit www.ccmhi.ca.

We thank you for taking the time to share your collaborative mental health activities. The information you provide is vital to the success of this national initiative and improving the state of mental health services in Canada.

Sincerely yours,

Scott Dudgeon
Executive Director
Canadian Collaborative Mental Health Initiative

The College of Family Physicians of Canada
2630 Skymark Avenue
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appendixA

DATA COLLECTION TOOLS

A5. Phone interview guide

Canadian Collaborative Mental Health Initiative | Initiative canadienne de collaboration en santé mentale

Phone Interview Guide

Steps:

1. Book phone calls.
2. ½ hour needed to prep before each phone call.
3. 1 hour needed per phone call. (1.5 hours average needed for each call)

Suggested phone script:

Hello, my name is _____ and I am calling on behalf of the Canadian Collaborative Mental Health Initiative.

A few weeks ago, we emailed you a survey to collect information about the collaborative mental health initiative you are working on. We have extended our response deadline so we can ensure that important initiatives, such as yours, are not missed.

The information you provide us with will be published in our report, *Collaborative Mental Health Care in Primary Health Care: A Review of Canadian Initiatives*. From this resource, others will be able to create more collaborative initiatives.

Can we send you another copy of the survey?

We greatly appreciate your assistance in completing this survey and returning it on or before **(insert appropriate date)**. The information you provide will be not only an important record of the state of interdisciplinary mental health care, but an invaluable resource to others hoping to improve mental health care in Canada through enhanced collaboration.

If you have any questions or comments regarding the survey, please email or call Marie-Anik Gagné, Project Manager, mag@cfpc.ca or (905) 629-0900 ext. 209.

Thank you for your time - we look forward to receiving information about your initiative.

General Project Information:

One of our key activities is the development of the report *Collaborative Mental Health Care in Primary Health Care: A Review of Canadian Initiatives* to demonstrate successful interdisciplinary, collaborative care in mental health. This resource is intended to document the 'state-of-the-art' in collaborative mental health

care and to provide a resource tool to assist others in developing their own initiatives. The Review will build upon and broaden the Compendium compiled in 2002 by the Collaborative Working Group on Shared Mental Health Care.

The survey can be filled out in one of two ways:

1. as an email (ie, completed in the body of the email itself and returned via email) or
2. as a word document, which can be downloaded, completed by word processing and returned via email or fax to (905) 629-0893.

Suggested questions:

1. Briefly explain why we are gathering this information (to produce a Review).
2. Explain the direction of the phone call (to gather more information about activities).
3. Ask contact to describe their program in 2-3 minutes or less.
4. Ask specific questions that get at the finer details of how the program works. For example:
    a. Who sees the patient/client first?
    b. Who assumes the role of the primary care provider?
    c. How do members of the team (or various providers involved) communicate patient information? (e.g., how often, using what methods, and where is the information recorded)
    d. Where are services provided?
    e. Are all providers located in the same building?
    f. Do the primary health care providers have access to the mental health specialists on an ongoing basis if needed?
    g. What are the service volumes?
    h. How are patients/clients involved in the program? Do you have consumer representation on your committee or board? Were consumers/families/caregivers involved in the development or evaluation of the program?
    i. What information technologies support the program?
    j. Is there opportunity for ongoing professional development?
5. Gather missing information using the Evaluation form as a guide.
6. Emphasize gathering information about consumer centredness.
7. Ask contacts to send evaluation information, or ask where it can be accessed.
8. Ask contacts about other initiatives they are aware of (title, location, contact).
9. Does the contact have any questions?
10. Remind the contact that a consent form will be sent to them, along with their description.

appendixA

DATA COLLECTION TOOLS

A6. Consent form

Canadian Collaborative Mental Health Initiative
Initiative canadienne de collaboration en santé mentale

Dear [INSERT initiative contact(s)],

Thank you for taking the time to share your collaborative mental health care activities. As discussed, a description of your initiative has been formatted to be included in the *Review of Collaborative Mental Health Care Initiatives in Primary Health Care* (2005, working title). For our next step we need:

1) Confirmation that your initiative information (see attached) is accurate (missing information is highlighted in yellow); and,
2) Your consent to include this information in this Review, being compiled by the Canadian Collaborative Mental Health Initiative (www.ccmhi.ca).

Please note any inaccuracies or required changes to the attached document and forward to Enette Pauzé (ep@cfpc.ca). We are restricted to 2-pages per initiative. Your description has been formatted to be concise (*approximately 300 words*) while trying to maintain the integrity of your initiative. ***Please provide your comments and/or consent on or before [INSERT date].***

To save time, if you will be making changes to the attached initiative description, please sign the consent from based on your revisions.

We thank you for your time and attention. Your information and experience will be an invaluable resource to helping others improve mental health care through collaboration! Please do not hesitate to contact me with any questions.

Kind regards,

Enette Pauzé
Research Coordinator
Canadian Collaborative Mental Health Initiative
ep@cfpc.ca
tel: (905) 629-0900 ext. 250
fax: (905) 629-0893

Consent Form

I hereby give the Canadian Collaborative Mental Health Initiative (CCMHI) consent to include the information presented in the attached initiative description: "[INSERT Initiative title]" in the Review of Collaborative Mental Health Initiatives in Primary Health Care (2005, working title) being compiled by the CCMHI.

Name: _____ Position: _____
(please print)

Signature:_____ Date: _____

Please complete and return the form by either:
Inserting you electronic signature and E-mail to Enette Pauzé (ep@cfpc.ca) or
Signing the form and faxing to Enette Pauzé (905) 629-0893

appendixB

EXAMPLES OF BARRIERS AND STRATEGIES

Examples of barriers experienced by the initiatives

Barriers	Examples
Buy-in	Lack of buy-in Misconceptions about the concept of collaborative care Fear of job loss Feeling threatened by other providers on the collaborative team Reluctance of providers to embrace new and unfamiliar work arrangements
Evaluation	Lack of evaluations published by comparable programs Lack of effective assessment tools and systems Little time for evaluation Lack of resources for evaluation
Funding/ remuneration	Lack of funding for meetings and other necessary collaborative activities Lack of funding for providers to participate in collaborative activities Lack of sustained funding Inadequate funding Difficulty obtaining funding for the start-up of the initiative Obtaining payment for providers to take part in educational initiatives Challenges with fee-for-services sites Inflexible remuneration strategies
Geography	Isolation of collaborative team members Geographic challenge of the province size Large distribution of patients, providers and specialized facilities
Human resources	Unavailability of targeted expertise Shortage of required resources Challenges with finding the appropriate ratio of providers per clinic based on required services Inadequate resources based on need Staff turn-over

Barriers	Examples
Policy and legislation	Legal issues related to recording visits when using an electronic medical record Challenges with sharing information between organizations Lack of a developed protocol to inform the patient/client of necessary information
Skill	Discomfort with providing mental health services Lack of skill to provide specific services Lack of providers with required skill sets
Structures/systems	Challenges with developing a model for collaborative care Lack of a designated coordinator Difficulty with sufficiently involving regional partners in the planning process Challenges with referrals High referral volumes Difficulty with meeting goals related to wait times Lack of space Lack of time Difficult to schedule providers who are very busy Required renovations to physical space
Team development	Difficulty building relationships with community partners, families, consumers, and caregivers Growing pains associated with team development Role diffusion Difficulty maintaining a common goal Each professional discipline has a unique perspective to providing care to consumers
Technology	Lack of database to analyze the information being collected in the program Lack of skills related to the technology used to provide services Lack of technical support Discomfort with using the technology, including video conferencing equipment

EXAMPLES OF BARRIERS AND STRATEGIES

Examples of strategies used to overcome barriers experienced by the initiatives

Strategies	Examples
Advocacy	Developed key partnerships with community resources Encouraged 'word-of-mouth' advertising Lobbied for the services and benefits of collaborative care Promoted a healthier lifestyle and/or increased quality of life to patients/clients
Buy-in	Received support from leaders/champions in the field Administrative/management personnel saw value in the collaborative activities Providers saw value in the collaborative activities
Evaluation	Used evaluations to dispel myths and support the benefits of collaborative initiatives Used an ongoing review of monthly statistics to ensure adequate resources were allotted to each collaborative initiative location Results of evaluation led to a refined service delivery model Regular performance reviews showed enhanced satisfaction of providers and patients/clients
Funding/ remuneration	Obtained adequate funding Obtained sustained funding Worked collaboratively with stakeholders to apply for funding Found creative funding sources Obtained additional funding to supplement fee-for-service arrangements Used salaried positions rather than fee-for-service arrangements Used creative funding sources to remunerate providers who were not funded by capitation
Geography	Staff visited mental health clinics outside of their region Isolation of providers was reduced through participation in monthly meetings, continuing education events, and professional development groups Used various information technologies to enhance communication with isolated sites

Strategies	Examples
Human resources	Received resources from internal sources Pooled resources with partner organizations Recruited providers that were willing to work in a collaborative initiative
Policy and legislation	A new mental health plan was developed and implemented in the region Worked closely with governments during the project development and its implementation to ensure the focus and expected outcomes were in line with the government framework Government incorporated mental health care into primary health care reform models Developed and implemented protocols regarding legal and health information to comply with statutes Developed a medical directive to allow providers to independently assess patients and share patient records
Skill	Funded additional skills training for providers Offered continued education opportunities Focused on capacity building of local providers and community members
Structures/ systems	Formed a working group composed of representatives of the various stakeholders so that the project reflected the input of those most involved in it Developed flexible structures to accommodate the needs of the community Created designated planning days for team meetings Implemented strong orientations for new team members Worked closely with key stakeholders to ensure that the initiative goals were achieved Implemented a coordinator who had clearly defined roles and responsibilities Reviewed partnership agreements and recommitted to the purpose, objectives, and service delivery methodologies with all of the key stakeholders Developed guidelines for appropriate referral strategies Developed strong links between primary-, secondary- and tertiary-level service facilities Developed communication strategies Obtained adequate space for necessary meetings Obtained additional funding for required space Obtained funding for renovations of physical space required Created more flexible work hours to accommodate staffing Offered flexible meeting times to accommodate busy work schedules

Strategies	Examples
Team development	Held meetings with all team members where they could share their concerns and success stories Developed respectful relationships with team members and members of the community Held regular planning days Encouraged regular, candid, and clear communication among staff members Involved both senior management and clinical leaders in the planning and implementation of the initiative
Technology	Used telehealth technologies to bridge the distance between isolated communities Used distance-based technologies to decrease costs Used electronic health records to enhance communication between providers

appendixC

INITIATIVE EVALUATIONS

- **Introduction**
- **Cluster A: Educational Capacity-building Interventions**
- **Cluster B: Traditional Collaborative Care Programs for People with Moderate Mental Illness**
- **Cluster C: Collaborative Care for People with Serious Mental Illness**
- **Barriers to Collaboration and Strategies Used to Overcome these Challenges**
- **Summary**

Introduction

The information presented in this section is based on a preliminary examination of evaluation information provided by collaborative mental health care initiatives. Further research is needed to produce a comprehensive analysis and discussion of the themes, trends and key findings, as they relate to previous research and better practices.

The participants were asked to submit any proposed evaluation strategies or evaluation results for analysis completed prior to January 2004. These data were then forwarded to researchers of the Continuous Enhancement of Quality Measurement (CEQM) in Primary Mental Health Care: Closing the Implementation Loop Project for further analysis.[13] As a sister project of CCMHI, the CEQM project provided advice for the current research, as presented in Volume I.

Documentation for 16 programs reviewed.

The following summary is based on a synthesis of findings from collaborative mental health care initiative program evaluations and other documentation related to primary care mental health collaborative care projects funded by the Primary Health Care Transition Fund.[14] Our goal was to identify and describe preliminary themes with respect to the outcomes achieved by programs, and the processes that had led to those outcomes.

Program Documentation and Types of Initiatives Reviewed

The documentation available for this analysis ranged from descriptive data (including program proposals, model descriptions and reports on program outputs), to process evaluations (using mainly qualitative methodologies), to outcome evaluations (using pre/post methodologies, or pre/post/ plus comparison groups, and using mixed qualitative and quantitative analysis). The programs reviewed also varied in their degree of maturity, having been in existence from nine months to eight years at the time the program data was gathered. Documentation for 16 programs in total was available (see Table A).

Table A **Number of Initiatives Providing Evaluation Information**

Province	Number of Program Evaluations Received
Alberta	3
Manitoba	1
Ontario	11
New Brunswick	1
Total	16

13 Eric Macnaughton, MA, PhD (candidate), University of British Columbia; and Dr. Paul Waraich, MD, MHSc., Assistant Professor, MHECCU, Department of Psychiatry, University of British Columbia.

14 Also referenced: Burley J. Initiating and developing a shared care relationship in your community. CPA Bulletin de L'APC. 2003 Apr;35(2):34-6. Available at: http://www.cpa-apc.org/Publications/Archives/Bulletin/2003/april/burley.asp, and 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>

Initiatives Reviewed:

1. Calgary Urban Project Society (CUPS)
2. Children's Mental Health Collaborative Care Clinic: A Shared Care Model of Youth Mental Health Consultation in a Family Practice Training Centre
3. Collaborative Mental Health Care Network
4. Diabetes Screening, Risk Management and Disease Management in a High-risk Mental Health Population
5. Early Psychosis Program
6. Hamilton Health Service Organization (HSO) Mental Health and Nutrition Program
7. Hospitalist: An Integrated Physician/Nurse-Practitioner Model
8. North Bay Ontario and Region Community Mental Health Consultation Service
9. Northeast Community Health Centre, Mental Health and Addictions Shared Care
10. Psychotic Disorders Clinic at McMaster University
11. Region of Peel Outreach Program
12. Shared Care Clinical Outreach Service
13. Shared Mental Health Care
14. The SEED Project (Support and Education for Primary Care Focusing on the Elderly with Disorders in Mental Health)
15. Transition into Primary Care Psychiatry (TIPP)
16. Winnipeg Regional Health Authority Shared Mental Health Care Program

The types of initiatives reviewed fell into three clusters. Each cluster varied by the degree that mental health specialists were directly or indirectly involved, (for example, by providing education or consultation to primary health care providers, without being actively involved in consumer care).

Cluster A: Educational Capacity-building Interventions

All of the interventions in the **first cluster** (*Educational Capacity-building*) consisted of indirect collaborative care. This means that mental health specialists provided education and/or skill-building for collaborative care providers (consisting primarily of general practitioners), so that they could deal more effectively with mental health issues on an independent basis (with consultation available).

The interventions in this cluster represent a range of educational strategies, delivered either as a multi-pronged approach, or individually. The range includes continuing medical education

Cluster A initiatives (*Educational Capacity-building*) consisted of interventions that used an indirect approach to collaborative care. Three of the 16 initiatives fit into this cluster.

events, mentor network development, the use of computer technology for knowledge exchange (e.g., e-mail, Web-based information approaches), small group case-based learning approaches, and educational case consultations or supervisory sessions. These interventions either address mental health issues as a whole or focus on specific issues (e.g., geriatric or children's mental health issues). They included a province-wide initiative, as well as projects targeting both urban and rural communities.

As a whole, these approaches are typically aimed at increasing knowledge, skills and the comfort level among family physicians (or other primary health care providers) with respect to mental health (e.g., addressing issues of detection, diagnosis, management, treatment choices, referral issues and awareness of community resources). Generally, these interventions focused on internal capacity-building and the network development of practitioners, rather than service delivery changes (e.g., development of new shared-care or collaborative care arrangements). The actual outcomes achieved by the initiatives were described most often in qualitative terms, and described the impact on the physician, rather than the consumer, based on the assumption that increased capacity will lead to improved quality and efficiency of care.

Findings/Common Themes:

1. There is evidence of increased knowledge, skill and comfort among providers related to dealing with mental health issues.
2. Early findings provide evidence that physicians feel more confident, comfortable and knowledgeable, less isolated, that they show a general "increased readiness" for change, and are more "oriented to intervene".
3. There is a link between case-based consultation and education, a commonly used and apparently effective strategy for capacity-building. Case-based education appears preferable and superior to "one-off" educational events, due to the opportunity for practical problem-solving, as well as small group dialogue on issues that are relevant and timely.
4. Mentor network development appears to be more valuable for providers in sole practice. For example, providers who are in group-based practices or who have established informal networks are more likely to turn to colleagues with whom they have a pre-existing relationship, before consulting an "outside" mentor. Being able to pick up the phone and have a conversation with someone with whom one has developed a relationship appears preferable to technological approaches such as e-mail and Web-based resources, which can make clear communication difficult, and often present technological or culture-of-practice barriers.

Cluster B: Traditional Collaborative Care Programs for People with Moderate Mental Illness

The initiatives in the **second cluster** (*Traditional Collaborative Care*), were also oriented towards capacity-building of the primary health care sector, but were also explicitly focused on developing new service delivery arrangements (i.e., collaborative care structures and processes/systems) to bring primary health care and mental health specialists into ongoing collaborative working arrangements. These initiatives varied in the extent to which collaborative care was directly or indirectly provided, and in the extent to which the mental health specialist maintained direct involvement in the care of consumers.

Cluster B initiatives (*Traditional Collaborative Care*) focused on developing new service delivery arrangements to bring primary health care and mental health specialists into ongoing collaborative working arrangements. Four of the 16 initiatives fit into this cluster.

The initiatives in this cluster generally provide support to people considered to have moderate mental illness (most commonly, depression and anxiety) and mental health concerns related to situational or relationship difficulties, using the direct collaborative care arrangement, where mental health specialists (psychiatrists and other professionals offering psychotherapy or counselling) provide services on-site at family physicians' offices or primary health care clinics. One program provides specialist services through an off-site clinic, an example of direct versus indirect collaborative care. Despite the term "moderate mental illness", data from one initiative suggested that the population served includes a high proportion (more than 50 per cent) of individuals with two or more disorders, who have a high degree of functional impairment, and conditions typically lasting one year or more.

Most of the initiatives in Cluster B involved case-based consultation and education from both counsellors and psychiatrists, and ongoing collaborative care arrangements in which the family physician retained responsibility for ongoing management, with backup available from a mental health specialist. The services offered by the therapist often used a "brief treatment" mode of practice (i.e., six to 12 sessions) involving goal-setting, problem-solving, stress management, psycho-education and/or cognitive behavioural therapy.

As a whole, the collaborative care strategies developed by these initiatives were aimed at achieving outcomes such as increased practitioner skills and confidence in detecting and managing mental illness, efficient use of mental health specialist services, and greater satisfaction of family physicians with their ability to gain access to specialist care when they need it, as well as overall satisfaction with communication and collaboration with specialty care. Given the relatively long history of the initiatives in this cluster, the available research gives more emphasis to outcome data, which generally contain findings related both to outcome and process.

Findings/Common Themes:

1. The satisfaction with collaborative care by family physicians is high, as evidenced by quantitative measures and other indirect indicators of satisfaction.

2. The case-based education and support provided via joint consultant/physician assessment or therapy sessions, and through ongoing case-based communication, appears to lead to increased capacity (e.g., skills, comfort, confidence) among primary health care physicians.
3. Increased primary health care capacity and efficiency was demonstrated by various types of indicators relating to the comfort level of family physicians or other primary health care practitioners in meeting the needs of consumers with mental illness. For example, one initiative found that 72 per cent of their provider participants improved their ability to identify and manage mental health concerns, resulting in a decreased level of referrals and a relatively low rate of follow-up visits (as compared to new visits) by consultants. In addition, another initiative reported a decrease of 10 per cent in inpatient admissions and a shorter duration of acute and outpatient care, due to better liaison and discharge planning.
4. Effective collaborative care arrangements lead to improved consumer-level outcomes. For example, there is greater confidence among consumers that their needs will be met. There is also a higher probability that more information will be offered to them about their illness, and that the impact of treatment on self-rated self-esteem, and quality of life will be greater. In addition, at least two initiatives reported highly significant reductions in depression, anxiety and somatization, falling to levels below diagnostic threshold, as well as small but significant reductions in illness-related disability.

Cluster C: Collaborative Care for People with Serious Mental Illness

The **third cluster** (*Collaborative Care for People with Serious Mental Illness*) consisted of initiatives that had taken traditional collaborative care approaches (e.g., originally developed for people with moderate mental illness) and adapted them to serve people with more serious and ongoing conditions (often with complex needs, such as homelessness). Initiatives in this cluster typically were in the process of developing collaborative relationships with the formal mental health system, serving people with serious and persistent mental illness.

Cluster C initiatives (*Collaborative Care for People with Serious Mental Illness*) took more traditional collaborative care approaches and adapted them to serve people with more serious and ongoing conditions. Nine of the 16 initiatives fit into this cluster.

Many of these initiatives have adapted the traditional collaborative care approach to better meet the specific needs of people with more serious mental illness (e.g., schizophrenia and other complex needs such as homelessness and substance use). One of the initiatives was implemented in the context of an urban community health centre that provides a range of physical health services. While it was sponsored in an institutional setting, another initiative provided health and mental health care to homeless individuals in hostels, also located in the inner-city area.

Most initiatives in this cluster attempt to provide both health and mental health care to people with serious mental illness, either by bringing mental health services into a physical health services

delivery context, or vice-versa. Two of the initiatives from Cluster C are not typical collaborative mental health care programs, but are included within this cluster because of their attempts to develop collaborative structures for ensuring that the health and mental health needs of people with serious mental illness are addressed in a more coordinated fashion. One provides health care services to residents of a provincial psychiatric hospital; the other seeks to provide early detection for diabetes in a high-risk population (users of new generation antipsychotic medications) within the city's case management teams.

Viewed as a cluster, these initiatives provide a continuum of care for people with serious mental illness, which complements the resources of the formal mental health system. This continuum ranges from early detection of first-episode psychosis and engagement of individuals with complex issues to direct provision of mental health and health services; services also include interim case management with links to health services and community resources, and quick access to ongoing treatment on an "as-needed" basis.

For example, one initiative provides an alternative to case management for individuals (both first-episode and those who were previous "heavy users" of services) who have reached the point where they can self-manage their care with the support of their family doctor and back-up from the initiative. Another initiative provides care for individuals who were previous high users of a downsized provincial psychiatric hospital or other acute care services, and consumers with serious mental illness from rural areas with particularly challenging access barriers to specialized or acute care. As a whole, these programs attempt to provide greater access, increased primary health care capacity, greater continuity and comprehensiveness of care, and more timely and efficient use of specialist or high-cost resources. They also provide more equitable access to both health and mental health care for a previously underserved population.

Findings/Common Themes:

1. Evidence from both qualitative and quantitative data suggested that access was increased through lessened stigma and an opportunity for gradual engagement in initiatives that provided mental health services in the context of health care, rather than as a standalone service. For example, several initiatives reported fewer no-shows at appointments and a tendency towards increased medication adherence.
2. Building capacity in primary health care settings through collaborative care also contributes to greater access and increased efficiency in use of resources in non-primary health care settings. Some programs reported:
    - A greater capacity for early detection, increased ability to deal with complex cases within the community health system and lower wait times for service in the clinic;
    - Early evidence that the use of emergency rooms and police services had been reduced; at the same time, there was increased access to emergency/acute care when it was needed, through the development of working relationships and formalized processes for admission and discharge planning for those in need of care;

- Apparent evidence that hospital admission rates had dropped considerably among program participants;
- A 50 per cent reduction in acute care admissions, a reduction in referrals to specialized outpatient care from 37 to one (over the six-month study period) and an increase in the complexity level of referrals overall; and
- A reduced need for high-demand case-management services for people with serious mental illness and fewer expensive transfers of fragile elderly consumers.

3. Capacity-building in non-mental health specific sites (e.g., hostels and community health centres) affords greater opportunity for early detection and reduces the tendency to exclude or use coercive strategies for individuals with mental illness who would have previously been considered "disruptive" by the on-site staff.
4. A considerable amount of activity involved accessing community resources related to the determinants of health for people with serious mental illness and complex needs, such as housing/shelter, income assistance, social support and diet. For example, at least one program:
   - Demonstrated that shelter/housing was found for approximately 20 per cent of their consumers in the reporting year and that income assistance-related advocacy was a major activity;
   - Suggested that formative evaluation led to the hiring of housing workers; and
   - Developed a "community resource network" with other downtown agencies.
5. The advocacy role for staff was identified as an important aspect of the shared/collaborative care model for people with serious mental illness and complex needs, who traditionally have not fit easily into existing services.
6. Consumer satisfaction ratings were uniformly high, based on both qualitative and quantitative indicators.

Barriers to Collaboration and Strategies for Overcoming these Challenges

Building on the documentation that was reviewed, several key barriers and strategies used to overcome the barriers experienced by the initiatives can be discerned. The majority of the barriers and strategies reported in Table B are specific to issues regarding the development, implementation or outcomes of evaluations conducted by the initiatives. The strategies listed below correspond to the specific barriers that were identified.

Table B **Barriers and Strategies Identified**

Barriers	Strategies
There is a need for information/education about available community resources (e.g., housing, income assistance, community agencies, and consumer information).	↝ Develop a resource guide. ↝ Include important providers (e.g., social workers) in consultations and educational events in order to share relevant information. ↝ Build in a case manager-type of function to help link primary health care consumers with other appropriate community resources.
There are some challenges in identifying which mental health issues require straight referral and others for which capacity-building is a better strategy (e.g., via a co-assessment/co-therapy session).	↝ Provide clearer education about the purpose of capacity-building approaches (e.g., to family physicians). ↝ Implement stepped-care algorithms to provide clearer guidance about when various collaborative care team members should be involved.
Evaluators note that the lack of a clear program logic model in some instances created problems with the ability to evaluate programs for their impact on practitioner capacity.	↝ Make more appropriate choices about the evaluation methodology used, since evaluability assessments or formative evaluations can help clarify logic models prior to conducting impact or outcome evaluations. ↝ Evaluate links to improved consumer outcomes, where data on increased provider capacity exists. ↝ Link education with service-level changes (i.e., joint education consultation model), which would set the stage for the evaluation of impact at the consumer level.
While access to both primary health care and mental health specialist services appears to have increased, this has been measured indirectly (via measurement of capacity-building), as opposed to being directly ascertained.	↝ Develop direct indicators of access (for example, use program or administrative data, or possibly ask/survey consumers directly about delays or system navigation problems).

Table B **Barriers and Strategies Identified, continued.**

Barriers	Strategies
The increased access created by collaborative care arrangements may tax the resources of mental health specialty services.	Develop referral threshold assessment forms. Specialists entering into collaborative care agreements should develop clear agreements regarding the nature and extent of their role, up front. Conduct joint educational consultations between specialists and family physicians, or other primary health care providers. Develop ongoing mechanisms for collaboration and knowledge exchange (e.g., joint care plans and shared records, and regular case conferencing). Develop other regular forms of communication, both formal and informal.
Collaborative care arrangements may result in a less than efficient use of mental health specialist resources, and the lack of a clear role for the specialist.	Give more attention to earlier intervention by the mental health specialist consultants.
There is a lack of clarity concerning the respective roles of the psychiatrist and the counsellor. There is also a general lack of an explicit rationale in the evaluative research is reviewed, regarding which practitioners should carry out which interventions, in what order, and why.	Develop treatment and stepped-care algorithms for guiding decision-making about choice, timing and order of treatment alternatives (e.g., medication versus psychotherapy versus both); also clarify the use of appropriate personnel at various "choice points".
While the integration between primary and mental health care is increasing, there are indications that the extent of collaborative relationships between primary health care providers and other potential partners could be better. In particular, the issue of continuity of care with the "rest of the mental health system" still remains challenging, including links with acute care, and the community mental health system (e.g., crisis care, supportive housing, rehabilitation) and with other community agencies.	Develop a "system navigator" role to help connect individuals with needed community resources, crisis services, or with the formal mental health system. Develop applicable engagement/case management strategies for the adaptation of collaborative care models for people with serious mental illness.
There is potential for staff burnout, especially for programs serving homeless people with mental illness and other complex needs.	Implement a leadership or coordination role for the overall project. Develop strategies for more effective use of team-based care, as a strategy for providing emotional and practical support to program workers, who would otherwise be at risk of feeling isolated. Develop realistic goals and expectation, based on staged outcomes (e.g., meeting basic needs, harm reduction goals first, then treatment issues, then empowerment/integration, when possible).

Table B **Barriers and Strategies Identified, continued.**

Barriers	Strategies
There is tension and a need for clarity and/or flexibility regarding the scope of the mandate of inner-city collaborative care models serving people with serious mental illness, since outreach programs result in contact with people with a range of complex mental health needs (e.g., people with issues regarding abuse/trauma, multiple diagnoses and concurrent substance use).	Design programs that are flexible with their program mandate, in order to meet the needs of consumers.
There is a need for clarity and flexibility with respect to potentially overlapping staff roles within team-based programs.	Implement formative evaluation and ongoing communication, because it helps to clarify inter-team roles; clear management can help to clarify these issues.
There are challenges involved in making efficient use of specialist resources (e.g., making sure medical or specialist care is available when it is needed).	Develop a paging system and clearer schedules. There is a need for specialists to take on consultation roles, as well as to make themselves available for direct service, when needed. Make access to the psychiatrist (or other specialist) easier (e.g., make direct referrals from the outreach worker to the psychiatrist possible, rather than using the team nurse as a referring agent).
There is potential for a lack of clarity of the program mandate in relation to the formal mental health system.	Formative evaluations have helped programs develop a clear logic model of program. One program has begun to conceptualize the function of an outreach worker as an "interim case manager" and developed working relationships with assertive case management teams, in order to facilitate referrals and reduce wait times for that service. Initiate joint planning/evaluation with ACT (assertive community treatment) teams. Create forums for dialogue with other community mental health services, including ACT teams.

Summary

The foregoing discussion suggests that educational capacity-building interventions (**Cluster A**) do have an impact on outcomes at the practitioner level (i.e., increased skills and confidence). As yet, the impact of these collaborative care interventions has not been assessed at the consumer level, or with regard to accessibility of services. It appears that increased primary health care capacity is best achieved by using case-based educational strategies delivered within the context, as part of an ongoing relationship between a primary health care practitioner and a mental health specialist.

This relationship, in turn, is best established when it is facilitated by an ongoing collaborative care arrangement, as it is implemented by **Cluster B** programs. These traditional collaborative care programs show evidence of high consumer satisfaction, as well as other consumer-level outcomes such as reduced symptomatology, improved self-esteem and small but significant improvements in functioning. Collaborative care primary health care providers also indicate high satisfaction with the specialists with whom they develop a working arrangement. While these programs appear to result in more timely and efficient use of resources from other parts of the mental health system (e.g., emergency and acute care), it appears that links with other aspects of the formal mental health system (e.g., community teams and supported housing) are less well-developed, and that knowledge about these resources is relatively low.

Evidence from **Cluster C** programs (for people with serious mental illness) shows that traditional collaborative care interventions can be successfully adapted for this population, including for people with complex needs. Qualitative evidence suggests that these programs are developing successful strategies for engaging people with serious mental illness, as well as for acceptable care for both physical and mental health conditions, resulting in high consumer satisfaction, and possibly, more timely and efficient use of other resources (e.g., emergency services and police services). These programs have also achieved success in meeting the basic needs of their consumers for shelter, income support and diet. Among the remaining challenging issues are the need for effective and clear team-based service delivery structures and clear relationships with other parts of the mental health system (e.g., with ACT teams).

KEY MESSAGES

Key Messages for Cluster A: Educational Capacity-building Interventions

- Educational strategies for capacity-building appear to be more successful when they are "case-based" versus broad-based, and when the education or consultation is provided in the context of an ongoing collaborative care working arrangement between a primary health care provider and a mental health specialist.
- Interventions which are purely based on "indirect" collaborative care have shown evidence of increased provider competence or confidence, but there is little evidence to date of them having an impact on system- or consumer-level outcomes.
- Personal communication appears preferable to consultative relationships mediated by e-mail or the Internet.

Key Messages for Cluster B: Traditional Collaborative Care Programs for People with Moderate Mental Illness

- Collaborative health care arrangements result in increased capacity (e.g., confidence, skills) within the primary health care sector, leading to more efficient use of specialist and acute care resources, and by inference, increased access to care by people with mental illness. They have also resulted in improved consumer-level outcomes.
- There is still some lack of clarity as to the relative roles of primary health care providers and specialists, as well as the relative roles of various specialists.
- Despite these challenges, general satisfaction with traditional collaborative care working arrangements is high.
- However, the satisfaction with and knowledge of other aspects of the formal mental health system shown by primary health care providers is relatively low.

Key Messages for Cluster C: Collaborative Care for People with Serious Mental Illness

- Collaborative care for people with serious mental illness appears to successfully increase their access through improved early detection and successful consumer engagement.
- One particularly successful strategy for engaging people in mental health services is that of providing general health care first.
- There is some evidence that increased capacity in the primary health care sector results in more efficient and appropriate use of emergency and acute care resources.
- It appears that, for Cluster C programs to be optimally effective, they must develop even stronger links with the formal community mental health system, and must address issues such as housing and income — in other words, they must help people with mental illness meet other basic needs, in addition to providing for their mental health and physical health care.
- These programs must also be clear about roles within the team, and roles relative to other potentially similar mental health services (e.g., ACT teams).

appendixD

GLOSSARY OF TERMS & ACRONYMS

Terms

BEST PRACTICES	Technique or methodology that through experience and research has proved to reliably lead to a desired result. [Interchangeable with 'Better Practices' and 'Good Practices.'].[15]
COLLABORATIVE CARE	An interprofessional process of communication and decision making that allows the knowledge and skills of different health care providers, along with the client/consumer, to influence the care provided to that consumer.[16]
COLLABORATIVE PRACTICE	Collaborative practice involves patient-centred care with a minimum of two caregivers from different disciplines working together with the care recipient to meet the assessed health care needs.[17]
COLLABORATIVE MENTAL HEALTH CARE	Collaborative care for the purposes of enhancing mental health outcomes.
CONSUMER	A recipient of health care and related support services to meet the individual's needs in any care setting. [Interchangeable terms include 'patient', 'user', 'client'.][18]

15 Canadian Collaborative Mental Health Initiative, 2005. In-house definition.

16 Oandasan I. Interdisciplinary education for collaborative patient-centred practice: research and findings report. February 20, 2004. Ottawa: Health Canada; 2004. p. ii. Available at: http://www.medfam.umontreal.ca/chaire_sadok_besrour/ressource/PDF/IECPCP_Final_Report.pdf

17 Canadian Medical Association; Canadian Nurses Association. Working together: a joint CNA/CMA collaborative practice project, HIV-AIDS example [background paper]. Ottawa: CMA; 1996. p. 9. Available through the CMA's Member Service Centre 1867 prom. Alta Vista Dr., Ottawa ON K1G 3Y6; e-mail: cmamsc@cma.ca

18 Adapted from: Canadian Medical Association; Canadian Nurses Association. Working together: a joint CNA/CMA collaborative practice project. HIV/AIDS example [background paper]. Ottawa: CMA; 1996. p. 24.

CONSUMER CENTRED	Care that is respectful and responsive of individual patient preferences, needs and values; ensuring that patient values guide all clinical decisions.[19]
HEALTH CARE PARTNERS	Primary and mental health care providers, consumers, families, and caregivers.
INTERDISCIPLINARY	A range of collaborative activities undertaken by a team of two or more individuals from varying disciplines applying the methods and approaches of their respective disciplines.[20]
MENTAL HEALTH SPECIALIST	An individual with mental health expertise related to health promotion, prevention, diagnosis, treatment, self-help, or peer support.[21]
PRIMARY HEALTH CARE	An individual's first contact with the health system characterized by a spectrum of comprehensive, coordinated, and continuous health care services such as health promotion, diagnosis, treatment, and chronic disease management. Primary health care is delivered in many settings such as the workplace, home, school, health care institution, office of a health care provider, home for the aged, nursing home, day-care centre, and

19 Institute of Medicine (U.S.). Committee on Quality of Health Care in America. Crossing the quality chasm: a new health system for the 21st century. Washington, DC: National Academy Press; 2001. Available at: http://www.nap.edu/catalog/10027.html

20 Reflects the discussions held in January 2005 between a number of national and regional initiatives funded by the Primary Health Care Transition Fund.

21 Canadian Collaborative Mental Health Initiative, 2004. In-house definition.

	community clinic. It is also available by telephone, health information services and the Internet.[22]
PRIMARY MENTAL HEALTH CARE	Mental health services provided in a primary health care setting.
PRIMARY HEALTH CARE SETTING	Primary health care is delivered in many settings such as the workplace, schools, home, health-care institutions, homes for the aged, nursing homes, day-care centres, offices of health care providers, and community clinics. It is also available by telephone, health information services and the Internet.[23]
REGIONAL HEALTH AUTHORITY(IES)	Governance structures for more localized health services, usually devolved from a provincial jurisdiction, with responsibility for the delivery and administration of health services in a specified geographic area.[24]

22 Adapted from: Mable AL, Marriott J. Sharing the learning: the Health Transition Fund synthesis series: primary health care health. Ottawa: Health Canada; 2002. Available at: http://www.hc-sc.gc.ca/htf-fass/english/primary_en.pdf and Nova Scotia Advisory Committee on Primary Health Care Renewal. Primary health care renewal: action for healthier Nova Scotians: a report of the Nova Scotia Advisory Committee on Primary Health Care Renewal, May 2003. Halifax, NS: NS Department of Health; 2003. p. 1. Available at: http://www.gov.ns.ca/health/primaryhealthcare/pubs/Primary_Health_Care_Renewal_Report_May_2003.pdf and Klaiman D. Increasing access to occupational therapy in primary health care. Occupational Therapy Now Online. 2004 Jan-Feb;6(1). Available at: http://www.caot.ca/default.asp?pageid=1031

23 Way DO, Busing N, Jones L. Implementation strategies: "Collaboration in primary care — family doctors & nurse practitioners delivering shared care". Toronto: Ontario College of Family Physicians; May 18, 2000. p.3. Available at: http://www.ocfp.on.ca/English/OCFP/Communications/Publications/default.asp?s=1

24 Canadian Collaborative Mental Health Initiative. 2004. In-house definition.

Acronyms

ACT	Assertive Community Treatment
AB	Alberta
BC	British Columbia
CCMHI	Canadian Collaborative Mental Health Initiative
CEQM	Continuous Enhancement of Quality Measurement
CHC	Community Health Centre
CHS	Community Health Survey
CUPS	Calgary Urban Project Society
EICP	Enhancing Interdisciplinary Collaboration in Primary Health Care
FTE	Full-time equivalent
GPOT	Geriatric Psychiatry Outreach Team
HSO	Health Service Organization
MB	Manitoba
NB	New Brunswick
NCCBH	National Council for Community Behavioural Healthcare
NL	Newfoundland and Labrador
NS	Nova Scotia
NT	Northwest Territories
NU	Nunavut
ON	Ontario
PE	Prince Edward Island
QC	Quebec
SACYHN	Southern Alberta Child & Youth Health Network
SEED	Support and Education for Primary Care Focusing on the Elderly with Disorders in Mental Health
SK	Saskatchewan
TIPP	Transition Into Primary Care Psychiatry
USDHHS	U.S.Department of Health and Human Services
WHO	World Health Organization
YT	Yukon Territory

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