

Initiative canadienne de collaboration en santé mentale

Health Human Resources in Collaborative Mental Health Care

September 2005

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Health Human Resources in Collaborative Mental Health Care

A discussion paper on Overcoming the Human Resource Barriers to Implementing Collaborative Mental Health Care in Canada

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September 2005

OUR GOAL

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

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EXECUTIVE SUMMARY

Mental illness and addiction are prevalent among Canadians. Resources need to be available to meet the needs of consumers, families, and caregivers in all health care settings. Collaborative mental health care is one mechanism that can improve the mental health and well-being of Canadians by strengthening relationships and improving collaboration among, consumers, families, communities, and health care providers. Leadership is needed to ensure that mental health human resources are available and accessible to help facilitate collaborative mental health care.

The Canadian Collaborative Mental Health Initiative (CCMHI) was created to develop and implement collaborative consumer-centred care strategies to improve the mental health and well-being of Canadians by strengthening relationships and improving collaboration among, consumers, families, communities, and health care providers. The CCMHI's mandate also includes developing specific strategies for removing barriers to implementing collaborative care approaches and adapting these approaches to meet the mental health and addiction treatment needs of Canadians.

The CCMHI recognizes that there are barriers to achieving collaboration in the delivery of mental health and addiction services. The barriers to maximizing the effectiveness of mental health human resources must be overcome in order to implement collaborative care approaches within Canada's health care system.

Key mental health human resource themes that need to be addressed include:

- The need for a coherent mental health delivery system.
- The requirement for additional funding for collaborative mental health care delivery.
- The implementation of strategies for the mental health workforce.
- Definition of scopes of practice for mental health care providers to facilitate collaborative care.
- The need for support for interprofessional education and training.

Key barriers to collaboration among mental health human resources include lack of comprehensive legislation and policy, insufficient remuneration, undefined scopes of practice, uncertain liability, the absence of interprofessional education and challenges facing peer support models. These barriers are aggravated by a shortage of health care providers and an absence of funding to support collaborative activities. An analysis of the issues related to these barriers, undertaken using research conducted by the CCMHI, contains approaches and solutions that can be employed to overcome the barriers. Information gaps need to be identified and further researched to help facilitate collaborative mental health care.

Key recommendations in the removal of these barriers include:

Implementing effective collaborative mental health human resource planning.

- Establishing reimbursement and funding priorities for collaborative mental health care.
- Developing a comprehensive legislative framework for collaborative mental health care.
- Developing a policy framework for collaborative mental health care.
- Building a case for interprofessional education in mental health and addiction.

Collaborative mental health care is achievable. Experiences in international jurisdictions can provide lessons on successful collaboration. More needs to be done to reveal the success of existing Canadian collaborative mental health programs. Critical to the success of this collaboration is the commitment of all governments, health regulatory bodies, health care professions, mental health care providers, consumers, families, and communities to make collaborative mental health care a priority.

This paper provides an overview of the key issues related to collaborative mental health care as well as a summary of the approaches and solutions that have been considered or may be employed by stakeholders to overcome barriers. The paper will also identify information gaps and make recommendations that the CCMHI Steering Committee may consider in moving forward on its mandate.

OVERVIEW OF CCMHI ACTIVITIES AND PURPOSE

Mental disorders and addiction rank first and second as causes of disability in Canada, the United States, and Western Europe. The economic impact of mental illness in Canada was estimated at \$14.4 billion in 1998. It is estimated that about three per cent of Canadians suffer from severe and chronic mental disorders.¹ It has been reported that there is a shortage of mental health providers.² Given these statistics, most health care groups recognize that mental health human resource problems, including shortages, must be addressed to ensure that the health care needs of Canadians with mental illness or addiction are met.³ Leadership is needed to develop a strategic, multi-year, national mental health human resources plan that would synergize with an overall national human resources strategy.4

The Canadian Collaborative Mental Health Initiative (CCMHI) received funding from Health Canada's Primary Health Care Transition Fund to develop and implement collaborative consumer-centred care strategies to improve the mental health and well-being of Canadians by strengthening relationships and improving collaboration among health care providers, consumers, families, and communities. This includes developing specific strategies for removing barriers to implementing collaborative care approaches and adapting these approaches to meet the mental health and addiction treatment needs of Canadians. The CCMHI recognizes that there are barriers to achieving collaboration in the delivery of mental health

and addiction services. These problems include limited access to the services of specialized mental health care providers, poorly integrated primary health care and mental health services, lack of knowledge of care providers' scopes of practice, and the absence of both a funding infrastructure and a communications infrastructure.

The key objectives of this paper are to:

- Develop a better understanding of current mental health human resources programs and collaborative practices taking place across Canada.
- Identify the barriers and issues affecting collaborative mental health care.
- Identify the specific mental health human resource issues concerning these barriers.
- Determine the appropriate approaches to overcoming these barriers.

Based on research conducted by the CCMHI and this author, the paper provides an overview of the key issues related to mental health human resources. It also summarizes the approaches and solutions that have been considered or may be employed by stakeholders to overcome the barriers. Finally, the paper will identify information gaps and make recommendations that the CCMHI Steering Committee may consider in moving forward on its mandate.

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WHAT WE KNOW

CCMHI Research

Mental Health Care Human Resource Themes

An analysis of the CCMHI's research has identified both problems and solutions related to the key mental health human resource themes depicted in the table below.

table 1

Mental Health Human Resource Themes, Problems, and Solutions

Theme	Problem	Solution
The need for a coherent mental health delivery system.	Effectiveness of services and support is inconsistent.	Replace existing service "silos" with a comprehensive system that integrates the delivery of mental health services
		Improve coordination between primary and mental health care providers.
		Make allocation of resources more efficient and rational because it affects service delivery.
The requirement for additional funding for collaborative mental health care delivery.	 Mental health services and treatment are underfunded relative to their prevalence and the economic burden of illness. Funding for mental health services is covered 	Provide funding through pilot or demonstration projects on a short- term basis.
	only through hospitals and physicians under the Canada Health Act. ⁵	
	The current physician remuneration structure in Canada (primarily fee-for-service) provides little or no incentive for physicians to collaborate nor does it facilitate the integration of the care they provide with that of other mental health care providers. ⁶	

Theme	Problem	Solution
The implementation of strategies for the mental health workforce.	 The shortage and maldistribution of mental health care providers is well documented, with urban areas generally better served than rural and remote areas are. For example, psychiatrists in Canada are in short supply, as are nurses working in the mental health arena, social workers, and occupational therapists. Challenges in the recruitment and retention of mental health care and primary health care providers are significant. There is a system-wide lack of mental health human resource plans. Already-overworked health care providers do not have time to learn to work in new ways. 	 Increase mental health workforce. Link supply management to Canadian mental health and addiction treatment needs. Improve working conditions, including reducing workloads, allowing flexible hours, and improving benefits.¹⁰ Create mechanisms to facilitate collaboration.¹¹
Definition of scopes of practice for mental health providers to facilitate collaborative care.	 Mental health services must be made acceptable to the full range of stakeholders. Some mental health care provider groups, such as the Canadian Association of Social Workers, have developed national scopes of practice for social workers and standards for interaction with other professions. Sconsensus is required on the competency requirements of service providers. Heavy requirements of service providers training, capabilities, and limitations; Sconsensus is required and may have limited knowledge of community resources and social services. There is a lack of clarity about accountability and liability within team practices. The some mental health sconsensus is required on the competency requirements of service providers. The service providers are often uncertain of their roles; lack knowledge of other providers training, capabilities, and limitations; Sconsensus is required on the competency requirements of service providers. 	 Address and define scopes of practice for mental health care providers to facilitate collaboration. Harmonize relevant legislation and regulations across jurisdictions.²³ Develop new models of liability insurance, including tort law reform.²⁴
The need for support for interprofessional education and training.	 Health care providers lack understanding of mental health care issues. Collaborative mental health training is very limited in existing university/college health discipline curricula, as well as in professional association continuing education programs.²⁵ 	 Educate and train health care providers about the benefits of collaborative mental health care.²⁶ Standardize credential assessment and establish bridging programs.²⁷ Integrate culturally appropriate curriculum and training opportunities.²⁸

CCMHI Studies

The CCMHI commissioned two studies that provided insight into the key issues that affect mental health human resources. These studies are the Centre for Collaborative Health Professional Education Survey and the Human Resource Factors Survey.

i) Centre for Collaborative Health Professional Education Survey

The CCHPE survey revealed that the majority of respondents support the development of curricula focused on collaborative mental health care; however, this majority does not currently offer formal pre-licensure, post-licensure, or interprofessional education courses; workshops; or modules involving collaborative mental health care.²⁹

ii) Human Resource Factors Survey

A preliminary human resources survey was circulated in September 2004 to mental health care providers who are members of the representative organizations that are part of the CCMHI. The survey was created to obtain insight into the issues related to broader human resources themes. The results provided insight into the specific barriers that respondents are encountering in their practice environments with respect to implementing collaborative care. Survey findings are summarized in Table 2.

table 2	ссмні	Survey Findings	
Theme		Key Findings	
Remuneration: F service	ee-for-	No fee-for-service mechanism exists for non-physician mental health care providers within the public health system but providers can bill patients through private insurance.	
		Remuneration policies and processes vary depending on practice settings and between public and private health systems (e.g., employer/insurer).	
		Many services that mental health care providers offer are either not compensated for or are covered only by a nominal fee (e.g., preparation of patient reports) unless patients are charged directly.	
Remuneration: Salary		Compensation packages for salaried positions are not comprehensive and do not reflect the work environment of mental health care providers.	
		Salaries vary widely from region to region across Canada (e.g., salaried psychologists in Nova Scotia are paid 30 per cent more than their Ontario counterparts are).	

Theme	Key Findings
Working Conditions	The roles of mental health care workers in the case management of patients are not clear in terms of accountability and service delivery.
	There is insufficient time for consultation, preparation, interaction with other health professionals and patients, conducting follow-ups, or participating in collaborative team and patient rounds.
	➢ Access to tools that facilitate interaction with other care providers for client consultation is limited and in some cases non-existent (e.g., video conferencing).
	There is concern about continuity of care and client safety when clients are transferred between health care settings (e.g., from hospital to out-patient care).
	➢ It is not clear what constitutes a mental health care team within a health care setting (e.g., what disciplines can provide a continuum of care for mental health clients within certain health care settings).
Regulation	There is a lack of clarity about which non-physician health care providers (e.g., nurse practitioners) would be able to diagnose and prescribe for mental illnesses.
	≈ Regulation of management of patient files (e.g., record keeping) is needed.
	Privacy legislation presents a barrier for mental health care workers in accessing or sharing patient information among other care providers, consumers, family members, and caregivers.
Professional liability	➣ The scopes of practice and competencies within a collaborative care environment are unclear.
	➢ There is a lack of clarity on liability coverage for the mental health care provider.
Support tools facilitating collaborative mental	Implementation of case management teams should be a priority to facilitate effective collaborative mental health care.
health care	➢ Specific funding is available, but is often limited and with no long-term commitment.

Summary of Mental Health Human Resources Issues

The literature reviews conducted by CCMHI and Health Canada³⁰ describe the current situation and trends developing across Canada as well as in other jurisdictions.

Canadian Trends

Key mental health human resource observations and trends include the following:

- i) Health System Reform is Needed
- Mental health care delivery is undergoing significant change across the country because of the increasing cost of health services and the pressure to reshape publicly funded health services to keep them sustainable.³¹
- Primary health care renewal is occurring in all jurisdictions and different team-based models of care are being introduced to better serve the population's health needs.
- Changes in working environments for health professionals do not always support good patient outcomes. For example, an inadequate supply of registered nurses, high absenteeism, expensive overtime, and poor staffingmix decisions are threatening patient safety.³²

- ii) Shortages of Mental Health Care Personnel and Heavy Workloads Must be Managed
- Workloads continue to be a concern in all areas of the country, but especially in northern and rural communities, which face the highest turnover rate. Recruitment and retention strategies have focus on attracting specialists, family physicians, and nurses from outside Canada to designated underserviced regions.^{33,34}
- iii) Scopes of Practice Need to be Expanded
- Regulated health professionals are concerned that profession-specific work will be carried out by generic or multiskilled workers, resulting in a loss of provider accountability.
- Use of para-professional health providers (i.e., "assistants") is increasing.³⁵
- There is ambiguity and/or conflict over roles and responsibilities, including leadership, authority, and accountability.
- iv) Compensation for Mental Health Providers is Inconsistent
- Differences in compensation are especially apparent for providers who shift between institutional and community care practice environments.

- v) Mental Health Human Resources Planning is Required
- Duplication of efforts and resources is occurring across the country, with each province developing its own "silo" plan, independent of mental health human resource strategies.
- There is often a disconnect between mental health care reform and other relevant social issues (e.g., housing, education, the judicial system).
- Federal and provincial/territorial governments are moving forward by taking gradual steps in the planning and management of health care human resources.
- Funding is not always available to implement health care policies and may not be a priority for governments.
- vi) Service Gaps Exist
- Mental health care providers are increasingly filling service gaps in Canadian communities. Social workers, for example, are increasingly assessing and diagnosing in some jurisdictions, but certain health provider groups feel that they do not have the training to do this.
- vii) Progress in Interprofessional Education is Needed at the Provincial/Territorial Level
- Some provinces and territories have implemented initiatives and programs to encourage interdisciplinary learning but these are offered through

- demonstration projects, with minimal support from decision-makers.
- viii) Data on Mental Health Human Resources are Needed
- Data are required to develop an understanding of the demographics of mental health care providers and their practice settings. Existing data are more comprehensive for physicians and nurses than for other mental health care providers. 36,37,38

International Trends

An international review of health workforce planning was conducted by Mable and Marriott³⁹ for Health Canada; it examined trends and issues in health care human resources planning in Canada and internationally. The study revealed that despite increasing reference to and use of team approaches in health care human resources planning and deployment, most countries continue to use traditional profession-specific approaches and models. Physician workforce planning continues to dominate these models.

Countries such as Australia, New Zealand, the United Kingdom, and the United States are experiencing shortages of mental health professionals. Recruitment and retention are areas of focus – programs have been introduced to ease the shortage in some countries. Although these programs have met with some success, they have not been fully assessed to determine whether they have overcome the barriers to effective use of mental health human resources in the long term.⁴⁰

WHAT ARE THE MENTAL HEALTH CARE HUMAN RESOURCES ISSUES?

An examination of international trends reveals that Germany, and the Netherlands still focus on physician workforce planning, while New Zealand, the United States, and the United Kingdom have begun to look at the total workforce and integrated workforce-wide planning. Australia is said to be the exception because it has adopted "multi-modality" workforce planning methodologies and processes.⁴¹

The U.S. is using non-specialty health workers to provide mental health care services in rural areas through "shared care" team approaches to collaborative mental health care. The U.K. is moving to integrated planning for the entire health care human resource workforce; this move underlines that country's commitment to multidisciplinary team deployment. The U.K. is focussing on workforce planning initiatives⁴² as well as on establishing a framework for mental health human resources that includes a mental health policy implementation plan. 43,44,45

Several barriers prevent Canadians from receiving the mental health care services they may need. These include problems accessing the services of specialized mental health care providers and lengthy waits between the time of referral to a mental health care provider and the initiation of treatment or intervention.

The mental health care and addiction treatment systems across Canada are not, in fact, systems, but rather a complex array of services delivered through federal, provincial/territorial, and municipal jurisdictions and private providers. The mix includes acute-care

services in general hospitals, specialized services for specific disorders or populations, outpatient community clinics, community-based services providing psychosocial support, and private counselling. These services often operate in self-contained "silos" and are disconnected from the general health care system; this has a negative effect on collaborative mental health care. Primary health care services are often poorly integrated with the services of specialized mental health care providers and community and social services.

Key barriers preventing collaboration among mental health human resources include lack of comprehensive legislation and policy, insufficient remuneration, undefined scopes of practice, uncertain liability, the absence of interprofessional education, and challenges facing peer support models. These barriers are aggravated by a shortage of health care providers and an absence of funding mechanisms to support collaborative activities. The current systemic barriers impeding the development of collaborative mental health care are explored in depth in the following sections.

Legislation and Policy

Key legislative and policy issues identified 46,47,48,49 as concerns for mental health human resources are outlined in Table 3.

table 3

Legislative, Regulatory, and Policy Issues

Legislative Issues

- Relevant regulations include laws governing the self-regulation of professionals, and employment, health system, and malpractice laws.
- ≈ Scopes of practice are widely viewed as a barrier because they are too rigid.
- Contextualization of regulation is important, including understanding the impact of rules and processes within workplaces and the impact of placing boundaries between workplaces.
- > Privacy legislation places restrictions on the sharing of patient information, but sharing information is often necessary for interdisciplinary collaboration.
- The legal culture needs to change. Currently, the focus is on finding someone guilty when things go wrong, rather than looking at the distribution of liability within a team.
- > Developing and amending existing legislation continues to be a slow but useful process that will bring long-term sustainable change.

Regulatory Issues

- **Scopes of practice**: Inconsistencies in definitions of scopes of practice exist across jurisdictions. Flexibility is required in defining scopes of practice to promote innovation and collaboration in primary health care.
- > Standards of practice: Imposing consistency in standards of practice and competencies across jurisdictions and between professions will require improved collaboration.
- **Confidentiality**/*privacy and access to information*: Interdisciplinary collaboration requires effective and open communication to promote quality patient care and reduce duplication of client information and testing. Patient concerns about confidentiality and access to health information must be considered and resolved.
- Regulatory frameworks for interdisciplinary collaboration: Frameworks are required within each province and territory, with particular attention to the division of responsibilities between provincial/territorial governments and professional regulatory bodies. The current system can be described as having:
 - Broad, inflexible, conflicting, inconsistent scopes of practice.
 - A multiplicity of regulators.
 - Regulatory "turf protection".
 - Regulatory fragmentation.
 - Federal/provincial and inter-provincial gaps.
 - An inflexible legal infrastructure.

Policy Issues

- The lack of coordination between primary health and mental health care reforms are leading to a fragmented health care system with gaps and overlaps in the delivery of care.
- > Health care human resources policies and funding have provided neither an adequate supply of the requisite professionals to manage the growing demand for care, nor reward systems that allow reasonable access to the full range of capabilities to meet the demands.
- Many remuneration structures do not support collaborative interaction among care providers. Payment methods are based on services delivered by individuals.

Canada's current legislative and regulatory framework is inconsistent. Each provincial/territorial regulatory body issues its own legislation and regulations defining scopes of practice for health professions, as well as standards of education, ethics, and competencies in practice, and systems of accountability.

Mental health policies, programs, and legislation are the responsibility of both provincial/territorial and federal governments, while funding and delivery of mental health services and support are primarily the responsibility of provincial/territorial governments. There is little consistency among provinces/territories in mental health service provision or related legislation. At present, each province and territory has its own mental health act (except Nunavut, where Northwest Territories law applies). All provincial and territorial mental health legislation, however, defines criteria for involuntary admission to hospital for psychiatric treatment, treatment authorization and refusal, conditional leave, and review and appeal procedures.⁵⁰

Legislative and regulatory reviews are currently being conducted with respect to scopes of practices (e.g., for nurse practitioners in Quebec, Alberta, and Ontario).

Regulation can be a barrier to facilitating collaborative care according to some experts. It certainly makes sense that only qualified individuals provide complex care, but it must be recognized that serious human resource shortages in health care are affecting patient outcomes.⁵¹ Improving outcomes should be the number one priority for regulators, who instead run the risk of introducing regulations that support ongoing turf protection.

Although changes in regulation and legislation are often slow, they are nevertheless

necessary. Regulatory issues may pose challenges, but they are largely manageable ones and do not represent a clash of values.⁵²

From a systemic perspective, it is well known that current professional practices work against the integration of health services, fostering instead a system of separate silos of professional practice and imposing major constraints on the development of interdisciplinary work.

At the **government level**, legislative and regulatory reforms need to keep up with changes and trends in the practice environment, which to this point has largely not been the case. Barriers at the **organizational level** have to do mainly with the lack of responsiveness and the unwillingness of health care groups to change or work together even though, according to the Clair report⁵³, professional groups acknowledged the urgent need for health system renewal and offered their co-operation.

Within institutions, support and funding for collaboration among health professions is fairly minimal owing to the inherent incremental operating and administrative costs involved. Policy-makers must give organizations and local/regional authorities the autonomy to resolve barriers impeding the systemization of collaborative mental health care practices. Autonomy could be in the form of increased budget allocations, decentralization of services, increased human resource management, competency development, etc.

To achieve collaborative mental health care at the **individual level**, the prevailing mindset on how health care professionals can work together needs to change, given the entrenched attitudes about scopes of practice and the resistance to change.

Remuneration

In Canada, fee-for-service remuneration by provincial and territorial ministries is the predominant form of reimbursement for services delivered by physicians. Some jurisdictions allow other approved providers to bill ministries directly for their services. These non-physician billing arrangements are changing, however, as provinces de-list services not considered medically necessary.⁵⁴

Financial competition, especially within the fee-for-service environment in most provinces, and concerns about job security are considered barriers to collaboration among health care professionals.⁵⁵ Although reimbursement is primarily provided to physicians on a fee-for-service basis, other professionals are usually on salary.

Resolution of funding issues is key to promoting and supporting interprofessional collaboration. Provincial/territorial reimbursement and funding concerns include the following:

- The way mental health providers are paid needs to change.
- Staffing changes are needed to account for administrative work (e.g., completion of forms).
- Non-monetary incentives should include continuing education and training.
- Funding for some mental health professionals is insufficient and compensation disparities among occupations exist.

- The lack of funding to support the involvement of consumers, families, and caregivers is a concern.
- Funding available for collaborative projects is limited and is often derived from a variety of sources.⁵⁶
- The lack of funding to train students and to place them in clinical settings in collaborative environments raises concerns about staff shortages.
- Funding schemes do not always support long-term planning.
- Money plays a large role in recruitment and retention of people in remote and isolated settings, but so do lifestyle preferences, amenities, level of education, access to professional development, and opportunities for professional advancement.⁵⁷ Incentives include pay for travel time, reimbursement for associated travel expenses, and administrative staff support.

There is no mechanism in place to pay for non-physician services provided by others on the team, including nurse practitioners, dietitians, social workers, and counsellors.⁵⁸

The literature suggests that financial competition among health care practitioners may obstruct collaboration among physicians and therefore impede the enhancement of patient care.⁵⁹ Pringle et al argued that the current way physicians are paid in Canada works against collaborative interprofessional practice in primary care.⁶⁰ Way et al suggest that changes are needed to find creative reimbursement mechanisms for health care

professionals such as nurse practitioners and family physicians. ^{61,62} Even in jurisdictions where government policy is clearly facilitative, significant funding barriers remain. ⁶³

Scopes of Practice

Lahey and Currie have explored the legislative issues relevant to promoting interprofessional practice. Their research identified the barriers to a more integrated health care system, and to interprofessional practice in particular, and looked at the impact collaborative care could have on processes within mental health provider workplaces. Key barriers to collaboration identified include legislative rigidity, systemic disparity in regulatory frameworks, and lack of recognition within malpractice law and insurance structures of collaborative work environments.

Reforming the legislation relating to scopes of practices is challenging. Expanding scopes of practices to better use the skills of care providers in the health system is critical, but with this expansion will come changes to the way people have worked throughout their careers and to the role the public expects them to play.⁶⁶ Romanow stated that "Despite much rhetoric about interprofessional co-operation, in reality, the professions tend to protect their scopes of practice."⁶⁷

Although there have been legislative reviews on reforms for scopes of practices, ^{68,69,70,71,72,73} a national regulatory framework has not been developed to provide a process to define scopes of practice among mental health care providers in Canada. Such a framework could aid in advancing opportunities for collaborative

mental health care and address mental health human resource problems.⁷⁴ Each jurisdiction is either pursuing or has implemented legislative measures to expand the scopes of practice of nurses and pharmacists,^{75,76} but this move has not affected allied health professionals, such as other mental health care providers.

The health care system's reliance on professional self-regulation presents limitations. According to Lahey and Currie, "...the more limited use of self-regulation outside health care reflects the concerns that self-regulation carries with it the highest risk of regulatory misappropriation – the use of regulatory power for the benefit of the profession instead of the benefit of the public..." This situation poses a potential barrier to interprofessional practice.⁷⁷ Deber and Baumann's paper state that there needs to be a scope of practice for each profession. This is particularly important where there are inconsistencies in how scopes of practice are defined in different jurisdictions. Scopes of practice should differentiate between overlapping or shared competencies and profession-specific ones.⁷⁸

The use of care providers other than physicians raises the issue of regulating scopes of practice, and in most jurisdictions in Canada, the issue remains unresolved. Defining scope of practice falls to provincial/territorial ministries of health, together with their respective health regulatory colleges.

The literature suggests that the lack of understanding of scope of practice boundaries and parameters among many of the health professions is a key cause of health care professionals not working to the full extent of their training.

Liability

Liability issues arise from the enforcement of standards of practice. Professionals performing below a set standard or outside their scopes of practice can expect sanctions to be levied, not only through the courts, but also through the complaint and discipline process of their respective professional regulatory bodies. In addition, provider organizations are often responsible for the practices of the professionals working within their facilities. In hospitals, for example, an established legal tradition

partitions responsibilities (and liability) between professionals and the hospitals that employ them.⁷⁹

Concern about malpractice and other liability issues can cause any health care provider to be reluctant to include consumers, families, and caregivers in the collaborative process. Current liability practices may actively discourage collaboration among health care providers. Key elements of malpractice law and major liability issues that affect interprofessional collaborative mental health care are summarized in Table 4.80,81

table 4

Malpractice Law and Liability Issues

table 4	walpractice Law and Elability 135de5		
Malpractice Law Liability Issues		Liability Issues	
≫ Emphasizes in	ndividual accountability.	➢ Liability for non-physicians and institutions is unclear.	
➢ Has undetermined capacity to adjust to collaborative		➢ No mechanism for control of accountability exists	
practice.		➢ Standards of care could be "transferred".	
May create liability exposure, especially during transition to collaborative practice.		 Defining roles, responsibilities, and documentation is increasingly important. 	
		Re-allocation of accountability and the standard of care are uncertain.	
		There is potential judicial insistence on individual accountability.	
		➢ Liability "net" could broaden.	
		Health care providers who participate in the early stages of the care process could be exposed to liability.	
		Culture of blame needs to become a culture of patient safety and risk management.	
		Clarification among providers of the potential liability issues in an interprofessional setting is required.	
		➢ Legislative reform is needed.	

Currently, not all health care professionals are required to obtain malpractice insurance. The requirement for individual malpractice insurance varies according to the type of practice and the type of health care professional. Within hospitals, health care employees (e.g., nurses and laboratory technicians) are provided with malpractice insurance as an employee benefit or are covered through the vicarious liability of their employers. Within private health care settings such as pharmacies and commercial laboratories, the corporation/employer pays for liability insurance.⁸²

Professionals involved in collaborative mental health care are unclear about their liability. The nature of the professionals' employment is a significant factor. If they are self-employed on a fee-for-service basis, they need to know if their existing liability insurance is adequate.

There is uncertainty about the legal liability inherent in the working relationship among health care professionals in terms of scopes of practice and responsibilities.⁸³ A primary concern is that not all health care professionals carry liability insurance; this has implications for membership on a health care team. For those without liability insurance, the question arises: Which members of a health care team are ultimately responsible for adverse patient outcomes?

Interprofessional collaboration will expand the scope of liability among team members. The case of DeJong vs. Owen Sound General represents the first substantial attempt by a Canadian court to deal with the issue of liability in interprofessional collaboration. In this case, the patient was admitted to the psychiatric ward of a hospital where an interdisciplinary team

structure was in place (the team included a psychiatrist, a psychologist, nursing staff, and a social worker). The patient was injured when he broke through a window and was subsequently involved in a traffic accident. In the final judgment, the psychiatrist, psychologist, and a number of nurses were found to have been negligent. The trial judge was open to evaluating the interprofessional collaboration, while making clear that each team member would be subject to individual liability on the basis of how the team performed.⁸⁴

The ruling in this case led the Canadian Medical Protective Association and the Canadian Nurses Protective Society to develop a joint statement on liability protection for nurse practitioners and physicians in collaborative practice.⁸⁵ Significant points include the following:

- Each health care professional, both individually and as a member of the collaborative practice team, is accountable for his or her own professional practice.
- It is essential for physicians and nurse practitioners working in collaborative practice to verify that all members of the collaborative practice team and the facility or institution have adequate professional liability protection in place at the beginning of the work relationship and on an ongoing basis.

Key elements of self-regulation are enforcement of standards of practice and how liability will be interpreted by the courts and regulatory bodies. It is important to clarify roles and responsibilities for team activities that would require modification of legislative and regulatory frameworks. Additional research is required to better understand the impact of interdisciplinary collaboration on liability and tort law reform. Health Canada has commissioned a paper to investigate liability issues in greater detail.⁸⁶

Interprofessional Education

Interprofessional Education in Canada

Although examples of interprofessional education have been reported,⁸⁷ there is minimal evidence about its effectiveness in promoting and achieving collaboration in terms of best practices. A systemic review revealed that there is no evidence that interprofessional education promotes collaboration at the pre-licensure stage. There is, however, some evidence that post-licensure collaborative interventions provide positive health outcomes within specific population groups such as the elderly, neonates, and mental health care patients.^{88,89,90}

Although some academic institutions have taken some leadership by incorporating interprofessional education as part of their academic curricula,⁹¹ there has been minimal – or no – interprofessional education incorporated into mental health human resources planning at a provincial inter-ministry level. It is not deemed a priority among provincial and territorial governments.

Many colleges and universities have profession-specific training and educational curricula, but for the most part, they do not represent new models of service delivery nor do they encourage a multidisciplinary approach to delivering care, particularly in mental health. ⁹² Certain academic and research institutions, however, have taken the lead in exploring interprofessional education models for inclusion in their health sciences programs. This training is sometimes offered as elective courses, as exemplified by the Colleges of Health Disciplines at the University of British Columbia, the Health Sciences Council at the University of Alberta, the Centre for Collaborative Health Professional Education at Memorial University of Newfoundland, and graduate programs within the Faculty of Health Sciences at McMaster University.

Interprofessional Education for Collaborative Mental Health Care

According to the CCMHI survey, education enabling collaborative mental health care activities is limited. Due to budget constraints, funding for individual professional development in most cases is not available. The focus becomes training teams in activities that support program goals rather than discipline-specific goals.

Table 5 summarizes the barriers to interprofessional education enabling collaborative mental health care that were identified by the survey.⁹³

table	e 5
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Barriers to Interprofessional Education: CCHPE Survey

Phase I: Pre-Licensure Training (academia)	Phase II: Post-Licensure Education (community practice level)
Significant barriers:	Significant barriers:
Problems with scheduling (e.g., lack of time for teaching, clinical hours, and meeting colleagues; timetable conflicts).	Lack of financial resources (e.g., cost of education to provider, lack of government funding, lack of good funding models for interprofessional education).
Rigid curriculum (e.g., differing levels and content	Lack of administrative support.
knowledge needed by different mental health care providers).	Problems with scheduling (e.g., access for care providers, lack of time, curriculum restraints).
➢ Lack of reward for faculty.	Low-rated barriers:
➢ Lack of financial resources.	
Low-rated barriers:	➢ Faculty, board, member attitudes (e.g., limited
➢ Lack of administrative support	resources and knowledge base, lack of
➢ Faculty attitudes (e.g., lack of buy-in for idea of	understanding of mental health issues).
interprofessional education)	Resistance to buy-in and lack of evidence about
➢ Student/learner acceptance	benefits).

Barriers preventing interprofessional education identified in the literature, and highlights from a survey of key health profession education programs in Canada, are summarized in Table 6.

Barriers to Interprofessional Education: Literature Search and Survey of Health Education Programs

Barriers Identified in the Literature ⁹⁴	Barriers Identified in Survey of Interprofessional Programs in Canada ⁹⁵	Categorized Barriers%	Categorized Requirements for Conducting Interprofessional Education in Universities
* Perceived loss of status in profession and discipline. * Curricular and scheduling challenges. * Lack of familiarity and comfort with IPE among universities and departments. * Unwillingness of both students and teachers to experiment with new ways of learning and teaching, or with the use of different learning and teaching and teaching and teaching and teaching materials (WHO 1988).	** Problems with schedule/ calendar. ** Rigid curriculum. ** Lack of financial resources. ** Lack of resources, interest, and time to co-ordinate. ** Concern over consequences of blending knowledge and diluting professional roles for the future. ** Accreditation requirements. ** Accreditation requirements. ** Perceived hierarchy among health care system. ** Perceived hierarchy among health disciplines. ** Concern within certain disciplines about domination by other disciplines.	Structural Requirements of professional bodies (graduation, accreditation). Pe Logistic difficulties (professional schools located in different buildings). Pe Lack of time for course planners to meet. Pe Lack of senior management support. Pe Lack of commitment. Pe Lack of commitment. Pe Lack of senior management support. Professional/Disciplinary Professional/Disciplinary Professional/Disciplinary Professional/Disciplinary Professional/Disciplinary Professional Disciplinary Professional Disciplinary	Rencourage departments to free up curricular time. Read Accommodate faculty schedules. Provide funding and faculty time to devote to curricular planning for IPE. Integration IPE throughout the student experience. Readent experience. Readent experience. Readent experience. Provide though this maybe difficult when the number of students is not evenly distributed across faculties. Provelopment and selection of appropriate scenarios of collaborative care is difficult. Provide support to the IPE modules in terms of student support and learning sources. Readilitate the development of IPE modules.

IPE = interprofessional education

table 6

Other studies have revealed results similar to the findings of the CCMHI survey.⁹⁸ Relevant findings include:

- Interprofessional education for collaborative practice is a priority among academic and health care institutions, as well as within communities.
- Funding is available on a macro level from the government and from leading health and education institutions.
- Community members can provide leadership, commitment, and support (e.g., by contributing time).
- Interprofessional education initiatives were established in response to specific patient or population needs.
- Implementation of education initiatives was linked to provincial reform initiatives.
- Willingness to change among all stakeholders evolved over time.
- A champion is needed to lead change, but secondary support is necessary for sustaining it.
- There is a wealth of information about interprofessional education available in Canada but it is not readily accessible.
- Existing successful programs have not received widespread recognition.
- Issues within the health care system as a whole, need to be addressed to move forward.
- For interprofessional education to be successful, programs must respond to

cultural and social concerns to address the population's needs.

Peer Support

Peer support models aimed at therapy face barriers similar to those encountered by mental health human resources since they are part of the primary health care delivery system in Canada. Peer support models comprise consumers, families, and caregivers who provide care during patient recovery. In most cases, peer support workers consist of individuals who have experienced mental illness or addiction.

Peer support programs offer services in many different ways. 99 These approaches include:

- The "para-professional" approach, in which workers are supervised by a professionally trained counsellor.
- Volunteer workers conducting outreach peer support.
- Former clients of vocational rehabilitation agencies providing peer support to new clients.
- Peer tutors providing independentliving skills instruction.
- Workers providing pertinent information on topics such as housing, social services, transportation, recreation, etc.
- Workers providing information about community networks and activities.

Peer support models expand the services and support that health care professionals provide. This support includes assistance with:

- Developing relationship skills.
- Learning problem-solving techniques.
- Building healthy friendships.
- Learning responsible wellness management.
- Increasing independence in the community.

Studies show that consumer-based services and the use of consumer care providers can ensure access to peer support. Such services are an important resource for people recovering from mental illness or addiction.¹⁰⁰

Given their role, peer support programs are also affected by the barriers that prevent

collaborative mental health care. There is limited funding for peer support programs from provincial and territorial governments; certain services are funded or supported by charitable and volunteer-driven organizations. Since they are part of the mental health care process, consumers, families and caregivers should be engaged in the dialogue and reforms addressing barriers to collaborative mental health care.

Mental health peer support programs and models have been supported and implemented across Canada and internationally.¹⁰¹ These programs have helped overcome barriers preventing access to collaborative mental health services. They have also helped address the misconceptions and negative attitudes about mental illness and addiction during the recovery stage, which usually takes place within the community.

APPROACHES AND STRATEGIES FOR COLLABORATIVE MENTAL HEALTH CARE

Approaches to Overcoming Barriers

Progress has been made in reducing legislative, service delivery, and funding barriers preventing collaborative mental health care. Successful approaches to overcoming the barriers are briefly described in this section.

Legislation and Policy

Many recent reviews have noted the presence of regulatory barriers and issues related to scopes of practice that get in the way of changing the way various health professionals work in Canada. Legislative reform would help enable multidisciplinary team care. Some jurisdictions currently have health profession legislation that enables shared care, while others do not. We need to determine what measures and processes were employed to achieve successful legislation. ¹⁰²

The need to use provincial and territorial regulations and legislation to foster collaboration among regulated health care professionals has become paramount because of changing clinical realities.

If interdisciplinary collaboration is to become institutionalized and sustainable in primary health care, legislation needs to be more flexible as it relates to the regulation of health professionals. Lahey and Currie identified key steps to surmounting the legislative barriers to collaborative mental health care practice:¹⁰³

Reviewing and adjusting scopes of practice.

- Mandating accountability for facilitating interprofessional practice.
- Eliminating unnecessary regulatory restrictiveness.
- Creating flexible, responsive legislative machinery.
- Broadening institutional integration.

There are opportunities to move collaborative mental health care forward through legislative means. The focus should be on:

- Eliminating unnecessary legislative rigidity.
- Encouraging administrative flexibility.
- Improving accountability and transparency.
- Developing an integrated system of regulation.
- Demonstrating the potential of collaborative practice and the reality of barriers.
- Developing a collaborative regulatory culture.
- Creating linkages with broader reforms and system changes, including health care human resource planning.
- Learning from aggressive reforms in countries such as the United Kingdom and New Zealand.

Remuneration

Alternative funding through different payment plans can influence change by creating new roles for practitioners that promote collaboration and new health care delivery models. Exploring innovative compensation models (such as salary) in practice settings can encourage collaboration. For example, some provinces have initiated efforts to explore how physicians and other health care practitioners can work together and be reimbursed within a comprehensive primary health care setting.

In recent years, there has been some progress in fee schedules for indirect care and in adjusting alternative funding plans and funding mechanisms that are population-based. Developments across the country since 2002 indicate a growing willingness on the part of both government and care providers, especially general practitioners and psychiatrists, to address barriers to both collaborative primary and mental health care. The following are examples of changes that have been implemented. 104

- The British Columbia Medical Association and the British Columbia government signed an agreement that includes new ways for family physicians to be remunerated for the delivery of mental health care.
- Alberta Health and Wellness, the Alberta Medical Association, and the provincial regional health authorities signed an agreement creating Local Primary Care Initiatives, which offer family physicians new incentives to work in multidisciplinary teams.
- In Nova Scotia, a new provincial contract with primary care physicians and psychiatrists includes an alternative funding plan, which should expand the

- number of payment options available in the future.
- The Physician Payment Model Working Group in New Brunswick is developing and implementing alternative models for physician remuneration.

Funding interdisciplinary collaborative teams will require the creation of organizations to act as intermediaries between providers and governments/health authorities, since governments are unlikely to want to employ a huge number of new people on a salary or fee-for-service basis. These new intermediary organizations, whether they are family health teams or primary health groups, are unlikely to be financed exclusively on a fee-for-service basis for the reasons already mentioned.¹⁰⁵

Linking financing and funding decisions for collaborative mental health care provides real opportunities for the appropriate use of non-physician care providers. It would also free up scarce resources to allow physicians to engage in more cost-effective activities and would resonate more loudly with policy and physician communities. The creation of publicly funded interdisciplinary teams will require additional public investment, since many non-physician care providers are currently funded by private sources. ¹⁰⁶

When considering financing and funding, it is important to distinguish between how much funding is provided and how that funding is allocated to services and providers. Payment mechanisms clearly affect incentives; however, a fuller understanding of the implications of funding – and when it acts as a barrier to and when it can facilitate collaboration – is required.¹⁰⁷

table 7	Payment Me	chanisms			
	Basis of Payment				
Payment to	Costs	Time	Services	Population	Outcome
Individual	≫ Cost plus*	➢ Salary➢ Sessional➢ Hourly	➢ FFS per task➢ FFS per visit	≫ NA	Performance contracting
Organization	 ➢ Line- by-line budgets⋅ Average cost models 	➢ Per diem➢ Hourly	➢ FFS➢ Diagnosis- related groups	CapitationFixed budget for a catchment area	Performance contracting
Analysis of Payn	nent Mechanisms				
Options	Description Advantages		Disadvantages		
Cost	 Pay providers on the basis of the costs (e.g., drug benefit programs whereby pharmacists are reimbursed for the cost of the drugs plus a professional fee). Organizations given line-by-line budgets based on historical expenditure patterns. 		≈ Simple and easy to implement.		Inflexible.Offers little incentive to reduce costs.
Time	 Reimburse based on time spent. Time units can be based on hourly rates or aggregated into sessional fees or salaries. 		"churn" patie → Provider may	to over-service or to	May negatively affect productivity.No incentive to ensure that time is well spent.
Services	➢ Pay fixed fee for each service.➢ Payments relate to a standardized fee schedule.		short patient	but at potential cost of visits. ntive for efficient	May present implementation difficulties if unit costs legitimately vary across organizations.
Population	> Funding is allocated on the basis of population of the region. (i.e., rostering).		 Providers are given fixed payment (i.e., capitation) for each patient in providing a set of health services. Allows adoption of best practices. Offers incentive to control costs. 		Patients may not be given choice to seek health care from another provider.
Outcome	➢ Providers are paid based on outcomes achieved.			based payment, this used as part of a	Technical issues need to be addressed in obtaining data on utilization trends and patient health status.

^{*} Pays providers on the basis of the costs they have incurred or are expecting to incur

Some jurisdictions outside Canada have successfully introduced alternative reimbursement models for mental health care providers. In the United Kingdom, policy innovation played a key role in developing new reimbursement models. For example, payments are made to the health care practice (which also provides mental health services), not to individual practitioners, to encourage a collaborative team approach. This proved highly successful in altering behaviour among providers. 108 Literature describing the Australian experience supports the idea of negotiating new approaches within the overall framework of health system goals. International studies have stressed the importance of a funding system that covers the cost of all professionals working together.¹⁰⁹

Dewa, Hoch and Goering¹¹⁰ suggested an approach to understanding the various remuneration schemes. This approach involved a consultation liaison model of shared care to examine reimbursement schemes and associated economic incentives. In their assessment of these researchers, this would be the most effective approach for Canada. Highlights of various reimbursement models are given in Table 8.¹¹¹

table 8

Characteristics of Reimbursement Models for Shared Care in Collaborative Mental Health Care

Fee-for-Service	Capitation	Blended Payments
Allows credentialed non- physician mental health care providers to bill for consultations	Works if focus is on services delivered, not on provider delivering care.	Logical place to start because full- scale change in reimbursement scheme is not likely.
with family physicians with the goal of increasing consultations, and for mental health treatments. Allows physicians to bill for	Allows development of practice groups involving a variety of professionals in full- and part-	➢ Builds on fee-for-service plan and introduces capitation to support shared care and reduce incentives
mental health treatments delivered by mental health providers affiliated with their practices (similar to a dentist— dental hygienist relationship). None of the above would address the rift between primary mental health care providers and psychiatrists.	time capacities. Physician would be reimbursed no matter who actually provided services. Financial incentives would encourage procurement of psychiatric consultations or use of other specialists to provide services beyond scope of primary care practitioners.	to provide unnecessary services. Capitation would provide guaranteed payment and would subsidize use of mental health specialists in primary care settings, with specialists providing consultation or direct care. Capitation would change scope of practice of primary care physician beyond direct patient care and encourage coordination-of-care responsibilities. Use of fee-for-service would counteract tendency to undertreat; the rate would have to be set at a level that discourages billing for unnecessary consultations but high enough to encourage necessary ones. Prerequisite in any capitation scheme is patient rostering – assigning people to single practice for a period of time, theoretically leading to a loss customer choice.
 ➢ The above would make it more feasible and financially rewarding for primary care practitioners to treat people with mild mental illness in primary care, but at the risk of changing the case-mix of psychiatrists to include only the most severe cases. ➢ Reliance on fee-for-service financing in its present form does not support shared care: shared care is seen as viable by physicians only when they can recoup additional costs through revenues based on increased numbers of customers. 	Capitation payment would have to be high enough to equal the costs of referrals.	
	Risk is that professionals with lesser credentials might be intentionally selected to work in the practice to minimize costs.	
	 Policy issue is one of contrasting the delay in or lack of treatment by a specialist mental health clinician, with timely treatment offered by mental health providers with less training. Incentive to attract healthier patients remains because of low 	
	financial risk. Soft capitation plans with risk reduction related to degree to which objectives are met may be more fruitful.	
	Salaried doctors might be offered bonuses to work in collaborative programs.	

Scopes of Practice

Although regulations are frequently noted as potential barriers to implementing collaborative care, more careful scrutiny suggests that regulatory problems are manageable. 112
Certainly, when various health professionals find overlap in the scope of services they can perform, turf wars and resistance to change can result. Nonetheless, the existing shortages of mental health human resources in many communities can act as a facilitator. Hospitals already have regulatory frameworks that allow interdisciplinary activities and that could presumably be adapted for primary health care organizations. 113

Human resource substitution is a policy that can be used to achieve some of the goals of community-based health care, including achieving cost-effectiveness, ensuring service accessibility, and distributing resources equitably.114 Role substitution can occur so that one professional or team member can provide services that are functionally equivalent to those provided by another member, sparing the time of professionals who are in short supply, or whose specific competencies are not required. Role substitution is feasible and effective when done properly. Developing competency profiles for collaborative mental health care programs and generic staff roles is an effective support for role substitution.

The Romanow report proposed a variety of options, gathered from a number of health policy reports and other literature, for addressing scope of practice issues and barriers

vis-à-vis collaborative mental health.¹¹⁵ These include:

- Permitting a larger and more independent role for nurses, psychologists, physiotherapists, speech therapists, and others as part of primary care teams.
- Encouraging national or intergovernmental health human resources planning, including education and training, as well as more co-ordinated long-term forecasting.
- Boosting incentives for health care providers to work (and live) for longer periods in rural and remote parts of the country.
- Improving morale by ensuring that care providers are able to meaningfully participate in the design and implementation of future major health reforms.
- Moving towards an integrated educational curriculum for health providers, including common courses that would facilitate co-operation and build mutual respect among different types of providers.
- Understanding that increasing the supply of health professionals and changing attitudes and behaviours is necessarily a long-term proposition.

Liability

At a leaders' forum on interdisciplinary collaboration in primary health care, 116 the

following approaches to ameliorating liability problems were proposed:

- Reforming tort law, including establishing a liability threshold and a class action procedure.
- Securing a common insurer for all members of a particular primary health care group.
- Increasing focus on health outcomes and best practices.
- Creation of an effective team process in which policies, procedures, and best practices are clarified.
- Involving clients in their care.
- Communicating effectively.
- Performing more research on collaborative work.

The Canadian Medical Protective Association made recommendations about how to limit liability for physicians in a team structure that could apply to mental health care providers, ¹¹⁷ as outlined below.

- Ensure that the patient record includes the physician's own assessment and recommendations for treatment.
- If the team makes a decision contrary to the judgment of the physician, the physician should not only voice his or her concerns, but also ensure that the record includes his or her clinical findings, treatment options, and recommendations.
- Physicians should request a second opinion when appropriate.

- If a team's decision is still to be implemented contrary to the physician's recommendation, the physician should transfer the care of the customer to another physician.
- When a team is caring for a customer, the physician should ensure that the patient and the family are aware of how the decision-making process works.

In their extensive research on regulatory and medico-legal barriers to interprofessional practice and on overcoming related liability issues, Lahey and Currie¹¹⁸ discuss the following options:

- Tailoring collaborative practice to the requirements of tort law.¹¹⁹
- Collectively promoting a vision of collaborative practice that proactively addresses accountability issues and "educates" the courts – that is, pushing the collaborative agenda before the courts.
- Reforming regulations and legislation.

Interprofessional Education

Collaborative practice in mental health care is key to enhancing the quality and coordination of care. It has been suggested that deficiencies in knowledge and skills – and poor attitudes – pertaining to collaborative practice are the result of the way in which health professionals are educated and trained. But there is support for the development of interprofessional bridges between mental health professionals. The importance of teaching skills for open, honest, and clear communication within mental health care teams is important.

table 9

Enablers of Interprofessional Education for Collaborative Mental Health Care

Enablers of Interprofessional Education	Incentives for Offering Interprofessional Education, Community Practice Level
 Positive attitudes (e.g., willingness to work). Internal and external support: "champions". Collaboration and relationship-building (e.g., developing relationships with faculty from other professional schools). Clinical placements and service learning. Cross-faculty teaching. More funding (e.g., for pilot projects and workshops). Research on interprofessional education in collaborative mental health care. Curriculum development. Assessment of activities to encourage student participation in IPE. Requiring professions to increase education level of mental health care providers to allow other professional groups to participate in IPE. Administrative co-operation (e.g., willingness of multiple groups to be flexible in scheduling). 	 Leads to better delivery of product to customers (e.g., enables more co-ordinated and efficient service to patients). Leads to interconnectedness (e.g., team building and networking). Enables transfer of knowledge and leveraging partnerships with experts in the field. Offers accreditation/recognition (e.g., continuing medical education credits). Offers an opportunity to allow changes to address emerging practice reality. Brings in professional development funds. Improves professional morale and job satisfaction. Allows flexibility.

The CCHPE survey and the Oandasan et al¹²¹ literature review identified factors that would foster and promote interprofessional education for collaborative practice, as outlined in Table 9.

Common themes noted in the literature among most health care settings and all health professionals were:

- All undergraduate programs were successful and sustainable; however, challenges still exist in obtaining program recognition among other faculties.
- Interdisciplinary undergraduate and postgraduate programs were funded either through the university's global budget or through research grants.

- Student participation was primarily at the undergraduate level.
- Most universities offered interdisciplinary education courses as electives within the program curriculum, whereas at the University of Alberta, such courses are mandatory.
- Not only are students learning interdisciplinary skills and techniques through classes, workshops, tutorials, or seminars, but many also participate in community placements to obtain hands-on experience in collaboration in a clinical/health care practice setting.
- Roles and responsibilities were clearly defined. Both the academic and health institutions primarily provided the

- funding and resources, while champions and community leaders provided the support for program implementation.
- Communications played a role in fostering collaboration. This included newsletters, consultation meetings, tutorials, and the encouragement of feedback.

Factors contributing to the success of interprofessional education included:

- Openness to ideas held by other professional groups.
- Support from senior administrators and organizations.
- Conducting interprofessional education sessions through.¹²²
 - learner-centred approaches
 - use of more interprofessional education strands in pre-qualifying programs to counter negative stereotypes
 - more flexible and innovative approaches to education
- Sound program logistics and administration.
- Balanced participation from different professional/discipline groups.
- Programmatic and financial sponsorship.
- Participant compensation.

Lessons from Other Jurisdictions

Collaborative health care arrangements are being encouraged in the United Kingdom, Australia, New Zealand, and the Netherlands through policy and funding support. The effects of these stimulating government measures are being studied in various research projects.

The Regional Office for Europe of the World Health Organization provides policy and other leadership for co-ordinated mental health care initiatives across Europe. Building on this policy framework, the Netherlands Institute of Primary Health Care (NIVEL) has identified the relationship between primary and mental health care as a top priority. One positive outcome of NIVEL's focused activity is the more effective use of resources. This has been achieved by increased co-operation among family physicians, social workers, and primary care psychologists; by increased practitioner competency gained through additional training and support for consultation; by strengthening social work services; and by including primary care psychologists in public health insurance coverage.¹²³ In the National Health Service in the U.K., community mental health teams demonstrated effective communication among mental health care providers and physicians, which resulted in better patient outcomes. 124,125

Another relevant initiative is INTERMED, an international network of multidisciplinary professionals in Europe, the United States, and Japan. The network has developed a risk assessment tool to detect and treat people with complex mental health care needs. The tool is currently being used mostly by practitioners in hospital settings; these practitioners then

approach primary care providers to participate in the design and implementation of postdischarge individualized treatment plans.

Studies have shown that when expanded interdisciplinary scopes of practice are thoroughly and effectively implemented, outcomes remain at satisfactory or even improved levels. In summary, while there are a number of barriers and challenges facing those attempting to set up collaborative care arrangements, international experience confirms that there can be real benefits for mental health providers, consumers, families, and caregivers. 126

The literature describes various enablers of and barriers to collaborative mental health care that need to be addressed at the macro, meso, and micro levels. ¹²⁷ They are outlined in Table 10.

Collaborative Mental Health Human Resources: Success for Canada

Factors critical to the success of health human resource deployment practices that can be applied to collaborative mental health care are summarized below. ^{128,129} Deployment practices must:

- Be based on clearly established population— and health needs—based approaches, which are articulated in health policies and strategies (rather than being ad hoc practices).
- Be clearly defined, with coherent scopes of practice, and must be clearly articulated to both the health professionals deployed and to

- associated professional groups working with the professionals in question.
- Include clearly defined standards of practice, which must be enforced by the provincial executive authority and supported by the required legislative and regulatory framework.
- Be accompanied by the required education and training to support the new skills and capacities needed to provide the health service.
- Use evidence-based best practices that have been demonstrated through evaluation studies.
- Include patient outcomes and satisfaction, quality of service, efficiency, effectiveness, and value for money when measuring and evaluating service delivery.
- Encourage exposure to systematic education in interdisciplinary collaboration.

In outlining the barriers that deter collaborative mental health care practice, the literature does provide examples of success. Broadly, factors that contribute to the success of approaches aimed at addressing barriers include:

- Priority: Government, decision-makers, and health care human resource planners make it a priority to include collaborative mental health care as part of primary health care reform.
- Funding: New sources of funding are available to test new models of health care delivery.

table 10

Approaches to Overcoming Barriers to Collaborative Mental Health Care

Macro Level: The Broader System

- **≫** Provide existing care providers with continuing education in collaborative care.
- > Train future practitioners in collaborative mental health care.
- > Promote collaborative relationships among professional organizations, such as undertaking joint projects on collaboration, developing joint statements about collaborative care that build on best practices, and providing joint training and peer support programs.
- > Develop national mental heath policies that set out goals and mechanisms for primary-secondary mental health care integration.
- > Ensure that policies support decentralization of mental health services, integration of mental health and general health care, and collaboration with non-medical providers.
- > Establish provincial departments of mental health.
- > Provide financing for recruitment, training, and employment of personnel; adequate supply of medicines; and a network of facilities, including transportation, data collection, and research.
- > Provide internal and external incentives to integrate collaborative mental health care into the health care system.
- **≫** Conduct systematic strategic planning.

Meso Level: The Practice Level

- > Provide clear job descriptions that include well-defined expectations of professionals working together.
- > Use team members' expertise appropriately, especially when specialists are part of the team.
- > Develop and use team protocols so that roles and functions are defined, with clear separation of leadership/coordination functions from clinical/professional responsibility so that service objectives are clear.
- > Ensure availability of supportive infrastructure, such as a client register, client information system, and recall system.
- Have well-defined clinical processes and pathways that emphasize early detection and collaborative work, with outcomes being solution – not process – oriented.
- > Use treatment guidelines and screening tools.
- > Work in an open-door style that involves both spontaneous and as-needed consultations and more formal meetings.
- > Ensure that the physical space is suitable (i.e., blended into the mainstream of the primary care setting).

Micro Level: Local System Level

- > Improve interaction at the primary care—mental health care interface by promoting the delivery of primary care in the mental health setting for people with serious mental illness, and/or promoting the development of mental health care capacity in the primary care setting.
- > Train mental health workers in the new tasks of training and supporting non-specialized health workers who work in primary care settings.
- > Focus on continuous improvement.
- > Involve experienced staff in collaborative care.
- **≫** Commit to evaluation.
- > Use information technology to enhance communication and information-sharing in team-based settings.

- Commitment and support: There is long-term commitment and support at all levels.
- Servicing a need: Mental illness is prevalent among Canadians and resources should be available to meet the needs of consumers, families, and caregivers in all health care settings.
- Mindset: Health care and education sectors are gradually opening doors to new models of health care delivery at the institutional level, but this openness needs to be transferred to the community level among all health professions.
- Opportunities: Canadians are looking forward to change to ensure the sustainability of the health care system and to guarantee the effective use of our health care resources.
- Linkage with health reform: Most provinces and territories have established health care plans and priorities for an integrated health care system; collaborative mental health care should be part of that process.

Despite the extensive research conducted to date, there are still gaps in knowledge, preventing full understanding of the barriers to maximizing the effectiveness of mental health human resources and whether proposed models and solutions implemented in international jurisdictions would be feasible in Canada. Information gaps can be categorized as follows:

Mental health workforce dynamics

- There is still very little information about how mental health workers interact with other professions; no information exists on effective strategies for promoting collaboration, be it across professions, between employers and employees, or among levels of government.¹³⁰
- The characteristics of the mental health workforce, such as job tenure, salary and benefits, case workload, and working conditions, have not been centrally recorded.
- There is no current analysis of the factors relating to suitability and efficacy of locating collaborative mental health care personnel within a given type of organization.

Compensation and funding for mental health care providers

More research is needed on the effects of reimbursement policy on care providers. Studies have already provided key insights into the impact of alternative reimbursement systems, but further work could improve our understanding of key concerns in this area.¹³¹

WHAT WE DON'T KNOW: INFORMATION GAPS

We need to learn about the level of leadership and commitment among regulatory bodies and health professions because they will play an influential role in advancing collaborative mental health care and in establishing priorities for mental health human resources at the meso level.

Legislative reform framework for collaborative mental health care

- Although legislation relating to health care human resources is being revised in supportive ways, we do not know whether specific legislation or scope of practice acts have been implemented that relate to collaborative mental health care. An in-depth analysis is needed to determine this (e.g., comparative scope of practice inventories).
- There is limited information on self-regulated professions such as pharmacists, midwives, chiropractors, etc. and how they function in a collaborative care environment. Information is non-existent for unregulated workers. 132
- Gaps in information about health care human resource planning, integrated delivery models, overlapping scopes of practice, and increased use of other health professions need to be filled if policy-makers are to do their jobs effectively. 133
- An analysis, through legislative tracking, of changes in provincial legislation should be conducted to determine

success factors for supporting/facilitating optimal use of health care resources.

Interprofessional education

- We do not know the level of priority by all governments and academic institutions for the development and implementation of initiatives in interprofessional education fostering collaborative mental health care.
- Research into new models of interprofessional pre- and post-service education is needed.

Best practices for patient care

- Understanding, and having knowledge of, population needs is critical to the success of collaborative practice programs. A national central resource to drive education, research, and faculty development may be required. Further, more can be learned by drawing on existing successful collaborative mental health care—related initiatives.
- We can learn from other jurisdictions about how collaborative mental health care delivery has been successfully implemented.
- Reports of seeing both a family physician and a psychiatrist were the highest in the Maritimes and British Columbia and the lowest in Quebec. These findings suggest that rates of collaboration are variable across the country, which likely stems from the differing systems for funding and for delivery of mental health services. These findings, however,

do not tell us whether family physicians are managing patient care with additional support from psychiatrists or other providers, without referring the patient to these other care providers.¹³⁴

Need for mental health human resources data

- Numerous reports, ministers and deputy ministers of health, and several stakeholder groups have identified significant gaps in the information we have about health care personnel; these reports and stakeholders have called for data development at the national level. In particular, data on the allied health care workforce is lacking.
- The priority is to build and strengthen the evidence base for national planning. Although there is progress in developing minimum data set standards, collection of data should include all information required to analyze demand factors, utilization, or needs-based planning, as well as comprehensive profession-specific data. 135,136,137

Role of peer support

Although peer support plays a key role in the recovery phase of individuals with mental illness or addiction, because peer support workers work in communities, we do not know their level of interaction with health care professionals and mental health care providers as it affects collaborative mental health care.

Although the review of collaborative mental health care initiatives did not focus primarily on the health care human resource framework, it did allow the opportunity to make some relevant observations.¹³⁸

- More supportive policy and legislation is needed, particularly as they relate to alternative remuneration strategies for physician services, liability, and scopes of practice.
- Special remuneration and other incentives to aid recruitment and retention of primary and mental health care providers in rural and remote areas must be considered.
- More training of primary and mental health care providers in the benefits of collaborative mental health care will benefit everyone who works in and uses the health care system.
- Continued use of broad-based collaborative mental health care community planning is necessary to identify both general needs and resources and those of special populations.
- More research and program evaluation is needed to demonstrate the effectiveness of collaborative mental health care through consumer outcomes in primary health care and strategic dissemination of these findings, such as the Continuous Enhancement of Quality Measurement in Primary Mental Health Care in British Columbia.¹³⁹
- A common understanding of organizational structures and processes within collaborative mental health

WHAT CAN BE DONE

- care will assist in creating the right framework.
- There is a need to redefine roles and understand resistance to change.
- There is a need to build consumer, family, and caregiver awareness and understanding of interdisciplinary approaches to collaborative mental health care.
- Structural problems that may make interdisciplinary teamwork difficult, including inadequate resources to support the team, need to be recognized and addressed.
- A link is needed between funding incentives and the commitment to a collaborative model.

There is recognition that these barriers need to be removed to facilitate collaborative mental health care; the question is how to do it. In developing an action plan to move collaborative mental health care forward in Canada, consideration should be given to the recommendations described in the next section.

Recommendations

1. Implement Effective Collaborative Mental Health Care Human Resource Planning

Implement a nation-wide, long-term, madein-Canada mental health human resources strategy. Initiatives are underway to develop a national health care human resources strategy that encompasses all professions; mental health must be part of that process, including

- the development of standards for data collection on mental health care providers and service delivery.
- Initiate collaborative stakeholder consultation. There should be a co-ordinated effort to include all stakeholders to work collaboratively on mental health resources.
- Develop a template for collaborative mental health care. This should include:
 - development of national standards
 - implementation of evidence-based interventions
 - exploration of alternative service models based on examples of good practice
 - measurement of progress
 - development of policy and clinical instruments (currently underway by CCMHI); these instruments (e.g., tool kits) include regulations and incentives that will influence the supply of mental health care providers, facilitate changes to their work practices, enhance their responsiveness to the needs and expectations of clients, create incentives that improve performance, and reward innovation.

2. Establish Reimbursement and Funding Priorities for Collaborative Mental Health Care

Priorities should be established for providing separate funding programs and/or initiatives that foster collaborative mental health care for

education, research, and practice. Priorities include:

- Undertaking a review of existing program funding requirements, specifically how mental health providers are funded in both the public and private health insurance sectors; this includes conducting research on access to data.
- Supporting research on health care delivery models that facilitate collaboration by each specific health discipline that works in teams in various practice settings.
- Exploring alternate compensation (non fee-for-service) models for health care practitioners that allow health care professions to work in collaborative environments in mental health care delivery; this could include developing mechanisms to involve all health care practitioners, including funding for consultation.
- Developing new and stable funding models that are not volume-driven but instead are based on community needs and are tied to funding outcomes.
- Creating organizations to act as intermediaries between providers and governments/health authorities; they would receive funds from government or health authorities and remunerate health care professionals who practice interdisciplinary collaboration.
- Considering shifting resources within primary health care to new services and providers.

- Continuing to rely on private sources of payment for non-physician services and using them as revenue streams for new primary health care organizations.
- Linking reform to available resources and providing whatever range of services can be afforded, given needs and budgets.
- Using a population health approach that includes prevention and promotion to fund and deliver collaborative mental health care.

3. Develop a Comprehensive Legislative Framework for Collaborative Mental Health Care

Revisions to scope of practice rules and other regulations are necessary to promote greater flexibility and encourage collaboration. A strategy for law reform suggests that regulatory bodies have specific statutory accountabilities for facilitating, enabling, and supporting the development of interdisciplinary collaborative practice. A national framework is required to define scopes of practice by:

- Reviewing scope of practice rules and regulations affecting mental health care delivery for the purpose of developing proposals that would outline ways of ensuring that the skills and competencies of mental health care providers are fully utilized and that collaborative mental health care services are delivered by the most appropriate qualified health care provider.
- Promoting collaboration to leaders in the health care community in order to effect change. Obtain and leverage support from high-profile champions who are

- interdisciplinary care providers in mental health.
- Reviewing how collaborative mental health care would effect change in the scopes of practice of health disciplines. Working with accreditation and regulatory bodies, determine how collaborative practices effect change in health care service delivery, particularly through new approaches to collaborative mental health care.
- Developing core competencies for collaborative mental health care initiatives. Regulatory and accreditation bodies need to explore and define the types of collaborative competencies they believe health professionals should demonstrate before completing their training. If competencies are to be developed and introduced into accreditation standards, special attention should be paid to the descriptions used and the terminologies developed to ensure clarity and consistency across health professions.
- Exploring the idea of changing entry and licensing requirements so that program content fostering collaborative practice is required to meet identified competencies. The goal should not be to displace one mental health care provider with another, but rather to look at the unique skills each one brings to the team and to co-ordinate the deployment of these skills.
- Conducting further research on malpractice and liability through the creation of a national coalition of

provincial/territorial regulators to effect legislative reform. The development of joint statements from professional liability protection providers, such as the Canadian Medical Protective Association and Canadian Nurses Protective Society, will inform and educate mental health care providers about their responsibilities and liability implications in working in collaborative environments.

4. Develop a Policy Framework for Collaborative Mental Health Care

The following policy recommendations could be considered:

- Maintain flexible use of non-physician providers via "any willing provider" laws and expanded provincial practice acts to allow professionals to maximize the use of demonstrated skills and competencies.
- Advocate that modifications to federal and provincial/territorial health care coverage legislation (including the *Canada Health Act*) include parity in mental health financing.
- Implement a standardized national health care workforce database.
- Standardized mental health quality indicators, including stratification across provider types and cultural competency and language access standards.
- Expand funding of mental health service research so that the costeffectiveness and optimal mix of various

mental health care providers across organization types can be determined.

5. Build a Case for Interprofessional Education in Mental Health and Addiction

- Review current education and training programs for mental health care providers to focus more on integrated approaches. Education programs should be changed to focus more on integrated, team-based approaches to meet mental health care and service delivery needs and to encourage best practices.
- Propose that teaching institutions adapt training programs designed for future professionals in the mental health and social services sector to fit with the new realities of the health system and to address the demands of interdisciplinary team work.

CONCLUSION

Collaborative health care, including the provision of mental health and addiction services, is gaining ground, but it is hampered by barriers and a lack of awareness of how interprofessional practice can effectively manage our health care human resources and improve patient outcomes. There is an increasing amount of international literature, and a growing number of examples, describing approaches to overcoming these barriers. Canada needs to explore and fully assess its adaptability for mental health care reform in order to meet the needs of consumers, families, and caregivers.

It is clear that there is a need for a coherent mental health care delivery system. Key to creating such a system is obtaining committed funding to support collaborative mental health care delivery. In establishing effective collaboration, strategies will need to be created that address the mental health and addiction treatment workforce, scopes of practice, and interprofessional education and training.

Research reveals that there is a shortage of mental health human resources and that mental health care providers need to be connected to the development and implementation of strategies and programs at all levels. Certain Canadian jurisdictions have taken steps to address the barriers to collaborative mental health care through demonstration projects; more needs to be done to create an effective system at the national level.

Collaboration is achievable. To ensure success, the barriers that impede success must be removed at all levels. This paper provides an overview of some of the issues that affect successful collaboration.

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appendixA

GLOSSARY OF TERMS & ACRONYMS

Terms

BEST PRACTICES

Technique or methodology that, through experience and research, has proven to reliably lead to a desired result. Interchangeable with 'Better Practices' and 'Good Practices'.¹⁴¹

CCHPE

Centre for Collaborative Health Professional Education

CCMHI

Canadian Collaborative Mental Health Initiative

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.¹⁴²

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.¹⁴³

COLLABORATIVE MENTAL HEALTH CARE

Care provided by a team of different health care professionals for the purposes of enhancing mental health outcomes.

COLLABORATION IN PRIMARY HEALTH CARE

Two or more primary health care providers working together with the patient and/or caregiver for the purposes of improving health outcomes and system capacity. The process involves joint information sharing, goal seeking, and decision-making.¹⁴⁴

INTERDISCIPLINARY

A range of collaborative activities undertaken by a team of two or more individuals from different disciplines applying the methods and approaches of their respective disciplines.

INTERPROFESSIONAL EDUCATION

Occasions when two or more professions learn from and about each other to improve collaboration and the quality of care.

NIVEL

PRIMARY HEALTH CARE

Netherlands Institute of 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, schools, health care institutions, offices of health care providers, homes for the aged, nursing homes, daycare centres and community clinics. It is also available by telephone, health information services and the Internet.¹⁴⁶

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