



Canadian
Collaborative
Mental Health
Initiative

Initiative
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Current State of Collaborative Mental Health Care

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Current State of Collaborative Mental Health Care

*A paper for the
Canadian Collaborative Mental Health Initiative*

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O U R

G O A L

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

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PREFACE

This report synthesizes the following reports commissioned by the Canadian Collaborative Mental Health Initiative:

Advancing the Agenda for Collaborative Mental Health Care

Reviews the barriers that keep people from accessing mental health services in primary health care. Describes collaborative mental health care and how this approach can alleviate some of these barriers.

What is Collaborative Mental Health Care? An Introduction to the Collaborative Mental Health Care Framework

Identifies four key elements of collaborative mental health care and the fundamentals that influence collaborative mental health care.

Annotated Bibliography of Collaborative Mental Health Care

Reports the trends found in the literature between 2002-2004 on the integration of mental health care in primary health care. Reviews over 800 articles/chapters.

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

Reviews approximately one hundred collaborative mental health care initiatives in Canada. Each initiative is described and emerging trends discussed.

Collaborative Mental Health Care in Primary Health Care Across Canada: A Policy Review

Reviews relevant mental health and primary health care policies and legislation in each province and territory that support or hinder the implementation of new collaborative mental health care initiatives.

Collaborative Mental Health Care: A Review of Selected International Initiatives

Examines activities related to the integration of mental health services in primary health care in select countries. Outlines policies that support collaborative mental health care and provides examples of initiatives.

Interprofessional Education Initiatives in Collaborative Mental Health Care

Reports on a survey of university departments, professional associations, and community organizations conducted to determine the extent to which courses in mental health were being offered in a collaborative fashion to a wide range of health care professionals.

Prevalence of Mental Health Illnesses and Related Service Utilization in Canada: An Analysis of the Canadian Health Survey

Analyzes the Canadian Health Survey: Mental Health and Well-Being, to show which professionals people with mental health problems consult in their treatment, as well as whether there is collaboration among professionals in treating individuals.

Providing Mental Health Services to Aboriginal Peoples through Collaborative Mental Health Care: A Situation Report

Summarizes research, reports, and statistics that document and address major mental health challenges facing Aboriginal Canadians. Provides an initial examination of current mental health care models serving Aboriginal people.

INTRODUCTION

The Canadian Collaborative Mental Health Initiative (CCMHI) is a reflection of the growing awareness of the importance of high quality collaborative mental health care delivered within the primary health care setting. It also reflects the urgent need to strengthen the capacity of primary health care providers in this context. The CCMHI was formed to advance this agenda by a consortium of twelve national organizations, representing community services, consumer, family and self-help groups, dietitians, family physicians, nurses, occupational therapists, pharmacists, psychologists, psychiatrists, and social workers.

The CCMHI received funding in 2004 from Health Canada's Primary Health Care Transition Fund to undertake a comprehensive review and analysis of what is known about collaborative mental health care. The goal of the CCMHI is to enhance the capacity of primary health care providers to meet the mental health care needs of consumers through collaboration among key partners – primary and mental health care providers, consumers and families. To this end, the Initiative commissioned reports on a range of relevant topics and produced an annotated bibliography (see Preface).

The intent of these commissioned reports is to capture a snapshot of the current state of collaborative mental health care. Specifically, as leaders in this 'new' field, the CCMHI – through its Steering Committee – intended to describe an accurate baseline picture in order to develop clinical, policy, education, and consumer and caregiver toolkits. The Steering Committee also intended to draft and sign a Charter that would promote the development of collaborative mental health care in directions consistent with

the view shared by its members. Namely, the Steering Committee is committed to:

- ∞ promoting collaborative mental health care, to enhance the entire continuum of mental health care in primary health care, from prevention to rehabilitation;
- ∞ providing tools that enable a range of necessary providers to overcome noted barriers and collaborating to provide more integrated mental health and physical care; and
- ∞ upholding the notion that consumers and caregivers are experts in their own right and are to be respected partners in:
 - ∞ determining treatment options and setting goals in their recovery;
 - ∞ developing collaborative mental health care initiatives and program evaluations.

The purpose of this overview is to provide a cohesive summary of this large body of work. This overview is shaped by, and limited to, the descriptions and analyses contained in all nine commissioned reports, each of which was reviewed in full. The reader is encouraged to read the individual reports for more detailed discussions.

The commissioned reports and this overview were developed by the CCMHI in the context of a Collaborative Mental Health Care Framework, which was derived from previous research and current service delivery approaches. The Framework positions the consumer at the centre and identifies the goals of collaborative mental health care as: increased access, decreased

burden of illness, and optimized care (Figure 1).

The implementation of collaborative mental health care is effected by four *fundamental factors*: government policy and legislation, funding, research-based practices, and community needs. Policies, regulations, standards and legislation need to be congruent with the principles of collaborative mental health care, and sufficient and diverse resources need to be made available to facilitate the implementation

of collaborative mental health care initiatives. Collaborative mental health care initiatives should also emerge from evidence-based research, by identifying and implementing best practices, and should be based on the needs and resources of individual communities.

Collaborative mental health care is defined by four *key elements*: accessibility, collaborative structures, richness of collaboration, and consumer centredness.



Figure 1: Collaborative Mental Health Care Framework

ACCESSIBILITY

The goals of collaborative mental health care are met by increasing *accessibility* to first-line mental health services for the general population. This includes mental health promotion, illness prevention, detection, and treatment in primary health care settings, or “bringing the services closer to home.” Providing mental health services in primary

health care settings can be accomplished through various means, including:

- ∞ providing direct mental health care in primary health care settings; or
- ∞ providing indirect mental health support to primary health care providers in primary health care settings.

In the first instance, mental health care is provided by a mental health specialist; in the second, mental health care is delivered by a primary health care provider who is supported by or consults with a mental health specialist. Strategies developed by various collaborative mental health care initiatives to provide mental health services in primary health care settings include the following:

- mental health specialist offers direct mental health care in primary health care setting:
- scheduled visits in primary health care settings;
- co-location of mental health and primary health care services;
- mental health specialist offers indirect mental health care in primary health care setting by supporting primary health care provider either formally or informally.

COLLABORATIVE STRUCTURES

Successful collaborative mental health care initiatives recognize the need for *systems and structures* to support collaboration. First, providers will either create, or be part of, an organizational *structure* that will define the ways in which people have agreed to work together. This structure can be:

- formal (e.g., service agreements, coordinating centres, collaborative networks); or
- informal (e.g., verbal agreements among providers).

Second, providers will organize or create *systems* that will define how they agree to accomplish certain key functions of collaborative mental health care, for example:

- referral strategies (e.g., forms and referral networks);
- information technology (e.g., electronic client records, Web-based information exchange, teleconferencing, videoconferencing, e-mail, and list serve);
- evaluation (e.g., developing evaluation instruments and agreeing to adopt certain common evaluation instruments, methodologies and software).

RICHNESS OF COLLABORATION

A central feature of effective collaborative mental health care is the *richness of collaboration* among health care partners, including: primary and mental health care providers, consumers and caregivers. Characteristics of *richness of collaboration* include:

- knowledge transfer among health care partners through various educational initiatives, for example:
 - courses, lectures, tutorials, seminars, rounds, rotations, case discussions, internships, workshops, seminars, symposia;
 - education materials, such as: research papers, studies, books, guides, manuals;
 - situational/informal learning-mentoring through cases;
- the involvement of health care partners from a wider range of disciplines (e.g., nurses, social workers, dietitians, family physicians, psychologists, psychiatrists, pharmacists, occupational therapists, and peer support workers);
- communication among all health care partners.

CONSUMER CENTREDNESS

The needs of consumers are at the core of collaborative mental health care. *Consumer centredness* calls for consumers to be involved in all aspects of their own care, from treatment choices to program evaluation. It also calls for initiatives to be designed to address the needs of specific groups; in particular, those that are often underserved or have a great need for both primary and mental health care. A growing number of collaborative mental health care initiatives emphasize the role of the consumer by allocating time and resources to the consumer and/or caregiver through:

- ✧ education (e.g., educational materials, sessions or information centres);
- ✧ peer support;
- ✧ participation in developing collaborative mental health care initiatives (e.g., focus groups and committees) and in developing and implementing program evaluations (e.g., instrument design and roles as interviewers or respondents);
- ✧ participation in adapting mental health promotion and treatment interventions to individual needs, including cultural experience.

MENTAL HEALTH AND MENTAL HEALTH CARE IN CANADA

The CCMHI commissioned a review of mental health prevalence and service utilization patterns in Canada. The review reiterates the reality that mental health issues affect us all, either directly or indirectly as family members, neighbours, community members, and care providers. Although determining the prevalence of mental illness in a population is a complex task, researchers have estimated that nearly one in five Canadian adults will personally experience a mental illness during a one-year period (Health Canada, 2002). Many Canadians, however, do not receive the mental health care and support they need. For example, a study of Ontarians with depression found that more than half the respondents did not receive any form of treatment or intervention (Parikh et al., 1999). This may be partly related to whether individuals seek help from the formal care system. Another study showed that only 60% of community-residing individuals who suffer from an affective disorder seek professional assistance, with 76% of those consulting only their family physician (Richards et al., 2004).

The latter phenomenon is critical to understanding the importance of collaboration among providers in the primary health care and mental health care systems. In a study specific to Ontario residents, over 60% of respondents who reported a psychiatric

Mental health issues affect us all, either directly or indirectly as family members, neighbours, community members, and care providers

disorder indicated they had received their mental health care from their family physician, often with no involvement from other mental health care providers (Parikh et al., 1997). Furthermore, data indicate that mental health needs of patients consume 25% to 50% of family physicians' time (Craven et al., 1997). In fact, more patients with mental disorders are cared for in the primary health care sector than in the mental health care sector, despite the fact that primary care providers may not have adequate knowledge, skills, and/or time needed for the whole range of mental health problems they deal with in their practice. Being treated in the primary health care system also may mean that patients do not have access to the broader range of mental health specialist services in their community due to lack of awareness and coordination. In short, family physicians and other primary health care providers are often the first and only contact for individuals with mental health problem—a reality that may mean that early detection and intervention, which are linked to better outcomes for consumers, are less than optimal.

An analysis of the self-report data from the most recent (2002) Canadian Community Health Survey (CCHS) Cycle 1.2 on Mental Health and Well-Being was undertaken on behalf of the CCMHI to further inform our understanding of the prevalence and service utilization issues

referred to above. This survey asked Canadians to comment on specific illnesses and their use of specified services. The highlights of this analysis are as follows:

- ∞ The 12 month prevalence¹ of self-reported mental disorders varied across Canada, from a low of 8% in Prince Edward Island to a high of 12% in British Columbia (B.C.).
- ∞ Gender differences in prevalence rates were seen in all provinces, with significantly higher rates in women than men.
- ∞ Only 61% of individuals with a self-reported mental disorder had consulted a professional for their mental health during their lifetime.
- ∞ Family physicians were consulted most frequently (45% overall), while psychiatrists (25% overall), psychologists (23% overall with much more variation across provinces than for other professionals), social workers (20% overall) and nurses (almost 6% overall) were consulted much less frequently.
- ∞ Almost 14% of respondents had not received help for their emotions when needed. The primary reason offered was that respondents “preferred to manage oneself.”
- ∞ Of the 14% of respondents who did not receive help, they reported reasons related to acceptability (77%), accessibility (18%) and availability (17%).

- ∞ Approximately 7% of respondents reported using various self-help approaches during their lifetime.

Canadian studies of the relationship between primary health care physicians and mental health services have consistently identified two problems: first, the perceived lack of respect and support for the role of the family physician, and second, the difficulties encountered by family physicians in accessing mental health services and communicating with mental health service providers.

The mental health service system in Canada is itself generally regarded as highly fragmented and not especially consumer centred. For

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several years, policy makers and governments have tried repeatedly to reform mental health care, but the funding and policy support for a collaborative

consumer centred approach never materialized. Current reform initiatives in several provinces make explicit the need to deal with stigma and to address the barriers identified above. However, many consumers continue to experience serious difficulty in accessing the right services and supports in a timely way from the appropriate providers—a continuum of services and supports from promotion/prevention and crisis through to community- and hospital-based treatment, and a wide range of supports including housing, employment, and income. The recommended paradigm shift

from mental illness as chronic to that focused on recovery is also occurring at a slow pace.

Individuals who live in rural and remote communities generally face greater difficulty in accessing appropriate mental health services, whether primary health care providers or mental health specialists. This results from the well-documented difficulties in recruiting and retaining health professionals in these communities, and from the additional costs associated with travel to and from these communities.

A report commissioned by the CCMHI makes it clear that Canada's Aboriginal people face unique challenges to their mental health and well-being and in receiving the appropriate services, and have done so for many years. The literature identifies a high number of interactive factors, many of them historical, which contribute to mental health problems among Aboriginal people. These include the creation of reserves, enforced residential schooling, enforced use of a second language, exposure to new diseases, as well as poverty, unemployment, and lack of adequate housing. Aboriginal people report that these historical and current factors lead to feelings of loss of self-determination, hopelessness, and loss of pride in being Aboriginal. Alcohol and other substance abuse, depression, and suicide (particularly among youth and young adults) are much more prevalent in Aboriginal communities than in the general population. This may be an under-representation, as mental

Canada's Aboriginal people face unique challenges to their mental health and well-being and in receiving the appropriate services

health and related issues are often not reported, partly because they are considered part of daily life in many Aboriginal communities, and partly because of stigma and confidentiality concerns.

The provision of mental health services in First Nations, Inuit and Métis communities is highly variable, but generally inadequate. Many Aboriginal people live in small, isolated communities with very limited in-community primary and mental health care resources and very limited access to resources from outside their communities. The needs and service accessibility of Aboriginal people living in urban settings are even less well-documented and understood. These realities are exacerbated by a general lack of coordination between the federal/provincial/territorial government and across relevant ministries within federal/provincial/territorial jurisdictions.

It is fair to say that there is an absence of a clear national mental health policy and plan for First Nations, the Métis and Inuit populations. Although there have been recent investments in such programs, existing Health Canada funding is inadequate and overly bureaucratic and inflexible.

For the reasons noted above, Aboriginal people have yet to experience collaborative mental health care, except in isolated pockets (e.g., Cornelia Wieman in Six Nations, Ontario and Brokenhead, Ojibway Nations, Manitoba). However, it would appear to have considerable potential given the emphasis in Aboriginal culture on viewing the person from a holistic perspective. To achieve the potential, collaborative mental health care approaches should:

- ∞ be developed by, and delivered in, the community;

- ∞ include culturally relevant components of treatment;
- ∞ involve culturally competent professionals; and
- ∞ focus less on the individual alone and more on the individual in the context of family and community.

KEY MESSAGES

- ∞ *Nearly one in five Canadians experience a mental illness each year.*
- ∞ *Many Canadians do not receive professional help for their mental health problems.*
- ∞ *Of those people that do, most receive help from their family doctor or primary health care provider.*
- ∞ *Primary health care providers may not have adequate knowledge, skills, or time to provide mental health care.*
- ∞ *Primary health care providers have difficulty accessing mental health specialist assistance.*
- ∞ *Aboriginal peoples and rural/remote communities face particular challenges in accessing mental health services.*

COLLABORATIVE MENTAL HEALTH CARE: THE EVIDENCE BASE

The CCMHI commissioned an annotated bibliography using the Collaborative Mental Health Care Framework as the lens to examine the most recent collaborative mental health care literature. Although a shared care annotated bibliography was developed in Canada in 2002 (Craven et al, 2002), interest in collaborative mental health care is growing worldwide, and researchers and practitioners are studying these activities and publishing reports and articles at an increasing rate.

Building an evidence base for collaborative mental health care is vital to guide the development of both policy and practice. More recent literature suggests that research in this field is in its infancy, and that providers are not yet able to speak knowledgeably about what works best for whom. Until then, it is inappropriate to endorse specific collaborative mental health care approaches or models.

To begin with, as is usually the case in a developing field, there are no widely accepted standard terms or definitions for what this Initiative is calling collaborative mental health care. Some of the more common labels are shared care, integrated primary care, primary behavioural health care, primary mental health care, and mental health/primary care interface. Definitions, if articulated, are also varied. Underlying most discussions of mental health care are theoretical or conceptual frameworks, often rooted in the perspective of the disciplines involved. The most common perspective is the traditional western medical view, which in itself is noted as being a barrier to collaborative

mental health care. The literature points out the need for practitioners involved in collaborative mental health care to have a shared set of values and goals for mental health services, that moves them beyond their own, often strong, set of discipline-specific beliefs.

There is also a difference in what authors define as being the appropriate population group for collaborative mental health care. Two basic approaches are evident. On one side, many authors argue that primary health care should meet all the mental health care needs

of the population it serves, just as it meets their physical health care needs (sometimes referred to as horizontal integration). Other authors suggest that specialized mental health services be designed to meet the needs of the high use/high cost population

(sometimes referred to as vertical integration). Worldwide, the vast majority of individuals with mental health care needs use primary health care (if they use any health service at all) to meet those needs. It is therefore important to articulate the relative roles and responsibilities of primary and mental health care providers in meeting the range of needs.

The literature also identifies a number of sub-populations for which the general collaborative care arrangement may need to be modified to ensure access to appropriate mental health services. These sub-populations include:

- ∞ people with serious mental illness;
- ∞ people with addictions and co-occurring mental illness and addictions;

Building an evidence base for collaborative mental health care is vital to guide the development of both policy and practice

- ❧ children and adolescents;
- ❧ seniors;
- ❧ homeless people;
- ❧ people with HIV; and,
- ❧ specific cultural groups.

Once again, there is no consensus as to what types of modifications will most likely achieve the best results.

The Benefits of Collaborative Mental Health Care

The literature identifies numerous reasons why collaborative mental health care is theoretically preferable to the historical provision of mental health care in two quite distinct and separate settings. These benefits occur at three levels: the individual consumer, the local provider and community, and the broader health system.

At the individual level, the benefits include:

- ❧ accessing the full range of health care needs in the close-to-home setting, given that most individuals present in primary health care settings;
- ❧ increased satisfaction because care is 'integrated';
- ❧ more accessible and less stigmatizing mental health care;
- ❧ improved quality of medical care for those with serious mental illness;
- ❧ improved safety related to medication regimes for individuals with co-occurring physical and mental health issues; and
- ❧ increased treatment compliance.

Benefits at the local provider and community level include:

- ❧ improved quality of care, as primary health care providers have the capacity to address the functional needs of consumers as well as symptoms of the illness;
- ❧ continuous long-term follow-up by primary health care providers with the right back-up or community-based primary health care services (without frequent personnel changes);
- ❧ improved efficiency of the system in general as it reduces the oft-noted difficulties associated with referrals to other practitioners;
- ❧ increased trust/respect/support among and across practitioners;
- ❧ reduced burden on primary health care providers, even on those with mental health training/skills, and increased overall capacity of this scarce resource;
- ❧ increased transfer of knowledge between the two sets of providers;
- ❧ increased provider confidence and job satisfaction; and
- ❧ potential to challenge the myths and reduce the stigma of mental illness.

Finally, the literature points to benefits that can accrue to the broader health system including:

- ❧ increased opportunities for prevention in both primary and mental health care;
- ❧ earlier access to care for both physical and mental health problems;
- ❧ containing total costs and possibly even some cost-savings;

- more efficiently deployed scarce health human resources;
- potential to achieve parity among mental disorders and other health/illness conditions – reduced stigma;
- integrating mental health with primary health care in less developed countries as the only reasonable approach to providing any mental health care; and
- intrinsic value of breaking down the barriers among disciplines and viewing health from a broader, more holistic perspective.

As noted above, the literature on collaborative mental health care is rapidly expanding as this field evolves. As a consequence, there is a lack of common language or conceptual framework for studying collaborative mental health care. Not surprisingly, there are almost as many ways of ‘doing’ collaborative mental health care as there are people writing about it. Those that write about it use a variety of approaches to categorize the plethora of collaborative activities and to identify what works and what does not work. Notwithstanding the variety of schemes used to describe the practice of collaborative mental health care, some of the elements notably overlap and the schemes share a common goal—to increase our understanding of how to integrate discrete disciplinary care approaches in primary health care settings to improve service delivery and outcomes for consumers with mental health problems.

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Collaborative Structures

The literature identifies a range of structural supports believed to facilitate collaborative activities across primary and mental health care providers. These can be categorized as supports at the practice level, the local service system level, and the broader health system level. Depending on the type of arrangement, supports at the practice level might include:

- adequate space to include mental health specialists in the primary health care setting;
- common administrative procedures;
- common waiting rooms and reception services;
- integrated appointment processing;
- common staff room;
- joint charting;
- protocols for team practice;
- formal and informal opportunities for joint learning; and
- position descriptions that articulate the collaborative dimensions.

The activities that support collaborative mental health care at the local service system level include:

- articulating among relevant community providers a common goal to improve or increase collaborative activities between the primary and mental health care sectors;
- developing a strategy for local primary health care providers to be trained by mental health specialists;
- utilizing information technology, such as the electronic patient record;

- ∞ involving experienced practitioners from both sectors to develop collaborative activities; and
- ∞ designing and implementing evaluations of collaborative activities.

At the broader health system level, the following supports have been identified as being important to advancing the collaborative mental health care agenda:

- ∞ continuing education in collaborative care for existing providers;
- ∞ revising the curricula used to train future providers to include training in collaborative approaches and skills;
- ∞ increasing collaborative relationships and arrangements among professional associations and academic health programs;
- ∞ developing clear national policies and plans to support collaboration;
- ∞ providing funding to promote the development of collaborative care activities; and
- ∞ developing effective approaches for evaluating collaborative care activities.

Richness of Collaboration

Collaborative care means the coming together of individual professionals from different disciplines, who are now expected to undertake their work as members of a team. Although the number and types of professionals involved in collaborative care teams varies greatly, working as a member of a team often presents

new challenges to those who have historically practiced alone or in collaboration only with professionals of like disciplines.² While the delivery of specialized mental health care by multidisciplinary teams is a well-established model used in many jurisdictions, it is not the typical delivery model for primary health care services.

The potential range of traditional professionals involved in collaborative mental health care is wide—family physicians, psychiatrists, psychologists, psychiatric nurses, nurse specialists and practitioners, social workers, occupational therapists, pharmacists, and spiritual leaders. Although there is a trend to broaden the professional base of collaborative mental health

Collaborative care means the coming together of individual professionals from different disciplines

care teams, the reality is that most teams are more narrowly constituted. However, it is worth noting that collaborative mental health care in some jurisdictions has resulted in the creation of a number of new positions such as counselor, link worker, primary mental health care worker, gateway worker, care facilitator, and care extender—positions that may be filled by individuals with varied disciplinary backgrounds.

The literature points to a number of possible advantages of using teams that cross primary and mental health care to deliver mental health services in primary health care:

- ∞ facilitates sharing of important consumer information;

- facilitates optimal use of expertise of all disciplines involved in the assessment, treatment, and referral processes;
- increases opportunities for disciplines to learn from each other; and
- provides support for individual participants.

However, there are challenges to undertaking collaborative mental health care:

- different philosophies of care (including differing diagnostic and treatment protocols);
- ambiguity and/or conflict over roles and responsibilities, including leadership;
- unclear lines of authority/accountability;
- lack of understanding/acceptance of the value and skills of the disciplines involved;
- different levels/methods of remuneration; and
- fear of/resistance to a change in practice.

Successful collaboration requires blending professional perspectives, finding a workable balance in important areas such as interdependence/autonomy and participation/leadership, and developing mutual respect and trust.

Consumer Centredness

As articulated in the Collaborative Mental Health Care Framework, consumer centredness refers to the degree to which practices in service provider organizations reflect the importance of the consumer and his/her well-being. It is

widely and strongly agreed, at least in principle, that consumer centredness should be the fundamental focus of both the planning and implementation of individual care as well as the planning and evaluation of care processes. The literature identifies a number of approaches

Consumer centredness should be the fundamental focus of both planning and implementation of individual care

and activities that are intended to facilitate consumer centredness in care delivery:

- imbedding consumer centredness in the vision, mission, goals, policies, and procedures of provider organizations;
- developing mechanisms for consumers to participate in service planning and evaluation processes;
- promoting the view that consumers bring unique expertise and add value both at the individual care and the service planning levels; and
- promoting the view of care planning and delivery as being a partnership between the consumer and his/her care providers.

Fundamental Factors

The literature speaks to the importance of policy, funding, research, and community as fundamental factors in hindering or advancing the development of collaborative mental health care. To begin with, it is essential to

have a clearly articulated system-level policy framework at the national (and, if relevant, the provincial/territorial) level that endorses and supports collaborative mental health care if it is to become an integral part of the health care system. The policy framework also needs to identify the mechanisms that will address a range of practical issues relating to the implementation of collaborative mental health care, such as standards of care, provider training, and performance monitoring/measurement. The evidence suggests, however, that supportive

policy is necessary but not sufficient to bring about more collaborative mental health care. Resources, both financial and human, are critical ingredients. Approaches to program funding and provider payment need to be tailored to reduce the disincentives and increase the incentives for practitioners to become involved in collaborative care arrangements. These can be powerful levers for change. Furthermore, training current and future practitioners in the practice of collaborative care can also contribute significantly to the desired result.

As with any new approach to care, research can play an important role in legitimizing the new approach as being one that ‘works’ and ‘works better’ than previous or other approaches. As noted earlier, an in-depth review of the evidence is underway. In

Approaches to program funding and provider payment need to be tailored to reduce the disincentives and increase the incentives for practitioners to become involved in collaborative care arrangements

addition, the CCMHI will be facilitating a roundtable discussion with the country’s leading epidemiologists, health economists, and policy makers to review the evidence to determine if a business case can be developed to support collaborative mental health care, or to determine what data need to be collected to ensure that future initiatives reflect the ‘evolving best practices.’

Some broad recommendations are emerging to guide the development of relevant research, including:

- a new paradigm(s) acknowledging that primary mental health care is delivered by many types of professionals with varied skills;
- a broader definition of primary mental health care that reflects the determinants of health as well as the range of less visible non-health professionals providing informal services and supports;
- a closer examination of innovative brief treatment interventions, which are not merely adaptations of approaches in specialized mental health care that have been developed largely for a different population;
- more attention focused on how to identify consumers whose needs are best served in either primary or specialized mental health care, and at what point a referral to specialized mental health care is most appropriate;
- including mental health promotion and prevention activities when evaluating primary mental health care;

- more research conducted by interdisciplinary teams; and
- research approaches that bridge the research ‘world’ and the realities of real-life practice.

Regarding the community—the fourth fundamental factor—the literature notes the importance of knowing the local community context in designing relevant and successful collaborative care initiatives. It is necessary to assess need, resources and care pathways as initial steps in planning the appropriate approach(es) to collaborative mental health care in a given community. The planning process

itself is important and requires the participation of a broad range of stakeholders, including providers, consumers, families and caregivers. Attention also needs to be paid to implementing the selected practice changes, setting realistic time frames and providing good support throughout the transition.

KEY MESSAGES

- *Building an evidence base through research is vital to guiding the development of collaborative mental health care policy and practice.*
- *Research in the field of collaborative mental health care is in its infancy and translating knowledge into practice is even less developed.*
- *Collaborative mental health care can provide many benefits to consumers, families, caregivers, providers, and the broader health system.*
- *There is increasing collaborative mental health care activity using a variety of approaches.*
- *Government policy supporting collaborative mental health care and appropriate funding and provider-payment mechanisms are powerful levers of change.*
- *The local community context is important in developing feasible collaborative mental health care initiatives.*

FUNDAMENTALS UNDERLYING COLLABORATIVE MENTAL HEALTH CARE in CANADA

The previous section highlighted the conclusions from the literature related to the Collaborative Mental Health Care Framework's key elements and fundamental factors. The CCMHI commissioned a number of papers to review the extent to which policy and other fundamental factors are affecting the development of collaborative mental health care in Canada. The following summarizes the current status of these factors.

Mental health and primary health care policy at the provincial/territorial level play an important role in creating the context for the development of collaborative mental health care initiatives in primary health care settings in Canada. Six years ago, primary health care was not mentioned in provincial mental health plans and vice versa, but now most jurisdictions are recognizing this interface. Every province and territory now has either formal or informal policy statements related both to primary health care reform and mental health care reform. In a small number of jurisdictions, the two policy statements are coordinated, particularly when the development of the mental health policy/plan follows that for primary health reform. The lack of coordination across these sector reform strategies can constitute a policy barrier to collaborative mental health care; therefore, it is preferable that the policy frameworks guiding the reforms of these two sectors be coordinated and compatible.

Every province and territory now has either formal or informal policy statement related both to primary health care reform and mental health care reform

As a result of these policy frameworks, all provinces and territories have either created or are creating some form of local primary health care initiative that includes mental health or recognizes that mental health care must be integrated into the scheme. These include primary health care organizations, community health centres, 'Instances Locales', primary health care or family health teams and/or centres, and local primary health care initiatives.

Some of the policy frameworks have also emphasized the need for inter-department/ministry collaboration within government and for broadening the base of collaborative mental health care policy development beyond health to the social service and justice sectors.

Another policy development that has the potential to facilitate collaborative mental health care is the devolution of governance for a range of health services from provincial (9) and territorial (1) governments to Regional Health Authorities (RHAs). Ontario is the last province to undertake this significant reform with its 14 Local Health Integration Networks (LHINs) scheduled to start operating in a limited way in the spring of 2005. Most mental health services are part of the RHA umbrella; an exception is New Brunswick, where community mental health services are still operated by the provincial government, although the intention is to devolve these services later this year.

Legislation related to health human resources—in particular, issues related to remuneration and liability—can be a barrier or an enabler to collaborative mental health care. Across Canada, regulations governing the practice of health professionals are being revisited and revised to reflect the new realities of health care. One example is the legislation passed by several provinces to permit the use of nurse practitioners. In both Nova Scotia and Ontario, legislation has been changed to allow pharmacists to fill prescriptions written by nurse practitioners. However, important legal issues still need to be addressed, including professional liability for decisions made by interdisciplinary teams and scope-of-practice issues for family physicians, psychiatrists, and nurse practitioners.

While most jurisdictions have had alternatives to fee-for-service arrangements since the 1960s, many physicians continue to work within the fee-for-service model, in which the fee schedules include minimal payment for indirect services. This payment model is viewed as being an impediment to collaborative mental health care. In recent years, there has been some progress in fee schedules for indirect care, alternative funding plans, and population-based funding mechanisms. Over the last two years or so, there appears to be a growing willingness on the part of governments and physicians, particularly family physicians and psychiatrists, to address this barrier. For example, in 2004, the B.C. Medical Association and the B.C. government signed an agreement that includes new ways for family physicians to be remunerated for mental

health care services. In 2004, Alberta Health and Wellness, the Alberta Medical Association, and the provincial RHAs signed an agreement creating Local Primary Care Initiatives (LPCIs). LPCIs offer family physicians new incentives to work in interdisciplinary teams with various expertise and experience.

There are other health professional groups, in addition to family physicians and psychiatrists, whose payment system can work against collaborative care. Reliance on strict fee-for-service by non-physician providers, such as psychologists who are paid through private sources, can also be a deterrent to participating in interdisciplinary collaborative care arrangements.

There is evidence that other supports for collaborative care, such as the availability and use of information technology, is increasing. These supports include electronic client records, teleconference/videoconference clinical consultations, staff education/training, and telehealth/telemental health.

However, there are health human resource issues that continue to pose significant challenges to developing collaborative mental health care. For example, there are shortages of health professionals in most provinces, particularly outside the large urban centres, and it is becoming more difficult to retain health care professionals.

Another human resource challenge relates to the education and training of these health professionals. It has been suggested that

Across Canada, regulations governing the practice of health professionals are being revisited and revised to reflect the new realities of health care.

greater collaborative practice in mental health care is a key means for enhancing the quality and coordination of care that is provided to clients and families in the community. However, there are major challenges to fostering greater collaborative care, such as a lack of understanding of the roles and expertise of other mental health care providers; lack of knowledge and skills of collaborative practice and interdisciplinary teamwork processes; and negative attitudes towards teamwork, collaboration, and other professionals. It has been suggested that deficiencies in knowledge, skills and attitudes pertaining to collaborative practice are the result of the way that health professionals are educated and trained. Traditionally, health professions have been educated and trained in isolation of one another and as a result have little exposure to the expertise that other professions could contribute in consumer care. Interprofessional education has been defined as “*occasions when two or more professions learn from and about each other to improve collaboration and the quality of care*” (Canadian Association of Interprofessional Education, 1997 revised). It is believed that interprofessional education serves to: enhance awareness and understanding of the roles and expertise of other professions; foster positive attitudes towards teamwork and collaborative mental health care; overcome negative stereotyping; and enhance the collaborative mental health care competencies of health professional learners.

Greater collaborative practice in mental health care is a key means of enhancing the quality and coordination of care that is provided to clients and families in the community

The CCMHI commissioned a survey to ascertain the current state of collaborative mental health care education and training provided by health-related disciplines in Canadian universities and colleges, by national and provincial/territorial professional and regulatory associations, and by mental health advocacy associations. The full range of undergraduate and graduate training and post-licensure continuing education was canvassed.

The majority of academic institutions reported that no formal interprofessional courses, workshops, or modules for collaborative mental health care exist in health-related disciplines. Six universities or colleges described eight formal courses, workshops, or modules, mostly at the pre-licensure level (i.e., undergraduate or resident). One Continuing Medical Education (CME) program was also identified. Most are offered in a one-semester format (approximately 40 hours of instruction) using a variety of learning and assessment activities. Only one of the identified courses includes students from more than one profession, although all include topics such as working in interdisciplinary teams. Despite the scarcity of formal courses, many respondents described their general programs as encompassing content related to the practice of collaborative care, such as communication and teamwork skills, and knowledge of and sensitivity to the skills and values of other professionals. These respondents also identified a number of potential barriers to implementing interprofessional collaborative mental health care learning. The most significant barriers were scheduling, rigid curriculum, lack of reward for faculty, and lack of financial resources.

The response from professional, regulatory, and mental health advocacy associations was largely similar. Although the majority of associations do not offer formal interprofessional courses, they report that members are encouraged to participate in continuing interprofessional education with a focus on collaborative mental health care. Twenty-one of these groups reported that they offer post-licensure interprofessional education with an emphasis on collaborative practice in the area of mental health care, and a smaller number reported that they provide credits or accreditation for interprofessional education obtained elsewhere. The potential barriers

noted by these respondents are also similar, but include lack of executive support.

Respondents also identified several factors that they believe facilitate interprofessional education and training, including: ensuring recognition of and respect for all professions; increased communication and collaboration; access to time and other resources; and leadership support. Finally, it is important to note that respondents generally acknowledged the importance of interprofessional collaboration in mental health care and indicated a willingness to develop interprofessional working relationships.

KEY MESSAGES

- *All provinces and territories have formal or informal policies related to reforming primary health care and mental health care.*
- *These policies do not always address collaborative mental health care; however, progress is being made.*
- *All provinces and territories have or are creating some form of a local primary health care initiative that includes mental health or recognizes the need for collaboration.*
- *Health human resource legislation is being revised in supportive ways, but more needs to be done, including alternatives to physician fee-for-service payment.*
- *The use of information technology to support collaborative mental health care is increasing, and needs to be expanded.*
- *Pre- and post-licensure interprofessional collaborative mental health care training is underdeveloped.*

CURRENT COLLABORATIVE MENTAL HEALTH CARE APPROACHES in CANADA

The CCMHI commissioned a review of the current state of collaborative mental health care in Canada. Key informants were used to develop a list of contacts, building on an existing list compiled by a joint College of Family Physicians of Canada (CFPC) and Canadian Psychiatric Association (CPA) compendium of shared mental health care in 2002 (Kates et al, 2002). A combination of surveys and telephone interviews were used to obtain information on over 100 clinical projects, programs, and other related collaborative activities in primary health care settings across Canada. The information collected was analyzed using the key elements and fundamentals of the Collaborative Mental Health Care Framework.

Accessibility

Improving consumer access to mental health services in primary health care is being accomplished in different ways across Canada. Generally, access to mental health services falls into two categories – direct and indirect. In the direct approach, mental health specialists provide services to consumers in their primary health care settings. Specific arrangements vary, but typically include special visits by the mental health specialist(s) to the primary health care location; co-locating mental and primary health care providers; or connecting the consumer to the mental health specialist(s) by telemental health. In the indirect approach, the primary health care provider delivers

mental health services to consumers while receiving consultative support from a mental health specialist(s). The specialist support is typically provided via telephone, e-mail, videoconferencing, face-to-face consultation between the primary health care provider and the specialist, or face-to-face consultation involving the two (or more) providers and the consumer. These support arrangements may be formalized (as to type and frequency of contact) or occur informally on an unscheduled basis.

Another variation combines a little of each approach, namely that the primary health care provider identifies that a consumer needs mental health services, may or may not provide some initial service, and refers the consumer to a mental health specialist with whom he/she remains in contact.

The direct approach tends to be used in circumstances where the primary health care team is smaller, service volumes are lower, and the number of mental health specialist collaborators is smaller. The collaboration in this direct approach is most likely to involve family physicians and psychiatrists, although it is becoming more common to include social workers and nurses. The success of this approach relies heavily on strong referral agreements between the two sets of providers. The indirect approach tends to involve larger primary health care teams and service volumes and a greater range of collaborative mental health partners. This approach requires more time and energy from the primary health care

provider and its success is related to good communication and well-defined processes and structures. The indirect approach appears to better enhance the primary health care providers' capacity to assess and treat consumers with mental health problems, as there are inherent opportunities for knowledge and skill transfer.

It is important to note, however, that the direct and indirect approaches are not mutually exclusive and that in many cases some combination of direct and indirect approach is used – for example, it is becoming more common for collaborators to co-locate. The factors that influence which approach or combination of approaches is chosen are related to the level of 'buy-in' on the part of the primary health care provider, his/her needs, the resources available to that provider, and the availability of mental health specialists.

Collaborative Structures

The structure of a collaborative enterprise defines the ways in which people work together. Structure includes such things as how the enterprise is funded, monitored, and evaluated; where liability resides for care decisions; and what the roles and responsibilities are for each care provider. The major differentiating feature of collaborative structures is whether they are formal or informal. Formal structures are almost always described in the form of a written agreement and responsibility for managing the agreement is often assigned to a coordinating centre or a network of collaborators, for

example. Informal structures are usually based on verbal agreements.

Both formal and informal structures benefit from a range of supports, including referral forms and protocols, standardized assessment tools, and information technology to facilitate communication. Many collaborative care activities begin with an informal structure, and as the collaboration continues and/or expands, the structure becomes more formal.

The trend is towards more formalized structures to guide the collaborative care activities of a moderate size group of interdisciplinary practitioners, including a family physician, psychiatrist, and/or social worker or nurse. Most collaborative activities examined in the CCMHI

review have been or are currently being evaluated. Evaluation tends to be more rigorous for initiatives that are funded on a pilot/demonstration/research basis and where funds for the evaluation have been budgeted.

The major differentiating feature of collaborative structures is whether they are formal or informal

Richness of Collaboration

Richness of collaboration refers to the breadth and depth of the collaboration among primary and mental health care providers, and among providers and consumers, families and caregivers. A rich collaboration is characterized by an interdisciplinary approach to care, significant interdisciplinary communication (verbal and written, informal and formal), and substantial knowledge and skill transfer (using a variety of methods to transfer to providers, consumers and caregivers). Activity in any

of these areas can have a synergistic effect on the others. The primary goal is to enhance the capacity of all the partners, particularly that of primary health care providers, in order to contribute positively to the mental health of the consumer. Rich collaboration is also characterized by the meaningful participation of consumers, families and other caregivers as members of the team. Knowledge transfer to consumers appears to be focused on providers working with consumers to identify treatment goals, to increase understanding of the illness and develop self-care behaviours, and to identify other learning and support opportunities (e.g., self-help/peer support groups and written materials). In some instances, caregivers are provided with knowledge – such as a better understanding of the illness and their role in the recovery process – and support to increase their capacity to assist consumers. Not surprisingly, the 100 or so collaborative mental health care initiatives reviewed indicate that the richness of collaboration varies, but that some initiatives demonstrate considerable richness in all three dimensions.

Consumer Centredness

Involving consumers, families and caregivers as active partners in collaborative mental health care initiatives in Canada is a growing trend. However, the initiatives reviewed appeared to vary considerably. For example, there is variation in the extent to which consumers of mental health services and their families and

caregivers are involved in the development and implementation of their own individual treatment plans. There is also considerable variation in the design, implementation, monitoring, and evaluation of collaborative mental health care initiatives, as well as in the transfer of knowledge to other consumers and caregivers.

Most initiatives reported that consumers are actively involved in developing their own treatment plans. Consumers and/or caregivers appear to be less involved in developing collaborative mental health care initiatives, tending only to be involved after the initiative has been developed. In fact, very few initiatives have consumer,

family and/or caregiver representation on their steering committees or advisory groups. An increasing number of initiatives are using consumer feedback as part of their approach to improving service quality. If new funds become available to enhance an existing initiative, there is a greater chance that consumers, families and/or caregivers will be invited to participate. On a somewhat different aspect of consumer centredness, many initiatives are clearly designed to meet the needs of special populations (e.g., the homeless, youth, the elderly).

Fundamental Factors

Although the review of these collaborative mental health care initiatives was not focused on how the fundamentals in the Collaborative Mental Health Care Framework impact on the

Involving consumers, families and caregivers as active partners in collaborative mental health care initiatives in Canada is a growing trend

respondents' work, it was possible to identify some relevant observations by the respondents. These include the need for:

- more supportive policy and legislation, particularly as they relate to alternative remuneration strategies for physician services and liability and scope of practice issues;
- adequate start-up and ongoing funding for collaborative mental health care in primary health care;
- special remuneration and other incentives to aid recruitment and retention of primary and mental health care providers in rural and remote areas;
- more training of primary and mental health care providers about the benefits of collaborative mental health care;
- continued use of broad-based collaborative mental health care community planning processes to identify both general needs and resources and those of special populations; and
- more research and program evaluation to demonstrate the effectiveness of collaborative mental health care concerning consumer outcomes in primary health care, and strategic dissemination of these findings.

KEY MESSAGES

- *Collaborative mental health care activity in Canada is increasing and a variety of approaches are being used.*
- *The approach whereby primary health care providers are supported by mental health specialists appears to enhance knowledge transfer between the two sets of providers.*
- *Collaborative structures are either informal or formal, but the trend is towards more formalized structures for a moderate size group of interdisciplinary practitioners.*
- *The richness of collaboration varies across the initiatives.*
- *The involvement of consumers, families and caregivers in collaborative mental health care is a growing trend but needs more focused attention.*
- *Collaborative mental health care initiatives have identified areas where continuous improvement is needed, namely in the areas of government policy, funding, provider payment systems, interprofessional collaborative mental health care training, and research or program evaluation.*

COLLABORATIVE MENTAL HEALTH CARE IN THE INTERNATIONAL COMMUNITY

A review was undertaken on behalf of the CCMHI of collaborative mental health care approaches in selected international jurisdictions, including Australia, New Zealand, the United Kingdom (U.K.), the United States (U.S.), and Europe, particularly the Netherlands. These jurisdictions were selected based on an initial literature review that indicated focused activity in the collaborative care area, aspects of which may be applicable to Canada.

There is no consistent conceptual framework or definition of collaborative care across these jurisdictions, and there is a wide range of approaches being taken. However, it is clear that the level and type of activity in the collaborative mental health care domain is greatly influenced by government policy. Collaborative care arrangements are being actively encouraged by governments in Australia, New Zealand, the U.K., and the Netherlands. In the U.K., for example, the National Health Service Frameworks set goals for providing mental health care in primary health care settings. Changes in government policy in Australia have driven the growth of Divisions of General Practice that embody a distinct move to the group practice modality, including collaborative care. In New Zealand, a recent policy shift involving a restructuring of health services to focus on broad-based primary health care organizations has led directly to more collaborative care arrangements. And,

Collaborative Care arrangements are being actively encouraged by governments in Australia, New Zealand, the U.K., and the Netherlands

beginning in 1999, the Dutch Public Health Ministry has provided substantial financial support for a comprehensive package of collaborative mental health care services. The effects of these recent government policy stimuli are being studied in a variety of research projects.

The picture in the U.S. is somewhat mixed. There is no national policy guiding a broad-based movement to enhance the capacity of primary health care to provide mental health care. In addition, there are insurance

barriers. However, several individual Health Maintenance Organizations (HMOs) and Managed Care Organizations (MCOs) provide some excellent examples of collaborative care arrangements; these arrangements are said to result

in improved medication compliance and overall health for patients.

Adequate financial resources are also an important factor in the development of successful collaborative mental health care. Collaborative initiatives are often hampered by the expectation that already burdened primary health care practitioners would extend or enhance their services to new populations without additional financial resources. Separate budgets for mental health care providers and general physicians can also be barriers to collaborative arrangements, as can lack of funding for staff to perform coordinating and case management functions. Even in

jurisdictions where government policy is clearly facilitative, there are significant funding barriers.

Other barriers noted in the international literature include the challenge associated with building a cohesive team of care providers with different training and backgrounds. Building the needed cross-practitioner trust and respect requires explicit attention. There are several other barriers noted, most of which are similar to those identified in Canada, including: significant shortages and poor geographic distribution of family physicians and mental health specialists; low salaries; underdeveloped recruitment and retention strategies; less than optimal mental health skill levels in both primary care and mental health care; and lack of exposure to mental health in basic primary health care provider training and continuing education.

There are a number of different types of arrangements between primary and mental health care providers in these jurisdictions. These range from regular telephone consultations between family physicians and mental health professionals (often referred to as a consultation-liaison model), to regular visits to a family physician's office by a mental health worker. There are also case conferencing/case discussion models where primary health care providers (mostly family physicians) and mental health professionals meet on a regular basis to discuss cases. Further along the collaboration continuum, there are also structured or integrated shared care/structured collaborative care models, which may involve service agreements, protocols, and co-location.

Other arrangements are focused on a contractual agreement between a specialist

service and a family physician. These include the:

- ❧ attached mental health professional model, in which the mental health worker is employed by the specialized (secondary or tertiary) service but works within the primary health care practice setting;
- ❧ liaison model, in which the specialist service employs a mental health worker who is dedicated to assisting the family physician in accessing mental health services; and
- ❧ liaison attachment model, in which the specialist service provides a mental health worker on a visiting basis to primary health care clinics for consults in which the family physician is not usually involved.

As noted above, the emphasis in Australia is on building local Divisions of General Practice, based on the framework articulated in its *National Primary Mental Health Care Initiative* (1999) and *Mental Health and Shared Care in Australia* (2001). The framework is an organizational structure designed to enable family physicians to work together; to provide family physicians with primary mental health care training; and to facilitate the development of partnerships among family physicians or groups of family physicians and mental health specialist services.

New Zealand's collaborative care approaches are situated in the *Primary Mental Health Care Framework*. The foundation of this Framework comes from the development of local Primary Health Organizations (PHOs). These PHOs

have a broad mandate, including providing services that address the needs of their enrolled populations who present with mild to moderately severe mental health problems. The PHOs are also mandated to form strong partnerships with specialized mental health services for effective care for those with moderate to severe problems. A *Service Development Toolkit* (2004) was developed for PHOs to build capacity to respond to mental health needs. Each PHO must also develop a mental health plan as part of its overall business plan, including activities that are intended to improve outcomes.

Collaborative care activity in the U.K. is being guided by the National Service Framework (NSF) for Mental Health (1999), one of several NSFs that set national standards, describe key interventions for a defined service or care group, identify strategies to support implementation, establish target dates, and provide a range of measures to assess quality. The aim of the NSF for mental health is to “deliver better primary mental health care, and to ensure consistent advice and help for people with mental health needs, including primary care services for individuals with severe mental illness” (ibid: Section 2, page 1). Consumers are to be referred to specialist services for further assessment, treatment, and care only when the need is clear. The subsequent National Health Service (NHS) Plan in 2000, which builds on this Framework, introduced several new types of health professionals in primary health care settings to improve mental health services, as well as a position described as a ‘gateway worker’. Many family physicians in the U.K.

International experience confirms that there can be real benefits for consumers and professionals

already practice in teams that often include other health care professionals, lending itself to collaborative care approaches.

As noted earlier, although there is no central government policy in the U.S. to direct collaborative mental health care development, individual HMOs and MCOs have developed a variety of collaborative care arrangements that span the continuum described above.

The Regional Office for Europe of the World Health Organization (WHO) provides policy and other leadership for coordinated mental health care initiatives across Europe. Building on this policy framework, the Institute of Primary Health Care (NIVEL) in the Netherlands 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 cooperation among family physicians, social workers and primary care psychologists; increased practitioner competency through additional training and supports for consultation; strengthening

social work services; and by including primary care psychologists in public health insurance coverage. In a recently published study that looked at access to primary mental health care in six European countries, the family physician was found to be the usual first health care contact for individuals with mental health problems. However, the organization and attributes of the individual jurisdiction’s health care system were found to significantly influence family physicians’ involvement in delivering mental health care.

Another relevant initiative is INTERMED, an international network of interdisciplinary professionals in Europe, the U.S., and Japan. The network has developed a risk assessment tool to detect and treat persons with complex mental health care needs. Currently, the tool is being used mostly by practitioners in hospital settings, who then approach primary health care providers to participate in designing and implementing post-discharge individualized treatment plans.

Studies of some U.S. examples of collaborative care have shown increased medication compliance, decreased number of

relapses, and higher client satisfaction.

In summary, while there are a number of barriers and challenges to setting up collaborative care arrangements, international experience confirms that there can be real benefits for consumers and professionals. A clearly articulated supportive government policy framework with appropriate funding to facilitate effective collaboration strategies is a significant factor in moving the collaborative mental health care agenda forward.

KEY MESSAGES

- *Internationally, collaborative mental health care is increasing, using a variety of approaches.*
- *Collaborative mental health care is most evident in jurisdictions where there is supportive and explicit government policy—e.g., Australia, New Zealand, the Netherlands, and the U.K.*
- *Collaborative mental health care in these jurisdictions still faces primary and mental health care provider shortages, funding challenges, and underdeveloped interprofessional education/training.*

CONCLUSIONS

Most individuals receiving formal care for mental health problems do so in primary health care settings, in which practitioners often do not have the knowledge, skills, or time to provide appropriate care. There is some evidence that collaboration among primary health care practitioners and mental health specialists can improve access to and quality of mental health services delivered in primary health care settings. Over the last 20 years, there has been a growing interest in developing collaborative mental health care initiatives, both at the policy and practitioner levels. The CCMHI undertook a comprehensive review of the state of collaborative mental health care in Canada and other selected international jurisdictions, done in the context of the Collaborative Mental Health Care Framework and informed by previous studies in this field.

Several common themes and observations emerged from the literature review and issue-specific reports commissioned by the CCMHI. The first theme is that the Collaborative Mental Health Care Framework's fundamental factors play a critical role in influencing the evolution of collaborative mental health care. Supportive and coordinated national/provincial/state government primary and mental health care policy frameworks are necessary to provide clear direction to local health planners and practitioners. In Canada, the provinces perform this function. Although most provinces have developed separate policy frameworks to reform primary and mental health care, only a small number have addressed the issue in policy statements of how to improve the interface between the two sectors.

The second and equally important fundamental factor is the role that resources play in the development of collaborative mental health care initiatives. The lack of adequate start-up and ongoing funding to support these new activities is often identified as a barrier. Collaboration is an added task to the existing heavy workload of both sets of practitioners and usually requires additional financial resources.

Human resource-related issues are also identified as being frequent barriers to implementing collaborative mental health care, both in terms of availability (supply) and skills. The shortage and poor geographic distribution of family physicians and mental health specialists is well-documented, with urban areas generally better served than rural and remote areas. Although frequently discussed, there is no evidence, at least in Canada, that these important workforce development issues are a priority for governments. The modest mental health knowledge and skill base of many primary health care practitioners is also well-documented. Both groups of practitioners require training in the content and process of interdisciplinary collaborative practice. This training is very limited in existing university/college health discipline curricula as well as in professional association continuing education programs. Training requires financial resources for trainers and time away from work for participants. Another human resource challenge is the way most physicians, at least in Canada, are remunerated – on a fee-for-service basis that provides little or no incentive for them to engage in collaboration. Medical practitioners continue to resist collaboration even though alternative payment options increasingly are

being made available by governments and other funders, and a growing number of physicians are choosing these alternative payment options.

Another resource domain is information technology. The timely sharing of accurate consumer information is essential for effective collaborative mental health care initiatives. The evidence indicates that there is some progress in this area, particularly in the availability of telehealth/telemental health and in the development of electronic patient records. Information technology needs to continue being expanded and used to facilitate communication, which is at the core of cross-practitioner collaborative care activity.

The third fundamental factor is research. There is a clear consensus that collaborative mental health care provides benefits to consumers and providers. What is less clear at this time is what approaches are most effective in achieving the consumer-related goals of collaborative mental health care – increased access, decreased burden of illness and optimized care. More research and program evaluation is needed to create a solid evidence base on which to refine approaches to collaborative mental health care and develop the tools that will facilitate improved mental health care in primary health care settings.

Collaborative mental health care is particularly underdeveloped in rural and

remote Aboriginal communities. Furthermore, the needs of and services for Aboriginal people living in urban settings are not well understood; this is an important area for further study. Three major barriers exist: the lack of a cohesive and comprehensive national policy framework for Aboriginal wellness; the inability of the federal and provincial governments to collaborate effectively on policy and funding initiatives; and the shortage of trained and culturally competent providers. The unique circumstances of Canada's Aboriginal people call out for a separate process involving relevant stakeholders to address how best to improve access to collaborative mental health care.

Finally, it is clear that a single type of collaborative mental health care arrangement does not exist, nor should exist, for all communities. Communities differ in terms of needs, resources, and practice patterns, and these variables should always be identified and influence the choice of collaborative mental health care arrangement. To be successful, communities should incorporate a broadly inclusive process to plan collaborative mental health care. Involving everyone in the planning process – from the family physician and mental health care specialist, to the consumer and family caregiver – is one important step to ensuring the successful implementation of collaborative mental health care.

REFERENCES

- Canadian Association of Interprofessional Education (CAIPE), revised 1997 cited in: IPE explained [page on the Internet]. Sheffield, United Kingdom: The WILen Project; c2002 – 2004.
Available at: <http://www.shef.ac.uk/wilen/ipe.html>
- Canadian Medical Association; Canadian Nurses Association. Working together: a joint CNA/CMA collaborative practice project, HIV-AIDS example [background paper]. Ottawa: CMA; 1996. p. 24. Available through the CMA's Member Service Centre 1867 prom. Alta Vista Dr., Ottawa ON K1G 3Y6; tel.: 800 663-7336 ext. 2307, fax: 613 731-9102, email: cmamsc@cma.ca
- Craven, M. and Bland, R. Better Practices in Collaborative Mental Health Care: An Analysis of the Evidence Base. *Can J Psych* 2006; 51 (Suppl 1, May). Forthcoming.
- Craven MA, Bland R. Shared mental health care: a bibliography and overview. [Article in English, French] *Can J Psychiatry*. 2002 Apr;47(2 Suppl 1):iS-viiiS, 1S-103S. Available at: http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=11989111
- Craven MA, Cohen M, Campbell D, Williams J, Kates N. Mental health practices of Ontario family physicians: a study using qualitative methodology. *Can J Psychiatry*. 1997 Nov; 42(9):943-949. Available at: http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=9429064
- Gagné MA. Advancing the agenda for collaborative mental health care. Mississauga, ON: Canadian Collaborative Mental Health Initiative; May 2005. Available at: <http://www.ccmhi.ca>
- Gagné MA. What is collaborative mental health care? An introduction to the collaborative mental health care framework. Mississauga, ON: Canadian Collaborative Mental Health Initiative; June 2005.
Available at: <http://www.ccmhi.ca>
- Gow T, MacNiven M. Collaborative mental health care: a review of selected international initiatives. Mississauga, ON: Canadian Collaborative Mental Health Initiative; In press 2005.
Available at: <http://www.ccmhi.ca>
- Gow T. Providing mental health services to aboriginal peoples through collaborative mental health care: A situation report. Mississauga, ON: Canadian Collaborative Mental Health Initiative; Internal background paper, 2005.
- Health Canada. A report on mental illnesses in Canada. Ottawa: Health Canada; 2002. 108p.
Available at: <http://www.phac-aspc.gc.ca/publicat/miic-mmacc/index.html>
- Holmwood C, Groom G, Nicholson S. Mental health shared care in Australia 2001: report for the Commonwealth Department of Health and Aged Care. Adelaide, South Australia: Flinders University; June 2001. 142p. Available at: <http://som.flinders.edu.au/FUSA/PARC/SharedCareReview.pdf>
- Institute of Medicine (U.S.). Committee on Quality of Health Care in America. Crossing the quality chasm: a new health system for the 21st century. Washington, DC: National Academy Press; 2001. 364 p.
Available at: <http://www.nap.edu/catalog/10027.html>

- Kates N, Ackerman S, editors. Shared mental health care in Canada: a compendium of current projects. Canadian Psychiatric Association and The College of Family Physicians of Canada Collaborative Working Group on Shared Mental Health Care; Spring 2002. 127p.
Available at: <http://www.shared-care.ca/pdf/compendium.pdf>
- Klaiman D. Increasing access to occupational therapy in primary health care. Occupational Therapy Now Online. 2004 Jan-Feb;6(1). Available at: <http://www.caot.ca/default.asp?pageid=1031>
- Lesage A., Vasiliadis HM., Gagné MA, Dudgeon S., Kasman N., Hay H. Prevalence of mental illnesses and related service utilization in Canada: an analysis of the Canadian Community Health Survey. Mississauga, ON: Canadian Collaborative Mental Health Initiative; December 2005.
- McVicar J, Deacon D, Curran V, Cornish P. Interprofessional education initiatives in collaborative mental health care. Mississauga, ON: Canadian Collaborative Mental Health Initiative; August 2005.
Available at: <http://www.ccmhi.ca>
- Mable AL, Marriott J. Sharing the learning: the Health Transition Fund synthesis series: primary health care health. Ottawa: Health Canada; 2002. 48p.
Available at: http://www.hc-sc.gc.ca/hcf-fass/english/primary_en.pdf
- New Zealand Ministry of Health. Primary health organisations: service development toolkit for mental health services in primary health care. Wellington, New Zealand: Ministry of Health; May 2004. 85p.
Available at: [http://www.moh.govt.nz/moh.nsf/0/E854BB1D8865F4FBCC256E8F007DC735/\\$File/PHOServiceDevelopmentToolkitMentalHealthServices.PDF](http://www.moh.govt.nz/moh.nsf/0/E854BB1D8865F4FBCC256E8F007DC735/$File/PHOServiceDevelopmentToolkitMentalHealthServices.PDF)
- Nova Scotia Advisory Committee on Primary Health Care Renewal. Primary health care renewal: action for healthier Nova Scotians: a report of the Nova Scotia Advisory Committee on Primary Health Care Renewal, May 2003. Halifax, NS: NS Department of Health; 2003.
- Oandasan I. Interdisciplinary education for collaborative patient-centred practice: research and findings report. February 20, 2004. Ottawa: Health Canada; 2004. Available at:
http://www.medfam.umontreal.ca/chaire_sadok_besrou/ressource/PDF/IECPCP_Final_Report.pdf
- Pautler K, Gagné MA. Annotated bibliography of collaborative mental health care. Mississauga, ON: Canadian Collaborative Mental Health Initiative; September 2005. Available at: <http://www.ccmhi.ca>
- Pauzé E, Gagné MA, Pautler K. Collaborative mental health care in primary health care: a review of Canadian initiatives. Volume I: Analysis of initiatives. Mississauga, ON: Canadian Collaborative Mental Health Initiative; November 2005. Available at: <http://www.ccmhi.ca>
- Pauzé E, Gagné MA. Collaborative mental health care in primary health care: a review of Canadian initiatives. Volume II: resource guide. Mississauga, ON: Canadian Collaborative Mental Health Initiative; November 2005. Available at: <http://www.ccmhi.ca>

- Pawlenko N. Collaborative mental health care in primary health care across Canada: a policy review. Mississauga, ON: Canadian Collaborative Mental Health Initiative; June 2005. Available at: <http://www.ccmhi.ca>
- Parikh SV, Lesage AD, Kennedy SH, Goering PN. Depression in Ontario: under-treatment and factors related to antidepressant use. *J Affect Disord.* 1999 Jan-Mar;52(1-3):67-76. Available at: http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=10357019
- Parikh SV, Lin E, Lesage AD. Mental health treatment in Ontario: selected comparisons between the primary care and specialty sectors. *Can J Psychiatry.* 1997 Nov;42(9):929-34. Available at: http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=9429062
- Primary Health Care Policy Framework. Primary health care. [updated 2003 Apr. 30]. Winnipeg, MB: Manitoba Health. Available at: http://www.gov.mb.ca/health/primary_health.html
- Primary Mental Health Care Australian Resource Centre. Primary mental health care program design examples [page on the Internet]. Adelaide, South Australia: Flinders University; [updated 2004 Sep 2]. Available at: http://som.flinders.edu.au/FUSA/PARC/Design_Examples.htm
- Richards JC, Ryan P, McCabe MP, Groom G, Hickie IB. Barriers to the effective management of depression in general practice. *Aust N Z J Psychiatry.* 2004 Oct;38(10):795-803. Available at: http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=pubmed&dopt=Abstract&list_uids=15369538
- Statistics Canada. Canadian Community Health Survey (CCHS), Mental Health and Well-being, Cycle 1.2. Ottawa, ON; September 2003. Available at: <http://www.statcan.ca/english/freepub/82-617-XIE/index.htm>
- United Kingdom Department of Health. National service framework for mental health: modern standards and service models. London: Department of Health; September 1999. 149p. Available at: <http://www.dh.gov.uk/assetRoot/04/01/45/02/04014502.pdf>
- Way DO, Busing N, Jones L. Implementation strategies: Collaboration in primary care-family doctors and nurse practitioners delivering shared care. Toronto: Ontario College of Family Physicians; May 2000.

appendixA

GLOSSARY OF TERMS AND 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']. ⁴
COLLABORATION CARE/ COLLABORATION PRACTICE	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. ⁵
COLLABORATIVE MENTAL HEALTH CARE	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. ⁶
CONSUMER	Collaborative care for the purposes of enhancing mental health outcomes.
CONSUMER-CENTRED	A recipient of health care and related support services to meet the individual's needs in any care setting. ⁷ [Interchangeable terms include 'patient', 'user', and 'client']
HEALTH CARE PARTNERS	Care that is respectful and responsive of individual patient preferences, needs and values; ensuring that patient values guide all clinical decisions. ⁸
	Primary and mental health care providers, consumers, families and caregivers.

INTERDISCIPLINARY	A range of collaborative activities undertaken by a team of two (2) or more individuals from varying disciplines applying the methods and approaches of their respective disciplines. ⁹
MENTAL HEALTH SPECIALIST	An individual with mental health expertise, be it related to health promotion, prevention, diagnosis, treatment, self-help or peer support. ¹⁰
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, the family physician's office, homes for the aged, nursing homes, day-care centers and community clinics. It is also available by telephone, health information services and the Internet. ¹¹
PRIMARY MENTAL HEALTH CARE	Mental health services provided in a primary health care setting.
PRIMARY HEALTH CARE SETTING	Primary health care is delivered in many settings such as the workplace, schools, home, health-care institutions, homes for the aged, nursing homes, day-care centres, offices of health care providers, and community clinics. It is also available by telephone, health information services and the Internet. ¹²
REGIONAL HEALTH AUTHORITY (IES)	Governance structures for more localized health services, usually devolved from a provincial jurisdiction, with responsibility for providing for the delivery and administration of health services in a specified geographic area. ¹³

Acronyms

B.C.	British Columbia
CCMHI	Canadian Collaborative Mental Health Initiative
HMO	Health Maintenance Organizations
MCO	Managed Care Organizations
NIVEL	Institute of Primary Health Care
NSF	National Service Framework
PHO	Primary Health Organizations
RHA	Regional Health Authorities

ENDNOTES

1. Based on the Canadian Community Health Survey (CCHS) Cycle 1.2, on Mental Health and Well-Being, conducted in 2002. This survey examined the prevalence of various mental disorders (i.e., major depressive episode, manic episode, panic disorder, agoraphobia, and social phobia), and mental health problems (i.e., alcohol and drug dependence, gambling, suicide, distress, and eating disorders).
2. The broader literature on collaboration documents the inherent challenges in undertaking collaborative action.
3. The following section is based on the findings reported in Gow T, MacNiven M. Collaborative mental health care: a review of selected international initiatives. [Internal background paper, unpublished] Mississauga, ON: Canadian Collaborative Mental Health Initiative.
4. Canadian Collaborative Mental Health Initiative, 2005, In-house definition.
5. Oandasan I. Interdisciplinary education for collaborative patient-centred practice: research and findings report. February 20, 2004. Ottawa: Health Canada; 2004. p. ii. Available at: http://www.medfam.umontreal.ca/chaire_sadok_besrouer/ressource/PDF/IECPCP_Final_Report.pdf (and see Footnote vii).
6. Canadian Medical Association; Canadian Nurses Association. Working together: a joint CNA/CMA collaborative practice project, HIV-AIDS example [background paper]. Ottawa: CMA; 1996. p.24. Available through the CMA's Member Service Centre 1867 prom. Alta Vista Dr., Ottawa ON K1G 3Y6; email: cmamsc@cma.ca
7. Adapted from: Canadian Medical Association; Canadian Nurses Association. Working together: A joint CNA/CMA collaborative practice project. HIV/AIDS example [background paper]. Ottawa: CMA; 1996. p. 24.
8. Institute of Medicine (U.S.). Committee on Quality of Health Care in America. Crossing the quality chasm: a new health system for the 21st century. Washington, DC: National Academy Press; 2001. 364 p. Available at: <http://www.nap.edu/catalog/10027.html>
9. Reflects the discussions held in January 2005 between a number of national and regional initiatives funded by the Primary Health Care Transition Fund.
10. Canadian Collaborative Mental Health Initiative. 2004. In-house definition.
11. Adapted from: Mable AL, Marriott J. Sharing the learning: the Health Transition Fund synthesis series: primary health care health. Ottawa: Health Canada; 2002. 48p. Available at: http://www.hc-sc.gc.ca/htf-fass/english/primary_en.pdf and Nova Scotia Advisory Committee on Primary Health Care Renewal. Primary health care renewal: action for healthier Nova Scotians: a report of the Nova Scotia Advisory Committee on Primary Health Care Renewal, May 2003. Halifax, NS: NS Department of Health; 2003. p. 1. Available at: <http://www.gov.ns.ca/health/primaryhealthcare/Final%20Report%20May%202003.pdf> and Klaiman D. Increasing access to occupational therapy in primary health care. 2004 Jan-Feb;6(1). Available at: <http://www.caot.ca/default.asp?pageid=1031>
12. Way DO, Busing N, Jones L. Implementation strategies: Collaboration in primary care-family doctors and nurse practitioners delivering shared care. Toronto: Ontario College of Family Physicians, May 2000. p. 3.
13. Canadian Collaborative Mental Health Initiative. 2004. In-house definition.

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