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POSITION PAPER

The Evolution of Collaborative Mental Health Care in Canada: A Shared Vision for the Future

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Executive Summary

The last 10 years has seen a burgeoning interest in building collaborative partnerships between primary care and mental health care providers, including the integration of mental health services within primary care settings. Collaborative models have improved access to mental health care and increased the capacity of primary care to manage mental health and addiction (MH&A) problems. Successful projects in Canada and other countries have demonstrated better clinical outcomes, a more efficient use of resources, and an enhanced experience of seeking and receiving care.

There are many steps that can be taken by any primary care practice or MH&A program to promote collaboration and improve access to mental health care, often without requiring additional resources. To support these initiatives, regional and provincial planners need to look for opportunities to introduce collaborative projects into their service provision strategies, fund targeted projects that will broaden the scope and knowledge base of collaborative care, and implement specific policies that

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will enable this work to take place. Evaluation of these projects and new research also further our understanding of the benefits and potential of these new models.

In addition, academic centres and continuing education departments must prepare learners and practitioners to work in collaborative interprofessional partnerships. Above all, consumers, family members, and consumer groups must be active partners in collaborative partnerships, both when receiving care and in the design and evaluation of programs and services.

If this can be accomplished, we stand to make substantial gains at the system level and contribute significantly to the overall well-being of Canadians. We can increase the capacity of our existing MH&A and primary care systems so that people with issues affecting their mental health have access to essential services in a timely manner. Collaborative partnerships within reorganized systems of care can lead to a prudent and more efficient use of resources, while supporting consumers and their families in self-management, and serve as models for the integration of primary care with other specialized services.

This position paper also acknowledges that effective collaboration can involve providers from any discipline. However, because of the mandate of the Canadian Psychiatric Association (CPA) and the College of Family Physicians of Canada (CFPC), it focuses on the role that family physicians and psychiatrists can play in collaborative partnerships, but most of the concepts and activities will be applicable to any health professional.

Background

In 1997, the CFPC and the CPA produced a groundbreaking position paper[1] on shared mental health care in Canada. Following the publication of that paper, the two organizations established a collaborative working group on shared mental health care, to foster and support collaboration between the two sectors, focusing specifically on psychiatrists and family physicians.

Much has changed in the ensuing 12 years,[2,3] including a shift from using the term shared care to talking about collaborative mental health care, the phrase used in this paper. A remarkable expansion in collaborative activities has taken place. Between 2003 and 2007, the Canadian Collaborative Mental Health Initiative—a Primary Health Care Transition Fund project—played a leading role in promoting and supporting better collaboration.[4] Collaborative mental health care is now seen as an integral component of provincial and regional planning, and local, provincial, and national networks of practitioners have been established. This trend toward the integration of MH&A services within primary care is also taking place in many other countries, and has been supported by the World Health Organization as a way of improving access to person-centred mental health care.[5]

However, the prevalence of MH&A problems in primary care remains high, and many of these problems are still managed without the involvement of a psychiatrist or MH&A service.[6] Participating in collaborative partnerships allows family physicians, who are identified by most Canadians as the first point of contact for a mental health or addictions problem, to enhance the care they can deliver.

Improving collaboration is a key tenet of primary care and consistent with the emerging concept of the patient-centred medical home.[7] It is also integral to the transformation of primary care that is currently taking place in almost every Canadian province and territory. Concurrently, MH&As reform is beginning to acknowledge the key role primary care plays as the first and sometimes only point of contact in Canada's MH&A care systems. There is a recognition in both sectors that access to services and the quality of care and support for people with MH&A issues can be improved through better collaboration between MH&A and primary care providers and services.

Why a Revised Position Paper?

Much has been learned during the last decade. The gains made and the opportunities emerging as a result of successful collaborative health care delivery have spurred the CPA and the CFPC to update the original position paper.[1] This new paper recommends steps that will enable MH&A services and primary care providers to work together to advance a shared agenda, better meet the needs of populations and communities that traditionally have difficulty gaining access to the care they require, prepare future practitioners for a more responsive and person-centred style of practice, and influence the evolution of health care delivery in Canada. Implementing these recommendations can help our health care systems achieve the triple aim of better outcomes for populations being served, an enhanced experience both for patients and for providers, and models of care that are affordable and sustainable. While this paper focuses mainly on the activities of family physicians and psychiatrists, most of the recommendations are applicable to all primary care and MH&A providers.

What Is Collaborative Mental Health Care?

Collaborative care is care that is delivered by providers from different specialties, disciplines, or sectors working together to offer complementary services and mutual support. As in any effective partnership, common goals, clear and equitable decision making, and open and regular communication are key. In addition, collaborative mental health care is:

1. Built on personal contacts.

2. Based on mutual respect, trust, and a recognition of each partner's potential roles and contributions.
3. Based on effective practices that are evidence- and experience-based.
4. Responsive to the changing needs of patients, their families, other caregivers, and resource availability.
5. Shaped by the context and culture in which care takes place.
6. Relevant and responsive to local resource availability, and the skills and interests of participating partners.

Models of Collaboration

There is no single collaborative model or style of practice. Any activity that enables MH&A and primary care providers to work together more effectively to improve the care they deliver can be collaborative. Collaborative models include the following:

Effective Communication

This involves transmitting relevant information both about individuals and about programs in a timely, legible, relevant, and understandable manner. Information flows smoothly between providers and consumers, as well as between different providers and services. Communication may occur in person, by telephone, or through other media, including electronic records.

Consultation

This usually takes place in one of two ways:
1) psychiatrists and other MH&A professionals provide advice, guidance, and follow-up to primary care providers to support care of patients and families while sharing ongoing responsibility for care, or 2) family physicians provide advice on the management of medical conditions in individuals with mental health or addiction problems. Such consultations can occur in a primary care setting, a mental health facility, a psychiatrist's office, or by telephone.

Coordination

Coordination of care plans (including discharge plans) and clinical activities helps providers avoid duplication, use resources efficiently, and guide people to programs they require. Coordination can also include interprofessional educational programs where different providers present material or learn together, as well as visits to primary care settings or the use of the Internet or email.

Co-location

This may involve psychiatrists and other MH&A staff working in a primary care setting or the addition of primary care clinicians to MH&A services to address the physical health needs of people using those services. While helpful, co-location alone does not guarantee effective collaboration, without some of the elements listed above.

Integration

Integration of mental health and primary care providers within a single service or team usually takes place within a primary care setting, although it can occur in other community locations as well. This model is characterized by shared care planning and decision making, charting in a common medical record, and collaborative activities, with care being shared according to the respective skills and availability of participants.

What We Have Learned So Far

There is convincing evidence from Canadian projects and from the international literature, including a 2006 review by Bland and Craven[8] as to the benefits of collaborative partnerships, in both the shorter[9–57] and longer[23,24,28,39,40] terms. This has been measured by symptom improvement,[11,12,14,16,21,26,28,33,37,49] functional improvement,[45] reduced disability days,[42] increased workplace tenure,[37] increased quality-adjusted life years,[37] and increased compliance with medication.[27,38] These benefits have also been identified for populations such as youth,[47] seniors,[21,30] people with addiction problems,[50] and indigenous populations.[54]

There is also evidence that collaborative programs are cost-effective and can lead to reductions in health care costs owing to a more efficient use of medications,[38] reduced use of other medical services (especially for people with chronic medical conditions),[44] more efficient use of existing resources, and a greater likelihood of return to the workplace.[46] Concurrently, the literature has identified the need for initial investment in these new services, if savings are to be achieved over the long term.[27,39,41]

The most effective collaborative programs include multiple linked intervention components and the redesign of existing processes of care with an emphasis on quality improvement.[12,20,37,38,41] Common components of successful programs include some or all of the following:

1. The use of a care coordinator or case manager.[12,21,23,24,27,37,38,41,48,49]
2. Access to psychiatric consultation.[14,19]
3. Enhanced patient education or access to resources.[12,22,24,25,37,38]
4. Introduction of evidence-based treatment guidelines.[12,19,31,33,37,40,50]
5. Screening of people with chronic medical conditions for depression or anxiety.[42]
6. Skill enhancement programs for primary care providers.[13,21,37]
7. Access to brief psychological therapies,[23,36,57] including motivational interviewing.[50]

Increasingly, programs have identified that to support these interventions, optimize their benefits, and increase sustainability, there is a need to organize and (or)

redesign primary care and (or) mental health systems of care by changes, such as:

1. Team-based care and clarity in the roles of different providers.[15,19,22,26,45,55,56]
2. Systematic (proactive) follow-up.[12,16,21,22,37,39,45,53]
3. Improving coordination of care.[12,17,21,22,24,28,37]
4. Support for self-management.[46]
5. Telephone follow-up.[16,49]
6. Improved communication and (or) team meetings.[14,22,34,37,41,45]
7. Inviting feedback from consumers and families regarding effectiveness of interventions and access to essential services.[58]

Challenges to the Growth of Collaborative Partnerships

There are numerous potential barriers to implementing collaborative partnerships, including:

1. Current levels of funding and funding models that do not support the restructuring of primary care practices, the introduction of information technology, and collaborative interdisciplinary practice models.
2. Current models of remuneration that do not compensate physicians for participation in collaborative activities.
3. Time constraints faced by providers in both sectors.
4. Lack of clarity regarding medico-legal standards and documentation requirements. However, in this regard, a report by the Canadian Medical Protective Association (CMPA)[59] supported collaborative practice and case discussions as an integral part of current practice, as long as these are documented and consistent with expected standards of practice, and roles are clearly understood. The CMPA stated that existing medical liability legislation would cover almost all eventualities.
5. Lack of preparation of learners at undergraduate and postgraduate levels to work collaboratively with other specialties and disciplines.
6. Culture of some health care services that may not be prepared for, or accustomed to, collaborative practice.
7. Views of some providers that collaborative care is not relevant to their practice.
8. Lack of access to family physicians and other primary care providers in many provinces and territories.
9. Geographic disparities that can make access to resources challenging. Concurrently, collaborative models (including telehealth) that use scarce resources efficiently and effectively have demonstrated their value in addressing limited access, as well as shortages of health care professionals in urban and rural settings.

A Vision of an Integrated System

We envisage communities and provinces developing well coordinated MH&As systems that optimize the role of primary care providers, supported by ready access to secondary and tertiary mental health services, with both sectors working collaboratively to ensure people with MH&A problems reach the services they require, when they need them. Roles in the new system would be as follows:

Primary Care

In the envisaged system, family physicians would play an integral role, supported by ready access to mental health services. Primary care, ideally with teams that included MH&A providers and psychiatrists, would be the first point of care for people with MH&A problems, and the place where ongoing care could be monitored and coordinated. MH&A services that complement those offered in the traditional MH&A system would be integrated within primary care. Primary care would also address coexisting physical and mental health issues.[60,61]

Because individuals and their families often have frequent contact and ongoing relationships with their family physician across their entire lifespan, primary care (with appropriate supports) is well positioned to provide the following:

1. Early detection of mental health problems, including comorbid problems in people with general medical conditions:

This can be assisted by the use of simple screening tools. To improve outcomes, detection needs to be linked with easy access to treatment.[62]

2. Early intervention and (or) initiation of treatment with both the first presentation of an MH&A problem or with an emerging recurrence or relapse:

This can be assisted by the use of evidence-based treatment algorithms and electronic health records to monitor individuals and populations; by closer partnerships with MH&A care providers; and by close monitoring of people with early, undifferentiated presentations.

3. Support for mental health promotion and wellness:

This includes stress management and encouraging healthier lifestyle choices, such as advice on safer consumption of alcohol, smoking cessation, sleep, hygiene, and physical activity. These messages can be incorporated into any visit with a family physician.

4. Monitoring and follow-up of people with mental health problems:

This includes follow-up after discharge from a mental health service, regular recall for proactive or planned care, and monitoring of progress or possible medication changes. Care or wellness plans should be updated based on an individual's changing needs.

5. Crisis management:

Many MH&A crises can be managed successfully in primary care, especially if the family physician has ready access to support and advice from MH&A and other community services. Primary care is often the place where care is provided or coordinated after an emergency psychiatric assessment.

6. Integration of physical and mental health care:

Treatment plans should include interventions aimed at both mental and physical health, including screening for and managing comorbid depression and anxiety in people with chronic medical conditions. It is often more convenient and acceptable for an individual and their family to receive MH&A care in a familiar environment where all aspects of care can be integrated.

7. Coordination of care:

This is an integral role for primary care that is reinforced by strong collaborative links with secondary and (or) tertiary levels of specialized care services within the community and health care institutions. It is also supported by links with community services, such as home care as well as housing and income support services and recreation programs. The importance of assistance with navigating complex and often disconnected systems of care cannot be overstated.

8. Support for families and other caregivers:

The needs of families caring for someone with mental health problems or comorbid medical conditions are often overlooked by the MH&A system. Primary care can support and assist family members as they come to terms with the mental health and (or) addiction issue and learn about management, including the role they can play. Helping a family identify their own—sometimes separate—needs, and providing support and links with community resources, is an important role for primary care.

Secondary and Tertiary Mental Health and Addiction Services

In an integrated system, MH&A services would support expanded roles for family physicians. Services they could offer would include:

1. Provide rapid access to consultation and advice, including telephone advice, especially for people who are experiencing a crisis.
2. Respond quickly to requests for assistance with urgent and emergent situations.
3. Prioritize people who cannot be managed within the primary care setting (either because of problem complexity or a lack of necessary resources) and provide care on an ongoing basis, as required.
4. Stabilize people who have MH&A problems, and then return their care to primary care providers for ongoing management and monitoring, based on a comprehensive plan that has been developed in consultation with the primary care provider.
5. Continue to be available to the primary care team after care has been returned to the primary care provider, to maintain continuity of care for both the primary care provider and the individual.
6. Provide information on available community resources and assist with access to these services.

Improved Collaboration

Improved collaboration between primary care and MH&A services would include personal contacts and regular communication between staff working in different settings that would:

1. Facilitate the flow of patients from one service to another and remove barriers to access.
2. Provide advice and build mutual support that would enable all sectors to increase their capacity for consumer- and family-centred care.
3. Avoid duplication of services and help ensure that existing resources were used as efficiently as possible.

Achieving This Vision

Achieving this vision will require a redesign of the way practices, services, and other stakeholders function to support and enable collaborative interprofessional practice. In addition to changes within each sector, some re-organization will be needed across the system.

Primary Care Providers

All family physicians and other primary care providers should possess core competencies in mental health care. This does not mean that every physician is expected to be an expert in diagnosing and treating people with mental health issues. However, all family physicians should have the skills required to screen for and detect mental illness; initiate, monitor or discontinue treatment, where appropriate; provide brief, motivational interventions; develop appropriate links with other partners in care; and organize their practice to ensure that people with mental illness and addictions (and their families and [or] caregivers) are treated with respect for, and sensitivity to, their often complex needs. This might include the following:

1. Use motivational approaches to modify health behaviours and promote healthy lifestyle changes.
2. Routinely screen people with general medical disorders for depression and anxiety and initiate treatment or referral as required.
3. Improve the experience of consumers by:
   a. Supporting self-management as an integral component of all care plans.
   b. Including people with lived experience and families in the planning and evaluation of new projects and services.

   c. Regularly collecting and using consumer and family and (or) caregiver feedback for continuous quality improvement measures.
4. Apply the principles of chronic disease management to MH&A problems, where applicable, including:
   a. Incorporating guideline-based care and treatment algorithms.
   b. Developing a list (registry) of patients who have a specific problem (for example, depression). These lists can be used to support planned visits, proactive recall, relapse prevention, and early detection strategies.
5. Use innovative approaches to improve skills and knowledge, such as web-based resources, educational events within the family physician's office, case-based learning using e-mail or teleconferences, and learning collaboratives.

Psychiatrists

Psychiatrists must recognize and build on the valuable role primary care plays in delivering mental health services, and see consultation to their family medicine colleagues as an integral part of their clinical activity. This includes communicating with primary care practitioners in a timely, relevant, and useful manner, whether in person, in writing, or by telephone. It also involves integrating psychiatrists' care with that of family physicians in the medical management of people with comorbid MH&As and physical health issues.

Mental Health Services

In addition to delivering services within primary care settings, mental health care providers, including psychiatrists, should explore innovative ways to work more closely with primary care partners to coordinate treatment approaches, manage the potential metabolic effects of psychopharmacotherapy, and meet the physical health care needs of people being seen. Strategies might include the following:

1. Make intake processes efficient and user- (referral source-) friendly.
2. Provide telephone backup to family physicians.
3. Offer rapid consultation, with a follow-up plan sent to the family physician. The individual can then be placed on a waiting list for ongoing treatment, if necessary. Follow-up advice, or even a reassessment, could be provided if the situation changes.
4. Involve family physicians in discharge planning and completion of the follow-up plan.
5. Implement routine telephone follow-up with the consumer after discharge to ensure they are following through with the plan.
6. Transmit reports and plans rapidly at admission and after discharge.
7. Maintain and make available to primary care providers inventories of relevant MH&A personnel, resources (self-help and other), and programs.
8. Produce one-page newsletters that update family physicians on services offered and new programs.
9. Involve family physicians as well as consumers and families, in the planning and evaluation of services and programs.
10. Strengthen links between emergent and (or) urgent services and family physicians.

Across the System

There are changes that can be made across the entire system (mental health and primary care) to optimize the potential of collaborative partnership.

1. Include individuals and their families and (or) caregivers as partners in their own care. Ensure that people with mental health problems have clear treatment or wellness plans, developed in partnership with the individual and based on their own goals. A copy of these plans should be provided to the individual.
2. Include individuals and their families and (or) caregivers in the planning and evaluation of collaborative projects. To a large extent, the development of new projects needs to be based on what we can learn from the stories and journeys of people with lived experience about where our systems are failing them and how care could be improved.
3. Develop strategies that will reduce stigma and discrimination among all health care providers, including those that will lead to a better understanding of cultural diversity.
4. Promote mental health, wellness, and recovery as goals of system changes.
5. Focus on quality improvement, access, and efficiency as drivers of system change.
6. Define competencies for all health professionals working in collaborative mental health partnerships.
7. Ensure that respective roles and responsibilities of all partners are clearly defined and understood.
8. Strengthen personal contacts by organizing events, such as joint clinical rounds, joint educational rounds, practice observation, and formal continuing professional development events, that bring together MH&A and primary care clinicians and staff.
9. Use new technologies for managing information, including a common electronic medical record and evidence-guided algorithms to enhance collaboration and efficient data collection and analysis; registries to support proactive, population-based care; and telemedicine, which offers new ways to link providers, enhance collaboration, and provide consultation to underserved communities.

10. Build networks of providers, information technology experts, researchers, and consumers interested in collaborative mental health care to enable participants to exchange ideas, share experiences, and work together to develop new projects.

Provincial and (or) Territorial Governments and Regional Health Authorities

Funders and policy-makers must recognize and support the role that primary care can play in an integrated MH&A service system by building links between MH&A and primary care planners at the provincial and the regional health authority levels. This would increase the likelihood of well-coordinated collaborative initiatives. These bodies can also support the development of integrated primary mental health care teams.

Working in collaborative models may be new for many MH&A and primary care providers, and adequate preparation to work effectively in these partnerships is a prerequisite for their success. This may include assistance with project design, workshops, and training sessions, visits to existing projects with similar models, access to relevant materials and resources, and ongoing support once programs are under way.[58,63,64,65]

Other strategies include:

1. Give priority to collaborative projects that offer opportunities for:
   a. Early detection and intervention, and ongoing monitoring of children and youth with mental health problems and their families and (or) caregivers.
   b. Early detection and intervention, ongoing monitoring and relapse prevention of seniors with mental health problems and the needs of their caregivers.
   c. Meeting the needs of populations that may be marginalized or have particular difficulty with access to services, including Aboriginal populations, people who are homeless, people from different cultures, and people whose first language is neither English nor French.
   d. Community-based intervention for the integrated management of crises.
   e. Access to interdisciplinary models of care when individuals or their families identify the lack of these services within their primary care services.
   f. Addressing shortages of health resources, including those created by geographic disparities.
   g. Supporting collaborative education projects, especially those that take place in the primary care setting.
   h. Mentoring and email or telephone support of family physicians by psychiatrists, as in the successful Ontario Collaborative Mental Health Project,[65] which is now being extended to other specialties.
2. Test demonstration projects that provide data on how collaborative projects can help address common problems faced by health care systems, including:
   a. Meeting the needs of underserved populations.
   b. Serving people in isolated communities.
   c. Improving outcomes for people with chronic medical conditions.
   d. Reducing waiting times and improving access to care.
   e. Improving physical health outcomes for people with mental disorders.
3. Develop strategies to ensure that people with mental illnesses and addictions have access to appropriate and comprehensive primary health care,[32] including incorporating primary care clinicians (nurses, nurse practitioners, physician assistants, and family physicians) into mental health programs.

Provincial Medical Associations and Other Professional Negotiating Bodies

These organizations should promote appropriate payment schemes and other policy changes that facilitate collaborative, interprofessional practice.

Academic Institutions, Including Departments of Psychiatry and Family Medicine

A key to the long-term sustainability of collaborative partnerships will be to prepare learners to work in collaborative models, including:

1. Strengthening interdisciplinary collaborative partnerships within the curricula of undergraduate and postgraduate programs, so that collaborative care becomes an integral and expected part of practice for future practitioners.
2. Finding ways for learners from different disciplines to learn together and from each other.
3. Involving people with lived experience in educational sessions.

However, it is acknowledged that many teachers and academic programs face challenges in responding to multiple requests for curricular changes in medical education systems that may be underresourced.

Resident Training

It is essential that residents in family medicine and psychiatry be able to understand and see, firsthand, how better collaboration can improve care and outcomes.

Family medicine residents in several programs have the opportunity to experience shared care, or collaborative mental health care approaches during their training. The

training of family medicine residents in behavioural science continues to be strengthened, with an increased emphasis on integrating MH&As training into family medicine teaching units, and linking it with residents' clinical activities. The Working Group recommends that family medicine residents be trained in primary care contexts in which collaborative care is modelled and taught over the full range of family medicine content, including mental health.

An extensive curriculum review by the Royal College of Physicians and Surgeons of Canada regarding the postgraduate training of psychiatrists has recently been completed, and new training guidelines have been introduced. Psychiatry residents are now required to spend a minimum of eight weeks in collaborative projects, ideally in primary care, if placements are available. Training programs need to work with primary care partners to develop appropriate clinical placements. This needs to be supported by the development of relevant resources that can be made available to all residency programs, such as seminar topics and (or) presentations and references.[66]

Research and Evaluation Community

Building on the work of the Continuing Enhancement of Quality Measurement in Primary Mental Health Care: A Primary Health Care Transition Fund National Envelope Project,[67] there is a need to identify common screening, monitoring, and evaluation tools and measures that will provide comparative data. Including an evaluation component, as part of every collaborative project, will drive further improvement in service delivery and add to the pool of Canadian data. In addition, our understanding of what works in collaborative mental health care can be furthered by evaluation and research projects, including multicentre studies, that measure:

1. Individual and population outcomes of new initiatives.
2. Economic benefits and (or) costs (including offset costs).
3. Impact of standardized approaches to treatment.
4. Impact of collaborative care on referral patterns, wait times, and access.
5. Competencies required to work in collaborative models.
6. Benefits to health care providers.
7. Consumer and (or) family satisfaction with care.
8. Which problems and populations are best served in primary care and which need specialized MH&A services.

Workplace

While this is beyond the scope of this position paper, it is important to acknowledge that workplace factors, including injuries leading to disabilities, often play a role in MH&A problems. Collaboration between the workplace, employee health services, and primary care and MH&A providers can help reduce the impact of MH&A problems and assist the individual to cope more effectively.

CPA and CFPC

Support from the CPA and the CFPC, and the working partnership they have established, has been a major factor in the evolution of collaborative mental health care in Canada. To build on the gains already made, the two organizations need to continue to promote this model with their members and in the broader Canadian health care community. The two organizations have supported ways to link providers from different disciplines, such as:

1. A central information point for providers, planners, and consumers interested in collaborative care. This will include descriptions of programs, resources, and assistance for training programs, learning communities, and individuals starting new initiatives. There is currently a Collaborative Mental Health Care, shared care, website,[68] whose role can be expanded.
2. The annual Canadian Collaborative Mental Health Care conference, which brings together providers, consumers, and funders to exchange ideas and explore future collaborative initiatives.

Conclusions

In the last 12 years, much progress has been made in building collaborative partnerships between primary care and MH&A services, and family physicians and psychiatrists. Increasing acceptance of and interest in this approach by providers, funders, and people using these services provides an opportunity to expand these approaches to address broader issues facing Canada's health care delivery systems. Learning from what has worked and adapting successful models to meet new needs will enable us to improve the health of our communities, enhance the experience of seeking and receiving care, and provide services in an affordable and sustainable way.

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