Canadian Collaborative Mental Health Initiative

Initiative canadienne de collaboration en santé mentale

Establishing collaborative initiatives between mental health and primary care services for *individuals with substance use disorders*

A companion to the CCMHI planning and implementation toolkit for health care providers and planners

PROVIDERS AND PLANNERS

INDIVIDUALS WITH SUBSTANCE USE DISORDERS EXPERT PANEL

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A Toolkit

February 2006

OUR GOAL

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

Table of contents

Preface i

Executive summary iii

Introduction 1

Defining the population 2

Lessons from the literature 5

Collaborative models and initiatives 6

Key elements and fundamentals of collaborative mental health care 9

Accessibility 9
Collaborative structures 10
Richness of collaboration 12
Consumer centredness 13
Policies, legislation and regulations 14
Funding 15
Evidence-based research 16
Community needs 16

Planning and implementation 17

Eight steps to implement collaborative care for substance use disorders 17

Key issues for consideration 19

References and related readings 21

Appendix A: Consultation process 27

Appendix B: Tools and resources 29

Appendix C: Glossary of terms and Index of acronyms 33

Preface

Welcome to the CCMHI toolkit series!

The Canadian Collaborative Mental Health Initiative (CCMHI) is led by 12 national organizations representing community services; consumers, families and caregivers; self-help groups; dietitians; family physicians; nurses; occupational therapists; pharmacists; psychiatrists; psychologists; and social workers. Funded through Health Canada's Primary Health Care Transition Fund, the goal of the CCMHI is to improve the mental health and well-being of Canadians by increasing collaboration among primary health care and mental health care providers, consumers, families and caregivers.

The CCMHI toolkits contain practical tools to:

- Assist providers and planners in the implementation of collaborative initiatives.
- Help mental health consumers and their family members understand mental illness and work with other members of the care team.
- Inform educators of the benefits of interprofessional education and provide tools to teach about collaborative mental health care.

Each toolkit was developed with an interprofessional expert panel and guided by a working group representing a number of key stakeholder groups. We hope that readers of any of the toolkits in the series will recommend them to others (e.g., consumers referring toolkits to their providers and vice versa).

In addition to this series of 12 toolkits, the CCMHI has developed a Charter of principles and commitments that will influence the future of mental health care in Canada and a series of reports that capture the current state of collaborative mental health care. The reports highlight health human resource issues, provide an annotated bibliography, summarize best practices, review initiatives from across the nation and summarize provincial and territorial mental health and primary care reform. These documents guided the development of the toolkits and are available at www.ccmhi.ca.

Implementation toolkits

Collaboration between mental health and primary care services. A planning and implementation toolkit for health care providers and planners is a guide for providers wishing to establish or enhance the mental health services they provide through collaboration. This general toolkit offers readers a guide to all aspects of planning, implementing and evaluating a collaborative mental health care initiative, including assessing need, setting goals and objectives, developing a budget, building a team, maintaining a well-functioning team, managing change and monitoring the initiative.

Eight population-specific toolkits, entitled *Establishing collaborative initiatives between mental health and primary care services,* are designed to be used in conjunction with the general toolkit. They offer tips on adapting the general toolkit for Aboriginal Peoples,

children and adolescents, ethnocultural populations, rural and isolated populations, seniors, individuals with serious mental illness, individuals with substance use disorders and urban marginalized populations. There is some overlap in the toolkits; for example, information about collaborative mental heath care and the homeless may be found in at least three toolkits: individuals with serious mental illness, individuals with substance use disorders and urban marginalized populations. Readers are encouraged to consider all the toolkits that may be relevant to their needs.

The general and population-specific toolkits are not intended as clinical practice guides but offer practical advice on different aspects of establishing successful collaborative initiatives.

Consumer, family and caregiver toolkits

Consumers, families and caregivers developed both of these toolkits for consumers and their loved ones.

Working together towards recovery: Consumers, families, caregivers and providers is intended for all consumers, families and caregivers wishing to know more about mental health and mental illness, how to access services and the type of professionals that can assist them in their recovery. This toolkit also offers an outline of complementary therapies and self-care as well as the contributions and needs of caregivers. Finally, this toolkit includes a guide to "getting involved", describing how government and boards of directors work, and why consumers and families should participate.

Pathways to healing: A mental health guide for First Nations people is a toolkit that offers a basic overview of mental health and mental illness along with a contextual section outlining the impact of history, social, economic and political conditions on the mental health of these peoples. There are tools in this toolkit to foster holistic care.

Education toolkit

Strengthening collaboration through interprofessional education: A resource for collaborative mental health care educators serves as an educational resource to assist in the implementation of educational initiatives and programs that promote collaborative mental health care in primary health care settings. The toolkit is targeted to education program developers in regulatory agencies, professional associations, regional health authorities, family health teams, governmental departments, and educators within both academic (universities and colleges) and care delivery settings.

This toolkit highlights the importance of interprofessional education in promoting collaborative care. It offers four case studies and several activities accompanied by a sample lesson plan and other useful tools to aid educators in the implementation of educational events.

Executive summary

Introduction

Problems involving drugs and alcohol are invariably intertwined with a wide range of health and social factors, requiring an integrated perspective on prevention and care. While there is considerable evidence that primary health care providers can positively impact substance use in their practice setting, low rates of detection and treatment through primary health care underscore the need for greater co-ordination and collaboration in the provision of care.

The goal of this toolkit is to describe opportunities to accelerate the transfer of knowledge and the enhancement of care for individuals with substance use disorders through improved interprofessional collaboration. Highlights of the toolkit include nine key issues for consideration; eight steps to implement collaborative care for this population; and key tools and resources.

Defining the population

This toolkit focuses on those individuals that have substance use disorders stemming from the use of licit and illicit drugs. The use of psychoactive substances including alcohol, tobacco and illicit drugs contributed to 12.4% of deaths worldwide in the year 2000 (World Health Organization, 2002). Alcohol alone is estimated to be responsible for 4% of the global burden of disease.

Consultation process

An Expert Panel representing diverse professions across Canada was established. There was intensive study of collaborative primary health care in other jurisdictions, including the UK, and input from three interprofessional groups that are currently leading the implementation of collaborative care in British Columbia and the Yukon. In addition, a 'think tank' took place during a conference in Whitehorse supporting regional implementation of collaborative primary health care for substance use problems.

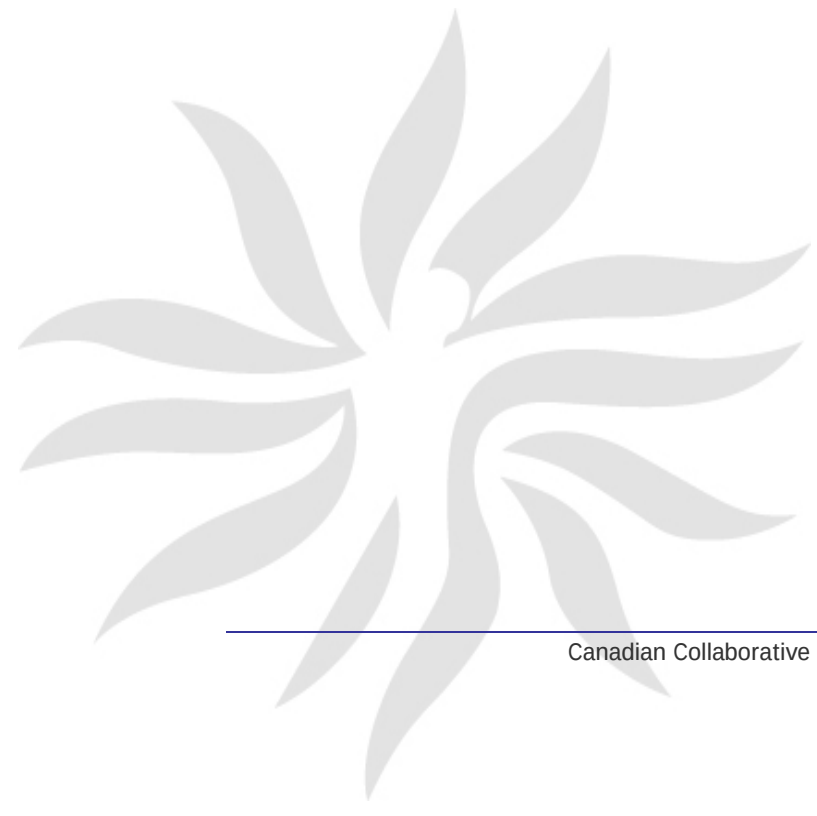
Key messages

- **Improving access to treatment** will require not only increasing the availability of services but changing practices that take place once the threshold of care has been crossed. Universal screening is necessary to identify substance-related health needs because people with these problems (or risks) often do not present for treatment of the substance problem *per se*. Therefore, universal screening is necessary to identify substance-related health needs. Professionals and consumers alike need greater access to information concerning best practices. The administration of services must be reformed so that consumers have access to the blend of primary health care supports that are appropriate for them.

- A given Canadian community may have a dozen or more agencies that provide services for substance use problems. **There is a need to clarify the roles, responsibilities and scopes of practice** between primary health care and other service settings and to establish practices and documentation strategies that can be implemented consistently across different services, e.g., complementary approaches to screening and assessment. Consideration should also be given to developing a common foundation of expertise across health care providers, which can be augmented by particular specialized skills.
- **All successful treatment for substance use problems is consumer-centred**. Consumer-centred care can be organized around the principles of timeliness, appropriateness, continuity and inclusiveness of services. Effective collaboration requires that relevant information must travel faster than the consumer. Health professionals should examine the possibility of harmonizing practices concerning the ascertainment and exchange of information (e.g., informed consent) so that each professional has a complete health record, and so that the demands on consumers are minimized (e.g., retelling their history to different providers).
- **Policies and legislation may require reform in order to support collaborative care models.** Health care providers can play an important role in identifying needed policy reforms. Potential areas of reform include policies concerning smoking cessation, impaired driving and methadone maintenance, and practices regarding informed consent, sharing of consumer information and record-keeping.
- **Integrated practice is impeded by a lack of integrated funding**. The impetus to create collaborative primary health care for substance use must follow a strategic plan, and funding must be allocated in a manner that supports the strategic plan, including the integration of physician and other health services, interprofessional education and other supports such as effectiveness research and common information systems.
- **Evidence-based collaborative care must be developed and refined through continuous and meaningful evaluation**. This requires ongoing partnerships between clinicians, policy makers, administrators and researchers.
- **Two general models** for integrating the services of primary health care, mental health and substance use services are presented: centralized models bring providers and consumers together under a single site; decentralized models involve the development of linkages and shared practices across separate providers.
- **Models of interprofessional care present opportunities** to better co-ordinate referrals from primary health care to specialized services; to improve transitions from specialized services to primary health care settings (e.g., using a multidisciplinary team located in a detoxification centre); and to integrate behavioural and

pharmacological approaches to the treatment of substance use disorders.

- **Administrators must support ongoing discussion** among primary health care providers and other clinicians, consumers and the community to ensure that health resources are attuned to the changing needs of consumers with substance use problems.
- **Steps to implementing collaborative care** for substance use disorders, based on Kotter (1998) include:
  - Establish a sense of urgency.
  - Form a powerful guiding coalition.
  - Create a vision.
  - Communicate the vision.
  - Empower others to act on the vision.
  - Plan for and create short-term wins.
  - Consolidate improvements and produce still more change.
  - Institutionalize new approaches.



Introduction

Substance use problems are like a giant in our midst, casting an enormous shadow on the health and welfare of our population. By the time of young adulthood, virtually everyone has experience with substance use, and few people are unacquainted with excessive or problematic use among their friends or family.

Much is known about the development of substance use problems, as well as their prevention and treatment, but this knowledge is distributed across a number of "silos", and is applied in a fragmented and haphazard manner (Sorenson et al, 2003). In addition, the rate of technology transfer from research to the practice of effective interventions has been slow (Lamb et al, 1998; Sorensen et al, 2003). After systematically reviewing the alcohol treatment literature, Miller et al (2003) memorably observed:

> *"The negative correlation between scientific evidence and treatment-as-usual remains striking, and could hardly be larger if one intentionally constructed treatment programs from those approaches with the least evidence of efficacy." (p. 41)*

The sheer prevalence of substance use disorders eclipses the capacity of specialized health service providers. Moreover, problems involving drugs and alcohol are invariably intertwined with other health and social risk factors and problem areas, requiring an integrated perspective on prevention and care. Related to this, the typical course of substance use problems is variable over time, including lapses in use that may recur over several years. The process of overcoming substance use problems is predominantly (or sometimes entirely) managed by the individual concerned and those close to them. Regardless of the role of acute services, the task of preventing relapse remains a long-term necessity and challenge.

Primary health care is arguably the most compelling hub around which to build a comprehensive series of substance-related collaborations. Primary health care providers are often well informed about the social and developmental history of individual consumers and maintain the type of long-term relationships that are frequently necessary for the management of chronic health concerns, including substance use. Moreover, primary health care occupies a broad middle ground between population health and specialized treatment, with the ability to adopt a wide view and advocate in relation to a range of health resources.

While primary health care occupies a major (perhaps the most prominent) professional role in relation to the management of substance use problems, we believe that optimizing the capacity of primary health care is dependent on a concerted program of reforms that includes other services and sectors. Our premise is that people in a variety of roles can

and should actively contribute to the identification and treatment of substance use problems. This includes people with problems, their family members, diverse professionals, clinical administrators and policy makers, and researchers.

The purpose of this toolkit is not to review the diverse and important technical advances in the field of substance use, although a number of references are provided. Rather, our primary goal is to describe opportunities to accelerate the transfer of knowledge and the enhancement of care through improved collaborations. We hope that this information is helpful to administrators and clinicians who are already in the "action" stage of collaborative primary care, and that we can help consolidate commitment to change among those who are contemplating this type of reform.

The authors of this toolkit represent a diverse range of perspectives and experiences. We are grateful to the many people who have helped shape the ideas presented here. Our greatest debt is to our clients and collaborators who have struggled with substance use disorders as their insights are the hardest won. We also are grateful for the opportunity to work closely with policy makers and professionals in different regions of Canada as they pursue the vision of integrated care for substance use. Our experience working with these groups is the basis for many of our observations.

Defining the population

This toolkit focuses on those individuals that have substance use disorders stemming from the use of alcohol, tobacco and illicit drugs. Regional variations in the rates of substance use disorders have been reported across studies using essentially similar methods of assessment. Between different regions, the lifetime prevalence rates of alcohol-related problems vary fivefold, and lifetime prevalence rates for other illicit drug-related problems vary 28-fold (Somers et al, 2004). Variation exists between countries, and between regions within the same country (e.g., urban versus rural). In addition, longitudinal research reveals that the preferences for particular substances (i.e., drugs of choice) vary over time, as well as by different region (National Institute on Drug Abuse, 2003). Together, these observations underscore the need for monitoring and clinical flexibility in order to respond effectively to community needs as they change over time.

Much of the health and economic cost associated with substance use is not driven by dependent users, but by harmful or risky use in the general population. The large number of at-risk individuals is rarely seen in specialized addictions programs and often receives treatment in primary health care settings. Undiagnosed and untreated substance use generates an immense health and financial toll (Lewis, 1997). Detection rates for smoking have been observed at about 50%, for alcohol about 20-50% and for illicit substance use about 20% (Dietz et al, 1994; Duszynski et al, 1995). There is some evidence that substance use problems are undertreated even when they are identified (Hanna, 1991). Low rates of detection and treatment through primary health care have been

linked to a variety of factors including inconsistent recommendations regarding screening practices (Duszynski et al, 1995); difficulties differentiating substance-related from somatic symptoms (Katon, 1992); perceived barriers to the implementation of care (Rush et al, 1995); concerns about losing control of care to specialists (Roche & Richard, 1991); or negative expectations regarding outcomes for substance use treatment (Thom & Tellez, 1986; Van der Walde et al, 2002). These points all underscore the need for greater co-ordination and collaboration in the provision of care.

Lessons from the literature

The use of psychoactive substances, including alcohol, tobacco and illicit drugs, contributed to 12.4% of deaths worldwide in the year 2000 (WHO, 2002). Alcohol alone is responsible for 4% of the global burden of disease, which is equal to the rates of death and disability due to tobacco and hypertension combined (Rehm et al, 2003; WHO, 2002).

For additional information on lessons from the literature consult two CCMHI reports available at www.ccmhi.ca:

- *Annotated bibliography of collaborative mental health care*
- *Better practices in collaborative mental health care: An analysis of the evidence base*

Substance use disorders are associated with a host of health and social problems. Persons who use and abuse substances are at risk for multiple co-morbidities including bloodborne infectious diseases, sexually transmitted diseases, social instability, metabolic and endocrine diseases and malnutrition (Kresina et al, 2004).

Low birth weight and adverse neurological effects in infants are associated with smoking, alcohol and substance use. The exact prevalence of Fetal Alcohol Syndrome (FAS)/atypical FAS is unknown. On the basis of three population studies, Sampson et al (1997) estimated the incidence of FAS to be between 2.9/1000 and 4.8/1000 live births, and the incidence of a combination of FAS and Alcohol-Related Neurodevelopmental Disorder (ARND) to be at least 9.1/1000 live births.

Large-scale epidemiological studies illustrate the frequent co-occurrence of substance use with other psychiatric disorders (Kessler et al, 1997; Regier et al, 1990). Among individuals with co-occurring disorders, the overall severity of their psychiatric symptoms is an important predictor of treatment outcome regarding substance use (McLellan, 1986). Moreover, the effectiveness of substance use treatment increases when consumers are provided with services to address co-existing problems (McLellan et al, 1998).

Having a substance use problem significantly increases the likelihood of having other medical problems. However, there is evidence that people with substance use disorders do not receive adequate medical care (D'Aunno, 1997; Saitz et al, 1997). Implications for primary health care include the need for improved screening of substance use disorders, better integrated care for behavioural and medical disorders, and the development and deployment of specialized disease self-management techniques (Dickey et al, 2002).

The use of guidelines and placement criteria can stimulate increased screening of substance use by primary health care providers (ASAM, 1996; NIAAA, 1995). A wide variety of references are available to guide aspects of treatment including *Identification and Treatment of Substance Abuse in Primary Care Settings* (O'Connor, 1996) and *Practice*

Guideline for the Treatment of Patients with Substance Use Disorders (APA, 1995).

There is considerable evidence that primary health care providers can deliver effective treatment in their practice setting. On their own, primary health care providers can facilitate self-care for substance use problems (Sanchez-Craig, 1990) and they can deliver brief interventions that are cost effective and have a lasting therapeutic impact (Babor, 1990; Fleming et al, 2000; Heather 1995). Methadone maintenance therapy remains a standard treatment for opiate dependence and is effectively provided through primary health care settings (Rettig & Yarmolinsky, 1995). There is also evidence that management with naltrexone through primary health care is effective for alcohol-dependent individuals (O'Malley et al, 2003).

An array of strategies have been documented detailing options for conjoint therapy involving primary health care providers. Some of these are described in the following section.

Collaborative models and initiatives

Samet et al (2001) described two general models for integrating the services of primary health care, mental health care and substance use services. Centralized models bring providers and consumers together at a single site while distributive models involve an active liaison between health providers in different settings. Decentralized collaborations rely on improving the effectiveness of diagnosis and referral processes. Saitz et al (1997) described research involving 1440 individuals who had a primary health care provider and who were undergoing substance abuse treatment. Of the total, 45% reported that their primary health care provider was unaware of their substance abuse.

For additional information on positive practice initiatives in Canada, consult the following document available at www.ccmhi.ca:

- *Collaborative mental health care in primary health care. A review of Canadian initiatives: Volumes I and II*

The need to better co-ordinate referrals from primary health care to specialized services is mirrored by the importance of improved transitions from specialized treatment to primary health care settings. Individuals undergoing specialized care, including detoxification, often lack a primary health care provider. Alcohol- and drug-dependent persons without primary medical care have a substantial burden of illness compared to age- and gender-matched US population controls (De Alba et al, 2004). Using a multi-disciplinary clinic located in a detoxification unit, Samet et al (2003) were able to significantly increase rates of primary health care over 12 months following discharge. Among people who have no primary medical care, several characteristics are positively associated with the establishment of a link with primary health care following detoxification in the US. These included female gender, no recent incarceration, support

for abstinence from family and friends, health insurance, and visiting a medical clinic or physician (Saitz et al, 2004).

There is some evidence that centralized collaborations present advantages to consumers. For example, Friedmann et al (2000) reported that the inclusion of additional on-site health services at an outpatient drug treatment centre promoted increased consumer utilization of allied services. Transportation services and on-site case management services also led to increased allied service utilization. By contrast, off-site case management, referral agreements and other formal arrangements had no detectable impact on service utilization. More recently, consumers who attended substance use programs with on-site primary care had less addiction severity at 12-month follow-up than those discharged from programs without primary care or with off-site primary care (Friedmann et al, 2003).

Unfortunately, a variety of legal and organizational barriers impede the integration of physical and behavioural health care in a centralized service (Grazier et al, 2003). Responsibility for substance-related services is distributed across a large number of agencies and providers and organized under a number of governmental and non-governmental organizations. The impact of system-level factors underscores the need for the involvement and support of administrators and policy makers in the development of collaborative models.

The emergence of new models of primary health care presents immense scope for integrating behavioural, pharmacologic and lifestyle-change approaches to the treatment of substance use disorders. Multidisciplinary primary health care teams, which might include physicians, nurses, social workers, dietitians, rehabilitation specialists, pharmacists, psychologists, psychiatrists, consumers/families/caregivers, etc., have the potential to provide cost-effective treatment based on principles of stepped care, escalating the intensity of interventions as indicated based on the consumer's response. Such teams are also well positioned to address the myriad medical and psychological problems affecting substance-dependent individuals, including HIV infection, hepatitis C, anxiety and mood disorders, poor nutrition, lapses in use, and relapse. The following sections review key elements and factors to consider in the selection and implementation of collaborative practices.

Key elements and fundamentals of collaborative mental health care

Figure 1 Framework for collaborative mental health care

Accessibility

Improving access to treatment for people with substance use problems is not only a matter of opening doors; it is equally a matter of changing the practices that take place once the threshold of care has been crossed. Significant numbers of people with substance use problems do not receive continuous health care. Many will be in contact with the educational system, social services, the justice system, non-governmental organizations or acute and emergency services. Avenues of access to primary health care must be established for each of these systems.

Within the domain of health care, access from primary health care to specialized services is necessary and vice versa. This includes mental health and addictions services as well as child and youth, home support and services for seniors. Of those who do receive regular primary health care, rates of screening, assessment and treatment are low. At a structural level, there are pressing needs to improve access to (and between) providers. At the level of clinical care, there are pressing needs to improve access to dialogue about substance use, including substance-related harms and motivation for change. Consumers regard it as appropriate for primary care providers to inquire about substance use as part of their overall health status but they are less likely to volunteer information unless prompted. Opportunities for dialogue begin with increased screening.

Two additional access issues challenge primary health care for substance use: access to 'best practices' (i.e., "What should we be doing?"), and access to performance feedback (i.e., "How are we doing?"). The need to improve access to information, including relevant research, is well documented in the substance use field (Lamb et al, 1998).

A daisy chain of interconnected accessibility issues is summarized below:

Accessibility Issue	Key Change Agents
Access to best practices	Researchers, administrators, consumers
Access to services	Consumers, administrators, providers
Access to engagement	Providers
Access to referral	Providers, administrators
Access to feedback	Administrators, consumers, researchers

Collaborative structures

BC/Yukon Collaborative Care Initiative

The BC/Yukon Collaborative Care Initiative (BCYCCI) is designed to improve primary health care for substance use disorders. The service delivery areas represented in this initiative have, on average, over 16 agencies or provider groups with responsibilities that include substance use problems. Long-term planning for primary health care collaboration must take into account the resources and consumer needs represented by each of these entities. However, to maximize the likelihood of success, the planning process must be instigated by the smaller number of groups that work most closely with primary health issues. In many regions of Canada, this might include community alcohol and drug services, mental health services, family physicians, nurses, nurse practitioners, dietitians and other allied health professionals, and child and family services.

The BCYCCI established change structures that are both 'top down' and 'bottom up' in their influence. Top-down leadership is provided by the agencies responsible for primary health care reform, physician and nursing services, and hospital and community services for addictions and mental health. This includes federal, provincial/territorial and regional bodies.

Bottom-up leadership is provided by working groups consisting of local champions representing interprofessional contributors to primary health care for substance use disorders. Some working group members are predominantly administrators, others are primarily practitioners. They represent intact agencies (e.g., community mental health centres) as well as aggregates of independent clinicians (e.g., nurse practitioners).

The combination of top-down and bottom-up processes is a standard approach to strategic planning in industry (Mintzberg, 1994). In the area of substance use and primary care, however, this combination is not simply good strategy, it is a practical necessity.

Clinical (bottom-up) leaders draw upon their knowledge of local service needs, capabilities and the practical opportunities for collaboration. They are needed to lead the implementation of change. Their work requires candour. They must look realistically at variations in the practices of, and cultural differences between, different provider groups. For example, an alcohol and drug agency may be open 24/7 and accept self-referral. In contrast, the local community mental health centre may have regular intake hours and require a physician referral. Each agency may have inclusion/exclusion criteria that build on their respective strengths, but that are not well co-ordinated across other local agencies. Nurse practitioners and family physicians may be unclear about where to refer when faced with co-occurring substance use and mood disorder. Provider groups will have different standards regarding their screening and assessment practices. Their standards for recording consumer information often vary. Differences may also be found in the approaches used to establish consent to treatment, maintenance of confidentiality, and the conceptualization of substance use problems.

Administrative (top-down) leaders are needed to safeguard and drive the process of change. They help ensure that locally driven initiatives are in alignment with regional priorities and they cultivate resources to help ensure their success. Administrative leaders in the BCYCCI have managed a diverse array of interagency resource issues. Some of these are listed below:

Type of Collaboration	Agencies/Providers Involved	Resource Issues
Specialist clinician in family practice setting	Solo and group practices, mental health and alcohol/drug agencies	Coverage at specialist care setting, space at family physician setting
Telephone decision support to primary health care	Mental health, detox, alcohol/drug	Re-allocation of specialist time (e.g., psychiatrist)
Information sharing across primary health collaborators	Mental health, alcohol/drug, nurses, physicians, child/family clinicians, dietitians, pharmacists	Harmonized confidentiality agreements, method of information sharing (e.g., EHR)
Mutual adoption of common approaches to screening and assessment	Mental health, alcohol/drug, nurses, physicians, child/family clinicians, mental health clinicians	Self-study and review of options, staff development and training in new procedures
Introduction of stepped care model of treatment	Mental health, alcohol/drug, nurses, physicians, child/family clinicians, mental health clinicians	Reduction of overlapping services, emphasis on complementary expertise
Development of common "culture" across system of primary health care	Mental health, alcohol/drug, nurses, physicians, child/family clinicians, allied health professionals	Identify components (e.g., dual-diagnosis capability; building motivation for change) and train

Committed leaders are vital in the creation of collaborative structures. At this stage, it would be premature to commend a particular structural model of collaborative care for substance use problems. Instead, we advise beginning with an environmental scan of prospective collaborators – both individuals and agencies. We suggest recruiting

participants that command relevant clinical resources and are prepared to work with others (ready); have a high level of commitment to the value of collaboration (willing); and carry a mandate to work with other providers along with the long-term support to develop their own model of collaborative practice (able).

Developing collaborative care for substance use problems is a process, like building a snowball. Agencies that provide services are distributed across the landscape like snowflakes. And like fallen snowflakes, the agencies and providers typically do not have a sufficient perspective (or the authority) to begin coming together and pooling their resources. Administrators act like mittens, beginning to group services and providers. They must maintain a clear perspective on how large the snowball should become (police and court services? schools and churches? housing and human resources?). They must also keep an eye on the forecast (Will a change in the weather, e.g., regional redesign, melt away the collaborative structures?).

Over time, a dominant structural model of primary health care for substance use may emerge in Canada, perhaps in the form of an integrated primary health care centre, or, following the National Health Service's example, Mental Health Trusts. However, the majority of Canadian communities are at the beginning stages of collaborative care for substance use. The first steps toward collaboration must be solid and secure if greater partnerships and integration of services are to have any chance of developing in the long term.

Richness of collaboration

The potential 'richness' or complexity of a primary health care collaborative for substance use problems will vary among communities in Canada. Regional differences in resources are accompanied by regional differences in consumer need. Nevertheless, a rationale can be developed for the initial composition of a core 'team'.

Recent studies have examined the viability of improving linkages with primary health care for consumers who have entered treatment for substance-related problems (Friedmann et al, 2000; Saitz et al, 2004; Samet et al, 2003). The benefits of these strategies include increased rates of retention in primary care and securing placements in primary health care for individuals who had previously lacked a provider. But what can be done to improve primary health care for the large number of people who are 'at risk' or have undetected problems and who are already in contact with a primary health care provider?

Why have collaborative care practices for substance use problems not proliferated in primary health care? Marshall and Deehan (1998) report several explanations for low screening and treatment activity among general practitioners including insufficient training, lack of confidence and concerns about role support (i.e., availability of help when needed). The latter concern (role support) may be commonplace to many family

physicians and nurse practitioners in Canada. In relation to substance use problems, these practitioners often ask:

- Where should I refer?
- How will I know if the consumer has been admitted?
- How will I remain informed about how treatment is going?
- What will my role be in providing continuing care?
- How will additional indicated referrals be arranged?
- In the event of further referral, will the consumer need to repeat his/her history to different specialists (e.g., first mental health, then addictions, or vice versa)?
- Which services are publicly insured and which are not?

In planning the BCYCCI, each region undertook the initial step of harmonizing the services provided by leading publicly funded agencies, including alcohol and drug and mental health services. Harmonization involved the selection of consistent approaches to screening and assessment, and the implementation of procedures to facilitate sharing information, when indicated and consented to by consumers. It also included a long-term commitment to joint training and staff development activities involving topics of mutual relevance and importance (e.g., motivational enhancement therapy, assessment and treatment of concurrent disorders). Based on these reforms, participating agencies promoted a streamlined interagency referral process (see Appendix B), markedly improving the transparency of their services to the public and referring professionals alike.

Each cluster of regional specialist resources identified their capabilities and limitations in relation to collaboration with generalists in the community. Capabilities included:

- Deployment of staff to provide regular service in solo or group practices
- Involvement of referring health professionals in team meetings (e.g., intake and discharge planning regarding their own referrals)
- Provision of psychiatric or other specialist decision support (real time or on-call)
- Access to information in support of medical and continuing care

A small number of generalists (general practitioner and nurse practitioner) consulted on this initial phase of work, but the process of recruiting generalists to join a collaborative care venture was deliberately forestalled until greater integration between specialists had been achieved.

Consumer centredness

All successful treatment for substance use problems is consumer-centred. This is obviously true for the majority of people who recover from substance use problems without the involvement of a health professional but it is no less true when change includes professional involvement. Consumers do the overwhelming majority of work in order to change patterns of harmful substance use. Consumer-centred care for substance

use can be organized around the principles of timeliness, appropriateness, continuity and inclusiveness of services.

Timely substance use services reach people when they can be of benefit. This includes prevention services. Some regions of the BCYCCI have included youth community services within their primary health care collaboratives. This partnership helps expedite care for youth in immediate need but also communicates information about services to youth who may seek help at a later time. Timeliness can be served by making self-care information readily available, and through routine screening and assessment.

The stepped care model exposes the consumer to levels of care that are matched to their level of need. This is a meaningful advance in the appropriateness of substance use treatment, in contrast with a 'one-program-fits-all' approach to care. In addition, primary health care collaboratives may need resident or in-service support regarding the social context of substance use among members of their geographic community.

The effective long-term treatment of a substance use problem involves the maintenance of positive changes (Prochaska et al, 1992) and strategies for long-term recovery management (Dennis et al, 2003). The fact that changes must be sustained indefinitely is an illustration of continuity of care. In contrast, there is risk of numerous discontinuities in the system of care for substance use in which the consumer encounters a succession of acute services with limited follow-up. Collaborative primary health care can effectively overcome many potential discontinuities through practices including universal screening, early intervention, and continuous and integrated record-keeping. Primary health care teams might consider substance use problems alongside other conditions for which chronic disease management strategies are deployed.

Consumer-centred care must be inclusive of diverse individuals and of the diversity of factors within individuals that contributes to substance use. Many of the same populations that are under-represented in primary health care are over-represented with substance use problems. Individual diversity is reflected in differences in readiness for change, cultural and personal attitudes and expectations concerning substance use, and the potential hierarchy of treatments (e.g., acupuncture, exercise and yoga).

Policies, legislation and regulations

Policies regarding licit and illicit substances contribute to the prevalence and harmfulness associated with substance use. Health professionals can play an important role in the implementation of policies in areas such as smoking cessation, impaired driving and methadone maintenance. The services associated with these domains of practice typically involve counselling, assessment and therapeutic skills. The providers best able to do this work are rarely well linked with primary health care. Counselling services for injection drug users or psychoeducation for impaired driving are examples of services that may

reflect local or regional policies and may provide an impetus for the formation of a collaborative.

Policies across agencies and between providers should be examined to ensure their compatibility. This includes policies regarding informed consent as well as the sharing of consumer information. Policies and practices regarding record-keeping often vary between professionals (e.g., reference to third parties).

Health professionals and administrators should develop clear roles and responsibilities among collaborative primary health care providers. A number of professional groups provide substance-related services and each will have an associated scope of practice. These scopes of practice should be reviewed to ensure that collaborative care builds on defined areas of expertise. The act of diagnosis is fundamental to substance-related treatment but is reserved (e.g., physicians and psychologists). Some substance-related treatments involve concurrent pharmacotherapy, psychotherapy and lifestyle changes. In the immediate term, it is necessary to ensure that duly qualified professionals are aligned alongside one another in the provision of these services. In the longer term, it may be valuable to extend select scopes of practice so that individual providers can take responsibility for integrated treatment (e.g., nurse or psychologist prescribing).

Funding

Integrated practice is currently complicated by a lack of integrated funding. Substance-related services in Canada are funded through a variety of contracts and agreements, often spanning several Ministries, and involving fee-for-service, salaried and block-funded schemes. The fragmentation of funding is associated with disparate performance mandates and service targets that are different for different providers. In the immediate term, collaboration must succeed despite, and not because of, these administrative 'silos'. The impetus to create collaborative primary health care for substance use must be developed within a strategic plan, and funding must be provided to support the implementation of this plan.

Funding may need to address the time of fee-for-service physicians as well as salaried clinicians, including back-fill for clinicians working away from their usual practice setting. In addition, funding may be required for joint professional education and for ancillary costs such as communications with the public and professionals. Funds are needed to support time away from practice in order to actively shape the collaborative process (divisions of labour, roles and responsibilities, next steps and inclusion of additional resources, etc.). Administrators may need to accept that developing collaborative substance use initiatives may be non-linear (i.e., two steps forward, one step back). Hence the commitment of funds to interprofessional planning over a sufficient timeline (e.g., 1-2 years), may be critical. In addition, some key contributors to collaboration must be adequately funded. These include research support, psychological services and

information systems, and honoraria and other support for meaningful consumer involvement including NGOs.

Evidence-based research

Effective strategies are available to reduce substance use problems across a continuum of care, ranging from self-directed and brief interventions to intensive treatments.

Best practices in collaborative primary health care for substance use are available in abundance. They emphasize universal screening, brief interventions, assessing and managing motivation for change, close liaison with relevant specialists, integrated management of concurrent health and psychological problems, and continuity of care.

It may be sensible for new collaboratives to implement change based on the typical chronology of consumer services, beginning with an emphasis on screening and assessment and then proceeding to treatment and continuing care. Communities in the BCYCCI have developed material based on their synthesis of best practices (see Appendix B).

The single most important element of 'evidence-based' collaborative care is continuous and meaningful evaluation. Information is needed in relation to changes in substance-related problems and needs (i.e., secular trends), and the responsiveness of the collaborative primary care system (e.g., rates of detection, referral and treatment). In addition to the foregoing examples of quantitative information, it is equally important to monitor the process of implementing collaborative care (e.g., 'readiness' to collaborate among different providers or groups; perceptions of roles and responsibilities within professional groups; and expectations regarding the roles/responsibilities of other groups and providers). Without valid and reliable information, communities are unable to compare their own activities against established benchmarks and are deeply compromised in their ability to effectively manage and nurture the steady evolution of collaborative care.

Community needs

Communities are often ambivalent about collaborative care for substance use problems. This includes communities of providers, administrators and consumers. There is typically a great deal to co-ordinate in order to create collaborative primary health care in this area, and the administrative challenges can be significant and enduring. Local as well as general population health needs can be a useful catalyst for reforms. It is also necessary to continuously assess local needs in order to evaluate progress and to remain attuned to specific problems as they arise. Toward this need, information systems are of paramount importance. Leaders of collaborative reforms must be sensitive to the values of their local communities but must also be in a position to present compelling evidence of need. Often, the first step is to gather the necessary evidence.

Planning and implementation

Achieving a sustainable primary health care collaborative initiative requires a long-term commitment to managing change. Organizational restructuring involves stages of change that resemble the evolution of change in individuals. One of the most widely cited models of organizational change is that of Kotter (1998). Below is a summary of the steps that have informed the BCYCCI, which are based on Kotter's influential framework.

Eight steps to implement collaborative care for substance use disorders

1. **Establish a sense of urgency.**
   - Identify and discuss crises due to gaps in substance-related supports including potential crises or major opportunities to improve services.
2. **Form a powerful guiding coalition.**
   - Assemble a group and give them enough power to lead the change effort.
   - Encourage the group to work as a team, and enshrine methods for gathering information that provide relevant feedback at the clinical and organizational levels.
3. **Create a vision.**
   - Create a long-term vision for collaborative substance use treatment to help direct the change effort.
   - Develop strategies for achieving that vision in the near term.
4. **Communicate the vision.**
   - Use every vehicle possible to communicate the new vision and strategies to health professionals, administrators and the public. Teach new behaviours to peer groups of clinicians and others based on the example of the guiding coalition.
5. **Empower others to act on the vision.**
   - Get rid of obstacles to change.
   - Change systems or structures that seriously undermine the vision.
   - Encourage risk-taking and nontraditional ideas, activities and actions.
6. **Plan for and create short-term wins.**
   - Plan for visible performance improvements, including communications to professionals and the public.
   - Recognize and reward administrators, clinicians and consumers who are involved in the reform process.

7. **Consolidate improvements and produce still more change.**
   - Use increased credibility to change systems, structures and policies that don't fit the vision. This may include bringing new agencies or providers into the collaborative care program. Draw guidance and a rationale for change based on hard information.
   - Hire, promote and develop individuals who can implement the vision.
   - Re-invigorate the process with new projects, themes and change agents.

8. **Institutionalize new approaches.**
   - Articulate the connections between the new collaborative practices and organizational success, including clinical outcomes and benefits to consumers.
   - Commit to ongoing leadership development, and ensure that leaders have the capacity to extend the collaborative initiative into new areas and with additional partners.

Collaborative care for substance use problems is an idea whose time has come. An abundance of evidence-based strategies and opportunities await all those who are keen to take up the cause.

Key issues for consideration

1. ***What is the range of expertise and the consistency of values among providers in my community?***

   Substance use services are provided by a surprisingly diverse group of agencies and practitioners, including community mental health, alcohol and drug services, family services, child and youth services, pharmacy services, occupational therapy, nutrition services, home care, vocational services, clergy and various consumer-led initiatives. An environmental scan is needed to identify these potential allies, and a plan developed to stage the inclusion of their expertise.

2. ***How will substance-related needs be identified?***

   Universal screening is an important practice to expose the substance-related needs within clinical samples. Other sources of insight into community needs include police, teachers, parents, individuals using substances and the diverse professionals working directly with individuals using substances.

3. ***What clinical practices and documentation strategies can be implemented consistently across different services?***

   Roles, responsibilities and scopes of practice differ between primary health care and other specialized service settings. Consider whether the same approaches to assessment can be implemented across settings, or whether a consistent therapeutic approach (e.g., motivational interviewing) can be implemented across practices.

4. ***How can consumers be assured that they won't need to repeat their history and relevant information if they wish not to?***

   Effective collaboration requires that relevant information must travel faster than the consumer. Processes must be developed between providers regarding the process of informed consent, as well as the type of information that is essential to providing care while minimizing the demands on consumers to reiterate their history.

5. ***How will expertise and responsibilities be shared between providers?***

   In practice, collaboration supporting primary health care can take a wide variety of forms, including on-site interprofessional models and remote e-health strategies. Indeed, the value and relevance of these options may vary over time due to changes in the composition of one's practice or changes in the local clinical workforce. The selection of models is secondary to the development of collaborative relationships.

6. ***How can consumers be assured that they won't be 'bounced' unnecessarily from one agency or provider to another?***

   Despite having complementary expertise, a variety of health providers should have the capability to treat substance use problems. One of the benefits of collaboration should be the maintenance of a common platform of expertise across providers.

7. ***How will the collaborative enterprise be sustained?***

   Administrators must support ongoing discussion among primary health care providers and other clinicians so that they can refine their collaborative practices. This discussion, like a quality circle, will not produce a single model of care. More importantly, it will help ensure that the collective capabilities of each community are attuned to the changing needs of consumers with substance use problems.

8. ***How does the collaborative care model mesh with policies and legislation regarding substance use?***

   Models of treatment may be at odds with the policies maintained by schools, the practices of police and the values of individuals.

9. ***How does the collaborative care model mesh with the substance-related needs of the community?***

   Needs will vary between communities and within communities over time. Both illicit and licit substance use trends are variable as are other demographic factors (e.g., substance use among the elderly). Collaborative primary health care must maintain the flexibility to monitor and adapt to these needs.

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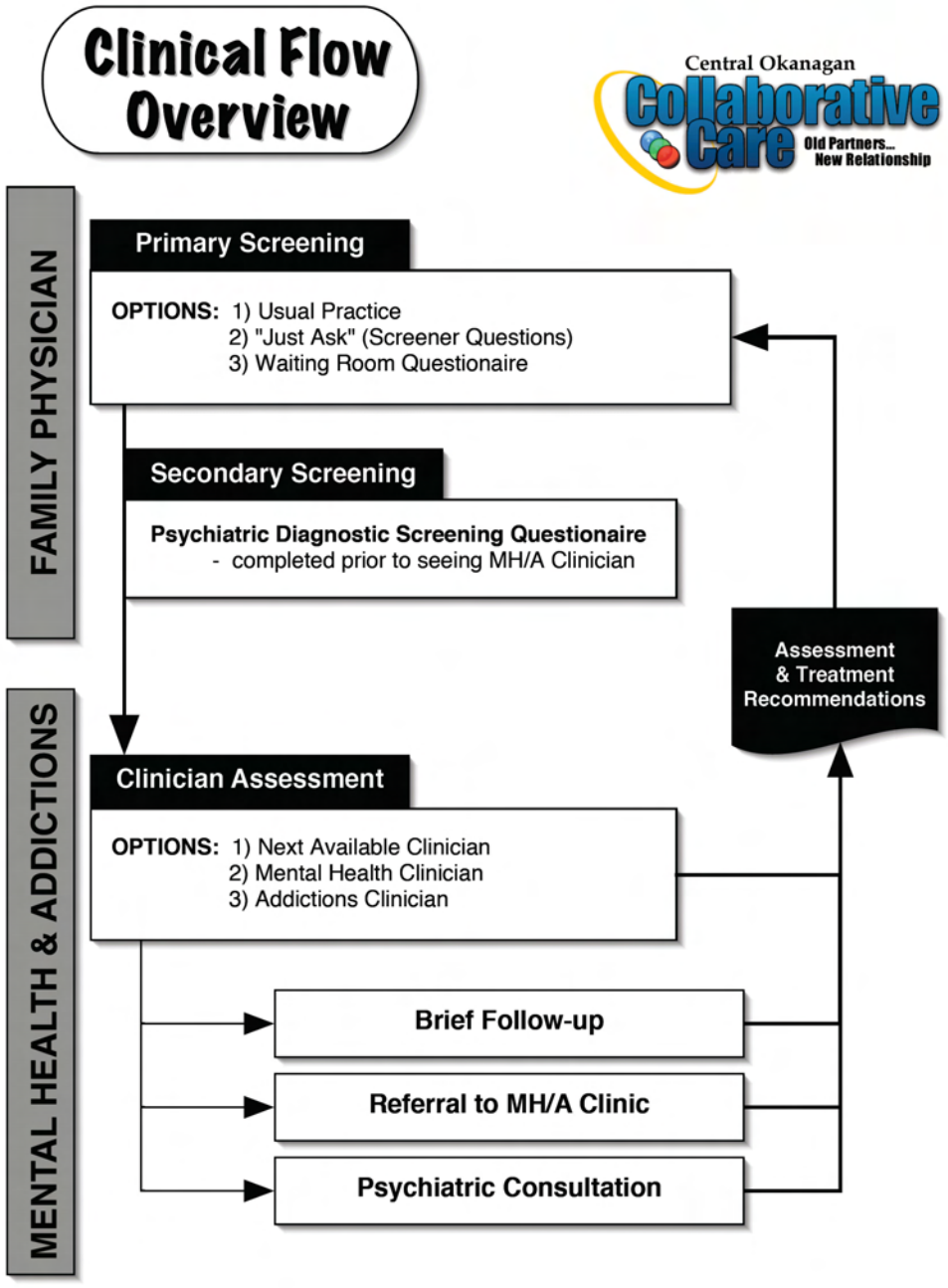
Appendix A: Consultation process

- Several consultation strategies were used to develop this toolkit, including:
  - Collaboration of an Expert Panel representing diverse professions across Canada.
  - Study of collaborative primary care in other jurisdictions, including the UK.
  - Solicitation of input from three interprofessional groups that are currently leading the implementation of collaborative care in BC and the Yukon.
  - A 'think tank' that took place during a conference in Whitehorse supporting regional implementation of collaborative primary health care for substance use problems.

Appendix B: Tools and resources

DRAFT Clinical Flow Overview



Screening and Referral Guide

SCREENING AND REFERRAL GUIDE

Yukon Collaborative Care
Mental Health and Addictions

STEP 1: PRIMARY SCREENING QUESTIONS

Ask all your adolescent and adult patients:

- Mental health best practices screening questions **and**
- Addictions best practices screening questions or use the CAGE-AID

STEP 2: FURTHER SCREENING AND ASSESSMENT

If the answer to any primary screening question is 'yes' you and your patient can involve:

- Alcohol and Drug Services (ADS)
- Mental Health Services (MHS)
- Yukon Family Services Association (YFSA)
- Use the Referral/Request for Services form and fax it to the agency you and your patient consider most appropriate

STEP 3: SHARING CARE

ADS, MHS and YFSA can share the care of people with mental health and addictions problems with you. This can include case conferences, consultation and joint care planning.

PRIMARY SCREENING QUESTIONS:

For Mental Health Screening Health Canada Best Practices recommends asking:

- Have you ever been given a mental health diagnosis by a qualified mental health professional?
- Have you ever been hospitalized for a mental health-related illness?
- Have you ever harmed yourself or thought about harming yourself but not as a direct result of alcohol or drug use?

For Addictions Screening Health Canada Best Practices recommends asking:

- Have you ever had any problems related to your use of alcohol or other drugs?
- Has a relative, friend, doctor or other health worker been concerned about your drinking or other drug use or suggested cutting down?
- Have you ever said to another person "No, I don't have (an alcohol or drug) problem", when around the same time, you questioned yourself and FELT, "Maybe I do have a problem"?

For Addictions Screening you can also use:

CAGE-AID (Cut-down, Angry, Guilty, Eye-opener)

- Have you ever thought you ought to cut down on your drinking or drug use?
- Have people annoyed you by criticizing your drinking or drug use?
- Have you felt bad or guilty about your drinking or drug use?
- Have you ever had a drink or used drugs first thing in the morning to steady your nerves or get rid of a hangover or to get the day started?

Yukon
Health and Social Services

YFSA

CONTACTING ADS, MHS AND YFSA

Yukon Collaborative Care
Mental Health and Addictions

ALCOHOL AND DRUG SERVICE (ADS)

Sarah Steele Building, 6118 6th Ave., Whitehorse, YT, Y1A 1M9

Counselling and Treatment:

Whitehorse:	(867) 667-5777
From communities:	1-800-661-0408
Fax:	(867) 667-8471
Drop in:	Tuesdays, 09:00-11:00
Detox: (collect calls accepted)	(867) 667-8473

MENTAL HEALTH SERVICES (MHS)

Whitehorse:	(867) 667-8346
From communities: (collect calls accepted)	(867) 667-8346
Fax:	(867) 667-8372

YUKON FAMILY SERVICES ASSOCIATION (YFSA)

Whitehorse office (Carmacks) and Youth Outreach Program:	(867) 667-2970	Fax: (867) 633-3557
From communities (collect calls accepted)	(867) 667-2970	
Yukon communities:		
Dawson City Office (for Dawson, Mayo and Pelly Crossing)	(867) 993-6455	Fax: (867) 993-6456
Haines Junction Office (for Haines Junction, Beaver Creek, Burwash Landing, Destruction Bay)	(867) 634-2111	Fax: (867) 634-2333
Watson Lake	(867) 536-2330	Fax: (867) 536-7854

Yukon
Health and Social Services

YFSA

Appendix C: Glossary of terms and Index of acronyms

Glossary of terms

Best practices – Activities and programs that are in keeping with the best possible evidence about what works [Interchangeable with 'Better Practices', 'Positive Practices' and 'Good Practices'] (Health Canada, 1998).

Chronic disease management (CDM) - A systematic approach to improving health care for people with chronic disease that emphasizes helping individuals maintain independence and keep as healthy as possible through prevention, early detection and management of chronic conditions (British Columbia, Ministry of Health Services, 2004).

Collaborative primary health care - The delivery of services at the first point of contact with the health system by two or more different stakeholders (health professionals, consumers, families, primary health care organizations, community agencies) working together in a partnership that is characterized by:

- Common goals or purpose
- A recognition of and respect for respective strengths and differences
- Equitable and effective decision-making
- Clear and regular communication

in order to:

- Improve access to a comprehensive range of services (treatment, health promotion, disease and injury prevention and management of chronic diseases and self-help), delivered by the most appropriate provider in the most suitable location
- Deliver high-quality and effective health care
- Make the most efficient use of resources
- Improve outcomes for the consumer

Determinants of health - Factors in an individual's living and working environment that can affect their health (e.g. housing, education, income, employment, culture, physical environment, equity).

Health promotion – The process of enabling people to increase control over and to improve their health (WHO, 1986).

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

Mental health promotion - The process of enhancing the capacity of individuals and communities to take control over their lives and improve their mental health (Health Canada, 1998).

Mental health specialist – An individual with mental health expertise, be it related to health promotion, prevention, diagnosis, treatment or rehabilitation.

Prevention – Interventions that target risk factors for specific illnesses in order to prevent the initial occurrence of a disease, arrest or retard an existing disease and its effects or reduce the occurrence of relapses.

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 mental health care – Mental health services provided in a primary health care setting. Settings where primary health care can be delivered include the offices of health care providers, community clinics, workplaces, schools, homes, health care institutions, homes for the aged, nursing homes and day care centres**.** Primary mental health care may also be available by telephone, health information services and the Internet.

Recovery – A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness (Anthony, 1993).

Index of acronyms

APA	American Psychiatric Association
ARND	Alcohol-Related Neurodevelopmental Disorder
ASAM	American Society of Addiction Medicine
BCYCCI	BC/Yukon Collaborative Care Initiative
CCMHI	Canadian Collaborative Mental Health Initiative
EHR	Electronic health record
FAS	Fetal Alcohol Syndrome
NGO	Non-governmental organization
NIAAA	National Institute on Alcohol Abuse and Alcoholism
WHO	World Health Organization

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