Introduction

This literature review was conducted to inform a Working Together model between Mental Health & Addictions (including psychiatrists) and Primary Health Care (including family physicians) at Capital Health. The literature review will identify a variety of options, barriers, and enablers for the planning and implementation of a primary mental health care model.

Through synthesis of the literature, the review will aim to describe the following areas:

- Background information about mental health and addictions care in primary care setting
- Principles and best practices for mental health and addictions care in a primary health care setting
- Methods of service delivery at various levels of Working Together, up to and including integration (communication, cooperation, coordination, collaboration)
- Barriers and facilitators for working together

The following databases were scanned for relative articles pertaining to the search terms below: PubMed, The Cochrane Library, Canadian Public Policy Collection, Canadian Health Research Foundation, PsychInfo, Google & Google Scholar.

Key search terms include: Primary health care and primary care, mental health/mental health services, physicians – family, addictions and substance abuse/use, collaborative care, concurrent disorders, delivery of health care, and models/organizational.

To supplement the literature review, a condensed jurisdictional scan was conducted to identify existing primary health care and mental health and addictions models operating within Nova Scotia. Appendix B contains key examples of initiatives outside of Nova Scotia.
OVERVIEW

Background

Mental health and substance abuse disorders present frequently in the primary health care setting. Approximately one in five people will experience a mental illness in their lifetime (CAMH, 2012). 20% of these individuals will also have a co-occurring substance use disorder (CAMH, 2012). Distinct substance abuse statistics indicate that one in ten Canadians (15 years of age and over) report symptoms consistent with substance dependence (CAMH, 2012).

Only one third of these individuals will receive appropriate treatment (CAMH, 2012). When those with a mental illness do seek treatment, they most often seek treatment from a family physician (Clatney et al., 2008). However, under-diagnosis, misdiagnosis, and lack of time devoted to appropriate treatment plans are commonly reported challenges for providing appropriate care (CAMH, 2012). Furthermore, a major barrier in receiving optimal chronic illness care, such as mental health care, is the lack of coordination, or fragmentation, within the health care system (Bodenheimer, 2008; Busse et al., 2010; Schoen et al., 2011; Smith et al., 2012a, Smith et al., 2012b). Patients’ perception of the quality of care received is strongly linked to how successful coordination is within the system. From a patient-centred care perspective, coordination involves having access to the appropriate type of care in the appropriate setting, receiving adequate information, continuity across settings, providers, and the span of the disease (seamlessness), and effective navigation of the system (Busse et al., 2010; Kodner, 2009).

There is a well-documented link between physical and mental health (Taylor & Sirois, 2009). This link is apparent in the primary care setting, particularly in individuals with chronic conditions and in the elderly. For example, depression is twice as common in individuals with chronic conditions and there is a strong positive correlation between the number of chronic conditions a person has and depressive symptoms (Coventry et al., 2011). This relationship may be mediated by self-perceived health-related quality of life (Gunn et al., 2010). Finally, individuals with untreated depression or anxiety and chronic physical condition face worse health outcomes and illness recovery rates than those without a chronic condition (CMHA, 2008).

Table 1 provides a snapshot of statistics relevant to mental health and addictions within Capital Health and Nova Scotia.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>CDHA</th>
<th>NS</th>
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<tbody>
<tr>
<td>Perceived mental health, very good or excellent</td>
<td>76.7%</td>
<td>73.6%</td>
</tr>
<tr>
<td>Perceived life stress</td>
<td>21.1%</td>
<td>19%</td>
</tr>
<tr>
<td>Mood Disorders</td>
<td>7.6%</td>
<td>8.1%</td>
</tr>
<tr>
<td>Heavy Drinking</td>
<td>22.8%</td>
<td>20.5%</td>
</tr>
<tr>
<td>Current smoker, daily or occasional</td>
<td>22.5%</td>
<td>23.2%</td>
</tr>
<tr>
<td>Patients with repeat hospitalization for mental illness</td>
<td>8.7%</td>
<td>10%</td>
</tr>
<tr>
<td>30-day readmission rate for mental illness</td>
<td>10.7%</td>
<td>11.8%</td>
</tr>
<tr>
<td>Suicides and self-inflicted injury deaths per 100,000</td>
<td>8.6</td>
<td>9.1</td>
</tr>
<tr>
<td>Contact with a medical doctor in the past 12 months</td>
<td>86.1%</td>
<td>83.5%</td>
</tr>
<tr>
<td>Mental illness hospitalization rate per 100,000</td>
<td>262</td>
<td>379</td>
</tr>
<tr>
<td>Mental illness patient days per 100,000</td>
<td>555</td>
<td>607</td>
</tr>
</tbody>
</table>


Table 1: Key Statistics for Capital Health and NS.
Improving access to care was a key driver of this recommendation, in addition to the following benefits:

- Addresses stigma (reduced stigma is associated with seeking treatment from primary health care providers as opposed to seeking mental health services)
- Improves treatment of co-morbidities
- Provides coordination of the condition across the lifespan
- Improves prevention and detection of mental health disorders
- Improves continuity with ongoing follow-up and monitoring
- Addresses mental health provider human resource shortages
- Improves health outcomes which are associated with improved access and high-performing primary health care systems

(adapted from WHO, 2007; Collins, 2010).

In Nova Scotia, the recent Mental Health and Addictions Strategy Together We Can (2012) prioritized early intervention and treatment at the first point of contact for individuals with mental health and addictions issues entering the system. Specifically, the strategy recommends the following action: “Collaborative care provided to people with mental health and/or addictions problems by primary health-care providers and professionals working in mental health and addictions will be strengthened” (Government of Nova Scotia, 2012).

Mental Health & Addictions in a Primary Health Care Setting

Primary mental health care services are defined as “the provision of basic preventative and curative mental health care at the first point of entry into the health care system” (Black, 2001).

The pathways to care model (Figure 1) is a commonly cited conceptual model used to describe the structure of mental health care in primary care (Bower & Gilbody, 2005 from Goldberg & Huxley, 1980). This model highlights the decreasing proportion of the total population that accesses higher levels of mental health services and the importance of the role of the family physician (or other primary care provider, e.g., nurse practitioner) in detection and referral (Bower & Gilbody, 2005).

In the primary care setting, it is important to differentiate between severe and long term mental health disorders and common mental health disorders. Severe and long term mental health disorders do not typically remit and result in significant disability for the individual (e.g., schizophrenia, bipolar disorder). The management of these conditions involves both primary and secondary care; however, greater reliance is placed on mental health specialists. Common mental health disorders (e.g., depression, generalized anxiety disorder, panic disorder) can be entirely managed in primary care. Providing adequate support to people with mild-moderate mental illnesses in primary health care settings has the potential to reduce demand on mental health programs, allowing them to provide more intensive or specialised care (Kates et al., 2008).

Collins et al. (2010) suggests a quadrant system for classifying physical and behavioural health issues and their most appropriate treatment setting (Figure 2).
In a literature review, Bunting et al. (2011) identified key principles for providing ideal mental health services in a primary care setting. These principles include:

- **Primary care services should provide comprehensive targeted assessments** based on standardized criteria that are focused on maximizing treatment options and minimizing risks.
- **Mental health diagnoses should be based on comprehensive assessment** that has followed standardized criteria.
- **Primary care services should build on and work with the local authority community services, with colleagues in secondary specialized services, and services in the non-statutory sector, in order to ensure continuity of care across all phases of care and service delivery.**
- **Primary care teams should work in partnership with caregivers.**
- **Services for adults with mental health needs should work with service users and others significant to them in a way that ensures their wishes, decisions and treatment options are facilitated in an atmosphere of trust and respect.**
- **Opportunities for mental health promotion should be taken and integrated into the role functions of all members of the primary health care team.**
- **Primary healthcare professionals should have the appropriate training to assess and treat adults with mental health needs.**
- **FPs should be aware that mental health disorders commonly co-exist with both physical disorders and other mental disorders, and they should be competent in recognizing and assessing these possible associations.**

Many family physicians report being interested in identifying and treating mental health problems (Clatney et al., 2008). However, generally, many family physicians report that they believe they are inadequately trained to provide mental health care in their practices and this is coupled with dissatisfaction with their access to mental health specialists (Kirby & Keon, 2004).

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**Figure 2:** Four quadrants of patient need (Collins et al., 2010; from Mauer, 2006)
Family Physicians in Nova Scotia

Focus groups held with family physicians across Nova Scotia in 2011 (n=60 family physicians) indicated the following top five challenges for managing mental illness in their practice:

- Lack of time for assessing, explaining, and treating (psychotherapy)
- Lack of availability of, or long waiting list for, psychiatrists/specialists
- Patients’ inability to afford medication
- Difficulty in making a diagnosis (e.g., subtypes of depression versus other disorders)
- Patient non-compliance

The same set of focus group participants suggested the following ideas for facilitating the provision of mental health care in their practice:

- Training program for mood and anxiety disorders
- Training in evidence-based brief psychotherapy strategies that can be delivered in a busy office setting, with perhaps, special interest psychotherapy focused practices across the district as an alternative resource
- Case based discussions with various disciplines and this model would include access to psychiatrists by telephone for support and access to professionals at primary care practices/centres
- Website

WORKING TOGETHER MODELS

Model Topology

The following provides an overview of the key model topologies identified in the literature for providing mental health and addictions care in a primary health care setting. Please refer to Appendix A for a summarized chart of potential Working Together models between Primary Health Care and Mental Health and Addictions and the type of Working Together relationship they require.

Numerous reviews on collaborative mental health care suggest different categorizations of models. As depicted in Figure 3, Bower & Gilbody (2005) suggest four key types of primary mental health care models as identified through a meta-review: training of staff, consultation-liaison, collaborative care, and replacement/referral. This type of model classification is reflective of the level of involvement required by the primary care provider and by the providers with advanced mental health training. Moreover, this model topology has been adopted by Cochrane Reviews for the purpose of organizing and evaluating collaborative mental health and addictions models.

![Figure 3: Models of Mental Health in Primary Care (Source: Bower & Gilbody, 2005)](image-url)
#1: Training Primary Health Care Staff

There is increasing evidence for treating mental health conditions at the first point of entry into the system within the primary care setting, particularly for the provision of treatment for common mental illnesses such as anxiety and depression (Bower et al., 2011; Government of Nova Scotia, 2012). Many health care professionals acknowledge that their professional education did not provide them with adequate information about clinical issues, practices, and approaches related to addiction and mental illness (Addictions Ontario et al., 2010). This suggests that building family physician and other primary health care providers’ capacity for common disorders is warranted. The training of primary health care staff may include improving prescribing, providing psychotherapy skills, dissemination of information and guidelines, and educational seminars (Bower & Gilbody, 2005). Theoretically, the training of primary care providers is the type of intervention likely to have the greatest effect for the greatest number because recognition and subsequent treatment or referral of mental health disorders are essential functions for increasing access to appropriate care as primary care providers play a gatekeeping role to the rest of the system (Bower & Gilbody, 2005). Finally, in order for training to be effective, guidelines and psychotherapy interventions must be brief and easy to use in a primary health care setting (Addictions Ontario et al., 2010).

Despite the numerous benefits associated with training, there is limited evidence for its effectiveness in the literature. The findings of Bower & Gilbody's meta-review (2005) suggested that most types of training (e.g., passive dissemination of guidelines and short-term courses) were ineffective in improving outcomes for patients. This is consistent with other reviews on the passive dissemination and adoption of clinical practice guidelines (e.g., Flodgren et al., 2011). More intensive training, such as specific training in psychosocial interventions, showed more consistent evidence of benefit (Bower & Gilbody, 2005). Similarly, Christensen et al. (2008) concluded that training GPs in depression care and the provision of clinical guidelines is not sufficient on its own and that this training must be coupled with other types of interventions to facilitate improvements in mental health care.

This model typically requires a communication working together relationship between primary health care providers and mental health and addictions providers.

Key Examples:
- GPSC Practice Support Program – Mental Health Module
- CHEER Initiative

#2: Consultation-Liaison

The consultation-liaison model involves mental health professionals entering into an ongoing relationship with primary health care providers. This is an educational relationship where mental health providers provide support for caring for individual patients, where referrals to specialist services may only be merited in a small number of cases. The primary care provider would be the main mental health care provider (Bower & Gilbody, 2005). Typically, the consult is a mental health nurse or psychiatrist, but could also be a social worker or psychologist (Parker et al., 2012).

Through several reviews, Bower & Gilbody (2005) identified that the consultation-liaison approach can affect the behaviour of primary care clinicians; however, there was no evidence that there were benefits for other providers and no evidence for direct improvements in patient outcomes. Alternatively, Parker et al. (2012) presented evidence to support the consultation-liaison approach in the primary care setting, citing the following advantages:
- Improved detection and diagnosis of mental health issues in earlier, less acute stages
- Increased likelihood for receiving early intervention for mental health problems
- Improved mental health outcomes in the primary care setting
Improved accessibility
Maintained continuity of care
Improved communication between services
Model is rated positively by primary care clinicians

(Parker et al., 2012; Williams et al., 2006)

The Parker et al. (2012) literature review identified a strong evidence base for this model in the hospital setting and increasing evidence to support its effectiveness in a primary health care setting; however, the diagnostic profiles of patients in a hospital setting versus a primary care setting would be quite different and thus, the evidence base is not directly applicable. The literature shows that the majority of referrals to this type of model are for mood disorders, particularly depression, in the early and less acute stages (Parker et al., 2012). Consequently, outcomes are well established for depression; however, the model is not well studied for substance abuse (Chang et al., 2012).

This type of basic, distance collaboration is suggested as a good first step when first initiating a collaborative primary health care and mental health and addictions project because it is easy to start with existing relationships and/or disconnected departments (Collins, et al., 2010). Key considerations for this model include: information sharing policies between areas where there are privacy concerns, re-allocation of specialist time, and adopting a method of communication, which may or may not be standardized (e.g., forms, phone call, email) (Collins, et al., 2010). The actual consultations between primary health care and mental health and addictions providers can occur through a variety of communication channels. The consultations may occur in person, via telephone, electronically, in organized meetings (e.g., case conferences) or through telehealth. No studies were identified that comparatively analyzed different methods of consultation to determine which methods are more effective than others.

This model typically requires an ongoing coordination working together relationship between primary health care providers and mental health and addictions providers.

**Key Examples:**
- Alberta Health Services “The Calgary Model”
- Consultation-Liaison in Primary Care Psychiatry (CLIPP) South Australia model

**#3: Collaborative Care**

The precise definition of collaborative care in the literature is highly varied as different areas conceptualize collaborative care in different ways. As a result, the term ‘collaboration’ is often used interchangeably with the terms ‘coordination’ and ‘integration’ despite all three terms not being synonymous. Collins et al. (2010) suggests a collaboration continuum (see Figure 4) for primary care and behavioural health partnerships. On the collaboration continuum, coordinated models would refer to previously mentioned approaches, such as the consultation-liaison approach.
Key types of collaborative care models are listed below:

1. Traditional Collaborative Care (Interdisciplinary Teams, Case Management)

Collaborative care involves the incorporation of mental health specialists into the ongoing treatment of a patient, typically in the form of a case manager or interdisciplinary team. This implementation of ‘third party’ mental health professional(s) into the patient-primary care provider relationship is a key distinction from the consultation-liaison model as the third party will have direct contact with the patient, unlike the consultation-liaison model (Bower & Gilbody, 2005). Collaborative care is often based on chronic disease management principles. This model may involve elements of the training and consultation-liaison approach; however, it builds upon that to also include screening, education of patients, changes in practice routine, and developments in information technology (Bower & Gilbody, 2005).

Collaborative care models are generally considered to have good evidence to support their use (Bunting et al., 2011). Specifically, Bower & Gilbody’s meta-review (2005) identified that collaborative care showed small to medium improvements on health status, patient satisfaction, and compliance. However, an important limitation of the collaborative care evidence base is the lack of a universal definition of ‘collaborative care’ which results in a lack of consistency for comparison across different reviews. Moreover, although collaborative care models are reported to be more effective than care as usual, they are also more resource intensive (time, money, health human resources) which results in a more expensive care model. Collaborative models have been shown particularly effective for those with high behavioural health needs, such as those in quadrants II and IV as depicted in Figure 2. (Bower & Gilbody, 2005).

Key elements for successful case management partnerships in primary care include: direct feedback to FPs, provision of some addition intervention (e.g., psychotherapy), and the case manager having a mental health background (Christensen et al., 2008). The case manager role is evolving in an attempt to increase access. As a result, other non-mental health staff are taking on the role, such as family practice nurses (Bower & Gilbody, 2005).

The collaborative care model may require a coordination working together relationship or a collaboration working together relationship. The type of working relationship will be contingent upon the level of collaboration between the providers and whether departments are fully integrated or not (Collins et al., 2010).

2. Shared Care

Shared care involves primary care physicians and specialist physicians engaging in the joint planning of delivery of care, informed by an enhanced information exchange over and above routine discharge and referral notices. It is a care model aimed at improving quality and coordination of care delivery across the primary-specialty care interface to improve outcomes for patients (Smith et al., 2009).

Shared care shows mixed results in the treatment of chronic illness (Smith et al., 2009). A Cochrane Review identified that overall, shared care showed no consistent improvements in physical or mental health outcomes, psychosocial outcomes, psychosocial measures including measures of disability and functioning, hospital admissions, default or participation rates, recording of risk factors, and satisfaction with treatment. However, there were clear improvements in prescribing (Smith et al., 2009). Future research in the area needs to address methodological inconsistencies between studies (e.g., follow up periods) and seek to understand the settings and patient groups in which shared care may be most effective (Smith et al., 2009).

Shared care requires an ongoing coordination working together relationship between physicians.
3. Co-location

Co-location involves primary health care and mental health professionals sharing the same space, but running separate services. As well, there is also reverse co-location which involves primary care professionals visiting specialized mental health facilities to address co-morbid physical and chronic illness (Collins et al., 2010).

A Cochrane Review (Harkness & Bower, 2009), identified evidence that mental health workers working in primary health care settings caused significant reductions in primary care professional consultations, reductions in psychotropic prescribing and prescribing costs, and reductions in referral rates to more specialized services. Mental health workers were defined as health professionals with the ability to deliver psychological therapies and psychosocial interventions as a distinct activity not part of the primary care consultation (e.g., not the family physician or practice nurse). The review did suggest, however, that the model did not affect prescribing behaviour towards the wider practice population and there was no consistent pattern to the impact on referrals in the wider patient population and thus, the results were not generalizable. As well, this model enhances communication relationships between providers (Bunting et al., 2011). Co-location is a variation of the replacement-referral model as outlined below and often treats patients with lower severity conditions than would be treated in the replacement/referral model.

This type of model requires a cooperation working together relationship.

4. Stepped Care

Bower & Gilbody (2005) suggest that a stepped care approach can be used to guide collaborative care at various levels of intervention intensity required. Stepped care is widely used in integrated behavioural health models (Collins et al., 2010). The goal of stepped care is to provide the most effective, yet least onerous intervention to the patient that includes a self-help component; if a patient does not benefit from the initial intervention, they are ‘stepped up’ to the next level of intervention intensity (Bunting et al., 2011). It is most commonly studied in the context of depression and other common mental health disorders.

A rapid review identified that the evidence base for stepped care is limited despite its widespread implementation. One study found some support for clinical and cost effectiveness; however, there was no evidence for overall effectiveness (Bunting et al., 2011). There is a paucity of research evaluating this model; a comprehensive literature review concluded that “a substantial research agenda needs to be fulfilled before a judgment can be made as to whether stepped care might be an efficient method of delivering psychological services (Bower & Gilbody, 2005).

This type of model will require a collaboration working relationship as it would require significant change in existing practice and processes of care.

Key Examples

- Collaborative Care: Ontario Family Health Teams (example: Hamilton Family Health Team)
- Stepped Care: Fraser Health Authority, British Columbia – the Integrated Primary and Community Care Mental Health and Substance Use Stepped Care Model; NICE Guidelines
- Co-location: The Ottawa Shared Mental Health Care Team

#4: Replacement/Referral

The replacement/referral model is most commonly associated with psychotherapy for more severe, long term mental health conditions. This model involves the primary care provider assessing and referring the case onto the mental health specialist for the duration of treatment (Bower & Gilbody, 2005).
Replacement/referral models are reported to be generally effective in the short term, with the type of therapy provided and the patient base being moderating factors (Bower & Gilbody, 2005). It is important to note that this type of model, similarly to collaborative care, focuses on more specialized mental health staff and involves patients of higher clinical severity.

There are several barriers associated with referral to mental health and addictions care from a primary care provider perspective that are important considerations for this model:

- Provider preferences: family physicians may be biased toward referral to medical specialties or specialized physicians, rather than to community resources or other non-physician health professionals.
- Lack of information about how to access community mental health and addiction services for their patients (confusion regarding navigation of the system, lack of awareness).
- Difficulties in obtaining timely access to services: access may be limited because of wait times, requirements for self-referral, lack of services for mild-moderate problems for individuals who may not meet the criteria for more specialized services, but still require some level of support (Addictions Ontario et al., 2010).

This type of model requires a cooperation working together relationship.

**Chronic Disease Management Approach**

Nolte & McKee (2008) suggest chronic disease is defined as: “conditions that require a complex response over an extended time period that involves coordinated inputs from a wide range of health professionals and access to essential medicines and monitoring systems, all of which need to be optimally embedded within a system that promotes patient empowerment” (p.1). The Chronic Care Model (CCM; Wagner et al., 1999) and particularly its expanded version (CCM-E; Barr et al., 2003) are the most widely recognized models in the literature as comprehensive and successful frameworks for chronic disease management at a population-health level (Morgan et al., 2007; Singh & Ham, 2006).

There is strong support in the literature for using the chronic care model as a framework for integrated primary health care and behavioural health partnerships (Collins et al., 2010; Woltman et al., 2012; Davis et al., 2011). As well, collaborative care models typically follow chronic disease management principles (Bower & Gilbody, 2005).

Woltman et al. (2012) determined that chronic care models can improve mental and physical outcomes for individuals with mental disorders across a wide variety of settings. As well, they provide a framework for clinical and policy integration in mental health (Woltman et al., 2012). The chronic care model is best understood in the context of depression. In a meta-analysis, Tsai et al. (2005) identified improvements in clinical outcomes and processes of care with interventions that contained one or more elements of the CCM for depression and numerous other chronic conditions.

**Self-management:** Individuals who are competent in self-management have reduced disease-related complications and use health services more appropriately because they are able to monitor their symptoms and know how to prevent and respond to certain health-related problems (Health Council of Canada, 2012; Nasmith, 2010).

**Key Examples:**

- Alberta Health Services: Red Deer Primary Care Network

This type of model requires a collaboration working together relationship as it requires moving toward integration.
LITERATURE REVIEW
MENTAL HEALTH AND ADDICTIONS IN A PRIMARY HEALTH CARE SETTING

ENABLERS AND BARRIERS

Enablers for Working Together

In order to enhance integration/coordination of services, there must be a strong interface between primary and secondary care. The following activities may facilitate coordination between primary and specialty care:

- **Electronic referral:** can improve access to specialists, reduce costs and improve care coordination
- **Referral agreements:** agreements between primary care and specialist physicians as to what conditions are best managed in primary care and what would be best managed by a specialist to ensure all referrals are warranted
- **Advanced practice nursing:** through hospital visits, post-discharge home visits, and telephone consultations which collectively, have been shown to reduce readmissions, deaths, and costs
- **Care coaches at transitions from hospital or other facility to community:** activates and prepares patients and families to coordinate their own care, fostering independence and enhancing self-management skills (Brodenheimer, 2008).

Enablers for effective working together at the service delivery level include:

- Clearly delineated roles, with providers clearly understanding each other’s’ roles and scopes of practice
- Appropriate physical space (e.g., to support co-location) and proactive space planning to facilitate collaborative practice
- Clear and easy to use guidelines for screening and treatment
- Dedicated administrative support to facilitate working together activities
- Provider buy-in to the model is essential (physician and other) (Addictions Ontario et al., 2010; Mulvale et al., 2008).

Enablers for effective working together at the system level include:

- Support of management/leadership to support a culture of collaboration
- Clearly defined vision of the collaborative model
- Electronic health record
- Appropriate remuneration mechanisms (Addictions Ontario et al., 2010).

Determinants of readiness for the implementation of a behavioural health care model into primary care are also a key factor for consideration. Chang et al. (2012) assessed various readiness factors for the implementation of a depression care model in primary care for the VA Health Care System. Readiness factors included:

- Resource adequacy (financial, space, IT support)
- Motivation for change
- Staff attributes (champions, staff efficacy)
- Organizational climate (teamwork, communication and cooperation, orientation towards quality improvement, competing demands, existing relationships)

The Chang et al. (2012) qualitative analysis determined that both readiness factors and characteristics of the model influenced adoption. As well, greater model simplicity increases attractiveness to those previously engaged in local quality improvement projects.

Barriers for Working Together

There are many barriers cited in the literature for developing effective working relationships between mental health and addictions clinicians and primary health care providers. These barriers mirror the challenges associated with interdisciplinary teamwork generally and the challenges associated with providing more coordinated (or integrated) care.
Barriers encountered for working together at the service delivery level include:
- Different practice cultures and styles
- Interdisciplinary tensions ("turf protection")
- Overlapping scopes of practice; lack of clarity regarding roles
- Different treatment and recovery philosophies (e.g., with addictions, harm reduction versus abstinence; degree to which client/patient is involved in decision making)
- Availability of staff during required times (e.g., for consultations)
- Confidentiality policies (both perceived and real barriers for sharing client information)
- Patient-perceived stigma (individuals may not want primary health care providers to have access to their mental health records because of a fear that physical problems may be dismissed)
(Mulvale, 2005; Addictions Ontario et al., 2010)

Barriers for working together at the system level include:
- Remuneration methods (e.g., fee for service)
- Insurance coverage and liability
- Funding sources (in areas where full integration does not exist)
- Health human resource shortages (particularly in rural areas)
- Wait times for specialized mental health and addictions services
- Lack of joint planning between mental health and addictions and primary health care
- Information sharing between departments, providers, and electronic systems
- Lack of service capacity (e.g., family physician supply, nurse practitioner led clinics)
(Mulvale, 2005; Addictions Ontario et al., 2010)

*Note regarding remuneration for key models:* no one ideal model of remuneration has been identified in the literature for providing primary mental health and addictions care and reimbursement should be contingent upon the type of model adopted, the time commitment required by professionals, and the level of collaboration required between staff.

**CONCLUSION**

**Evaluation**

The specific evaluation model will depend on the degree of integration; however, the literature recommends several key elements for evaluating primary mental health and addictions care models:
- Individual and population health outcomes of new initiatives
- Economic benefits and/or costs
- Perception of working relationship from practitioners and client perspectives
- Impact of collaborative care on referral patterns, wait-times and access
- Impact of standardized approaches to treatment
- Consumer satisfaction with care received
- Whether care is efficient, effective, equitable, and timely
(Kates et al., 2011; Kates et al., 2012; Addictions Ontario et al., 2010)

**Conclusion: Recommendations for Going Forward**

Implementing a mental health and addictions model in primary health care will require a planned approach with consideration of the above mentioned barriers and enablers for working together.
The literature suggests the following key considerations for beginning a partnership and choosing a model of working together:

- The current services available and their accessibility and capacity
- The level of awareness and knowledge about mental health and addictions issues in the primary health care workforce
- Organizational support for providing services and for developing a working relationship
- Reimbursement factors
- Target population characteristics
- Consumer preferences
- The context of the community or region; there is no “one size fits all model” for all communities

Overall, the model should increase access, reduce stigma, maximize provider efficiency, provide support for complex patients, and take into account co-occurring behavioural health and physical health issues (adapted from Collins et al., 2010; Mauer & Druss, 2007).
References


### APPENDIX A: Key Models by Type of Working Together Relationship

<table>
<thead>
<tr>
<th>Working Together Relationship</th>
<th>The Goal</th>
<th>Key Model (s)</th>
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<tbody>
<tr>
<td><strong>Communication</strong></td>
<td>To share general information about one or more topics of mutual interest</td>
<td>• Training Primary Health Care Providers (educational sessions, guidelines, brief screening and psychotherapy techniques)</td>
</tr>
<tr>
<td><strong>Cooperation</strong></td>
<td>To provide each other with balanced and objective information and knowledge to support a common understanding. To ask for and listen to feedback from each other. To match and adjust the type of work that must be completed to meet the goals of each partner. To support each other to complete the required work. To limit duplication.</td>
<td>• Co-location • Reverse Co-location • Replacement/Referral Model</td>
</tr>
<tr>
<td><strong>Coordination</strong></td>
<td>To work together, usually through established mechanisms, to meet a specific goal. To align some resources and efforts, have some shared processes, and rely on the support of each partner. To make sure that the organizational mandates, concerns, ambitions, policies, and practices of the partner groups are understood and considered. To address an area of need where partners believe working together will be more effective than working separately.</td>
<td>• Consultation-Liaison Model • Collaborative Care (low level of collaboration) • Shared Care</td>
</tr>
<tr>
<td><strong>Collaboration</strong></td>
<td>To bring about systems change by radically altering the way that we think, behave, and operate. To bring together the resources, knowledge, skills, and capabilities of partners to develop solutions for complex problems. To work together on an area of need or a problem that cannot be effectively addressed by individual partners. To work closely with each other at each step of decision making and implementation.</td>
<td>• Stepped Care • Collaborative Care (high level of collaboration) • Chronic Disease Management Approach (integration)</td>
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APPENDIX B: Examples of Key Models

**Note:** This Appendix was primarily prepared using presentations from the 13th Canadian Collaborative Mental Health Care Conference held in June 2012. A full list of presentations can be retrieved from: http://www.shared-care.ca/page.aspx?menu=66&app=251&cat1=628&tp=2&lk=no

**Training Primary Health Care Staff**

1. **GPSC Practice Support Program – Mental Health Learning Module**

   This learning module provides training to help family physicians screen patients for mental health conditions and in treatment approaches for Axis I mental health conditions. The treatment approaches provided through the module are designed to enhance the skills and confidence of GPs to provide effective, primary care.

   Competencies gained through the module:
   - Diagnostic screening skills
   - Cognitive behavioural therapy skills
   - How to maximize use of resources currently available
   - How to better use specialized mental health services for patients with complex mental health needs
   - Understanding billing supports and options for providing mental health care.

2. **Mental Health Commission of Canada – CHEER Initiative**

   Collaborative Healthcare: Exchange, Evaluation, and Research (CHEER) is a pan-Canadian initiative to improve primary mental healthcare in Canada. The CHEER Initiative will bring together key stakeholders across Canada who are currently active in primary mental healthcare, as well as a wider group of stakeholders with lived experience and expertise, to identify and leverage existing best practices. The CHEER Initiative focuses on using knowledge exchange strategies to improve access to quality primary mental health and substance use services in rural and remote communities, enhancing existing training programs to increase the competencies of health professionals to work collaboratively in the areas of mental health and substance use, and improving the experience of receiving care by fostering inter-professional collaboration and addressing barriers to accessing care.

**Consultation-Liaison**

1. **Alberta Health Services – The Calgary Model**

   The Calgary Model is a mentoring/consultation model that follows a consultation-liaison approach for providing collaborative mental health care in a primary care setting. 150 physicians and 11 clinicians are currently participating in the model. A survey conducted with participating physicians indicated improvements in skills, improvements in quality of care, and improved access to mental health services. Moreover, almost 60% reported a decrease in the number of referrals they make to specialty mental health and substance use services.

2. **Consultation-Liaison in Primary Care Psychiatry (CLIPP) South Australia model**

   The CLIPP initiative in Australia has three main components:
   - Consultations between psychiatrists and GPs
   - If necessary, transfer processes to facilitate shared care
   - Case registration and tracking
The primary diagnoses of referrals are depression (48%), adjustment disorder, and anxiety disorder. Consultation decision trees and standardized referral forms aid the consultation process. Benefits of CLIPP versus regular care include: more clients being able to be treated in primary care by the GP, patients being able to be treated in continuing care, significant physical health gains, and increased access. A manual for CLIPP is available.

**Collaborative Care**

1. **Collaborative Care: Ontario Family Health Teams – Hamilton Family Health Team**

Kates et al. (2011) Abstract: "For 16 years, the Hamilton Family Health Team Mental Health Program has successfully integrated mental health counselors, addiction specialists, child mental health professionals, and psychiatrists into 81 offices of 150 family physicians in Hamilton, Ontario. Maximizing the potential of a "shared care" model requires changes within the primary care setting, to support the addition of mental health and addiction professionals, active involvement of primary care staff in managing mental health problems of patients, and collaborative practice. This coordinated effort allows mental health treatment through onsite support from a mental health team and supplants the need to refer most patients to the mental health setting."

Key model elements:

- Enhance access by making mental health and addictions staff available
- Support primary care physicians to expand their scope of practice
- Stepped approach to a shared care model where family physicians or nurses attempt to address mental health and addiction issues before involving part-time onsite counselors, addiction specialists, child mental health professionals, or psychiatrists. If necessary, for those with more severe illness, referrals may be made directly to secondary and tertiary services in Hamilton's mental health and addictions network
- Providers involved: family physicians, practice nurses, mental health counselors (RN or MSW), psychiatrists, child and youth specialists, dieticians, and pharmacists
- A central management team composed of a manager, a medical director, and 3 support staff coordinates activities in the practices

2. **Stepped Care: Fraser Health Authority – the Integrated Primary and Community Care Mental Health and Substance Use Stepped Care Model**

The goal of collaborative mental health care at Fraser Health is to enhance the capacity of primary care and Mental Health and Substance Use (MHSU) services through their realignment so they are more closely integrated with each other. The work will support primary care providers in managing individuals with mild to moderate mental health and substance use disorders in a primary care setting.

The diagram shown below is a depiction of the Fraser Health Mental Health and Substance Use Integrated care model which takes a stepped care approach.
3. Co-location: The Ottawa Shared Mental Health Care Team\textsuperscript{8,9}

The Ottawa Shared Mental Health Care Team is a mobile interdisciplinary mental health team that travels to various Family Health Team offices to provide co-located consultative and direct care. Teaching and supervising family medicine and psychiatry residents is also included in their mandate.

Feedback from the model suggests that providing mental health services at FHT sites increases comfort and access and promotes early intervention as well as prevents the need for a more intensive intervention (e.g., emergency room visits). Challenges associated with the model include: access to clinical tools, working with multiple staff at multiple sites, office space, EMRs, office supplies, communication, and administrative support.

Chronic Disease Management Approach

1. Alberta Health Services, Red Deer Primary Care Network\textsuperscript{10,11}

The Government of Alberta in partnership with Alberta Health Services released an Addiction and Mental Health Strategy in September 2011. One of their priority areas of focus within this strategy is the development of healthy and resilient communities through primary health care. To do this, they will integrate mental health and addictions services within their Primary Care Networks (PCNs). One key element of this strategy is that it is guided by the application of chronic disease management principles.

Key initiatives include:

- Improving access within primary care through multidisciplinary team based approach, building on competencies of the mental health and addictions workforce, and creating tailored approaches for complex/high-risk populations
- Improving access to alternate levels of care and specialty services through telehealth, using family physicians with special training and interest in mental health
One specific example that has garnered attention is the Red Deer Primary Care Network. They provide "wellness-focused" care through proactive practice teams.

- They have a co-located primary health care teams at their sites consisting of: physicians, family practice nurses, pharmacists, and mental health counselors (psychologists and MSWs)
- They also have a centralized team that serves multiple sites for group programming consisting of: health basics coaches (kinesiologists, dietitians, and nurses) and mental health counselors

Appendix B: References