Canadian Collaborative Mental Health Initiative

Initiative canadienne de collaboration en santé mentale

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

6

June 2005

Author
Natalie Pawlenko, CCMHI Consultant

Steering Committee Reviewer
Keith Lowe, representing the Canadian Mental Health Association

Senior Editor
Annabelle Sabloff

CCMHI Secretariat
Maureen Desmarais, Project Coordinator
Scott Dudgeon, Executive Director
Marie-Anik Gagné, Project Manager
Valerie Gust, Communications Manager
Tina MacLean, Research Assistant
Jeneviève Mannell, Communications Assistant
Enette Pauzé, Research Coordinator
Enric Ribas, Designer
Shelley Robinson, Administrative Assistant

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Canadian Collaborative Mental Health Initiative Secretariat

c/o College of Family Physicians of Canada

2630 Skymark Avenue, Mississauga, ON L4W 5A4

Tel: 905-629-0900 Fax: 905-629-0893

E-mail: info@ccmhi.ca Web site: www.ccmhi.ca

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

A paper for the
Canadian Collaborative Mental Health Initiative

Prepared by:
Natalie Pawlenko, MSW

June 2005

O U R G O A L

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

TABLE OF CONTENTS

EXECUTIVE SUMMARY

The Canadian Collaborative Mental Health Initiative (CCMHI) received funding through the Primary Health Care Transition Fund to create strategies to encourage primary health care providers, mental health care providers, consumers, caregivers and communities to work together to develop collaborative mental health services. Among the fundamentals identified by the CCMHI to support the development of collaborative mental health care in primary health care services, is the existence of policies, legislation and funding structures and resources that are congruent with the principles of collaborative mental health care.[1] This working paper reviews relevant mental health and primary health care policies and legislation in each province and territory. Based on key informant interviews in each province and territory, this paper reports on the policies that support or hinder the implementation of new collaborative mental health care initiatives.

The findings are summarized according to the following themes:

1. There are primary health care and mental health policy frameworks that clearly support collaborative care, and there is the potential for coordination among these frameworks.
2. Progress has been made in reducing legislative, service delivery and funding barriers to collaborative care.
3. The availability and use of information technology supports, such as Telemental Health and 24/7 Telehealth services, are increasing.
4. There are a number of challenges to and opportunities for collaborative mental health care.
5. The status of health system reform in each province and territory is that of major system change.
6. Home care reform, in light of the Romanow Report recommendations regarding mental health case management and intervention centred in the home, has yet to be widely implemented.

About the Primary Health Care Transition Fund

Since September 2000, the Primary Health Care Transition Fund has been providing funding for projects designed to:

- increase the number of community-based primary health care organizations that provide comprehensive services to particular populations
- create more interdisciplinary teams in which nurses, pharmacists and other providers play an enhanced role
- develop better linkages between hospitals, specialists and other community services
- place more emphasis on health promotion, disease and injury prevention and the management of chronic illnesses
- expand access to essential services 24 hours a day, 7 days a week

INTRODUCTION

Mental health and primary health care policy play an important role in setting the context for the development of collaborative settings in Canada.

Collaborative mental health care enhances the capacity of primary health care providers to meet the needs of consumers through collaboration among health care partners, including: primary and mental health care providers, consumers and caregivers.

This research paper reviews mental health and primary health care policies in each province and territory that are relevant to collaborative mental health care. This paper also highlights policies that may support or hinder the implementation of new collaborative initiatives.

This analysis is based primarily on information gathered from key informants. Between June and November 2004, a total of 34 key informants were contacted, and 27 agreed to be interviewed.[2] The approach taken was to include a key informant from each province and territory that had one of the following roles:

1. A member of the Federal/Provincial/Territorial (F/P/T) Group of the Primary Care Transition Fund
2. A member of the F/P/T Mental Health group
3. An Executive Director of a branch of the Canadian Mental Health Association[3]

The document contains:

- a brief overview of the six themes (Thematic Overview)
- a detailed report of each province and territory in both narrative and tabular form (Provincial and Territorial Summaries)
- a glossary of terms and acronyms (Appendix A)
- a brief methodology (Appendix B)
- a list of informants (Appendix C)

THEMATIC OVERVIEW

Six themes emerged from the series of key informant interviews.

Themes

1. There are primary health care and mental health policy frameworks that clearly support the concept of collaborative care, and there is the potential for coordination among these frameworks.

Every province and territory has either formal or informal policy statements relating to both primary and mental health care reform. The majority have formal statements, and some are in the final stages of approval. Nearly every mental health policy document that follows a primary health care plan makes reference to primary health care reform and the place of mental health services in a population health-based system. This is a positive change from past policy documents, which were often written without reference to one another, as a lack of coordination among reform strategies can create a policy barrier to collaborative mental health care.

Many of the mental health policy papers note that the decades-long trend to deinstitutionalize people with mental illness has not resulted in a commensurate investment in community-based mental health services, and they reiterate the need to strengthen the continuum of mental health services in the community. New Brunswick has established a method to measure progress in this area. It has identified a number of performance indicators for mental health services, including one known as 'community/inpatient balance.' The most recent data on these indicators reveal a shift toward more care in the community and more investment in community services.

British Columbia has taken a different policy approach from other jurisdictions by making a deliberate decision to move to a chronic disease management model for primary health care. For mental health services, this approach has moved the focus beyond severe mental illness to include other chronic mental illnesses that contribute to the burden of disease, such as depression, anxiety and concurrent disorders. To support better management of these chronic illnesses, the province is providing tools to support collaborative practice, including evidence-based resource manuals, planning guidelines and best-practice publications. In 2004/05 the British Columbia Ministry of Health Services will release a guide for physicians, families and individuals on managing depression, anxiety disorders, early psychosis and substance-use disorders. This is in addition to a number of previously released publications dealing with other high-need areas.

In their policy frameworks, some jurisdictions have emphasized the need for interdepartmental collaboration within government, and for partnerships with supporting services in the health, social and justice sectors. For example, the Yukon Interdepartmental Collaboration Initiative, which involves the Departments of Justice, Health and Social Services, is intended to improve services for families who need sustained and integrated support from all three departments.

2. Progress has been made in reducing legislative, service delivery and funding barriers to collaborative care.

Legislative Barriers

Legislation and policies governing the utilization of health human resources – in particular, issues related to remuneration and liability schemes – can be barriers to collaborative mental health care.[4] Across Canada, regulations governing the practice of professionals are being revisited and updated to reflect the new realities of health care in the 21st century.

For example, many provinces have introduced legislation to enable nurse practitioners to practice. Both Nova Scotia and Ontario have made legislative changes to allow pharmacists to fill prescriptions written by nurse practitioners. These kinds of legislative changes help break down barriers to collaborative practice.

Service Delivery Barriers

Across Canada, there has been a significant improvement in the integration of primary health care and mental health service delivery. Nine of the ten provinces and one territory (Northwest Territories) have transferred responsibility for mental health services to regional health authorities, thus increasing the potential for implementing collaborative mental health care in primary health care settings.

All provinces and territories have either created or are in the process of creating some form of local primary health care initiative that includes mental health care or recognizes that mental health care must be integrated into the scheme (e.g., shared care arrangements, primary health care organizations, Instances Locales, Primary Care or Family Care Teams). This trend indicates a significant shift to a consumer-focused population health approach that views mental health as part of primary health care.

Funding Barriers

While most jurisdictions have had some alternatives to fee-for-service arrangements since the 1960s, most physicians in Canada continue to work within the fee-for-service system.

Developments across the country since 2002 indicate a growing willingness on the part of both government and health care providers, especially general practitioners and psychiatrists, to address barriers to collaborative primary/mental health care caused by certain funding arrangements.

For example, in 2004 alone:

- The British Columbia Medical Association and the British Columbia Government signed an agreement incorporating a significant component concerning the manner in which family physicians will be remunerated for the delivery of mental health care.
- In Nova Scotia, a new provincial contract with primary care physicians and psychiatrists includes an alternative funding plan, which should expand the number of payment options in the future.
- Alberta Health and Wellness, the Regional Health Authorities and the Alberta Medical Association signed a tripartite agreement that allows for the creation of Local Primary Care Initiatives, which offer general practitioners new incentives to work in multidisciplinary teams.

- The Physician Payment Model Working Group in New Brunswick is developing and implementing alternative models for physician remuneration.

3. The availability and use of information technology supports, such as Telemental Health and 24/7 Telehealth services, are increasing.

Successful collaborative mental health care initiatives recognize the need for supportive systems and structures.[5] Information technology (e.g., electronic client records, Web-based information exchange, teleconferencing, videoconferencing, e-mail, list serve) is an integral feature of supportive systems that facilitate policy reforms and promote collaborative care. Over the past few years, the use of long-distance clinical consultations, clinical case conferencing, educational presentations and administrative meetings have increased across the country. This indicates that most jurisdictions are developing the information systems needed to support collaborative care.

4. There are a number of challenges to and opportunities for collaborative mental health care.

Challenges

In their efforts to provide collaborative mental health services in primary health care, jurisdictions face a number of common challenges, summarized below.

Attitudes/Awareness, including:

- stigma associated with mental illness
- relative lack of attention given to mental health in the health care continuum
- difficulty experienced by people with mental health needs in accessing primary health care services
- artificial divide between 'physical' and 'mental' health (e.g., while a correlation between depression and cancer is well documented, the health care system is not structured to adequately detect, diagnose and treat individuals with both physical and mental illnesses)

Health Human Resources issues, including:

- shortage of mental health professionals
- problems recruiting and retaining mental health and primary health care providers, and a lack of mental health human resource plans
- lack of understanding of mental health care issues among health care providers and a lack of mental health training for health care professionals
- lack of coordination between primary health care and mental health providers and among community mental health providers
- need for education about the benefits of collaborative mental health care, training in collaborative care and other opportunities for multidisciplinary learning
- lack of time for already overworked health care providers to learn to work in new ways

Financial issues, including:

- existing compensation models for physicians that do not promote interdisciplinary collaborative care or recognize the complexities of caring for people with mental health needs

- reluctance on the part of many physicians to move to new funding models
- different payment systems for non-physician providers, such as psychologists, who are paid through private or third-party sources, adding to the difficulty of implementing interdisciplinary collaborative care models
- lack of adequate sustainable funding for mental health services (e.g., the inability, in primary health care settings, to provide the resource-intensive supports required by people with mental illness)
- lack of resources to develop or support collaborative care models
- need for more funding for public education and disease prevention
- Legal issues, including:
- confusion over professional liability for decisions made by an interdisciplinary team
- scope-of-practice issues for family physicians and psychiatrists
- union issues that may arise as roles of health care professionals/providers change over time

Information and Tools, including*:*

- lack of information on social and health determinants that point to populations at risk for mental illness
- lack of adequate knowledge of mental health resources available in the community
- need to develop screening tools and treatment protocols for health care providers and self-management tools for clients
- need to develop tools/technologies that will facilitate collaboration between primary health care and mental health (e.g., Telemental health, protocols for sharing client information, referral protocols, electronic record keeping)
- need for additional support for staff working in more remote areas (e.g., case conferencing, training)

Issues related to Health Care Reform, including*:*

- need for effective change management resources to guide major structural changes and service devolution occurring in health care systems across the country
- need to increase the capacity of home care services to play an expanded role in mental health care and case management

Other Challenges

In addition to the common challenges listed above, some jurisdictions – either because of geography or the nature of the populations they serve – face some unique challenges in providing collaborative mental health care, including:

- costs and other challenges (e.g., higher staff turnover rates) associated with providing care in large geographical areas in the North
- challenge of integrating mental health care and traditional Aboriginal ways of healing and dealing with serious mental illness
- need for evidence-based treatment programs that are relevant to the populations being served

Opportunities

Despite the serious challenges they face, most jurisdictions are able to identify a number of strengths in their systems that should enable collaborative mental health care, including:

Leadership/Commitment

- Most jurisdictions report having strong professional and political leadership and support for collaborative mental health care.
- In some cases, this leadership has led to extensive public education, community participation and citizen engagement.

Systemic Changes

- Some jurisdictions have made systemic changes (e.g., integrating health and social services into one department) that make it easier to enhance mental health programming within existing primary care structures.

Structures and Tools, including:

- common visions
- integrated management teams
- strong commitment to research and evaluation
- data registries to support interdisciplinary primary/mental health care
- the use of Telehealth technology
- information-sharing
- new approaches to remunerating professionals for mentoring and training other professionals
- offering primary health care service providers greater access to psychologists who provide care for patients with mild to moderate mental health problems

Successful Initiatives

- Some jurisdictions report that having successful models in place acts as an incentive to progress.

Both jurisdictions with smaller territories (e.g., Prince Edward Island) and jurisdictions with smaller populations (Northwest Territories, Nunavut) report that these conditions lead to a sense of community and a high degree of connectedness between primary health care and community mental health programs, which leads to a high degree of goodwill and awillingness to make the best use of limited resources.

One jurisdiction also notes that having fewer levels of government is associated with more streamlined decision-making, planning and implementation.

5. The status of health system reform in each province and territory is that of major system change.

Seven of ten of Canada's provinces have been or are currently engaged in major system reforms. Many of these reforms are designed to promote collaborative interdisciplinary care and have the potential to help integrate mental health services within primary care.

For example:

2002

- In British Columbia, 52 regions were amalgamated into five regional health authorities, together with one provincial health authority responsible for province-wide and specialized services.
- In New Brunswick, existing hospital corporations were transformed into Regional Health Authorities (RHAs).

The first elections to RHA boards occurred in May 2004. The transfer of responsibility of community mental health and public health services to the Regional Health Authorities is currently underway.

- Saskatchewan began to develop its Regional Health Authorities.

2003

- In Alberta, 17 Regional Health Authorities were amalgamated into nine, and most mental health services were devolved from the Alberta Mental Health Board to the RHAs.

2004

- Newfoundland and Labrador announced plans to integrate 14 health boards.
- In October, Ontario announced its intention to create Local Health Integration Networks.
- In Quebec, Centres locaux de services communautaires, hospitals and long-term care facilities have been merged into 95 Instances Locales.

Yukon is unique in that its government has been responsible for administering the full range of health services only since 1997.

6. Home care reform, in light of the Romanow Report recommendations regarding mental health case management and intervention centred in the home, has yet to be widely implemented.

The Romanow Report[6] made two very specific recommendations about home care services for people with mental health problems:

- A case management approach should be implemented whereby a case manager would work directly with the individual and with other health care providers and community agencies to monitor the individual's health and make sure appropriate supports are in place.
- Home intervention should be available to assist and support clients who have an occasional acute period of disruptive behaviour that could pose a threat to themselves or to others, thus avoiding unnecessary hospitalization.

While case management and home intervention services exist in varying forms and degrees across the country (e.g., 'Assertive Care Teams'), the home care sector does not play an integral role in either case management or home intervention for mental health care.

This section summarized the six major themes that emerged from the review of reports and key informant interviews. The next section reviews the mental health and primary health care policy as well as the challenges to and opportunities for implementing collaborative mental health care in each province and territory.

PROVINCIAL / TERRITORIAL SUMMARIES

Alberta

Alberta has witnessed significant policy and organizational changes over the past two years. The Mazankowski Report[7] led to several important changes, including the transition from 17 to nine Regional Health Authorities (RHAs) in April 2003. At the same time, the transfer of most mental health services from the Alberta Mental Health Board – which had historically administered community mental health clinics, institutional care and mental health care centres – to the RHAs was undertaken.

In January 2004, Alberta Health and Wellness, the RHAs and the Alberta Medical Association signed a tripartite agreement that allows for the creation of Local Primary Care Initiatives (LPCIs). These LPCIs offer general practitioners the incentive to work with specialists and other providers to offer comprehensive 24/7 access to primary health care services, and encourages a greater use of multidisciplinary teams. At this time, most physicians in these initiatives continue to work on a fee-for-service basis. The plan is to fund 12 Local Primary Care Initiatives across Alberta in 2004/05.[8]

The provincial mental health plan, "Advancing the Mental Health Agenda," was released in May 2004.[9] The plan was developed by a Steering Committee representing Alberta's nine RHAs, the Alberta Mental Health Board, the Alberta Alliance on Mental Illness and Mental Health, the Alberta Medical Association, the Alberta Psychiatric Association and Alberta Health and Wellness. The plan addresses key aspects of mental health services: a vision for the future of mental health in Alberta, the services required, how programs and services should be funded, how to ensure an adequate supply of highly trained mental health workers, and how research and evaluation should be applied to guide future plans.

Using the provincial mental health plan as their point of departure, Regional Health Authorities are expected to develop their own mental health plans by the spring of 2005. The anticipated result is a fully-integrated health system with a complete range of acute, continuing and home care services designed and delivered within each region in response to identified need. This includes increased emphasis on the primary care/shared care model and protected funding to ensure the inclusion of mental health care.[10]

One of the most successful initiatives in Alberta can be found in the Calgary Health Region, where forty-four family physicians, four psychiatrists and five other mental health practitioners have teamed up to provide care for people with mental health needs.[11] Based on a pilot initiated in 1997, this delivery model brings family physicians, psychiatrists, nurses, social workers and psychologists together for consultation and collaboration. The model has been well received by both clients and staff.

Status of Home Care Reform

Regional Health Authorities offer case management to mental health clients, linking them to treatment, employment, housing, income support, medication follow-up and other services and supports. However, the home care sector per se is not a major provider of services to people suffering from mental illness, whether it is in-home mental health services or case management.[12]

Use of Information Technology

The Alberta Wellnet Provincial Telehealth System serves all regional health authorities and the two provincial boards. The system became operational in September 2001 and has had robust use for clinical consultations, clinical case conferences, administrative meetings and Telehealth education presentations, including Telemental health.[13]

Challenges and Opportunities

Challenges

Some challenges to collaborative primary/mental health care that remain to be addressed in Alberta include:

- shortage of mental health professionals
- resource requirements of various collaborative care models
- additional education to demonstrate the benefits and ways of implementing an interdisciplinary shared-care approach
- overcoming physician reluctance to adopt new funding models

Opportunities

Alberta has unique strengths that can translate into opportunities. Some of these strengths include:

- strong support from Alberta Health and Wellness and its leadership
- the Calgary model, whose success has sparked interest.[14]

British Columbia

In the past four years, British Columbia (B.C.) has seen significant restructuring of its health care system, with 52 regions being amalgamated into five and a Provincial Health Authority created for province-wide and specialized services. Throughout this process, British Columbia has continued to demonstrate commitment to primary health care renewal. In the report "Renewing Primary Health Care for Patients in British Columbia,"[15] support is given to a range of identified practice models that might be adopted by health authorities, including Primary Health Care Organizations, Community Health Centres, Patient Care Networks and Shared Care Arrangements. The Regional Health Authorities are identified as the lead in the implementation of these initiatives.[16]

Underpinning primary health care renewal is a decision to move to a chronic disease management model. Within mental health specifically, there has been a broadened focus beyond severe mental illness to include the burden of disease, which includes mild-to-moderate symptoms of depression, anxiety and concurrent disorders.[17,18]

The Ministry of Health Planning and the Ministry of Health Services have also supported health authority planning and delivery of improved mental health and addictions services with the development and/or distribution of a variety of evidence-based resource manuals, planning guidelines and best practice publications, including the following:

- Guidelines on Diagnosis and Management of Major Depressive Disorder, Depression Toolkit, and Patient Guide
- Best Practices Guidelines Related to Reproductive Mental Health
- Electro-Convulsive Therapy Guidelines for Health Authorities in B.C.
- Supporting Families with Parental Mental Illness

- Peer Support Resource Manual
- Early Psychosis - A Care Guide
- British Columbia's Provincial Depression Strategy Phase 1 Report
- Provincial Anxiety Disorders Strategy (Phase 1)
- Crystal Meth and Other Amphetamines: An Integrated B.C. Strategy

Key system-wide policy initiatives currently under development (2004/2005) include:

- Provincial Depression Strategy Phase 2
- Provincial Anxiety Disorders Strategy Phase 2
- Mental Health and Addictions Information Plan (ongoing)
- Chronic Disease Management for Depression and Anxiety Disorders[19]

Most recently, the document, "Every Door is the Right Door: A British Columbia Planning Framework to Address Problematic Substance Use and Addiction"[20] was released. The Framework supports a comprehensive continuum of services and a collaborative model of community and health system responses to substance use, addictions and mental health care dovetailing with the models for service delivery identified in primary health care renewal.

The majority of mental health services are still being provided by physicians on a fee-for-service basis and through mental health centres. A recent agreement signed between the British Columbia Medical Association and the Provincial Government (July 2004) contains a significant section concerning the manner in which family physicians will be remunerated for the delivery of mental health care (details of which were not available at the time of this writing).[21] Enabling legislation for nurse practitioners was passed in 2003.

Historically, B.C. has had assertive case management available for people with serious mental illness, and through this vehicle, clients have accessed peer support, housing, rehabilitation and supportive employment. More recently, peer support workers with special training have joined case managers to assist people with serious mental illness to remain independent in their own homes.[22]

British Columbia has made available a number of tools to the general public, including a Health Guide handbook, 1-800 Nurse Line (24 hours and includes pharmacist services) and website. In addition, 50 sites across the province are providing videoconferencing Telehealth.

Challenges and Opportunities

Challenges

Challenges in moving toward a higher degree of collaborative mental health in primary care settings include:

- developing and distributing the right tools for health providers and self-management tools for clients to be able to provide the right care (e.g., screening tools, treatment protocols)
- decreasing stigma surrounding mental health care, and increasing its relative level of importance in the health care continuum
- providing adequate and sustainable funding for mental health services
- developing and implementing tools to facilitate better integration between primary health and mental health care (e.g., Telemental health, increased funding for physician time to spend with patients)
- finding the time for already overworked health care providers to learn how to work in new ways

Opportunities

Some of British Columbia's advantages include:

- strong commitment to research and evaluation, especially through a robust partnership with the University of British Columbia
- development of a number of data registries which facilitate the development of tools to support interdisciplinary primary/mental health care
- strong political support for collaborative mental health/primary care[23]

Manitoba

In April 2002, Manitoba Health issued the Primary Health Care Policy Framework,[24] which is intended to provide guidance to the 11 Regional Health Authorities in planning, developing and supporting formally integrated Primary Health Care (PHC) organizations. Some highlights of these PHC organizations are: common information technology systems, integrated team meetings, communication systems and filing systems, collaborative practice training within the core curriculum for health care providers, alternative remuneration models, an increased proportion of family physicians who practice under these models and a Provincial Call Centre linked to PHC organizations.

Regional Health Authorities (RHAs) in Manitoba have operational responsibility for mental health services, including planning, delivery and ongoing management of the services. The core mental health services that will be available to residents of all regions include:

- Acute-Care Treatment
- Assessment and Identification Services
- Mobile Crisis Intervention Services
- Crisis Stabilization Units
- Supportive Housing Options
- Psychosocial Rehabilitation
- Self-Help and Family Supports
- Intensive Case Management
- Long- Term Care and Treatment Capacity
- Prevention, Promotion and Public Education Services
- Community alternatives to acute care, including Safe House resources and Crisis Stabilization Units[25]

There are some individuals who do not meet the eligibility criteria for the Community Mental Health Programs of the Regional Health Authorities or the Community Living Program of Family Services and Housing, and who pose significant risk to themselves or the community. The Provincial Special Needs Unit is a tri-departmental initiative of the Departments of Health, Justice and Family Services, which became operational in fall, 2001. The Unit is comprised of a team that provides case management, consultation and support services to special-needs clients across the province.[26,27]

Manitoba Health also has an Office of the Chief Provincial Psychiatrist, which is responsible for administering the Mental Health Act, providing professional consultation to various sectors of the mental health system, coordinating the Career Program in Psychiatry and promoting the recruitment and retention of psychiatrists for under-serviced areas in Manitoba.[28,29]

For the past few years, mental health has been identified as a major priority within the Department of Health. This has increased the profile of mental health in Manitoba and provided the impetus required to achieve the objectives outlined in the Mental Health

Renewal policy (initiated in 2001).[30] Mental Health Renewal includes a broadening of the mandate of the mental health system and a re-orienting of mental health services toward a primary health care approach that stresses strategies focused on health promotion, prevention and early intervention. This approach is community-based and rests on a coordinated, integrated system. One of its key goals is improved integration and continuity of mental health and primary health care services.

In 2002-03 Manitoba Health continued to work toward the goals of Mental Health Renewal and, among other activities:

- provided new funding to the Regional Health Authorities for supported housing staff to assist people with mental illness to locate, obtain and keep housing in the community
- continued work with the Provincial Mental Health Advisory Council to develop a provincial policy on meaningful consumer participation
- funded and supported Partnership for Consumer Empowerment to promote consumer capacity building and participation within their communities.[31]

In Winnipeg, the Winnipeg Regional Health Authority, Manitoba Health, Family Services and Housing are collaborating in the Winnipeg Integrated Services Initiative. This access model makes access to health, housing and social services a one-stop activity for the 12 Winnipeg communities, an important issue when serving individuals with mental health needs.

The Winnipeg RHA has also recently developed some innovative collaborative initiatives, including:

- physician clinics – each providing the services of a family physician, shared care counsellor and psychiatrist – that provide supports to clients with mental health needs beyond those that can be addressed by the individual family physician
- case management pilot for people with high-intensity mental health needs.[32,33]

Challenges and Opportunities

Along with its opportunities, Manitoba continues to address challenges associated with the integration of primary and mental health services, including:

- liability issues
- scope-of-practice issues
- remuneration models for physicians
- recruitment and retention of qualified mental health professionals
- stigma surrounding mental health
- training for primary care physicians to diagnose and provide mental health care
- difficulty for people with mental health needs in accessing primary care physicians[34]

New Brunswick

In 2002, New Brunswick's existing hospital corporations were transformed into Regional Health Authorities (RHAs), with enhanced accountability and a broader mandate for the delivery of health services. The first elections to RHA boards occurred in May 2004, and the transition process to transfer responsibility of community mental health and public health services to the RHAs is currently underway.[35]

In the spring of 2002, the Provincial Government introduced legislation to facilitate the introduction of nurse practitioners to the province, an important component in the growth of the province's network of Community Health Centres, which use a multidisciplinary

model involving doctors, nurses, nurse practitioners and other health care professionals. Community Health Centres are now in place or in development in five New Brunswick communities.

A model for at least four new collaborative-practice clinics has been launched in areas of the province demonstrating a need for additional primary health care providers. These collaborative-practice clinics, the first of which opened in 2003, are staffed by physicians, nurses and nurse practitioners who work in teams. Most of the physicians remain on a fee-for-service schedule.[36]

The Department of Health and Wellness intends to create a new Primary Health Care Collaborative Committee which would review and make recommendations on establishing more accessible and effective primary care service delivery models. This emphasis on collaborative care has been reaffirmed by the government's recent policy document, "Healthy Futures: Securing New Brunswick's Health Care System."[37] This initiative will be supported by working groups, one of which is the Physician Payment Model Working Group which is developing and implementing models for physician remuneration that will support their participation in primary health care.

New Brunswick also has 13 Community Mental Health Centres whose responsibilities are to maximize the use of regional mental health resources and ensure effective linkages and coordination of services provided by the community mental health centres, the psychiatric unit and other relevant agencies in the region.[38]

New Brunswick has long been a leader in the field of delivering health services to residents in their homes. Over the next four years, mental health crisis intervention, early psychosis intervention and assertive community treatment will be expanded to better meet the needs of persons with mental health challenges in the home.

New Brunswick is in the initial phase of developing an electronic patient record, and has a Telemental Health program in one of the Health Regions. A second Health Region is ready to implement its own Telemental health program.[39]

Challenges and Opportunities

Challenges

Some of the challenges to effective collaborative mental health care in primary care settings include:

- ongoing and significant structural change, including service devolution, requiring focused change management
- inadequate numbers of trained mental health professionals

Opportunities

Core incentives and opportunities for collaborative mental health care in primary care settings include:

- collaborative management meetings with all community mental health centre vice-presidents and mental health directors
- sharing a common vision with common goals and best practices
- ongoing education of stakeholders, information sharing, planned change management.[40]

Newfoundland and Labrador

The past few years have seen a significant amount of planning and implementation with respect to both primary health care and collaborative mental health care in

Newfoundland and Labrador. In September 2002, the plan, "Healthier Together: A Strategic Health Plan for Newfoundland and Labrador," set out directions for the health and community services system for the following five years and identified the intent to establish a new model of primary health care.[41]

A year later, an implementation strategy entitled, "Moving Forward Together: Mobilizing Primary Health Care—A Framework for Primary Health Renewal for Newfoundland and Labrador,"[42] was released. This Framework described the transition to Primary Health Care Teams throughout the province. Primary health care renewal directed the creation of networks that would allow physicians, nurses, public health officials, social workers, occupational therapists, physiotherapists and other care providers to work together to provide comprehensive and accessible services to communities.

In the initial phase of renewal, seven proposals were accepted for implementation (six rural, one urban). The seven Primary Health Care Teams (with one additional team pending) have been given important supports through the creation of the following positions (the duration of which is 18 months):

- Coordinator – supports organizational change and manages administrative issue resolution
- Facilitator – supports the integration of the following elements of clinical care: wellness, chronic disease management (this includes mental health) and community capacity building
- Family Practice Physician Lead – supports physician integration into an overall leadership team.[43]

As the Primary Health Care Teams develop, the 14 existing health boards will be integrated and their numbers reduced. A mental health strategy, "Working Together for Mental Health: A Proposed Mental Health Services Strategy for Newfoundland and Labrador,"[44] was released in November 2003. Recognizing that persons with mental illness require strong support networks to help them manage their illness and that there are not enough community-based services available, such as day programs, home support and case management, this broad mental health strategy also identified mental health as a key component of primary health care.

Specific recommendations include the following:

- Community mental health clinicians and addictions counsellors should join Primary Health Care Teams as they become established throughout the province.
- A mobile crisis response system for mental health emergencies should be accessible by each Primary Health Care Team.
- Case managers are to be determined for each region and assigned to Primary Health Care Teams.
- Home support should be available for individuals with severe mental illness who require some supportive services in order to maintain functioning in their own home and within the community.
- Psychiatrists should enter into shared-care arrangements with primary health care physicians, which should facilitate support for primary mental health care and provide better care for consumers and their families.

While the implementation framework for the Mental Health Services Strategy has been drafted, it has not yet been approved by the province.

An example of a good mental health program

is the START clinic in St. John's, where an interdisciplinary team takes referrals from family physicians and, after conducting an assessment and developing a treatment plan, works together with the family physician to support the client.[45]

Challenges and Opportunities

Challenges

Some of the challenges that had to be addressed in order to facilitate collaborative mental health and primary health care in Newfoundland and Labrador include:

- the need to integrate the 14 Health Boards
- the lack of opportunity for professional development, especially for professionals working in rural/remote areas
- the need to integrate family physicians into the Health Boards
- an environment of fiscal restraint across the province

Opportunities

Some of Newfoundland and Labrador's success and unique advantages in furthering interdisciplinary primary/mental health care include:

- the small size of the population that makes reform easy to manage
- the strong desire among providers and on the part of the government to increase the collaborative care capacity in the system.[46]

Northwest Territories

The complex nature of primary health care and social service provision in the Northwest Territories (NWT) is a significant driver in the evolution of collaborative care in the Territory: the extensive geography and small population, limited distribution of professional resources and emerging self-government agreements all affect the organization of services and delivery of care.[47]

In March 2004, the Northwest Territories Department of Health and Social Services (DHSS) issued a policy paper entitled, "Integrated Service Delivery Model for the NWT Health and Social Services System," developed by the DHSS together with the eight Health and Social Services Authorities.[48] Building on earlier policy work describing a framework for primary community care in the NWT,[49] the Integrated Service Delivery Model plainly moves health and social service delivery toward a team-based, client-focused approach.

There are six core services delivered by each Health and Social Service Authority, namely: diagnostic and curative services, rehabilitation, protective services, continuing care services, health promotion and disease prevention, and mental health and addiction services. The delivery mechanism for these services is one of the following models: a primary community care team, a regional support team or a territorial support team, each respectively possessing an increased level of specialization and training.

In the case of primary mental health care, the focus is on investing in services at the community level and enhancing the capacity of existing resources. Chapter Six of the Integrated Service Delivery Model, "Mental Health and Addictions Strategy,"[50] sets out a framework for the development of a three-part caregiver structure:

- Community wellness workers – people with strong links to the community who may engage in prevention activities but

offer no direct counselling. They would receive supervision and some training
- Mental Health and Addictions counsellors – individuals with more formal, specialized training who engage in screening and direct treatment
- Clinical Supervisors – professionals who offer direct supervision and some training to wellness workers and counsellors and carry a small caseload as well

Due to geographic distances, telephone technologies, such as Telemental Health and general Telehealth, are increasingly being used. While Telemental Health is crossing the geographic divide, professionals are finding that it is not effective with every population, especially with certain Aboriginal populations, and therefore it would require some modification. There is a plan to at least expand Telehealth to every community in the NWT. A territory-wide 1-800 telephone information and triage line, "Tele-care NWT," was set up recently.[51]

Challenges and Opportunities

Challenges

In the NWT, the challenges of providing interdisciplinary collaborative primary mental health services have begun to be addressed through the initiatives mentioned above. Nevertheless, some significant challenges still remain:

- substantial costs of care in a large geographical area such as the NWT
- problem of recruitment and retention of qualified professionals
- stigma associated with mental illness and its associated labels
- tension between culturally traditional ways of dealing with serious mental illness and healing and the mainstream biomedical model

Opportunities

The NWT also has a number of opportunities and motivators, such as the small population (40,000), a high degree of connectedness and sense of community among its residents and the political will to enhance collaborative care and make services available to the residents of this territory.[52]

Nova Scotia

The year 2003 saw the release of a number of important policy frameworks in Nova Scotia for both mental health and primary health care reform. In February of 2004, the Department of Health released two reports: "Standards for Mental Health Services in Nova Scotia"[53] and "Strategic Directions for Nova Scotia's Mental Health System,"[54] while in May, the Nova Scotia Advisory Committee on Primary Health Care Renewal issued its report, "Primary Health Care Renewal–Action for Healthier Nova Scotians."[55]

While Nova Scotia has had geographically defined district health authorities since 1997, the shift toward a client-focused population health approach, which views mental health through a collaborative care lens, is a more recent trend. Policy development and coordinated service provision across various government departments responsible for housing, income assistance, employment, education and corrections, as well as increased integration of primary health care and continuing care services and a strengthening reliance on the network of non-governmental community services, has had an impact in providing a more seamless continuum of services.[56]

From an initial number of three demonstration sites for shared mental health

care in the Capital Health District (Halifax and surrounding area) in 1999, services have expanded to include five additional sites, with a greater multidisciplinary focus and added attention to children and youth in two of these collaborative practice sites.[57]

Primary Health Care Renewal espouses a commitment to evaluating different methods of delivering, managing and funding primary health care services. Four primary care demonstration sites, co-located in existing health care settings across the province, have been established.

Each demonstration site:

- has hired a nurse practitioner and developed and approved collaborative practice agreements between nurse practitioners and physicians at each of the demonstration sites
- has adopted non fee-for-service payment mechanisms for physicians
- is using advanced computer systems to support primary health care service delivery
- is participating in an evaluation of the initiative[58]

District Health Authorities are also developing a number of projects in primary health care with the assistance of the Health Canada Primary Health Care Transition Fund Provincial/Territorial envelope. These are mostly small projects, but they do include some larger initiatives. Their target populations and/or issues range from women's health, youth health and health literacy to service networks and expanded groups, some of which include mental health as one of their mandates. These will continue to develop with Transition Fund support, which continues to March 2006.

Provincially, additional facilitative actions include legislation passed in January 2002 allowing nurse practitioners to practice in Nova Scotia, followed by amendments to the Nova Scotia Pharmacy Act and Regulations to allow pharmacists to fill prescriptions written by nurse practitioners.[59] In 2004, a new provincial contract with primary care physicians includes a funding plan alternative to fee-for-service, with the hope of expanding the choice of payment options in future.[60]

While the Primary Care Teams appear to be effective, they are still being challenged by the need for more team resources: for example, nutritionists and mental health specialists, including registered nurses, social workers, psychologists, psychiatrists and addictions counsellors.[61]

The Nova Scotia Telehealth Network is a province-wide telecommunications program administered by the Department of Health. Videoconferencing is used to assist with the provision of patient care and education to individuals and families. The equipment can transmit medical data and provide videoconferencing between locations. Currently, there are 63 workstations in 46 health care facilities throughout the province. Under a new agreement between the government and psychiatrists on alternative funding arrangements, some barriers to the use of Telehealth services have been addressed. However, applications in mental health care are still limited.

Home care services are only available to mental health clients if there is also a physical health problem. Assertive community treatment and intensive case management services, as well as mobile crisis intervention services, are available on a limited basis. If mental health home care services were to be made available to mental health clients, as recommended by the Romanow Commission, there would be a need for additional training and hiring of resources to build capacity.

Challenges and Opportunities

Challenges

Some challenges to collaborative primary/ mental health care that remain to be addressed include the following:

- gaining acceptance for the collaborative, interdisciplinary care model
- achieving recruitment and retention of trained professionals
- increasing availability of children's, seniors' and acute crisis mental health services
- developing capacity in serving ethnocultural and First Nations communities
- sustainable funding structures for primary health care
- balancing family physician level of interest in mental health care and the demands of primary care practice
- obtaining dedicated and adequate funding to support an interdisciplinary care approach in the health teams

Opportunities

Nova Scotia's unique strengths include:

- the existence of mature district health authorities
- strong ties between primary health care and the community
- Nova Scotia's stable, less transient population.[62]

Nunavut

Nunavut faces one of the greatest challenges in Canada for addressing questions of primary health care and mental health care due to its immense size and low population density. Nunavut has approximately 30,000 residents and an area of 1.9 million square miles. Nonetheless, the Nunavut government, formerly a part of the Northwest Territories (NWT) and created only five and a half years ago, has taken decisive steps in moving ahead on mental health and primary health care reform.

In April 2000, the new government of Nunavut dissolved the Regional Health and Social Services Boards established under the NWT system. Health Board staff became departmental employees, and the Nunavut Department of Health and Social Services now directly manages these regional health services.[63]

In March 2002, the Department of Health and Social Services released a report on addictions and mental health strategy, the principles of which are based on a primary health care model that stresses health enhancement, illness prevention and community participation. Due to the very high rate of suicide, mental health problems and chronic addiction, Nunavut communities have placed mental health and addictions services high on their priority list.

The Strategy describes the continuum of addictions and mental health services to be developed in every Nunavut community. The continuum includes five components:

- illness prevention, health enhancement and community development activities
- self-help and mutual aid programs and services
- community-based programs and services
- crisis response
- facility-based and tertiary services, to be offered on a centralized basis

At the same time, Nunavut submitted its application to Health Canada's Primary Health Care Transition Fund. The funds received were

earmarked to assist Nunavut in undertaking structural change; specifically, to:

- increase the proportion of the population having access to primary health care organizations responsible for the planned provision of a defined set of comprehensive services to a defined population
- increase emphasis on health promotion, disease and injury prevention and management of chronic diseases
- expand 24/7 access to essential services
- establish interdisciplinary primary health care teams of providers so that the most appropriate care is provided by the most appropriate provider
- facilitate coordination and integration with other health services, whether in medical institutions or based in communities

Both documents place emphasis on traditional Inuit values and wisdom, resulting in a strong vision that guides these initiatives.

Today, the Community Health Centres (CHCs) act as an important hub for primary health care services. CHCs are located in 24 population centers. Typically, CHCs are staffed by registered nurses who provide acute care, on-call services with 24/7 coverage and public health nursing services. Nunavut is working toward a greater integration of all services, including mental health, so that clients have the benefit of broader access in terms of both timeliness and quality of services.

Nunavut has a north-south referral pattern for specialized services, with close ties to specialized care in Manitoba and Ontario for both primary health care and mental health services.

Home and community care services were first introduced in 1999, and they are primarily focused on the needs of seniors and chronically ill residents in the community.

Challenges and Opportunities

Challenges

Some challenges in moving toward a higher degree of collaborative mental health care in primary care settings include:

- the recruitment and retention of clinicians
- too few treatment resources
- the need for more funding for public education and illness prevention
- a vast geography with a land mass one-fifth the size of Canada

Opportunities

Some fundamental enabling agents for collaborative mental health care in primary health care settings include:

- the integration of health and social services as one department, facilitating integration across professional fields of practice and making it easier to enhance mental health programming as part of the existing primary health care environment
- the use of Telehealth technology
- extensive public education, community participation and citizen engagement

Ontario

In Ontario, a description of the latest developments in primary health care renewal can be found in a September 10, 2004 announcement from the Minister of Health and Long-Term Care[64] outlining the proposed creation of (an unspecified number of) Local

Health Integration Networks (LHINs). Ontario is the only province without a regionalized health care system, and while LHINs may appear to be a move toward regionalization, they are different in that they will not provide services directly and will have no 'hard boundaries' for patients.

Integral to transformation of the health care system are 150 Family Health Teams to provide comprehensive multidisciplinary front-line health care 24/7. These teams will act as health care coordinators to help patients navigate their way through the health care system. These teams will be developed through a community-ministry partnership.

The Ontario mental health care system has seen a great many policy documents in the recent past, the core document being "Making it Happen."[65] This was followed by the reports of nine Mental Health Implementation Task Forces that made recommendations for the implementation of mental health reform in their areas of the province.[66] The Ontario Government's "Mental Health Accountability Framework"[67] describes indicators that signal the necessity for greater collaboration with primary health care. All these documents emphasize the need to create partnerships within the health care system and develop key linkages with other services in the social service and justice sectors.

While policy changes are being made and alternative payment plans for physicians are being considered, collaborative mental health care in primary health care continues to unfold, formally and informally, among service providers in Ontario. For example:

- The Collaborative Mental Health Care Network, in its third year of operation and supported by the provincial government, brings together family physicians, general practitioner psychotherapists and psychiatrists, especially in rural and remote regions.
- Community Health Centres continue to offer a range of primary care services involving physicians, nurse practitioners, nurses, social workers and nutritionists, and take a comprehensive approach to health needs.
- Health Service Organizations have been a component of Ontario's healthcare system since the early 1970s, pioneering concepts of comprehensive care to enrolled populations.[68]

As in other provinces, the Primary Health Care Transition Fund has helped to support interdisciplinary collaborative mental health initiatives. In Ontario, Community Health Centres, home care and community mental health services have recently received significant funding increases. In the case of community mental health services, this is the first funding increase in the past 12 years.[69]

Recognizing the potential of nurse practitioners to help meet the demand of a growing aging population for primary health care services, the Ontario government has implemented a variety of initiatives, including significantly enhancing the number of nurse practitioner positions across the province, particularly in underserved areas. It has also introduced legislation to enhance the scope of practice for nurse practitioners.[70]

Ontario also has legislation in place for all primary health care providers through the Regulated Health Professions Act.

Ontario has a province-wide toll-free health information line staffed by trained professionals, as well as a province-wide Telehealth network. Also in place in some areas is an integrated telephone health advisory that links after-hours, weekend and holiday advice with an on-call physician in each of the primary care models

and provides next-day reporting on the nature of the call.

Ontario's home care services have worked diligently to keep up with the pressures of a rapidly evolving acute care system, and have identified mental health as an area requiring additional supports within their care portfolio.[71]

Intensive case management is provided to people with serious mental illness who require ongoing and long-term support. It is typically provided through community mental health programs and includes outreach, assessment, planning, service coordination, advocacy and coordination with other services.[72]

While there are ambitious plans for a province-wide, integrated patient health record system, the plans are waiting to be implemented.

Challenges and Opportunities

Challenges

While Ontario has made significant progress toward embodying collaborative mental health and primary health care, a number of barriers continue to impede further progress; for example:

- payment structure for family physicians does not support an interdisciplinary model, nor one that recognizes the complexities of caring for people with mental health needs
- psychologists, who could be part of a collaborative care model, are mostly paid through private or third party sources
- the divide between issues of physical health and mental health is artificial, and yet the health system continues to support this division

Further identified challenges include:

- lack of education/training of primary care practitioners to identify mental illness
- inability to provide the resource-intensive supports in primary health care settings required by people with mental illness
- lack of information on health determinants that might indicate populations at risk for mental illness
- lack of adequate knowledge of mental health resources
- inadequate coordination of care between primary care and mental health providers
- lack of contact with people with mental illness or with mental health settings in the education of primary health care providers
- more opportunities for multidisciplinary learning is needed
- lack of coordination amongst community mental health providers
- general practitioners and psychiatrists need training to work collaboratively
- shortage of family physicians
- no coordinated record keeping; lack of timely access to client information[73]

Opportunities

Ontario is also home to a number of collaborative mental health initiatives. This province has the professional leadership to further this approach and a government in place that has openly championed improvements in mental health care.

Prince Edward Island

Prince Edward Island (P.E.I.) has two initiatives that are unfolding concurrently, and both point primary health care and mental health services in the direction of interdisciplinary collaboration. In 2002, the Department of Health and Social Services unveiled "A Model for Mental Health Service Delivery for Prince Edward Island,"[74] which recognized that community mental health programs can be thought of as the 'primary health care of mental health.' The plan also provided for the expansion of children's mental health, an integrated case coordination approach for clients with complex concurrent disorders (mental health and substances abuse) and a specialized psychogeriatric program. P.E.I. has also recently developed and deployed assertive community treatment teams in four regions.

At approximately the same time, P.E.I. launched its "Primary Health Care Redesign,"[75] which is intended to:

- establish collaborative health care teams for first contact
- increase the focus on health promotion, illness prevention and chronic disease management
- increase coordination and integration of primary health care services with other components of the health care system and community that affect the health of the population

Four Family Health Centres have been established, bringing together three or more physicians, registered nurses and other health providers (e.g., dieticians, mental health workers) with shared responsibility for patient/client outcomes. Physicians join the Family Health Centres on a voluntary basis as salaried employees. In addition, patient/client records have been integrated at all four centres.

At least three more Family Health Centres, with mental health providers available, are in the planning stages. [76]

Legislation for the Nurse Practitioner role was passed in P.E.I. in December 2004.[77] Where there has been a shortage of nurses, P.E.I. has adopted a model employing para-professionals and other support personnel, who receive direction and supervision from professional teams.

Telemental Health is actively under development to allow psychiatrists to access psychiatry specialists and to allow physicians in rural locations to access psychiatrists for consultation.[78]

Challenges and Opportunities

Challenges

Some of the barriers to collaborative primary/mental health care include:

- poor understanding of mental health care issues among providers
- insufficient promotion of the model of collaborative care
- lack of standardized protocols for client information sharing, screening, referral
- lack of sufficient supports for staff information and training in more remote areas

Opportunities

Due to its small size, P.E.I displays some unique opportunities, namely:

- the positive ties between primary health care and the community
- an awareness of limited resources, which mobilizes providers to maximize those they have

- fewer levels of government, which contributes to relatively streamlined decision-making, planning and implementation.[79]

Quebec

Quebec is in the process of restructuring its entire health care system into a population-based health and social service system.[80] Centres locaux de services communautaires, which for years have served as a model for collaborative care at the community level, are being combined with hospitals and long-term care facilities to create 95 Instances Locales across the province, which will serve as the nuclei for a local network of health and social services. The Instances are also responsible for contracting with providers of specialized care for providing primary mental health services to clients.

The 18 existing regional health boards, to be renamed Regional Agencies, will continue to exist with their established catchment areas and will continue to be responsible for flowing funding to all service providers within their jurisdictions.

Family physicians are also being encouraged to create Family Medicine Groups – groups of practitioners with a responsibility for a given population within a set area. These Family Medicine Groups will have a contractual relationship with the Instances Locales and will contract to offer certain services. As an incentive to the development of Family Medicine Groups, the government is offering both infrastructure supports and a nurse.

The Quebec Mental Health Division is also in the process of generating a new mental health plan that will set out a vision for the next three years. The plan will pay special attention to primary care services in mental health, thus synchronizing with the primary health care reform initiative currently underway.

The academic health science centres are also being restructured to support a population-based approach. Four specialized networks are envisioned, with Instances Locales contracting for psychiatry and other services.

Nurse practitioners are expected to be practicing shortly in the areas of neonatal care, dialysis and tertiary cardiology, with mental health specialist nurse practitioners soon to be announced as well.

While Telemental Health is available across the province, there is no policy that outlines standards or evaluation procedures. Quebec has a province-wide health line, as well as a province-wide suicide help-line.

Home care services are not available specifically for people with mental health needs unless there is also a physical health problem. Assertive Community Treatment teams have been deployed across 40 per cent of the province and are considered a provincial priority, especially for those with serious and persistent mental illness.

Challenges and Opportunities

Challenges

Some of the challenges to effective collaborative mental health care in primary health care settings include:

- scope-of-practice issues for family physicians and psychiatrists
- lack of understanding of the potential for collaborative care
- inadequate numbers of psychiatrists

Opportunities

Core enablers for collaborative mental health care in primary health care settings include:

- exploring challenges to the fee schedule, (e.g., remuneration for activities such as mentoring and training other professionals)
- providing family practice groups with access to psychologists who could provide care for particular groups of patients, such as those with anxiety or depression, thus eliminating long waits in outpatient clinics and the experience of negative health outcomes

Saskatchewan

With the release of the "Saskatchewan Action Plan for Primary Health Care" in June 2002,[81] the Saskatchewan Ministry of Health set out the future direction of health care for the province. While the government defines the core services to be provided, the 12 newly developed Regional Health Authorities (RHAs) manage, operate and fund the primary health system. Mental health is viewed here as a core service.

The plan has several key elements:

- A key goal is to develop up to 140 primary health care teams over the next four to 10 years. The most common model would have at its core a group family physician practice and a primary care nurse practitioner, with home care, public health nursing and mental health services. In situations where a full-time person is not required, some team members (e.g., dietitians, pharmacists, social workers, speech and language pathologists, psychologists) might belong to more than one team. A team would be situated in a central location and in this way could serve a number of communities.
- Today, there are approximately 25 teams, involving between 80 and 100 primary care physicians, with another 9 to 12 teams scheduled to become operational in the next year. The agreement that would bring primary care physicians into the teams on an alternative-payment schedule is close to finalization.[82]
- Since 1997, 21 primary health service demonstration sites have been established across the province. Varying in size and complexity, they have in common a primary care nurse practitioner and, at minimum, visiting physician services. The sites presently involve 44 physicians, 21 primary care nurse practitioners and many other health professionals, among them mental health professionals. There is a strong emphasis on interdisciplinary, intersectoral and preventative care.[83]
- A Telephone Advice Line was established in 2003.

The development of the new Regional Health Authorities is further defined by the "Guidelines for the Development of a Regional Health Authority Plan for Primary Health Care Services."[84] RHAs are responsible for assessing the needs of their local populations, reducing health inequities and improving health. The long-term goal is for all communities to have access to primary health care located not more than 30 minutes away. The RHAs have developed system-wide administration teams, which meet regularly to discuss care needs within and across the Regional Health Authorities.[85]

The development of primary health care teams will include Mental Health Program Teams comprised of mental health specialists

(psychiatrists, psychiatric nurses, social workers, psychologists and allied professionals) based in mental health centres. These will take referrals from the mental health specialists from central primary health care sites. There are also opportunities for case consultation and staff training between the two types of teams.[86]

Saskatchewan also has five cooperative community clinics, which were developed in the early 1960s. They are based on collaborative care by a team of medical and social service providers. These clinics deliver a variety of services, including mental health, which depend on the size of the centre. The primary care physicians receive a salary, and the community clinics are considered a part of the overall network of primary health care services.

In 2003, the Saskatchewan Health Quality Council issued a report called "Mental Health Care in the Primary Care Setting: Challenges, Successes and Opportunities for Improvement."[87] The report looked at best practices in primary mental health care, current practices in Saskatchewan, and how to bridge the gap between the two. Recommendations included the need for health care agencies and providers to promote awareness of shared mental health care, the development of tools to support quality improvement and evaluation initiatives, and the provision of appropriate training opportunities in shared mental health care.

The Health Quality Council report was partially informed by a mail survey of all 816 family physicians in Saskatchewan to determine, from family physicians' perspectives, how common mental health problems were in Saskatchewan's primary care, the types and frequencies of interaction that family physicians had with mental health professionals, and strengths and areas for improvement in primary mental health care. Their findings: 83 per cent of family physicians reported that they were interested or very interested in identifying or treating mental health problems. Physician interest in mental health varied by community size (85 per cent very interested in small rural, 73 per cent in large rural, and 88 per cent in urban), but not by any other key variables.

Challenges and Opportunities

Saskatchewan continues to work toward the development of a primary health care system in which mental health services are part of a collaborative, integrated approach.

Some remaining challenges include:

- recruitment/retention of mental health professionals, primary care physicians and primary care nurse practitioners, and the lack of an overall mental health human resources plan
- remuneration schemes for mental health and primary care practitioners
- identifying and developing specific tools for a more integrated health system – for example, the electronic record
- increasing the availability of evidence-based treatment programs relevant to the populations being served in Saskatchewan
- resolving union issues that may result as roles of health care professionals/ providers change over time
- increasing home-care capacity to take on an expanded role in mental health care and case management.[88]

Yukon

The government of the Yukon has been responsible for administering the full range of health services only since 1997. With its 30,000 residents and large geographical area, Yukon

has its share of challenges in delivering health and social services.

In its proposal to the Primary Health Care Transition Fund,[89] the Yukon Department of Health and Social Services set out its goal to improve the coordination and integration of services in the health care system, to enhance health promotion and disease prevention programs and to improve access to services within the entire system with the intent of reducing pressure on the core primary health care system. For example, the Yukon government has undertaken two initiatives to develop a collaborative primary health care service delivery model in small, remote communities. The model of nurse practitioner and physician services in these two communities, where contracts with physicians are in place, is a good example of cross-discipline service integration in the Yukon.[90]

A particularly serious health issue in the Yukon is substance abuse and its consequences, such as accidents, injuries and the impacts on child, family and community health.[91] In a joint initiative with British Columbia, entitled "Integrating Primary Care with the Multi-Disciplinary Team: Collaborative Care for Substance Use and Concurrent Disorders,"[92] the goals are to improve prevention as well as the diagnosis and treatment of individuals with substance abuse and co-morbid conditions.

The key objectives of this initiative are:

- to increase access to essential mental health and substance use services
- to stimulate team-based care, drawing on the complementary clinical skills of multidisciplinary service providers
- to support the implementation of best practices in the identification and treatment of substance use and concurrent disorders
- to link rural and remote communities with more urban centers, where appropriate (e.g., intensive treatment consultations, discharge planning)
- by drawing on existing human resources and technologies, to ensure that reforms to the system will be sustainable over time[93]

Currently, a working committee is developing the pilot study to provide services to an initial group of about 20 individuals.

To understand the challenges of furthering collaborative mental health care within primary health care, one must understand the scope of available services in the Yukon. In Whitehorse, the main population centre, family physicians are usually the first point of contact for primary health care services. This contact may be in their private offices or in the emergency/outpatient department of the Whitehorse General Hospital. All family physicians in Whitehorse are paid on a fee-for-service basis. In communities outside of Whitehorse, primary health care services are provided through nursing stations. In communities without resident physicians, Whitehorse physicians travel on an itinerant basis to augment the services provided by nurses. This service may be paid for on a fee-for-service or sessional-contract basis, with government funding for travel time and expenses.

Mental health services are slim: there is one psychiatric bed in the general hospital, and the mental health centre is staffed with four clinicians; there are only two mental health nurses available. The Yukon does not have any mental health group homes or step-down programs; community supports are also thinly distributed.[94]

Additionally, First Nation land claim settlements are part of the everyday context of

Yukon life. This leads to increasingly complex program administration, which is discussed in detail in another report prepared for the CCMHI on the provision of mental health services to Aboriginal communities.

There is recognition that, especially with respect to mental health and substance abuse, cooperation and collaboration across sectors is required. The Interdepartmental Collaboration Initiative, involving the departments of Justice, Education, and Health and Social Services, has been set up to improve services to families that need sustained and integrated support from all three departments in order to function well. A key focus will be to improve working relationships and reduce barriers to information sharing when it would meet the best interests of the client's care.[95]

While there is no territory-wide crisis line in the Yukon, there is a pilot project that has set up Telehealth links and applications to support the delivery of mental health services, teleradiology, professional education opportunities, and family visitations in Whitehorse and several rural communities. As of 2003, six Yukon communities have access to mental health videoconferencing facilities.[96]

Challenges and Opportunities

Challenges

Some challenges in moving toward a higher level of collaborative mental health in primary care settings include:

- prohibitive costs of traveling out-of-territory for specialized care
- availability of fragments of services, but not a continuum of services
- difficulties in the integration of First Nations traditional medicine practices and the creation of culturally sensitive health services
- high medical staff turnover rate
- difficulties in the recruitment and retention of trained mental health professionals and primary health care providers

Opportunities

- Some fundamental enablers for collaborative mental health care in primary health care settings include:
- relatively small number of clients in a small population
- high degree of goodwill among providers, professionals and agencies
- strong political support for collaborative care

The findings for each province and territory are summarized in the tables that follow.

TABLES

Collaborative Mental Health Care
Provincial And Territorial Programs And Strategies

ALBERTA

Government Bodies of Primary Health Care and Mental Health	Alberta Health and Wellness Alberta Children's Services
Regional Health Authorities (RHAs)	9
Services included in RHAs	Acute care hospitals Home and community care Public health Mental health Long-term care facilities Diagnostic services
Services not included in RHAs	Health insurance plan Physician services Air and ground ambulance Drug benefits Alberta Alcohol & Drug Abuse Commission
Provincial Health Board	Alberta Cancer Board Alberta Mental Health Board -- provides advice to Minister of Health & Wellness, oversight for mental health services provided locally, and contracts services from RHAs, including forensic psychiatry, suicide prevention, aboriginal mental health, Telemental health services
Leading Edge of Collaborative Primary / Mental Health Care	**Policies / Discussion Papers** *Primary Care Initiative Trilateral Agreement* *Advancing the Mental Health Agenda: A Provincial Mental Health Plan for Alberta* **Planning and Coordination** April 2003 - services devolved from Alberta Mental Health Board to RHAs **Service Delivery** Calgary Health Region Interdisciplinary Care Model

BRITISH COLUMBIA

Government Bodies of Primary Health Care and Mental Health	Ministry of Health Services Ministry of Health Planning Ministry of Children and Family Planning Minister of State for Mental Health and Addiction Services
Regional Health Authorities (RHAs)	5
Services included in RHAs	Hospitals and emergency care Surgical services Home and community care Mental health services
Services not included in RHAs	Medical Services Plan Pharmacare Ambulance services
Provincial Health Authority	One (1) Provincial health authority, responsible for: - B.C. Cancer Agency - B.C. Provincial Renal Agency - B.C. Transplant Society - B.C. Drug & Poison Information Centre - B.C. Centre for Disease Control - Children's and Women's Health Centre - Riverview Hospital - Forensic Psychiatric Services
Leading Edge of Collaborative Primary / Mental Health Care	**Policies / Discussion Papers** *Renewing Primary Health Care for Patients: How Primary Health Care Transition Funding will Strengthen Patient Access to High Quality Comprehensive Care in British Columbia.* *Every door is the right door: a British Columbia planning framework to address problematic substance use and addiction.* **Planning and Coordination** University of British Columbia and Ministry of Health Services & Health Planning **Service Delivery** Primary Health Care Organizations, Community Health Centres, Patient Care Networks and Shared Care Arrangements

MANITOBA

Government Bodies of Primary Health Care and Mental Health	Ministry of Health
Regional Health Authorities (RHAs)	11
Services included in RHAs	Manitoba hospitals Health centres Personal care homes Mental health facilities Ambulance Program Northern Patient Transportation Program Manitoba Adolescent Treatment Centre
Services not included in RHAs	Self-help services Office of the Chief Provincial Psychiatrist Provincial Mental Health Centre–Selkirk Mental Health Centre Manitoba Farm & Rural Stress Line Provincial Special Needs Unit Cancer Care Manitoba
Provincial Health Authority	n/a
Leading Edge of Collaborative Primary / Mental Health Care	**Policies / Discussion Papers** *Primary Health Care Policy Framework (2002)* *Mental Health Renewal (2004)* **Planning and Coordination** Winnipeg Integrated Services Initiative (WISI) **Service Delivery** Physician clinics that provide supports to clients with mental health needs beyond those that can be addressed by the individual family physician Case management pilot for people with high-intensity mental health needs

NEW BRUNSWICK

Government Bodies of Primary Health Care and Mental Health	Department of Health and Wellness Department of Family and Community Services Department of Justice Department of Public Safety
Regional Health Authorities (RHAs)	7 Health Regions 8 Regional Health Authorities: 4 Anglophone, 4 Francophone
Services included in RHAs	Hospital services (including psychiatric services) Extra-mural services Addiction services Community health services Public Health and Community Mental Health (proposed) Wellness Health Human Resources Recruitment
Services not included in RHAs	Office of Chief Medical Officer Public Health Inspections Provincial Epidemiology NB Cancer Care Network Vital Statistics Medicare Prescription Drug Program Health Human Resources Planning Office of E-health Youth Treatment Program Some highly specialized services (obtained out-of-province) Psychiatric Patient Advocate Service
Provincial Health Authority	
Leading Edge of Collaborative Primary / Mental Health Care	**Policies / Discussion Papers** *Healthy Futures: Securing New Brunswick's health Care System - The provincial Health Plan 2004-2008* **Planning and Coordination** Primary Health Care Collaborative Committee **Service Delivery** Community Health Centres Collaborative Practice Clinics

NEWFOUNDLAND AND LABRADOR

Government Bodies of Primary Health Care and Mental Health	Department of Health and Community Services
Regional Health Boards (RHBs)	15: - 8 Regional Institutional Health Boards - 4 Regional health and Community Services Boards - 2 Regional Integrated Boards - 1 Regional Nursing Home Board (St John's) - Newfoundland Cancer Treatment and Research Foundation
Services included in RHBs	Acute care hospitals Home care & Continuing care Public health Mental health and alcohol/drug dependency programs Long-term care Some social services Diagnostic services Some salaried primary care physicians (25 per cent of all primary care physicians)
Services not included in RHBs	Newfoundland Cancer Treatment & research Foundation Air ambulance Optometry services Physician Services (75 per cent of all primary care physicians) Pharmaceutical services
Provincial Health Board	Newfoundland & Labrador Health Boards Association – Provides advocacy, group purchasing, physician recruitment, labour relations and pastoral/spiritual care coordination for the member Regional Boards
Leading Edge of Collaborative Primary / Mental Health Care	**Policies / Discussion Papers** *Moving Forward Together: Mobilizing Primary Health Care – A Framework for Primary Health Renewal for Newfoundland and Labrador* *Working Together for Mental health: A Proposed Mental Health Services Strategy for Newfoundland and Labrador* **Planning and Coordination** Amalgamation of 14 Regional Boards **Service Delivery** Primary health teams START clinic

NORTHWEST TERRITORIES

Government Bodies of Primary Health Care and Mental Health	Department of Health and Social Services
Health and Social Service Authorities (HSSAs)	8 (this includes the Territorial Health Authority which provides some local services in addition to Territory-wide services)
Services included in HSSAs	Diagnostic and Curative Services Rehabilitation Protective Services (includes referrals to specialized psychiatric facility) Continuing Care Services Promotion and Prevention Mental Health and Addictions Yellowknife Health & Social Services Authority has recently seen the addition of salaried physicians
Services not included in HSSAs	Physician Services Some highly specialized and tertiary services (provided out-of-territory)
Territorial Health Board	Stanton Territorial Health Authority – provides specialized territorial services as well as community support services to Yellowknife; refers people to out-of-territory specialized services
Leading Edge of Collaborative Primary / Mental Health Care	**Policies / Discussion Papers** *A Framework for Collaborative Service Networks: Integrated Service Delivery Model for the NWT Health and Social Services System* **Planning and Coordination** Joint Leadership Council Joint Senior Management Committee Representatives of the Dept of Health & Social Services and all the Health & Social Services Authorities are represented on both bodies **Service Delivery** 3 integration demonstration projects based on the Primary Health Care Model

NOVA SCOTIA

Government Bodies of Primary Health Care and Mental Health	Ministries Department of Health Department of Community Services
Distric Health Authorities	9, plus Izaak Walton Killam Health Centre
Services included	Acute care hospitals Mental health and addictions services Community care Public health
Services not included	Long term care Home care Insured services Cancer Care Nova Scotia Emergency Health Services
Provincial Health Board	n/a
Leading Edge of Collaborative Primary / Mental Health Care	**Policies / Discussion Papers** *Standards for Mental Health Services in Nova Scotia and Strategic Directions for Nova Scotia's Mental Health System* **Planning and Coordination** Provincial Mental Health Steering Committee **Service Delivery** Four primary care demonstration sites, co-located in existing health care settings across the province Eight mental health collaborative practice (shared care) sites, co-located in existing family practices, all in Capital Health District

NUNAVUT

Government Bodies of Primary Health Care and Mental Health	Department of Health and Social Services Departments of Justice; Education; Culture Language Elders & Youth and the Nunavut Housing Corporation
Regional Health Authorities	None
Provincial Health Authoriy	None
Leading Edge of Collaborative Primary / Mental Health Care	**Policies / Discussion Papers** *Nunavut Addictions and Mental Health Strategy (March 2002)* *Application to Health Canada's Primary Care Transition Fund (April 2004)* **Service Delivery** Moving mental health services outside a hospital setting into a community-based model

ONTARIO

Government Bodies of Primary Health Care and Mental Health	Ministry of Health and Long-Term Care
District Health Authorities	n/a 13 proposed Local Health Integration Networks
Provincial Health Authority	n/a
Leading Edge of Collaborative Primary / Mental Health Care	**Policies / Discussion Papers** *Ontario's Health Transformation Plan* **Planning and Coordination** Local Health Integration Networks **Service Delivery** Collaborative Mental Health Network Variety of shared care initiatives

PRINCE EDWARD ISLAND

Government Bodies of Primary Health Care and Mental Health	Department of Health and Social Services
Regional Health Authorities (RHAs)	5 (including Provincial Health Authority)
Services included in RHAs	Long Term Care Home Care Housing Continuing Care Nutrition Services Physiotherapy Occupational Therapy Child, Youth and Family Services Community Services Public Health Nursing Income Support Services Mental Health/Addictions Information Management Corporate Services Physician Services Volunteer Services Wellness
Services not included in RHAs	Acute care
Provincial Health Authority	1 Provincial Health Services Authority provides acute and specialized provincial services
Leading Edge of Collaborative Primary / Mental Health Care	**Policies / Discussion Papers** *Mental Health Plan Primary Health Care Redesign.* **Planning and Coordination** "Slim" bureaucracy enables planning across departments and divisions **Service Delivery** Family health centres

QUEBEC

Government Bodies of Primary Health Care and Mental Health	Ministry of Health and Social Services
Regional Health Authorities (RHAs)	18
Services included in RHAs	Hospital services (including psychiatric services) Mental health and addiction services Community health services Public Health - Outpatient medical lab services - Rehabilitation - Ambulance Salaried physicians Health Human Resources Recruitment
Services not included in RHAs	Cancer Care Physician services (fee-for-service)
Provincial Health Authority	n/a
Leading Edge of Collaborative Primary / Mental Health Care	**Policies / Discussion Papers** **Planning and Coordination** **Service Delivery** Family Medicine Groups Instances Locales

SASKATCHEWAN

Government Bodies of Primary Health Care and Mental Health	Ministry of Health
Regional Health Authorities (RHAs)	12
Services included in RHAs	Primary Medical Care Emergency Medical Services Community Mental Health AddictionsPublic Health (Population Health) Supportive Care (i.e., special care homes, respite care, adult day care) Home Care End-of-Life Care (Palliative Care) Laboratory and x-ray services Support for informal care givers Therapy Services (e.g., physiotherapy, occupation therapy, speech and language). Housing and supported living managed through RHAs
Services not included in RHAs	Air Ambulance Cancer Agency, Saskatchewan Children's dental care Chiropractic Services Medical Care Insurance Plan (Physician services) Optometry Services Provincial Drug Plan
Provincial Health Authority	n/a
Leading Edge of Collaborative Primary / Mental Health Care	**Policies / Discussion Papers** *Saskatchewan Action Plan for Primary Health Care (2002)Saskatchewan Mental Health Sector Study, 2002/2003* *The Guidelines for the Development of a Regional Health Authority Plan for Primary Health Care Services (October 2002)* **Planning and Coordination** System-wide Administration Teams (within the RHAs) **Service Delivery** Primary health care teams, including mental health teams with direct inclusion of primary care physicians in primary care teams

YUKON

Government Bodies of Primary Health Care and Mental Health	Department of Health and Social Services Department of Justice Department of Education
Regional Health Authorities (RHAs)	None
Services included in RHAs	n/a
Services not included in RHAs	n/a
Provincial Health Authority	n/a
Leading Edge of Collaborative Primary / Mental Health Care	**Policies / Discussion Papers** *Primary Health Care Transition Fund Application: Integrating Primary Care with the Multi-Disciplinary Team* *Collaborative Care for Substance Use and Concurrent Disorders* *Primary Health Care Transition Fund: Yukon Territory/British Columbia Multi-Jurisdictional Project* **Planning and Coordination** Interdepartmental Collaboration Initiative among the departments of Justice, Education, and Health and Social Services **Service Delivery** Multi-Disciplinary Team Collaborative Care for substance use and concurrent disorders Collaborative primary health care service delivery model in small, remote communities

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appendixA

GLOSSARY OF TERMS & ACRONYMS

Terms

Case management approach

An approach in which a case manager works directly with an individual and with other health care providers and community agencies to monitor the individual's health and make sure appropriate supports are in place. The Romanow Report recommended that such an approach be in place for people with mental health problems living in the community.[97]

Collaborative care/collaborative practice

An interprofessional process of communication and decision-making that allows the knowledge and skills of different health care providers, along with the client/consumer, to influence the care provided to that consumer.[98]

Collaborative practice involves patient-centred care with a minimum of two caregivers from different disciplines working together with the care recipient to meet the assessed health care needs.[99]

Collaborative partnership

A mutually beneficial arrangement, agreement or understanding where two or more parties work jointly toward a common end.[100]

Collaboration in primary health care

Two or more primary health care parties working together with the patient and/or caregiver for the purposes of improving health outcomes and system capacity that involves joint information sharing, goal setting and decision making.[101]

Collaborative mental health care

Collaborative care for the purposes of enhancing mental health outcomes.

Consumer

A reciplient of health care and related support services in any care setting. (Interchangeable terms include "patient", "user", "client").[102]

Consumer-Centred

Care that is respectful and responsive of individual patient preferences, needs and values; ensuring that patient values guide all clinical decisions.[103]

Interdisciplinary

A range of collaborative activity undertaken by a team of two or more individuals from varying disciplines applying the methods and approaches of their respective disciplines.[104]

Interdisciplinary practice

A functioning unit composed of individuals with varied and specialized training, who coordinate their activities to provide services to a client or group of clients.[105]

Interdisciplinary approaches to care are essentially team-based and necessarily driven by a collaborative leadership process that focuses on joint success rather than individual performance.[106]

"…[A]n interprofessional process of communication and decision-making that enables the separate and shared knowledge and skills of health care providers to synergistically influence the client/patient care provided."[107]

Mental health specialist

An individual with mental health expertise, be it related to health promotion, prevention, diagnosis, treatment, self-help or peer support.[108]

Population health (approach, system, planning)

A conceptual framework for thinking about health. The overall goal of the approach is to maintain and improve the health of the entire population and to reduce inequalities in health between population groups. In this approach, the entire range of known (i.e., evidence-based) individual and collective factors and conditions that determined population health status, and the interactions among them, are taken into account in planning for health improvement. Population health and primary health care are similar in that they focus on the broad determinants of health, rely on intersectoral collaboration, are committed to accountability and evidence and involve working with communities to find solutions. Primary health care is different from population health in that it has a service delivery component that is targeted to individuals, families and communities.[109]

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. [110] Primary health care is delivered in many settings such as the workplace, schools, home, health-care institutions, homes for the aged, nursing homes, day-care centres, offices of health care providers, and community clinics. It is also available by telephone, health information services and the Internet.

Primary health care setting

Primary health care is delivered in many settings such as the workplace, schools, home, health-care institutions, homes for the aged, nursing homes, day-care centres, offices of health care providers, and community clinics. It is also available by telephone, health information services and the Internet.[111]

Regional health authority(ies)

Governance structures for more localized health services, usually devolved from a provincial jurisdiction, with responsibility for providing for the delivery and administration of health services in a specified geographic area.[112]

Telehealth

The use of telecommunications and information technologies to overcome geographic distances between health care practitioners and service users for the purposes of diagnoses, treatment, consultation, education and health information transfer.[113]

Acronyms

24/7	24 hours a day, 7 days a week
B.C.	British Columbia
CCMHI	Canadian Collaborative Mental Health Initiative
CHC	Community Health Centre
DHSS	Department of Health and Social Services, Northwest Territories
F/P/T	Federal/Provincial/Territorial
HSSA	Health and Social Service Authorities, Northwest Territories
LHIN	Local Health Integration Network
LPCI	Local Primary Care Initiatives
NWT	Northwest Territories
P.E.I	Prince Edward Island
PHC	Primary health care
RHA	Regional Health Authority
RHB	Regional Health Board

appendixB

METHODOLOGY

Brief description of Research Method

Research relied mainly on interviews with key informants in each province and territory, with supportive materials provided by key informants and the CCMHI library. Web searches and research were also conducted.

Research took place between June and November 2004.

Key Informant Interviews

Individuals approached as potential key informants were members of 1) the Federal/ Provincial/ Territorial Group on the Primary Health Care Transition Fund, 2) the Federal/ Provincial/ Territorial mental health working group or 3) executive directors or designated staff of the provincial branches of the Canadian Mental Health Association. (See below for introductory communications and dates sent to each group.)

Out of 34 key informants contacted, 27 participated in the study. Twenty-four interviews were conducted by telephone and three were conducted via e-mail. On average, the telephone interviews were 50 minutes in length. (See below for the informal survey instrument used to guide the discussion.)

Key informants were all given an opportunity to review drafts of the sections of the report pertaining to their province or territory and to provide feedback in writing, usually via e-mail.

Introductory Communications to Key Informant Groups

1. *To Federal/Provincial/Territorial Primary Health Care Transition Fund members (Sent 7/29/2004)*

Dear Primary Health Care Transition Fund Member,

My name is Natalie Pawlenko and your name was forwarded to me through Ghyslaine Jalbert, Senior Program Officer with the Primary Care Health Transition Fund, Health Canada. I am a researcher with the Canadian Collaborative Mental Health Initiative (CCMHI) and am hoping to set up a few minutes to speak with you about primary care and collaborative mental health care in your province.

The CCMHI has been funded through the Primary Health Care Transition Fund Project (Health Canada), and is comprised of twelve national organizations, representing community services, consumers, family and self help groups, dietitians, family physicians, nurses, occupational therapists, pharmacists, psychiatrists, psychologists and social workers from across Canada. The Consortium is working together to improve the mental health and well-being of Canadians by strengthening relationships, improving collaboration and removing barriers to greater collaboration among health care providers, consumers and their families and communities (for more information please see http://www.shared-care.ca/consortium.shtml.).

I have been asked to prepare a research paper for the Initiative Steering Committee. This paper will be an overview of the policies and strategies undertaken by each province to enable, support and further collaborative mental health care in primary care settings. It is for this research paper, which must be completed by the beginning of September, that I am looking to you for your insights.

Could you please let me know when it is convenient for us to speak for about 30 minutes. I have listed the questions that I am pursuing below, for your information. It is possible that you might want to refer this interview to another colleague - please let me know if you think that this is the more appropriate approach to addressing this request. The questions could also be addressed in writing, if you prefer.

Many thanks in advance for your assistance, and I am looking forward to hearing from you. If I do not receive an e-mail reply by the end of day on Friday, July 30, I will give you and/or your assistant a call to follow up after the long weekend.

Sincerely,

Natalie Pawlenko, MSW
Researcher
Canadian Collaborative Mental Health Initiative
c/o The College of Family Physicians of Canada.

2. To Members of Federal/Provincial/Territorial Mental Health Group (Sent 7/27/2004)

Hello,

My name is Natalie Pawlenko and your name was forwarded to me through Carl Lakaski (Senior Policy Analyst, Mental Health Promotion Unit, Population and Public Health Branch) at Health Canada. I am a researcher with the Canadian Collaborative Mental Health Initiative (CCMHI) and am hoping to set up a few minutes to speak with you about primary care and collaborative mental health care in your province.

The CCMHI has been funded through the Primary Health Care Transition Fund Project (Health Canada), and is comprised of twelve national organizations, representing community services, consumers, family and self help groups, dietitians, family physicians, nurses, occupational therapists, pharmacists, psychiatrists, psychologists and social workers from across Canada. The Consortium is working together to improve the mental health and well-being of Canadians by strengthening relationships, improving collaboration and removing barriers to greater collaboration among health care providers, consumers and their families and communities (for more information please see http://www.shared-care.ca/consortium.shtml.).

I am writing a research paper for the Steering Committee of the Initiative that is an overview of the policies and strategies undertaken by each province to enable, support and further collaborative mental health care in primary care settings.

It is for this research paper, which must be completed by the beginning of September, that I am looking to you for your insights.

Could you please let me know when it is convenient for us to speak for about 30 minutes, and which number is best. I have listed the questions that I am pursuing below, for your information, and have taken the liberty of including a day/time schedule for your convenience.

It is possible that you might want to refer this interview to another colleague - please let me know if you think that this is the more appropriate approach to addressing this request.

Many thanks in advance for your assistance, and I am looking forward to hearing from you. If I do not receive an e-mail reply by the end of day on Thursday, July 29, I will give you and/or your assistant a call to follow up.

Sincerely,

Natalie Pawlenko, MSW
Researcher
Canadian Collaborative Mental Health Initiative
(250) 748-2925
The College of Family Physicians of Canada
2630 Skymark Avenue, Mississauga, ON L4W 5A4

3. To Provincial Branches of Canadian Mental Health Association (Sent 7/28/2004)

Dear Executive Director,

My name is Natalie Pawlenko and Bonnie Pape (Director of Programs & Research, CMHA National Offices) suggested that you be contacted. I am a researcher with the Canadian Collaborative Mental Health Initiative (CCMHI) and am hoping to set up a few minutes to speak with you about primary care and collaborative mental health care in your province.

The CCMHI has been funded through the Primary Health Care Transition Fund Project (Health Canada), and is comprised of twelve national organizations, representing community services, consumers, family and self help groups, dieticians, family physicians, nurses, occupational therapists, pharmacists, psychiatrists, psychologists and social workers from across Canada. The Consortium is working together to improve the mental health and well-being of Canadians by strengthening relationships, improving collaboration and removing barriers to greater collaboration among health care providers, consumers and their families and communities (for more information please see http://www.shared-care.ca/consortium.shtml.).

I am writing a research paper for the Initiative Steering Committee (of which Bonnie Pape is a member). This paper will be an overview of the policies and strategies undertaken by each province to enable, support and further collaborative mental health care in primary care settings. It is for this research paper, which must be completed by the beginning of September, that I am looking to you for your insights.

Could you please let me know when it is convenient for us to speak for about 30 minutes. I have listed the questions that I am pursuing below, for your information, and have taken the liberty of including a day/time schedule for your convenience. Alternatively, if you prefer to complete the questions in writing, please feel free to do so.

Many thanks in advance for your assistance, and I am looking forward to hearing from you. If I do not receive an e-mail reply by the end of day on Thursday, July 29, I will give you and/or your assistant a call to follow up.

Sincerely,

Natalie Pawlenko, MSW
Researcher
Canadian Collaborative Mental Health Initiative
(250) 748-2925
The College of Family Physicians of Canada
2630 Skymark Avenue, Mississauga, ON L4W 5A4

Informal Survey Instrument Used to Guide the Discussion with Key Informants

1. Please describe recent policy and/or funding changes in primary care, which support and further the goal of collaborative mental health care in primary care settings.
2. Which document(s) describes this change(s)?
3. Which part of your ministry regulates/flows the funding that impacts on mental health care as it takes place within the context of primary care?
4. What other branches of government or other organizations would you consider to be essential to the successful implementation & sustainability of collaborative mental health care in primary care settings? Why do you consider these other branches of government or organizations essential? Could you name a key contact in each?
5. What would you describe as the most successful collaborative mental health/primary care initiative in your jurisdiction? Why do you consider it successful? Do you consider this initiative to be sustainable and why?
6. The Romanow Report recommended the creation of home mental health care case management and intervention - has this recommendation been implemented in your province/territory as yet? If so, please describe how it has been implemented. If not, please describe why.
7. What do you consider to be the core barriers to effective collaborative mental health care in primary care settings?
8. What do you consider to be core enablers for collaborative mental health care in primary care settings?
9. Is there anything else you would like to add?

appendixC

KEY INFORMANTS

Alberta

Fern Miller

Project Team Leader, Population Health Strategies
Alberta Health and Wellness
23rd Floor, TELUS Plaza North Tower
10025 Jasper Avenue,
Edmonton, AB T5J 2N3
E-mail: Fern.Miller@gov.ab.ca
(Interviewed August 20, 2004)

Betty Jeffers

Senior Policy Analyst, Strategic Planning Division
Alberta Health and Wellness
Telus Plaza, 10025 Jasper Avenue, 18th Floor
Edmonton, AB T5J 2N3
Tel: (780) 415-2843 Fax: (780) 427-2511
E-mail: betty.jeffers@gov.ab.ca
(Interviewed August 26, 2004)

Peter Portlock

Assistant Executive Director
Canadian Mental Health Association, Alberta Division
328 Capital Place, 9707 - 110 Street NW
Edmonton, AB T5K 2L9
Phone: (780) 482-6576 Fax: (780) 482-6348
E-mail: division@cmha.ab.ca
Web site: www.cmha.ab.ca
(Interviewed July 28, 2004)

British Columbia

Gerrit van der Leer

Manager, Mental Health and Addiction Services
Planning and Innovation
B.C. Ministry of Health Services
6-1 , 1515 Blanshard Street,
Victoria, BC V8W 3C8
Ph. (250) 952 1610 Fax: (250) 952 1689
E-mail: Gerrit.vanderleer@gems5.gov.bc.ca
(Interviewed August 12, 2004)

Dr John Campbell

Mental Health and Addictions
B.C. Ministry of Health Services
(Interviewed August 12, 2004)

Eric MacNaughton

Mental Health Evaluation & Community Consultant
University of British Columbia
Vancouver, BC
(Interviewed August 19 2004 via e-mail)

Manitoba

Christine Ogarenko

Mental Health Branch, Manitoba Health
2 - 300 Carlton Street,
Winnipeg, MB R3B 3M9
(Interviewed August 4, 2004)

Marie O'Neill

Director, Primary Health Care
Manitoba Health
4036 - 300 Carlton Street,
Winnipeg, MB R3B 3M9
Tel: (204) 786-7176 Fax: (204) 779-1044
E-mail: maoneill@gov.mb.ca
(Interviewed August 4, 2004)

New Brunswick

Lise Girard

Advisor, Health Care Renewal
Health & Wellness
Government of New Brunswick
Carleton Place PO Box 5100,
Fredericton, NB E3B 5G8
(Interviewed August 19, 2004)

Rob Kelly

Director, Quality Management and Executive Support
Mental Health Services Division,
Health & Wellness
Government of New Brunswick
Tel: 506-444-5145
(Interviewed via e-mail exchange August 2004)

Newfoundland and Labrador

Juanita Barrett

Department of Health and Community Services
Office of Primary Health Care
P.O. Box 8700,
St. John's, NL A1B 4J6
Phone: (709) 758-1548 Fax: (709) 729-2159
E-mail: JuanitaBarrett@gov.nf.ca
(Interviewed August 17, 2004)

Joy Maddigan

Director, Policy Development
Health & Community Services
St John's, NL
E-mail: jmaddigan@gov.nl.ca
(Interviewed August 20, 2004)

Northwest Territories

Sandy Little

Mental Health Consultant, Community Wellness
Department of Health and Social Services
Government of the Northwest Territories
Box 1320 - GST - 6/ 5022 - 49th Street
Yellowknife, NT X1A 2L9
E-mail: sandy_little@gov.nt.ca
(Interviewed August 9, 2004)

Nova Scotia

Carol Tooton

Executive Director
Canadian Mental Health Association, Nova Scotia Division
63 King Street,
Dartmouth, NS B2Y 2R7
Tel: (902) 466-6600 Fax: (902) 466-3300
E-mail: cmhans@allstream.net
(Interviewed August 6, 2004)

Dr. David A. Gass, MD, FCFP

Director, Primary Health Care
Nova Scotia Department of Health
10th floor, 1690 Hollis Street,
P.O. Box 488,
Halifax, NS B3J 2R8
E-mail: gassda@gov.ns.ca
Phone: (902) 424-3076
Fax: (902) 424-3243
(Interviewed August 18, 2004)

Dr. John A Campbell, PhD

Director, Adult Programs
Mental Health Services Branch
Nova Scotia Department of Health
Halifax, NS
E-mail: jcampbell@gov.ns.ca
(Interviewed August 12, 2004)

Nunavut

Wayne Govereau

Executive Director, Population & Public Health Division
Department of Health and Social Services
Government of Nunavut
Box 1000, Station 1000
Iqaluit, NU X0A 0H0
Tel: 867-975-5709 Fax: 867-975-5705
E-mail: wgovereau@gov.nu.ca
(Interviewed via e-mail exchange September 22 - October 4, 2004)

Ontario

Lisa McDonald

Senior Policy Analyst, Mental Health Division
Ministry of Health and Long Term Care, Toronto, ON
Tel: 416-327-7592
(Interviewed September 8, 2004)

Dr. Barb Everett

Executive Director
Canadian Mental Health Association Ontario Division
180 Dundas Street W., Suite 2301
Toronto, ON M5G 1Z8
Phone: (416) 977-5580
Fax : (416) 977-2264 or (416) 977-2813
E-mail: info@ontario.cmha.ca
Web site: www.ontario.cmha.ca
(Interviewed August 9, 2004)

Kim Calderwood, PhD, RSW

Assistant Professor, School of Social Work
University of Windsor
Windsor, ON N9B 3P4
Tel: 519-253-3000 ext. 3083 Fax: 519-973-7036
E-mail: kcalder@uwindsor.ca
(Interviewed July 28, 2004)

Prince Edward Island

Tina Pranger

Mental Health Consultant, Department of Health and Social Services
Government of Prince Edward Island
P.O. Box 2000,
Charlottetown, PE C1A 7N8
E-mail: tpranger@ihis.org
(Interviewed August 18, 2004)

Quebec

André Delorme, MD, FRCPC

Directeur, Direction de la santé mentale DGSSMU
Ministère de la Santé et des Services Sociaux
1075, ch. Ste-Foy, 3e étage,
Québec, QC G1S 2M1
Tél: 418-266-6835 Fax: 418-266-8774
(Interviewed September 13, 2004)

Saskatchewan

Dr. Gill White

Acting Executive Director, Primary Health Services Branch
Saskatchewan Health
3475 Albert Street,
Regina SK S4S 6X6
Tel: (306) 787-0875 Fax: (306) 787-0890
E-mail: gwhite@health.gov.sk.ca
(Interviewed August 10, 2004)

Karen Gibbons

Director Program Support, Community Care Branch
Saskatchewan Health
3475 Albert Street,
Regina, Saskatchewan S4S 6X6
E-mail: kgibbons@health.gov.sk.ca
(Interviewed August 4, 2004)

Lorne Sier

Mental Health Consultant, Saskatchewan Health
Program Support Unit C
Mailing Address: 1st Floor, 3475 Albert Street, Regina,
SK S4S 6X6
Fax: (306) 787-7095
(Interviewed August 4, 2004)

Dave Nelson

Executive Director
Canadian Mental Health Association Saskatchewan
Division
2702 - 12th Avenue,
Regina, SK S4T 1J2
Phone: (306) 525-5601
Fax: (306) 569-3788
E-mail: cmhask@cmhask.com
Website: www.cmhask.com
(Interviewed August 3, 2004)

Yukon

Marie Fast

Clinical Manager for Yukon Mental Health
Mental Health Services (#4 Rd.)
Health & Social Services
Yukon Territorial Government
P.O. Box 2703,
Whitehorse, YT Y1A 2C6
E-mail: Marie.Fast@gov.yk.ca
(Interviewed August 2004)

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Canadian Collaborative Mental Health Initiative
c/o The College of Family Physicians of Canada
2630 Skymark Avenue, Mississauga, Ontario, L4W 5A4
Tel: (905) 629-0900, Fax: (905) 629-0893
E-mail: info@ccmhi.ca

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