



## Integrating Behavioral Health and Primary Care

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## Canadian Approach to Integrated Care

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**Chapter:** Canadian Approach to Integrated Care

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### Box 3.1 Key Points

- The past 20 years have seen a significant expansion in collaborative activities between primary care and mental health.
- Providers, planners, and funders are now considered to be an integral part of an integrated practice. An increasing number of family physicians have mental health professionals and psychiatrists working as part of the team.
- A collaborative model has been used to address the needs of many diverse and traditionally underserved populations.
- There are many adjustments any mental health services can make to work more collaboratively with primary care.

### Introduction



Canada has a federal government with limited responsibilities for health care (mainly health education and health care for the military, prisoners, and First Nations). Most health care is delivered by its 10 provinces and three territories, each of which has its own health care system and priorities, within a common framework laid down by the Canada Health Act. Proclaimed in 1964 and reaffirmed in 1984, The Canada Health Act identifies the five principles on which Canada's health care system is based:

accessibility, universality, portability, public administration, and comprehensiveness. Each province's health care is funded on a cost-shared basis, although the contribution of the federal government has shrunk from 50%, when Medicare was established in 1964, to less than 20%. In most provinces, health care consumes about 40% of total provincial spending.

The Canadian health care system is committed to "cradle to grave," 24/7 integrated physical and mental health care developed from within a primary care home.<sup>1</sup> Consequently, primary care is the place where the majority of mental health and substance use care is delivered, often without the involvement of specialized mental health providers. As in most other countries, up to 70% of individuals with a mental health or addiction problem in Canada will receive no treatment over the course of a year, although over 80% of these individuals will visit their family physicians in the same timeframe. This suggests that primary care is the best and perhaps the only place to detect many of these problems and to initiate treatment.

For almost 20 years, mental health and primary care services and providers have been rethinking their relationship, how they work together, and the roles each can play in a better-integrated and coordinated system. The goals are to improve access to care, maintain quality, and ensure that individuals reach the services they need when they need them.

In 1997, the Canadian Psychiatric Association (CPA) and the College of Family Physicians of Canada (CFPC) published a joint position paper to promote collaboration between the two sectors.<sup>2</sup> This position paper made the case that psychiatrists and family physicians need to improve collaboration and outlined principles to guide integrated care (or shared care as it was previously named). This paper also highlighted examples of ways to improve collaboration, emphasized the importance of training future practitioners in these models, and outlined the benefits of collaboration for underserved communities and populations. The two organizations then set up a conjoint national working group to oversee the implementation of the ideas in the position paper. This working group continues to meet regularly to promote system change with the ongoing support of the CPA and the CFPC.

In the 19 years since that first report, psychiatrists and other mental health providers have routinely collaborated with primary care colleagues. Provincial Ministries of Health Primary Care and Mental Health planners are working together, developing and funding integrated projects, either as single entities or as part of a more comprehensive provincial strategy. These projects include the Centres de Santé et de Services Sociaux in Quebec, Family Health Teams in Ontario (FHTs), Primary Care Networks in Alberta, and the Practice Support Program in British Columbia. These programs have all demonstrated improvements in access to services, reduced waiting times, and high levels of patient satisfaction with the services provided.

A major boost for multiple collaborative care projects was provided by two Federal Primary Care Innovation Funds at the beginning of the 21st century. One of these projects was the Canadian Collaborative Mental Health Initiative (CCMHI), which brought together 12 national organizations representing providers, consumers, and family members. By 2006, the CCHMI had laid down a conceptual framework for collaborative care, completed a comprehensive review of the existing literature, and developed web-based toolkits to guide the implementation of Collaborative Mental Health Care (CMHC) in general settings and for specific populations. This period also saw an expansion of collaborative partnerships, bringing together a broader range of health professionals, including nurses, psychologists, social workers, pharmacists, and occupational therapists. Of significance, these partnerships also included consumers and families, which was an important step in the greater acceptability of CMHC across the health care system.

Other changes have supported the growth of collaborative care:

1. Provinces have introduced changes in their billing tariffs to support telephone consultations between psychiatrists and family physicians.
2. The Canadian Medical Protective Association (professional insurance organization) has acknowledged that informal case discussions (corridor or curbside consultations) should be encouraged, as long as accepted standards of care for each discipline are followed.
3. In 2010, the Royal College of Physicians and Surgeons of Canada made training in collaborative care a routine requirement for all psychiatry residents, while the College of Family Physicians of Canada has introduced a new "Triple C" (Comprehensive education, Continuity of education, and Centered in family medicine) curriculum that emphasizes the integration of mental health care as a core practice into every family physician's practice.
4. In 2014, the Canadian Medical Association, in partnership with the Canadian Psychiatric Association, the Canadian College of Family Physicians, and the Mental Health Commission of Canada, produced a paper using the CanMEDS framework to outline mental health core competencies that all physicians, in all specialties, should acquire during their training.<sup>3</sup>

In 2011, these collaborative activities and changes led the CPA and CFPC to produce a second position paper<sup>4</sup> which presented the following: (1) summarized the evidence regarding the success of CMHC, (2) noted the key components of effective collaboration, (3) highlighted examples of successful models in Canada and elsewhere, (4) presented a framework for an integrated mental health and primary care system, with suggestions for ways to improve collaboration, and (5) pointed out the importance of additional and broader system changes to support collaborative care. These changes included academic departmental support of collaborative care experiences for residents in their training programs, provincial governments funding new projects, and developing billing tariffs that support collaborative activity, and national and provincial professional associations promoting collaboration among their members.

## Canadian Approach to Collaborative Care



For a summary and overview of the Canadian framework for collaborative care see Table 3.1.

Table 3.1. The Canadian Framework for Collaborative Care

1. A shared definition of collaborative care.
2. Common principles to guide any collaborative project.
3. A shared vision of the potential roles of primary care and mental health services within an integrated system.
4. Four kinds of activity that will improve collaborative practice:
  - i. Activities and strategies that any mental health service can implement
  - ii. Approaches that will increase the skills and capacity of primary care and primary care providers
  - iii. The integration of mental health services within primary care settings
  - iv. Visits to mental health services by primary care providers
5. Agreement on the need for broader system changes to support integration

Kates N, Mazowita G, Lemire F, et al. The evolution of collaborative mental health care in Canada: A shared vision for the future. Joint position paper of the Canadian Psychiatric Association and the College of Family Physicians of Canada. *Can J Psychiatry* 2011;56(5):11–110.

[http://www.cfpc.ca/uploadedFiles/Directories/Committees\\_List/Collaborative%20mental%20health%20care-2011-49-web-FIN-EN.pdf](http://www.cfpc.ca/uploadedFiles/Directories/Committees_List/Collaborative%20mental%20health%20care-2011-49-web-FIN-EN.pdf). Accessed May 15, 2016.

## A Definition of Collaborative Mental Health Care

The 2011 position paper<sup>4</sup> proposed the following widely accepted definition for collaborative mental health care: “an evolving partnership between two or more stakeholders (including patients and families) characterized by common goals or purpose; recognition and respect for strengths and differences; shared and effective decision making; clear and regular communication, to help ensure that all patients reach the right service, from the right provider, in the right location, at the right time.”

## Guiding Principles of Collaborative Mental Health Care Initiatives

Whatever the setting or focus, successful projects invariably share a number of features. In order for an initiative to thrive, it needs to be based upon principles which guide effective collaborative partnerships, rather than transplanting an external model from the outside. Among the key principles, the relationship between individual providers requires mutual respect and support, recognition of each other’s strengths and limitations, and the need for ongoing personal contact between providers working in different settings. Coordination between services should be centered on the needs of patients and their families, regular two-way communication between providers, a willingness on the part of all partners to make adjustments, sharing the responsibility for care, an agreement between services on the goals of the initiative, and ensuring that models of care respond to local needs and demands.<sup>4</sup>

## A Shared Vision of the Roles of Primary Care and Mental Health Services in an Integrated System

As most primary care practices look after a discrete population and have ongoing relationships with their patients, the family physician's office is often the first point of contact for someone with mental health or addiction problems. Primary care, with appropriate support, is well positioned to deliver services beyond the scope of traditional mental health services. Collaborative practices can foster integration of physical and emotional care (especially for individuals with complex conditions), provide preventive interventions and mental health promotion, and facilitate earlier detection of mental health and addiction problems. Practices can initiate treatment, provide monitoring after an episode of care, thereby preventing further relapses, and can help coordinate and navigate other needed systems of care.

In order for primary care to assume a broader role in mental health care, mental health services need to make adjustments in how they support these roles. Primary care providers need to offer rapid access to mental health and substance use consultation and reassessment for acute problems, even when there are delays in accessing long-term psychiatric care. In addition, mental health services need to provide targeted individual and programmatic care for selected individuals or groups of patients who cannot be managed in primary care. This targeted care is essential for patients requiring substance abuse rehabilitation programs or more specialized mental health treatment. In addition, mental health providers need to provide ongoing support and training for primary care providers in person, by telephone, via tele-behavioral health, or by using web-based applications. Finally, mental health services need to provide advice and consultation for population health, community management, and assistance with resource development.

## Activities and Strategies to Improve Collaboration with Primary Care Colleagues

Mental health and primary care providers can develop strategies that improve communication, working relationships, provide consultation, and coordinate care which can easily be introduced at little or no cost.

### Improving Communication Between Providers

The foundation of all collaborative partnerships is effective communication between providers who know, understand, and respect each other. Providers should know each other personally and understand the abilities and limitation of each other. Partners can simplify intake procedures and inclusion or exclusion criteria for referrals. They can develop protocols for communicating with each other, when a patient is admitted to a service or develop a process for initiating and managing medications or other treatments. Primary care and mental health providers can jointly plan for discharge and decide on appropriate referrals to other needed services.

Mental health professionals need to rapidly transmit concise, clear, and practical reports for a family physician to follow. This might include information about prescribed medications, changes in treatment, or specific guidance on use of community resources. Patients and/or their family members need to understand and retain a summary of their care plan to foster communication with the entire system of care. Mental health providers need to follow up with the family physician a week and a month after discharge to determine whether mental health connections have been made and how the care plan is working.

### Mental Health Consultation with Primary Care

While traditional face-to-face consultation with a patient remains a central activity for a mental health provider, family physicians can also access helpful advice about their patients. through telephone consultations<sup>5</sup>, e-mail communication, tele-behavioral health consultations, or communication via an electronic medical record.

To improve access to mental health care, when mental health appointment wait times are longer than 3 months, mental health providers can set up a rapid consultation service which offers a quick consultation and initial treatment/management advice to a family physician. The patient can remain on the mental health waiting list for ongoing care, as required. Such a rapid consultation may involve two mental health visits: (1) a visit with a nurse or social worker, conducting an initial assessment and (2) a brief, focused visit with a psychiatrist. Following the second visit, a report can be sent to the family physician, outlining key diagnoses and management strategies which also should include a clear interim treatment plan. The mental health team can continue to provide telephone or consultation advice/support to the family physician until the patient can gain full access to the appropriate mental health or addiction services, or until the problem has resolved. Collaborative care may also include discussion among the family physician, mental health professional, and patient or family member about active management of symptoms while a patient is on a waiting list. "What to do while waiting" can be integral to improving a patient's well-being and long-term outcome.

Treatment planning is an important part of both the rapid consultation and effective communication. Plans need not be lengthy, nor redundant with information from previous records. An effective plan includes a succinct, integrated impression of the patient's situation; a detailed, practical, point-by-point treatment plan; and when necessary, a contingency plan.

## Coordination of Care

Individuals with mental health and/or addiction treatment needs, often face difficulties arising from service fragmentation and difficulty in transitioning from one service or sector to another. To increase the ease and coordination of care, the following is recommended: (1) regular communication and decisions about responsibility for each part of the care plan, (2) support with guidelines for referrals and transition of care, (3) an individualized treatment plan that is brief, focused, practical, and accessible to the patient, and (4) the creation of a discharge planning checklist with specific steps routinely followed by all providers in a service. Review Table 3.2 for an example of an inpatient discharge plan.

Table 3.2. Inpatient Discharge Care Plan

- Contact the family physician at admission to discuss possible follow-up plans.
- Contact the family physician when a firm discharge date is envisaged.
- Discuss the follow-up plan with the family physician and determine which roles the family physician could take.
- Develop a written plan for post-discharge care, including medications.
- Give a copy of the plan to the patient.
- Fax, email, or send through an electronic medical record a copy of the care plan to the family physician on the day of the patient's discharge.
- Prepare a succinct and relevant discharge summary immediately after discharge, and get it to the family physician as soon as possible.
- Call the patient a week after discharge to ensure the plan is understood and is being implemented.
- Call the family physician a month after discharge to ensure the plan is being implemented.

A mental health provider may call patients at 1, 3, 6, and 12 months after completion of an episode of care to see how they are doing. Cases should be kept open so that a patient who is experiencing problems can be quickly reassessed to prevent further deterioration. If, on the other hand, the patient is doing well and the plan is working, the case can be closed. A mental health provider can also arrange the last appointment, before a mental health discharge from the office of the family physician, to ensure that everyone knows the plan and his or her responsibility for ongoing care.

## Building the Capacity and Capability of Primary Care Providers to Manage the Mental Health Problems of Their Patients

Initiatives in the primary care setting can be geared towards increasing the skills and comfort of family physicians and all other primary care providers in recognizing and managing mental health and substance abuse problems, thereby expanding the number of patients being seen, and the range of services being delivered. Teaching about mental health and addictions can be accomplished by formalized continuing medical education (CME) workshops, presentations, or conferences. CME is most effective when it is brief, practical, and taught interactively using a case-based or problem-focused approach. Topics addressed can be chosen by family physicians and should be relevant to the immediate realities of primary care. Presenters should include family physicians and specialists who also offer a follow up session one month later.<sup>7</sup>

Mental health specialists visiting the primary care setting expand the opportunities for learning and build on these CME principles. In-office consultations (around active and current cases) that are brief, focused, and immediately helpful are appreciated. A specific training program for a group of primary care providers or other members of the collaborative team may focus on the treatment for a specific problem, assist with population management, or help with the development of groups (see Chapter 28: Group Interventions in Integrated Care Settings) and can cement effective collaboration and bring new skills to the primary care practice.

Mental health providers can introduce the use of standardized screening instruments, management guidelines, and books geared toward patient self-management strategies, as well as links to readily useable and downloadable online materials, interactive resources for patients, and information on community programs, all contained within a single accessible web-based location. These materials can be used by the family physician both for his or her own information and as resources for patient discussions and teaching.<sup>8</sup>

### **Example: British Columbia's Practice Support Program Mental Health Module**

The Practice Support Program: Adult Mental Health Module (AMH), a joint initiative of Doctors of British Columbia (BC) and the BC Ministry of Health, is a training and support program for physicians and their medical office assistants (MOAs). The program is designed to improve clinical skills, practice management, and to enhance delivery of mental health patient care. The AMH offers a series of modules that include screening and assessment tools and three supported self-management approaches. The three modules include: (1) Bounce Back, a program that combines DVDs and workbooks for individuals with depression with or without anxiety, (2) an Antidepressant Skills Workbook, which teaches specific skills to improve overall well-being, and (3) The Cognitive Behavioral Interpersonal Skills (CBIS) manual,<sup>9</sup> which forms the core of the AMH. CBIS provides an organized, guideline-based system for physicians. This system aids in patient assessment as well as development of treatment strategies that incorporate self-management processes to empower patients to be active partners in their mental health treatment. The manual is also featured in the Canadian Medical Association's national e-learning anti-stigma course for physicians, in partnership with the Mental Health Commission of Canada.

Practice support (PSP) learning modules<sup>9</sup> are designed to teach the use of common screening scales, a diagnostic assessment interview tool, a tool for organizing patient issues, a cognitive-behavioral skills program, and the use of a patient self-management workbook. These learning modules are typically taught in three half-day group-learning sessions, offered locally in communities throughout the province. Each group session is followed by an action period of approximately 8 to 12 weeks, during which PSP participants test what they have learned in their own practices. MOAs are specifically targeted to receive the 2-day Mental Health First Aid training offered by the Canadian Mental Health Association to increase their confidence in dealing with patients they will see in their practices.<sup>10</sup>

During action periods, participants receive in-practice support to ensure they get as much benefit as possible from the learning sessions and have the guidance they need to incorporate newly acquired tools and processes into their everyday practice workflow.

The Child and Youth Mental Health (CYMH)<sup>7,11</sup> module offers similar screening and assessment tools designed for children and youth. Module training, tools, and resources encourage and support collaboration of the various practitioners in the multi-sectoral team who provide care for these young patients. Family physicians who complete the CYMH module training, learn how to work together with child and adolescent psychiatrists, pediatricians, child and youth mental health clinicians, and school counselors in their local communities. To date, over 1,600 family physicians have participated in the module. This model has been adopted by Nova Scotia, and has also been introduced in a variety of other jurisdictions. Evaluation has shown significant improvements in the skills and confidence of primary care providers in managing these problems, with these improvements being maintained over a 12-month period.<sup>12</sup>

### **Common Models for Integrating Mental Health Services Within Primary Care Practice Settings and Establishing Teams**

Different levels of integration of mental health services into primary care include the following:

1. Co-location of mental health and primary care; contacts or case sharing is usually incidental rather than planned.
2. Mental health professionals visiting primary care to provide educational presentations, complex case discussions or review, or a one-off clinical consultation or visit.
3. Mental health professionals coming to primary care for the final mental health discharge visit with a patient, so the family physician is actively involved in the follow-up plans and the patient is clear about the roles of all the providers.
4. Regular visits by a mental health team as an outreach activity of a mental health service.
5. Full integration of mental health providers as part of the primary care team.

For a description of levels of integrated care in the United States see Chapter 1: Conceptual Framework for Integrated Care:

## Multiple Models to Achieve Integrated Aims.

Most Canadian programs have adopted an approach that is similar to the Collaborative Care model developed by Wayne Katon and his colleagues in Seattle, Washington.<sup>13,14</sup> The collaborative care model utilizes a care manager/therapist/counselor, who may be a nurse, a social worker, and less frequently a psychologist, as well as a consulting psychiatrist; both mental health professionals are integrated within the primary care practice. The counselors can fill multiple roles and can facilitate the psychiatrists integration in the primary care setting. Such programs emphasize evidence-based practices, often introduced by the psychiatrist or mental health counselor with a population focus. Collaborative programs may address the needs of all patients being seen in a primary care practice, or may focus on specific populations, such as individuals with depression or anxiety, children and youth, older patients, or individuals with psychosis or addiction issues.

Most Canadian programs follow one of three approaches:

1. Visits by mental health providers working in a mental health program for a brief “one-off event,” such as a clinical consultation, an educational event, a case review, or for a patient’s final primary care visit when a patient is about to be discharged from a mental health service.
2. A “shifted” outpatient clinic, in which mental health professionals (MHPs) either individually or as a team visit the primary care setting for a specific number of half-days, usually as part of an outreach program of a mental health service.
3. The full integration of MHPs as part of the primary care team, as in the Hamilton Family Health Team Mental Health Program.

## Evidence for the Benefits of Collaborative Care

Convincing evidence has accrued from Canadian projects<sup>4</sup> and from the international literature<sup>12</sup> of the short and long term benefits of collaborative partnerships, measured by symptom and functional improvement of patients, reduced disability days, increased workplace tenure, increased quality-adjusted life years, and increased compliance with medication. These benefits have also been identified for youth, seniors, people with addiction problems, and indigenous populations.

There is also evidence that collaborative programs are cost-effective<sup>15</sup> and can lead to reductions in health care costs, through a more efficient use of medications, reduced use of other medical services (especially for people with chronic medical conditions), more efficient use of existing resources,<sup>14</sup> and a greater likelihood of a more rapid return to the workplace.

Collaborative care also improves the passage of individuals through the mental health system, by creating a better-coordinated continuum of care, making flow between services easier, enabling the sharing or shifting of resources as needed, ensuring mutual accountability, and strengthening linkages with other sectors.<sup>16,17</sup>

## Key Components of Effective Programs

Collaborative programs include multiple linked components, combined with a redesign of existing processes of care.<sup>4,14</sup> The key components employ screening of patients with chronic medical conditions for depression or anxiety, enhanced patient education or access to educational resources, and/or brief psychological therapies for those with a problem. Other key components focus on increasing the skills of primary care providers and changing the way care is delivered. Collaborative programs may introduce evidence-based guidelines for treatment, will monitor progress after treatment is started, treat a specific problem or diagnosis, and often utilizes telephone follow-up or other forms of consultations. In addition, changing the methods of systems/care delivery is usually required to support and get the most out of collaborative interventions. Systemic changes may include employing systematic (proactive) follow-up of patients after treatment is initiated or completed, supporting patient self-management, inviting feedback from patients and families regarding the effectiveness of interventions, and providing rapid access to essential services. Team-based care and clarity in the roles of different providers are also keys to better outcomes.

Whitebird et al<sup>18</sup> reviewed two programs: Improving Mood-Promoting Access to Collaborative Treatment (IMPACT) in Seattle and Minnesota’s Depression Improvement Across Minnesota, Offering a New Direction (DIAMOND) Program. Table 3.3 lists the nine identified factors that led to effective collaboration.<sup>18</sup>

Table 3.3. Whitebird’s Nine Factors Leading to Effective Collaboration

- An engaged psychiatrist who is available to all team members and responsive to patient needs.
- A strong family physician champion who actively promotes and supports the project.
- Supportive organizational leadership that understands and supports the goals of the project.
- Buy-in by primary care providers who support the model and are willing to make adjustments.
- Funding is not an obstacle, with adequate resources for the program to function.
- A strong care manager who understands the model and is a good fit with the practice.
- The care manager's role and expectations are clear and regularly reviewed.
- The care manager is onsite and is accessible and available, with adequate working space.
- Warm handoffs with referrals, case discussions, and reports conducted face to face.

Whitebird RR, Solberg LI, Jaeckels NA, et al. Effective implementation of collaborative care for depression: what is needed? *Am J Manag Care* 2014;20(9):699–707.

## Integrating Primary Care Providers Within Mental Health Services

Individuals with severe and persistent mental illnesses have an increased risk of developing chronic conditions such as diabetes, vascular disease, and respiratory problems. Patients often have more than just one medical problem. Many of these individuals have trouble accessing timely primary care, which can contribute to the chronicity of these conditions and reduced life expectancy. In some instances, this leads to the use of emergency departments for primary care services. Some psychiatrists may provide treatment for the physical as well as the psychiatric disorders, including prescribing, although many psychiatrists do not feel they possess the skills to safely manage medical problems.

With increasing frequency, a primary care provider may be added into a mental health service, sometimes referred to as “reverse shared care” or “reversed integrated care.” The provider can be a family physician or an advanced practice nurse, whose role is to assess the physical health problems of patients using a mental health service, initiate medical treatment, monitor progress, and refer on to more specialized medical care, if required. The primary care physician (PCP) is usually present for half a day every 1 to 2 weeks, and can also be available by phone, between visits. In these settings, the PCPs need to bring the full range of their usual clinical skills in chronic and acute disease management. They also need additional expertise in planned proactive care, motivational interviewing, trauma-informed care, supported self-management, and care planning.

## The Hamilton Family Health Team Mental Health Program: Integrating Mental Health Services in Primary Care

The Hamilton Family Health Team (HFHT) Mental Health Program,<sup>19</sup> established in 1994, became part of the Hamilton Family Health Team in 2006. Family Health Teams are Ontario's model of transformed primary health care, emphasizing comprehensive, round-the-clock care; prevention and health promotion; chronic disease management; and team-based care. The HFHT, located in the city of Hamilton, a community of 500,000 people in southern Ontario, serves approximately two-thirds of the population of the city. The HFHT is the largest in the province, and includes 170 family physicians, most of whom are in small (one- or two-person) practices. In total, there are 86 practices, each of which will have, in addition to the family physician(s), a nurse and other health professionals, such as pharmacists or dietitians, as well as a counselor and a visiting psychiatrist.

The mental health counselor is usually a nurse or social worker, experienced in outpatient mental health, and in working with people with severe and persistent mental illness. The counselor ratio is approximately one full-time equivalent (FTE) for every 7,000 patients or 1.5 days per family physician per week. In other words, solo physicians will have a counselor in their offices for two or three half-days a week; a four-physician practice will usually have one full-time counselor. For psychiatrists, the ratio is half a day per month per family physician, which means a four-person practice will have a psychiatrist in the office for half a day per week. Counselors and psychiatrists are well integrated within the practice, participate in team meetings and social events, and will use the same electronic medical records as the rest of the primary care team.

Although most psychiatrists and counselors are used to seeing adults rather than children, in primary care they see patients of any age. In addition to the adult mental health program, the HFHT has also recruited three child and youth mental health workers and a child psychiatrist, as well as three addiction specialists. Because of the size of the HFHT and the number of individuals with these problems, rather than delivering much direct care, these child and addiction teams have focused more on running psycho-

educational or other support groups. They also provide information on community resources, assist with system navigation, and provide consultation advice and support (in person, by phone, or using other electronic methods) to the general primary care clinicians working in the program. All counselors may see a selective small number of complex cases for a consultation. The roles and tasks of members of the HFHT are described in Table 3.4.

Table 3.4. Roles and Tasks of Members of the Hamilton Family Health Team

#### *Counselors*

- Conduct assessments (children, adolescents, adults, families).
- Deliver short-term therapies; average 6.5 visits (supportive, behavioral, social activation, solution-focused/interpersonal therapy, and cognitive-behavioral therapy) in a “shared care” model.
- Run groups (e.g., stress management for women, self-esteem, depression education, marital counseling).
- For selected cases, serve as a case manager or care coordinator.
- Assist individuals and families in navigating the system and accessing community and other resources.
- Support family physicians through case discussion, providing information on resources, and providing ongoing care in a shared care model.
- Establish and enhance links between primary care and mental health services.
- Treat or advise predominantly about depression; anxiety; situational problems; trauma; addictions; workplace, stress, family, or marital issues; finances or housing problems.
- Participate in other program activities as appropriate.

#### *Psychiatrists*

- Support the family physician and counselors.
- Provide psychiatric consultation.
- Where necessary, offer follow-up visits to complete an assessment or assist in the stabilization of an individual (50% of patients are seen more than once, the average being 2.1 total visits).
- Be available to see individuals (and with their families, as needed) with enduring problems on an intermittent/as-needed basis.
- Provide addiction advice and management.
- Assist the family physician with medication management.
- Advise the team on best practices in the treatment and management of individuals (and with their families, as needed) with mental illness.
- Be available to discuss cases and provide advice on medication, management, or available resources (usually brief case-based, curbside consultations or “huddles”).
- Offer more structured, case-based educational sessions for the primary care team.
- Back up the team by phone, email, or other forms of communication.
- Encourage a population health approach.

#### *Family Physicians*

- Continue to deliver integrated physical, mental health, and addiction care, including prescribing medication.
- Participate in brief mental health discussions and a daily “huddle.”
- Available to discuss cases with the counselor and psychiatrist as needed.
- Offer agenda for mental health learning topics needed by the practice.

## *Other Team Members*

- Medical office assistants: provide relevant background information on people being seen, including observation about their behavior in the waiting area or on the phone.
- Pharmacists: review psychotropic medications, contribute to discussions of patients with complex conditions, requiring multiple medications.
- Practice nurses: manage patients with chronic or complex conditions, make referral to community agencies.
- Dietitians: provide nutrition counseling for people with mental health problems/taking psychotropic medications, screen for eating disorders and other mental health issues.

## *Central Management Team*

The Central Management Team consists of the program medical lead, manager, three administrative supports, one of whom assists with program evaluation, and leads for specialized programs (child, addictions, group) who also work in the practices.

- Program administration.
- Links with the Ontario Ministry of Health and Long-Term Care (the program's funder).
- Recruitment and preparation of counselors and psychiatrists.
- Evaluation of the counselors, including career development.
- Program evaluation.
- Helping to solve problems that arise in a practice.
- Building partnership with community organizations.
- Overseeing any additional research projects.
- Assisting practices with the logistics of housing the mental health team.
- Providing educational resources and information on community programs to the practices.

## Data from the Program's Evaluation

The Hamilton program has significantly improved access to mental health services.<sup>19</sup> Today, family physicians refer approximately 11 times as many individuals for a general mental health assessment as they did before the program began and this improvement has been maintained over 20 years. The program has reduced both the number of mental health inpatient admissions and the length of stay for patients in the caseload of physicians in the program. It has also demonstrated continuing and significant improvement in measures of both mood, using the Center for Epidemiological Studies Depression (CES-D)<sup>20</sup> scale, and overall functioning, using the Short Form-8 (SF8).<sup>21</sup>

The Hamilton Program patients have given the service high ratings. They appreciate the shorter wait times, convenience of being seen closer to home, feel less stigma, and that their physical and emotional care is better coordinated. There is also a high level of satisfaction on the part of counselors, psychiatrists, and family physicians. Family physicians feel the program has increased their comfort and confidence in assessing and managing a broad range of mental health problems in their offices. The program has become a prototype for other family health teams in Ontario and elsewhere.

## Competencies for Mental Health Providers Working in Primary Care

For successful collaboration, mental health personnel need to remember they are “guests” in someone else’s home. They need to be both respectful and flexible, and understand that in primary care, their working conditions and practice styles will differ from a mental health setting. They need to be open to learning about new ways to practice, and avoid assuming that primary care must adapt to incorporate them and their skills. They must also be willing to learn about the demands of primary care and its possibilities and limitations in delivering comprehensive mental health care.

Building personal contacts is a key to successful partnerships; counselors and psychiatrists are more successful when they invest

time in getting to know their primary care colleagues. Often the informal contacts, brief conversations, and “hallway discussions” are the most helpful for family physicians.

Mental health professionals also need to be able to unpack their skills and adapt them to the demands of primary care. For example, it may be unrealistic for a counselor to devote 16 weeks to a single patient for cognitive-behavioral therapy (CBT) if the goal is to promote access and patient flow. In contrast, short-term approaches to CBT and solution-focused therapy have demonstrated their efficacy within five sessions.<sup>22</sup>

Mental health professionals need to be willing to see a wide range of problems and populations, including children, teens, and seniors. They must possess the skills to deliver interventions, individually tailored to the skills and interests of each family physician, and provide education that is specific, focused, brief, and problem/case-based to fit with the timeframe of a family physician’s day. Mental health providers need to write succinct notes without repeating known history, develop and document a treatment plan, and suggest contingencies in case the plan does not work. The well developed collaborative model reveals a shared relationship between providers and team members that recognizes complementary knowledge, expertise, and conceptual models.

The Hamilton Program meets all of Whitebird’s nine criteria for a successful integrated program. The counselor is always onsite and well integrated within the team. Expectations are spelled out by the central program team, laying down the program’s framework and ensuring that the FHT leadership remains aware and supportive of the project’s goals. Face to face referrals and case feedback, preferred by the family physicians foster physician buy-in and champions of the program.

## Successes and Challenges

### Successes

The Hamilton Program has been extremely successful in its primary goal, improving access to mental health care, and in providing opportunities for earlier detection and intervention, as well as relapse prevention. It has also been able to expand the range of available services in primary care, both through the activities of the mental health team and through an increase in the confidence and skills of family physicians in managing mental health problems. Developing groups to meet the needs of a variety of different populations has also expanded the range of available services in an effective and efficient manner.

The program has also been successful in using case-based learning to increase the skills and competence of participating family physicians, through discussion about individual patients and through more formally organized CME workshops, presentations, or conferences geared to the demands of primary care.<sup>23</sup> Because the mental health practitioner is present in the primary care setting, new opportunities for learning open up, building on these three principles.

Any case being seen or discussed in consultation presents educational opportunities. While usually brief and focused on the case at hand, often the formulations, treatment decisions, and management strategies can be generalized to other cases. For example, it is an educational opportunity for the family physician when the mental health provider gives reasons for choosing a particular antidepressant for a senior or explains differences in the ways that depression can present in adolescents. This kind of shared training can be reinforced through regular (usually monthly) meetings to discuss or review cases that are in the family physicians caseload, or cases they are finding challenging.

The mental health team is also able to provide links to readily useable online materials (e.g., a book with self-management skills for someone who is depressed) and can offer in-office educational presentations on a specific topic chosen by the primary care team. As well as being case-based, these can also teach new skills, including brief therapies that can be used in primary care, the introduction of standardized approaches, such as screening instruments, management guidelines, or information on community programs. The program also makes sure these are accessible either through individual electronic medical records or via a single accessible web-based location. Through the recommendations and advice of the psychiatrist and mental health counselors, evidence-informed guidelines are introduced into primary care.

The Hamilton Program has also helped practices build linkages with the rest of the health care system, better integrating primary mental health within the local mental health and addiction system, and also in building partnerships with community agencies and local schools. In some cases, the primary care practice is visited by community agency staff, such as child protection workers or community nurses. These linkages are often facilitated by the mental health counselors, who are able to assist with program information and with system navigation.

Overall, the Hamilton Program has provided a model for other programs in Ontario, in Canada, and internationally, whose leaders have come to Hamilton to learn from the program's experience and see how it functions on a day-to-day basis. It has also provided an invaluable training experience for psychiatry residents and other learners who are interested in making this type of practice a part of their careers.

## Challenges

The Hamilton Program has also faced some challenges. Many of these relate to its size and the logistics of supporting activities in over 80 unique clinical settings. Finding space for the counselors (along with other allied health professionals working in that practice) can also be difficult in smaller practices.

As the program has expanded, recruitment of psychiatrists to meet the needs of all the practices, particularly with the large number of solo physician practices in the program, has been a challenge. Most psychiatrists work only part-time (one to three half-days a week) in the program, and while the total psychiatry complement required is only five FTEs, this often requires as many as 15 psychiatrists interested in working in the program.

With such a large number of counselors involved in the program (close to 75, many of whom also work part-time), maintaining consistent standards of practice can also be a challenge. Consequently, it has not been easy to introduce standardized evidence-informed treatment approaches within all practices, or to introduce progress and outcomes measures used by every counselor.

Shifting from an individually focused model to integrating population approaches with individual treatment, something many practices are slowly moving toward, is an additional challenge.

## Implementing a Collaborative Project

Any collaborative project needs to be a joint endeavor from the outset, rather than one party approaching the other with predetermined ideas for the project. Shared ownership increases acceptance, and enables all parties to contribute their ideas and understanding to the eventual program. Partners need to begin by talking about the problems from their respective frames of reference, and work to understand the root causes of these problems. They can then identify their needs and discuss possible solutions. At this point, they may be ready to agree on specific goals for the project, but they may also need to bring these back to their own organizations to make sure there is buy-in from everyone involved. Each partner needs an opportunity to contribute additional suggestions when shaping the direction of the project. The importance of starting with a shared common purpose cannot be overstated. Each organization will also identify a liaison person, who will work with his or her counterpart around implementation. The organization may also wish to set up a small steering committee to oversee the project, especially in its early stages. The next step is to clarify the details of the new initiative, define how it will work on a daily basis, and explore its potential implications for everyone involved. It should be evidence-informed and draw on the experiences of similar programs in other settings, while adapting the learning to the local context. Roles of key participants need to be clarified, expectations spelled out, and criteria for measuring the success of the project determined. It is important to identify the "champions" for the project. Implementation can be effective when gradually introduced, so the impact can be measured and, where necessary, adjustments made along the way. If multiple components are to be introduced, they should be introduced one at a time so that the impact of each can be assessed or measured before the next is put in place. The steering committee should continue to meet to adjust the project based upon lessons learned and look at how the initial gains can be maintained, built upon, and spread to other colleagues.

## Advice to Others

Primary mental health care is not simply the delivery of mental health care in a primary care setting. The language, culture, time frame, and kinds of problems being seen in primary care differ from secondary care, and require mental health providers to be able to unpack their skills, approaches, and language and translate them to make them relevant to the world of primary care and general medical settings. MHPs working in primary care need to be able to adapt their skills and knowledge to the demands and realities of each individual physician or practice, rather than replicating the same thing in every office.

It is also impossible to overstate the importance of addressing children's mental health needs, and using the opportunities that arise in primary care to change the trajectory for children with multiple risk factors or who are coping with the consequence of adverse or traumatic events.

A practice always needs to examine whether staff are working at the highest scope of their training, because doing so will increase staff satisfaction as well as broaden the range of available services. One of the best ways to assess this is to ask primary care staff how they might raise their capabilities for delivering mental health care.

Organizationally, there needs to be a shared common purpose for any collaborative project, and agreed-upon goals. Clarity around program and service limitations, as well as a realistic understanding by all of what providers can and cannot accomplish are more likely to support successful change.

The importance of personal contacts and building relationships between staff, fostering an understanding of each other's strengths, limitations, and interests cannot be overstated. This is aided by physical proximity of co-location. The mental health team needs to be well integrated within the practice. A mental health clinician situated in an office somewhere in the practice, who receives referrals without opportunities for shared planning and goal setting, cannot be very effective. Even small distances between staff can significantly impact the degree of collaboration within a practice. Above all, patients and families always need to be at the center of care. Their views, lived experiences, opinions, and voices must always be included in the planning, implementation and evaluation process.

One of the keys to the sustainability of collaborative mental health care is to train learners to understand the principles and practices of working in collaborative models. All Canadian psychiatry residents now need to spend 1 to 2 months working in a collaborative care experience (usually in primary care, sometimes with a community agency), in which they will refine their collaborative skills and come to appreciate the role that primary care plays in delivering mental health care. Equally important in many ways is that the psychiatric residents will learn to consider and understand the role played by primary care and to involve the family physician for all their cases.

In most family medicine programs, training in behavioral health is integrated within the family medicine unit. At McMaster University, for example, the behavioral science half-day is divided into four parts, led by a family medicine tutor and a psychiatrist who model collaboration in their relationship and in the following ways: (1) a didactic session on topics of relevance to family medicine led by the two co-tutors, who each bring their own perspective, (2) discussion of cases seen by the residents, (3) a review of tapes (audio or video) of the residents interviewing patients, and (4) an opportunity to observe the psychiatrist conducting a consultation.

## Future Steps



As collaborative care models become more accepted as mainstream practice in Canada, opportunities arise to take advantage of the potential these partnerships offer to address wider problems in the health care system. Collaborative care can reduce avoidable emergency department visits, foster earlier detection and intervention in mental health problems, and improving access and transitions between services.

There is also a gradual shift toward incorporating concepts from the quality improvement agenda into collaborative care, with an increasing focus on population health and patient-centered care. The latter also gives practices a chance to listen to the experiences of people using collaborative services and to redesign these services accordingly.

The integration of mental health workers in primary care can allow primary care teams to address a broader range of problems, such as managing individuals with complex medical conditions and multiple problems, and understanding the interactions between the different enduring conditions. Integration also enables the management of other significant problems in which primary care may be the only place where effective interventions can take place. Examples include: (1) examining the issue of poly-pharmacy, and reducing the number of medications a patient uses and (2) focusing on the needs of specific populations, such as seniors with early cognitive impairment, or, in the Hamilton Program, turning an adolescent's routine visit into a "well teen" visit.

Collaborative care has already demonstrated its potential to address populations who often underuse mental health services, including individuals residing in shelters or suffering with addictions. Collaborative care has also been adopted by Canada's military. We now need to look at how these models can meet the needs of other populations, such as refugees and other newcomers to Canada, individuals struggling with adverse childhood events, and seniors, as well as finding ways to reduce the stigma associated with the presence of a mental health problem.

There is also a need to create frameworks or networks that will promote the spread of ideas that have worked in one location to other practices and other parts of the communities or different parts of the province, to accelerate the uptake of these concepts by patients and providers.

## Box 3.2 Summary of Recommended Treatment Approaches and Relevant Evidence

Strength of recommendation taxonomy (SOR A, B, or C)

- The Collaborative Care model developed by Wayne Katon and his colleagues in Seattle is an effective model of integrated care for the treatment of depression. (SOR A)<sup>13</sup>
- There is convincing evidence from Canadian projects and from the International literature as to the short- and long-term benefits of collaborative partnerships. (SOR A)<sup>4,13,16,17</sup>
- Collaborative programs are cost-effective and can lead to reductions in health care costs through a more efficient use of medications, reduced use of other medical services (especially for people with chronic medical conditions), a more efficient use of existing resources, and a greater likelihood of a more rapid return to the workplace. (SOR C)<sup>15,16</sup>
- Integrating primary care with mental health improves access to mental health care. (SOR A)<sup>4,14,16,19</sup>
- The Hamilton program has significantly improved and maintained access to mental health services. (SOR B)<sup>19</sup>
- Whitebird et al identified nine factors that lead to effective collaboration (see Table 3.4). (SOR C)<sup>4,18</sup>
- A collaborative-care approach can reduce length of stay on inpatient mental health units. (SOR B)<sup>19</sup>
- There are examples of short-term approaches to CBT and solution-focused therapy that have demonstrated their efficacy within five sessions. (SOR A)<sup>22</sup>
- Self-management support for depression in primary care is effective. (SOR C)<sup>8</sup>

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