
Opening Doors in Primary Health Care:
Strengthening the Interface between
Mental Health and Addiction Service Providers
and Primary Health Care

Final Report

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Prepared by

Addictions Ontario

Canadian Mental Health Association, Ontario

**Ontario Federation of Community Mental Health and Addiction
Programs**

with the support of the Centre for Addiction and Mental Health

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A. PREFACE

This document has been written and produced through the joint efforts of the Ontario Federation of Community Mental Health and Addiction Programs and the Canadian Mental Health Association, Ontario, and with the support of the Centre for Addiction and Mental Health and Addictions Ontario.

The Ontario Federation of Community Mental Health and Addiction Programs (OFCMHAP)

OFCMHAP brings together more than 200 community mental health and addiction services in the province of Ontario to help members provide effective, high-quality services through information-sharing, education, advocacy and united effort. Since 1988, the Federation has envisioned a community mental health and addiction system that is accessible, flexible, comprehensive and responsive to the needs of individuals, families and communities, shaped by many partnerships, dignity and accountability to those it serves.

Canadian Mental Health Association, Ontario

CMHA Ontario is a not-for-profit, charitable organization committed to improving services and supports for people with mental illness and their families, and to the promotion of mental health. CMHA, Ontario achieves its mission through applied research and policy analysis, advice on health system improvement, knowledge transfer and advocating for healthy public policy and an effective and efficient health system. Our 33 branches deliver community-based mental health services across the province.

Centre for Addiction and Mental Health (CAMH)

CAMH is Canada's largest mental health and addiction teaching hospital, as well as one of the world's leading research centres in the area of addiction and mental health. CAMH is fully affiliated with the University of Toronto, and is a Pan American Health Organization/World Health Organization Collaborating Centre. CAMH works to transform the lives of people affected by addiction and mental illness by applying the latest in scientific advances through integrated and compassionate clinical practice, health promotion, education and research.

Addictions Ontario (AO)

AO, formerly The Alcohol and Drug Recovery Association of Ontario, is a non-profit, charitable association that works with and for its members to provide the best possible addiction services for the people of Ontario.

Acknowledgements:

We gratefully acknowledge the contributions of experts and thought leaders from the Ontario mental health, addiction, and primary health care systems who provided information and advice, and the assistance of the Canadian Centre for Substance Abuse, which provided source documents for review

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B. INTRODUCTION

Let us recognize that there can be no health without mental health.¹

It's time to clear the air – addiction is a disease, and those who suffer with it need medical assistance just as those who suffer from heart disease or cancer.²

Despite these widely held beliefs, we have, historically, structured our health care system, and delivered services as if mental health and addiction problems were separate and distinct from other health conditions, and as if they could be treated effectively in isolation.

The result?

For too many years, people with mental illnesses or addictions have been marginalized and stigmatized. Mental health and addiction services have been the distant cousins of the health care system: planned and managed separately from other health services.³

The new 10-year Mental Health and Addiction Strategy that is currently under development signals the intention of the Ministry of Health and Long-Term Care to move away from the siloed approach that created that “distant cousin” relationship. With the publication of Every Door Is the Right Door, the MOHLTC has committed to an approach that:

... aims to integrate people with mental health and addictions into their communities, and to integrate mental health and addiction services with the rest of the health care system – to make every door the right door.⁴

Our organizations applaud the MOHLTC for that bold commitment. At the same time, we believe that there are a number of issues that must be addressed before linkages with the rest of the health care system, and specifically with primary health care (PHC) providers, can be improved. Further, we wish to suggest strategies which, we believe, are essential to the realization of the future envisioned for Ontario – one in which:

- Prevention and early identification are priorities
- Care is proactive and ongoing
- Providers and programs work collaboratively
- Services are integrated and coordinated
- Individuals are supported to lead their own recovery and to provide peer support for others.⁵

There is ample evidence to suggest that enhancing collaboration among the sectors can result in "...better health, improved access to services, more efficient use of resources, and better satisfaction for both patients and providers".⁶ It can facilitate delivery of the 'right services' by the 'right people' at the 'right time', and thus reduce the risks and impacts of the many other health conditions associated with addiction and mental illness.

Achieving those objectives will require bold action and unwavering commitment. Government must be prepared to promote, support, and, if necessary, mandate, fundamental changes in the operation of this province's mental health, addiction, and primary health care systems. The time is right for this endeavour.

This province has set a path which is consistent with the directions defined at the national level by both the Mental Health Commission of Canada⁷ and the National Treatment Strategy Working Group⁸ as well as many other planning, policy, and research bodies both here and abroad. The challenges, issues and strategies at the interface between PHC and mental health/addiction services are consistent across Canadian and international jurisdictions.

Those issues and strategies, the lessons learned through recent projects, studies and reports and advice from experts and key stakeholder groups, have informed the content of this document and the recommendations we present. Together, our organizations believe that we can help the government of Ontario achieve the goals to which it is committed, that is:

- Identify mental illnesses and addictions early and intervene appropriately.
- Provide high quality, effective, integrated, culturally competent, person-directed services and supports for Ontarians with mild to complex mental illnesses and/or addictions.⁹

We present this report in support of that commitment.

C. SOURCES OF INFORMATION

The purpose of this document is to provide recommendations and background information that will enable planners and funders to support a strengthened interface between PHC and addiction/mental health providers. Information obtained from the following sources was analyzed to develop our recommendations:

Reviews of relevant literature

Significant work has already been done in Canada and elsewhere to identify barriers and enablers of collaboration between PHC and other sectors. We reviewed the literature that speaks to the interface between PHC and mental health or addiction providers, as well as general guidelines for collaboration, to identify gaps, barriers, enablers, and promising practices. The literature reviews completed as background to this document are provided in Appendices: I (Mental Health and Primary Health Care) and II (Addiction and Primary health Care).

Interviews with key informants

Ten key informants with interest and expertise in primary health care, mental health, and addiction services were interviewed using a structured interview guide. The goal of those interviews was to obtain broad perspectives on the current state of the interface, barriers and challenges, enablers, and priority actions. The list of key informants and the interview guide are provided in Appendices V and VI respectively.

Consultation meeting

A roundtable discussion was held with a broad cross-section of stakeholders to obtain their input about strategies to meet Ontario's challenges. Thought leaders and champions from the primary health care, mental health, and addiction sectors were invited to a presentation of preliminary findings and a discussion of strategies to meet those challenges. The notes from the Roundtable discussion and a list of attendees are provided in Appendices III and IV respectively.

D. THE REALITY AND THE VISION

“Ontario has a fragmented system of services. People go through too many doors and struggle finding the services they need. In most cases, services are not integrated. They do not work together to meet people’s needs.”¹⁰

As the MOHLTC has noted, there is a considerable distance between our current approach to the delivery of health care in Ontario and the integrated, coordinated system we envision. As a result, there is also a significant gap between the outcomes we achieve and those to which we aspire – for the system as a whole and, most importantly, for the people who rely on it.

The Current Reality

For many people in Ontario with mental health and addiction problems, the fundamental challenge is not inadequate care, or uncoordinated care – it is gaining access to any care at all.¹¹

All Ontarians need and expect high quality primary health care. At present, however, many people have difficulty accessing that care – for those with mental health and addiction problems the challenge can be even more significant.

People who have mental health or addiction problems may present with a complex range of health care needs. As documented in the literature, physical co-morbidities are extremely common.

- Alcohol is a known risk factor for accidental injury and many illnesses¹² and the use of other drugs is also a well-established risk factor for a variety of illnesses and physical conditions (e.g. infectious diseases such as HIV/AIDS, Hepatitis, and STDs).¹³
- People with diagnosable substance abuse and dependence ... present with an even more complex morbidity profile¹⁴ and the risk of early mortality in these populations is also well established.¹⁵
- Similarly, there is no shortage of evidence to show that many mental illnesses are closely linked to physical illnesses¹⁶ (e.g. diabetes, lung diseases, and liver problems¹⁷).
- Individuals with serious mental illnesses living in the community have age-related mortality rates 2.4 times the rate for the general population. Additionally, it is estimated that 35% of individuals with serious mental disorders have at least one undiagnosed medical disorder.¹⁸

In a system in which PHC services are in short supply, providers may be reluctant to accept patients whose needs they perceive as complex and time-consuming, or those who they perceive as ‘unmotivated’ or ‘hopeless’.¹⁹ Given the prevalence of co-morbid physical illness among people who have an addiction or mental illness, an ongoing lack of primary health care is all too likely to result in significant burdens of illness for individuals and families, and significant costs for the health care system.

Even people who do have PHC providers may be reluctant to ask them for assistance with mental health and addiction problems due to the persistent stigma that surrounds those issues. In one study of 1440 individuals who had a primary health care provider and who were undergoing substance abuse treatment, 45% reported that their primary health care provider was unaware of their substance abuse.²⁰ The MOHLTC notes that:

*Only one-third of people with a mental illness or addiction seek help: the stigma of mental illness and addiction keeps many people from asking for help; most people do not know where to get help.*²¹

Indeed, “stopping stigma” is one of seven directions on the MOHLTC’s critical path toward “making every door the right door”.²² In identifying stigma and discrimination as major issues to be addressed, the MOHLTC is echoing concerns expressed by both the Mental Health Commission of Canada (MHCC) and the National Treatment Strategy Working Group (NTSWG). Addressing negative attitudes and misconceptions among PHC providers is critically important since they are usually the first, and often the only, contact for people living with addiction and mental health problems:

*While many people with mental illness and/or addictions may not seek help for these problems, they do see family health providers for other health reasons. During those visits, family health providers have the opportunity to promote mental health, screen for signs of mental illness or addiction, identify people at risk, provide supports, and make the appropriate referrals.*²³

People who do have access to primary health care may fare no better in obtaining help with mental health or addiction problems because PHC providers may be reluctant or unable to assist their patients in dealing with those issues. Providers themselves suggest that barriers to identification and care arise from at least six factors:

- The PHC system is designed to deliver care that is episodic, sporadic and focused on acute issues, rather than to provide the continuous care required for recovery from addiction and mental illness.
- PHC providers are reluctant to open a “Pandora’s Box” if they are uncertain how to proceed once it is open.
- They may lack confidence in their own knowledge of mental health and addiction issues and in their ability to intervene appropriately.
- Their payment structures do not allow them sufficient time (or sufficient compensation, if they take the time required) to deal with complex issues.
- They are unfamiliar with mental health and addiction systems and unaware of the information resources which would help them find the services their patients need.
- Many do not understand the structure, orientation and approaches of community-based mental health and addiction services, and consequently may prefer to make referrals to services delivered by psychiatrists, with whose orientation and approach they are more familiar.

Even when PHC providers are both willing and able to deal with mental health and addiction issues, and to refer to a mental health or addiction program when appropriate, people may be unable to access mental health and addiction services. Lack of funding support has resulted in lack of capacity and lengthy wait times in both the community mental health and addiction systems.

While mental health and addictions account for roughly 13% of death, disability and illness, it receives only 5% of Canadian public health care expenditure. Relative to other OECD countries, Canadian proportion of health care spending in this area is low, and relative to other Canadian provinces, Ontario's spending is low.²⁴

For people who do, ultimately, make their way into the community mental health or addiction systems, the experience may still be far from ideal. Without a solid working relationship between PHC providers and those systems, care is likely to be uncoordinated at best. At worst, providers may work at cross purposes, deliver mixed messages and pursue incompatible outcomes. Continuity and coordination between community mental health/addiction services and PHC providers is often impeded by:

- Differences in the professional culture and values base of the various provider groups, and among the sectors.
- A lack of understanding and, as a result, a lack of appreciation and respect among professional groups for each other's orientation, skills, and approaches.
- Poor collaboration skills on the part of service providers, and the lack of infrastructure to support collaboration.
- Inadequate time for consultation and joint planning.
- Policies and procedures which do not support collaborative approaches.

Additionally, communication between PHC providers and mental health/addiction agencies may be undermined by issues such as:

- Barriers (both real or perceived) related to limits on the sharing of personal health information imposed by the Personal Health Information Protection Act (PHIPA).
- Inadequate access to effective communication technologies and shared information systems.
- The preference on the part of some clients for limiting PHC access to information about their mental health and addiction issues.

The Costs

Our current reality brings with it significant costs – for the population as a whole, for people with diagnosed mental health and addiction problems, and for Ontario’s health care system itself.

Because we fail to screen, we miss critical opportunities to identify mental health and addiction problems in their earlier stages and, consequently, to reduce the risks and harms that accumulate when those conditions remain untreated. Those harms may include:

- Chronic illness, infectious disease, accident and injury
- Negative impacts on families and communities
- Loss of income and productivity
- Social instability, victimization and trauma, criminal justice involvement
- Premature death and suicide

If a PHC provider is unable to refer a patient to appropriate services and supports, for whatever reason:

- Those risks and harms increase
- Opportunities for secondary prevention are lost and recovery is impeded
- The PHC provider may lose motivation to identify and refer in future
- Otherwise avoidable health care and social costs accrue and accelerate
- Emergency rooms are overburdened with issues that could, and should be managed more effectively elsewhere

The human and social costs continue to mount – for the individual, for the family and for the community:

In total, mental illnesses and addictions cost Ontario at least \$39B a year – not including the overwhelming emotional costs to people with lived experience and their families and friends that we simply cannot measure.²⁵

Our Vision for the Future

All doors in the mental health and addiction system and the broader health, children and youth, education, social services, housing, seniors services, settlement services and justice systems lead to integrated, accessible, person-directed services and supports. Services focus on the hopes and needs of people with mental illness and/or addictions, and engage them in their own health and care.²⁶

Like the MOHLTC, our organizations imagine a future in which services are integrated, accessible and person-directed. Further, we aspire to a reality in which:

- Everyone in the province has access to a PHC provider.
- PHC providers understand that mental illness and addictions are health problems like any other, and embrace their responsibility to deal with those issues willingly, and with confidence, in collaboration with community mental health and addiction services.
- Universal screening for mental health and addiction problems is an integral part of 'every day' practice in primary health care.
- PHC providers have the knowledge, time, and resources required to screen and provide brief intervention with respect to mental illness and addictions.
- PHC providers understand the structure, orientation, and philosophy of the mental health and addiction systems, and have ready access to information about the services available to treat mental health and addiction issues.
- Funding increases in the community mental health and addiction systems result in reduced wait times and enhanced access to an appropriate range of community mental health and addiction services.
- Both PHC providers and mental health and addiction agencies see collaboration as a central pillar of their mandate and appreciate the benefits of collaboration to health outcomes.
- All providers (PHC, mental health and addictions) have the skills required to collaborate.
- The role of consumers/clients/patients in directing their own recovery is supported by all providers.
- The contribution of mutual aid groups and the often critical role played by families is recognized and supported.
- Both real and perceived impediments to the sharing of personal health information have been resolved.
- Administrative structures and processes enhance, rather than impede, collaboration.
- Information technology facilitates communication among providers.

The Benefits

There will be costs involved – both human and financial – in making that vision a reality. In the long-term, however, the benefits which will accrue will provide a more than adequate return on investment.²⁷

In addition to potential cost savings there are at least two other significant advantages related to improved collaboration between Ontario's primary health care, mental health, and addictions sectors.

Stronger links between the two sectors will mean more effective use of the skills of both family health providers and mental health and addiction specialists and shorter wait times for services.²⁸

Better collaboration and communication among services and service providers can help people get the care they need more easily and quickly...²⁹

To reap those benefits, we must abandon the beliefs and practices that impede collaboration between the sectors and learn new skills; we must invest in new tools and resources; we must adjust processes, systems and policies – and, according to the MOHLTC:

To make every door the right door for people with mental illness and/or addictions, the system must change. We must work differently, offer services in different ways, develop new skills and attitudes, and forge stronger partnerships between sectors and between service users and service providers.³⁰

E. CHALLENGES

The interface between primary health care and other health services has been the focus of numerous studies and initiatives in Canada and internationally. The literature provides a critical mass of information about the issues that must be considered in strengthening that interface and developing collaborative service relationships. This section provides a summary of the most significant challenges identified in the literature and corroborated by the advice of thought leaders and experts from Ontario's health care system:

1. Lack of Screening and Brief Intervention
2. Barriers to Referral
3. Impact of Stigma and Discrimination
4. Knowledge and Training Needs
5. Inter-professional Relationship, Trust and Respect
6. Professional Regulation, Culture and Norms
7. Organizational Practices
8. Funding
9. Lack of Service Capacity
10. Inadequate attention to knowledge transfer and evaluation
11. Impediments to Information Sharing

Lack of Screening and Brief Intervention

PHC providers should be an accessible 'first point of contact' for people who have mental health and addiction problems, however those issues are, at present, under-recognized in PHC settings. PHC providers do not routinely ask screening questions. And when they do, they often do not use consistent evidence-based practices and tools. Several impediments to screening and identification in PHC settings have been reported:

- Insufficient education and training in mental health and addictions result in gaps in competencies and lack of confidence among PHC providers
- Consistent practice standards and protocols are not in place and validated screening tools have not been identified and/or accepted for common use
- Some PHC providers are reluctant to ask screening questions because of concerns about the possible negative impact on their relationships with patients
- Misconceptions and negative attitudes about people with mental health and addiction problems may make PHC providers less inclined to address these issues
- Physician workloads limit the amount of time available for identification and intervention ³¹

Barriers to Referral

Referral to community mental health and addiction providers is a critical next step in ensuring that people who have significant mental health and addiction problems receive the right care from the right provider at the right time. Barriers to referral were identified in three major areas:

Provider preferences:

- Some PHC providers are biased toward referral to other medical specialties or specialized physicians, rather than to community resources whose approaches and standards of practices they may not understand.

Lack of information about how to access community mental health and addiction services:

- Some PHC providers are confused by the structure of the mental health and addiction systems, and frustrated by the variability of admission criteria.
- Physicians emphasize that, to be usable, information about services needs to be readily available and accessible within a very brief time frame.

Difficulties in obtaining timely access to services in the community mental health and addiction sector because of:

- Wait times: Patients who are referred to services may 'lose motivation' while waiting weeks or months for some types of community mental health and addiction services.
- Requirements for self-referral: PHC providers are concerned that patients will fail to follow up if required to self-refer.
- Lack of services for mild and moderate mental health problems: Since community mental health services are mandated to serve people who have serious and persistent mental illness, patients with mild to moderate mental health problems may not meet the admission criteria for those services.

Impact of Stigma and Discrimination

People seeking help for mental illness or addiction concerns experience some of the most deeply felt stigma and discrimination from health care professionals.³² Some individuals have had profoundly negative experiences with PHC providers – for example: being perceived without justification as incapable or 'not competent'; or having their health concerns dismissed or misdiagnosed. As a result, some consumers are reluctant to disclose mental health and addiction issues. Others are hesitant to obtain services at locations identified as community mental health and addiction agencies because they fear being labeled as 'addicted' or 'mentally ill'.

Many physicians and other PHC providers see addiction and mental health issues as a 'Pandora's box' which they are reluctant to 'open' if they are not confident that they can provide

appropriate assistance or referral. Many hold the biases and preconceptions commonly found in society – examples include:

- people with mental health and/or addiction problems are overly complex, difficult, manipulative, unmanageable, or ‘stuck’
- working with people who have troubled, chaotic lifestyles will be time consuming with little reward
- substance use problems are a ‘moral failing’ or result from lack of ‘will power’
- people with serious mental illness or addiction are not capable of making decisions about their own health care or participating in their own recovery

Stigma can also impact the way in which service providers mandated to deliver mental health and addiction services are perceived by PHC. Negative attitudes and beliefs about mental health/addiction services may preclude effective collaboration with community providers. Moreover, the historic disconnection of mental health and addiction services from the rest of the health care system can perpetuate stigma by reinforcing the misconception that mental illness and addictions are different from other health problems and somehow shameful.

Knowledge and Training Needs

Professional education immerses students in the philosophies, values, and basic theoretical perspectives inherent to their own professions. Historically, health care professionals have been educated in relative isolation from other disciplines. PHC providers acknowledge that their professional education did not provide them with adequate information about clinical issues, practices, and approaches related to addiction and mental illness.

Inter-professional approaches have not traditionally been utilized as a strategy for either professional education or subsequent training. As a result, health care providers do not learn about the expertise, responsibilities, skills, values and theoretical perspectives of other disciplines. Nor do they have adequate opportunities to participate in multi-disciplinary teams and to develop the collaboration skills that would result from that experience. Health professionals who lack an understanding and appreciation of the contribution of other disciplines, and who have little experience with inter-disciplinary teams, are ill-equipped to sustain collaborative relationships.

Inter-professional Relationships, Trust and Respect

Mutual trust and respect within inter-professional teams have been identified as key determinants of successful collaboration³³. Initiatives such as EnHANCE³⁴ have been designed to foster improved relationships and, consequently, have significant potential to assist PHC, mental health, and addiction providers in overcoming current barriers.

Currently, in the PHC system:

- Most providers appear to be poorly informed about the roles, training, and regulation of staff in community mental health and addictions agencies. As a result, they may lack

confidence in the competencies of those staff and the quality of care provided by agencies.

- Nor do most providers understand the recovery principles and harm reduction approaches that are so central to community mental health and addiction programs. Some PHC providers see involvement and empowerment of consumers/clients as antithetical to professionalism and/or to the use of evidence-based practices.

Similarly, in the community mental health and addiction systems:

- Negative or cautious views of the ‘medical model’ held by some community providers can lead to their lack of appreciation and respect for the important role that PHC can play for people who have mental health or addiction issues, or reluctance to communicate with PHC providers.
- Some of these views have their origin in the stigma and discrimination experienced in medical services by consumers, families, and staff of mental health/addiction services. Others reflect their concerns that medically-based services will undermine recovery by failing to consider the important impacts of psycho-social factors and determinants of health. Among some addiction sector providers, concerns about physicians’ prescribing practices can lead to negative attitudes.

Professional Regulation, Culture, and Norms

The cultures, norms, and regulation of professional disciplines can also have a significant impact on the quality of the interface among professional groups.

- Each of the regulatory colleges oversees its respective health discipline and defines its scope of practice. Although those functions are critical to determining the boundaries within which each profession can practice, they can also serve as barriers to collaboration by controlling occupational “turf” rather than facilitating integration.
- Historically, the professional culture of some disciplines has valued autonomy and control over interdependence and teamwork – skills required to function effectively as part of an inter-disciplinary team.
- Further, physicians may be less inclined to refer to and collaborate with non-medical specialists (i.e. community mental health and addiction services) because their training focused primarily on service relationships with other physicians
- They may also find it challenging to work as members of interdisciplinary teams, and to shift from self-employment to team-based structures, since many are accustomed to one-to-one consultation relationships with specialists or other health care providers.
- Finally, some PHC providers express concern about potential liability issues that could arise from their involvement in multidisciplinary teams or cross-organizational partnerships.

Organizational Practices

Although critically important, individual attitudes alone do not create the conditions necessary for success – collaboration most often occurs in a larger organizational context, with practices, policies, and cultures that may or may not be supportive of collaborative approaches.

Differing modalities and philosophies of service, lack of consistency in record-keeping policies and procedures, and incompatible information-sharing practices and inconsistent strategies for ensuring confidentiality can all present barriers to working effectively across sectors.

Funding

Health care funding structures have not been designed to support collaboration.

Currently, in the PHC system:

- Few physician compensation mechanisms provide remuneration for consultation and collaboration, and few primary health care providers have the resources necessary to purchase services from other health disciplines or from community mental health or addiction agencies.
- Concerns have been expressed about the negative impacts of rostering models that encourage physicians to sign up ‘healthy patients’ rather than those who require more attention and, as a result, more time. Some reports also suggest that, while family health teams with mental health and addiction components may increase access for middle class or high functioning patients, even that model marginalizes those who are most vulnerable and whose needs are most complex.³⁵
- Consequently, most of the existing PHC compensation models fail to promote or adequately support the provision of care to patients who have mental health and addiction issues and the complex care needs that often result.

In the community addiction and mental health system:

- Many mental health and addiction agencies report that their budgets will not allow them to provide consultation or clinical supports to PHC providers, or to free up time for important activities like joint planning and training.
- Most agencies report that their current resources are fully committed to provision of direct services and stretched to the limit as a result of historical underfunding.

Moreover, in both the PHC and community mental health/addiction sectors, collaboration and integrated practice is further undermined by the artificial divisions that result from historic funding ‘silos’ and the absence of integrated planning and accountability structures. The planning, monitoring, and funding of community addiction and mental health services are within the jurisdiction of Local Health Integration Networks (LHINs), while most primary health care services are outside of LHIN responsibility. Disparate performance mandates and service targets make it even more difficult to harmonize practices, bring stakeholders together, and address funding and resource issues between the sectors.

Lack of Service Capacity

Efforts to coordinate services and build collaborative relationships have been further confounded by inadequate service capacity in both the PHC and the mental health and addiction systems.

Ontario's primary health care system is reported to be at full capacity.³⁶

- The government of Ontario has made efforts to address capacity issues by increasing physician supply and funding nurse practitioner-led clinics, however, primary health care services remain in short supply in many areas of the province. Within the array of PHC models, inter-professional teams that incorporate mental health and addiction expertise remain relatively rare. Although advances have been made in inter-professional practices through the funding of innovative models such as Family Health Teams and Community Health Centres (CHCs), solo physician practice remains the most common method of delivering primary health care. Many solo practices have little or no access to mental health/addiction consultation or in-house clinical services.
- Lack of capacity in the PHC system means that some Ontario residents are unable to obtain primary health care from either a physician or nurse-practitioner-led practice. Workload pressures experienced by PHC providers can further restrict the amount of time available for screening with respect to mental health and addictions and for training, collaboration, and delivery of mental health and addiction-related services.

There are also significant capacity issues in the community mental health and addiction system. As a result:

- In some communities, an appropriate range of service types is simply not available.
- In others, community mental health and addiction agencies do not have adequate resources to meet the needs of the communities they are mandated to serve.
- In many parts of the province, consumers/clients encounter long wait times for many types of services, including assessment.

Inadequate Attention to Knowledge Transfer and Evaluation

- Provincial training and knowledge resources to support collaboration have not been developed. Without consistent and accessible supports for knowledge development:
 - 'Have not' agencies struggle to carve out resources to ensure that staff are trained in best practices, including those that support collaboration.
 - 'Champions' and 'early adaptors' lead the way in implementing promising practices, however their successes and 'lessons learned' are not systematically disseminated.

- Lack of evaluation data further inhibits efforts to design and deliver evidence-based collaborative care practices.
 - There is a clear need for further evidence of the effectiveness of collaborative care models as well as the characteristics of collaboration arrangements that support positive health outcomes, organizational efficiency, and enhanced patient and provider satisfaction.
 - Some efforts have already been made to catalogue promising practices and assess the outcomes of collaborative models; however, comprehensive mapping, evaluation and dissemination of the resulting findings has not yet been undertaken.
 - Given these gaps in information and 'hard evidence', some stakeholders (including service providers, planners, and funders) may be hesitant to invest significant energies in the development of collaborative relationships between the sectors.

Impediments to Information Sharing

Providers must be able to exchange information in a timely and coordinated manner. Technological resources have already been developed that have significant potential to support collaboration, however those resources are not universally available, nor do organizational policies necessarily support their use.

- Significant challenges arise from current gaps in the ability of the PHC, mental health, and addiction systems to coordinate patient records and to share information.
- Issues – both real and perceived – around the collection, use and disclosure of personal health information can create barriers to information sharing among providers.
- Incompatible electronic record systems may further impede effective communication.

F. STRATEGIES

Our review of the literature identified a broad range of strategies to strengthen the interface between the PHC, mental health and addiction sectors. The thought leaders and champions with whom we consulted corroborated those findings, while also providing focused advice about what will work in Ontario, given the specific issues and challenges, and the resources and structure of the health care system in this province. This section provides a synthesis of those strategies - key elements include:

1. Providing Leadership
2. Enabling Change
3. Providing Appropriate Expectations and Incentives
4. Addressing Stigma and Discrimination
5. Involving Consumers and Families
6. Enabling Implementation of Screening, Brief Intervention and Referral (SBIR)
7. Developing Collaborative Service Approaches
8. Implementing Best Practices in Clinical Services
9. Implementing Best Practices to Support Collaboration
10. Developing Workforce Competencies
11. Developing Core Principles

Providing Leadership

Fostering a strengthened interface among sectors with widely differing histories, cultures and approaches will require significant leadership. Collaboration must be modeled 'from the top'. The work of the Select Committee, and the MOHLTC's commitment to developing a provincial Mental Health and Addiction Strategy, have already laid the foundation. Development of a strong interface will require a 'sea change' – both in how services are delivered and how systems work together. It will require that the MOHLTC articulate the important role and specific responsibilities of primary health care providers with respect to mental health and addictions, mandate collaboration between PHC and community mental health/addiction sectors, and leverage the support of the all three sectors for those newly articulated roles and responsibilities.

A sustained commitment from relevant stakeholder groups will be required to effectively drive the implementation of the new strategy. The MOHLTC can generate that commitment by engaging leadership from within the PHC, mental health, and addiction sectors to jointly shepherd the change process. Relevant stakeholder groups should be charged with collaborative development of an implementation plan, including strategies, to measure progress and evaluate outcomes.

Enabling Change

Creating a person-directed system – making every door the right door – means a shift in culture in mental health and addiction services, in the health system, and in the broader community service systems.³⁷

As part of that culture shift, PHC providers need to ‘grow into’ their role as the first point of contact for people with mental health and addiction problems, and as portals to the specialized services provided by community mental health and addiction agencies. To execute that role successfully, they must improve their ability to work effectively with those systems.

One potential strategy for enabling that change would be the application of the Chronic Disease Prevention and Management (CDPM) framework to mental health and addiction services. In adopting the CDPM framework, the MOHLTC would be building on the new culture of collaborative care that is already emerging – both in Ontario and in other jurisdictions.

Whether or not mental illness and addiction are seen as ‘chronic conditions’, there are distinct benefits to the use of a CDPM framework in developing protocols between the PHC and mental health/addiction sectors. The CDPM framework uses holistic approaches to ensure the continuity of care and multi-disciplinary linkages necessary to support improved health outcomes for people with chronic diseases. CDPM approaches have set the agenda for refocusing PHC practices – requiring changes to primary health care that include an emphasis on collaborative care, improved linkages to community resources, and enhanced support for patient self-management – all of which would add immeasurably to the care provided to those with mental health and addiction problems.

Providing Appropriate Expectations and Incentives

Like others, people who provide mental health, addiction, and primary health care services are more inclined to work collaboratively when they are mandated by their funder to do so. Including a responsibility to collaborate in the service agreements that govern transfer payment agencies would help to ensure that community addiction and mental health service providers see collaboration as an integral component of their role. At the same time, the responsibility to work collaboratively must be reflected in agreements with primary health care providers.

Once providers understand their roles and responsibilities, they must be motivated to fulfill them. Simply adding additional requirements to the already long list of expectations placed on primary health care, mental health, and addiction services is unlikely to produce the desired results. Addiction and mental health agencies must be funded to build the required infrastructure, obtain the necessary staff resources, and develop the training tools and knowledge resources required to support collaboration. Similarly, primary health care providers must be appropriately remunerated for new roles and responsibilities, using innovative funding models and payment methods that enable them to meet those expectations.

Addressing Stigma and Discrimination

As noted, stigma – among the population in general, and among health care professionals in particular – presents significant barriers to both access and collaboration. For that reason, reducing the stigma related to mental illness and addictions is a critical component of any approach to improving care. In selecting strategies to address stigma, the MOHLTC can capitalize on successful experience related to other health conditions – cancer and HIV/AIDS in particular.

Ontario can also draw on the significant body of research which demonstrates that “contact” strategies (i.e. approaches that utilize direct personal involvement with people with lived experience, including family members) are most effective in dealing with the stigma of mental illness and addictions.³⁸ To that end, clients/consumers and families must be engaged in educating and training professionals.

To change the attitudes of providers in all settings, it is important to “normalize” mental illnesses and addictions, and focus on the strengths of people with lived experience... In the fight against self-stigma, peer support initiatives play a key role, as do opportunities to participate in meaningful ways in mental health and addiction services and in the community.³⁹

Involving Consumers and Families

In addition to their role in combating stigma, people with lived experience can play a significant role in planning and directing their own care. The empowerment of consumers and families as active partners ‘at the table’ has potential to transform the very nature of care.

When people with mental illnesses and/or addictions and their families (if desired) are empowered to make informed choices, they become partners in their (own) care. To forge true partnerships between the users and providers of services, it is important to recognize the strengths, skills and knowledge that both bring to the relationship, including the provider’s clinical expertise and training and the person’s and family’s lived experience. It is also important to recognize and overcome barriers to partnerships, such as power imbalances, stigma and lack of culturally competent services.⁴⁰

The skills, knowledge, and expertise of consumers and families have, for years, been recognized as central to the development of a mental health and addiction system that meets their needs. Organizations and planning bodies in the addiction and mental health sectors are leading the way in demonstrating the significant benefits that can be gained from collaboration between professionals and people with lived experience – for example:

- The Minister’s Advisory Committee and the Mental Health Commission of Canada have both called upon people with lived experience to illuminate the issues to be addressed and to develop effective strategies and approaches for addressing them.
- Most community addiction and mental health organizations engage consumers and/or families in active roles as members of their Boards of Directors.

- Some addiction programs hire staff members who are ‘in their own recovery’ (and who have appropriate training and/or credentials).
- Consumer/survivor organizations, operated for and staffed by people with lived experience, engage in advocacy, economic development and self-help,
- Many mental health programs employ peer support staff in paid positions.
- Both addiction and mental health agencies employ volunteers with lived experience in a wide variety of roles.

Recognition of the role of people with lived experience in primary health care – and strengthening of that role across the mental health, addiction, and primary health care systems – is critical to the development of an effective interface.

Enabling Implementation of Screening, Brief Intervention, and Referral (SBIR)

Given the evidence that positive outcomes can result from screening and brief intervention for mental health and addiction issues, it was suggested that universal integration of these practices in primary health care settings is critical. Strategies to support that objective include:

- Development of standardized screening tools for implementation in all PHC settings.
- Implementation of protocols for planned interaction, provider alerts, and reminders (e.g. screening as a part of annual check-ups).
- Development of protocols for delivery of brief intervention in PHC settings, and provision of appropriate training.
- Increased use of nurses and nurse practitioner-led practices for screening and brief intervention.
- Use of technology (such as computerized screening tools) as a ‘time-saving’ resource in primary care practice.

Before SBIR strategies can be implemented in primary health care practice, they must be mandated as responsibilities of PHC providers. Once providers accept their responsibilities in identifying mental health and addiction problems, providing brief intervention, and referring to community agencies, delivery of those services will require support at the community level by models of collaboration that enable addiction and mental health agencies to provide consultation and service support to PHC providers.

Evidence also suggests that mental health and addiction providers require support to ensure identification of health care issues that may need to be addressed by PHC providers. To that end, tools are needed in community mental health and addiction agencies to enable screening for health issues and protocols for referral to primary health care providers.

Once a PHC provider has identified a patient’s need for support from a community mental health and addiction agency, that provider must then have easy access to information about the services available to meet the patient’s needs. Stakeholders from both the PHC and mental health/addictions sectors have identified strategies for facilitating access to that information. While some stakeholders have suggested that Community Care Access Centres (CCACs) may

be in a position to develop the appropriate mechanisms, others have argued in favour of utilizing and expanding services with an already proven track record in information management at the provincial level, and specialist expertise in mental health and addictions.

Every Door is the Right Door is clearly calling for an expansion of the sort of information and referral service that Connex has developed to include a much broader range of health and social service points... Other initiatives (OACCAC/InformOntario) are already proving to be inadequate, constitute an unnecessary duplication of spending, and are fragmented across the LHINs, tied to the LHINs and vulnerable in any future re-alignment of the LHINs. What is needed is a comprehensive health- and social services- database with a province-wide scope through the cost-effective expansion of the already proven ConnexOntario system.⁴¹

Whichever approach to referral is ultimately selected, wait times and gaps in community addiction and mental health services must be addressed before referrals can consistently produce the desired results. If the lack of capacity in those systems is not resolved, even the most effective strategies to facilitate referrals from PHC providers will be undermined.

Developing Collaborative Service Approaches

The research identifies two types of approaches to integrating the services of primary health care, mental health and/or substance use services.⁴² Centralized models bring providers together and allow consumers to access services at a single site, while distributive models involve active liaison between health providers in different settings. The first of these approaches can be achieved through:

- hiring of mental health and addiction specialists by multidisciplinary Primary Health Care teams, with appropriate linkages to local community mental health and addiction providers to assist in transitions or linkages to the community,
- deployment of addictions and mental health agency staff to provide regular service in solo or group PHC practices, or
- provision of PHC services as a component of mental health and addiction services.

Both approaches rely on collaboration between mental health/addiction, and PHC providers. It has been suggested, both in the literature and by 'thought leaders', that there is no 'one right' approach or singular 'best practice' for collaboration but that 'what works' will vary with the differing needs, resources and infrastructure of each community.

Local communities can draw on the extensive work already done by champions and in targeted initiatives. A variety of promising models has been identified, with new programs and pilot projects implemented or proposed at both the federal level and in Ontario itself.

At the federal level:

- The Primary Health Care Transition Fund has generated a wealth of strategies and tools that can be drawn upon to develop or enhance collaborative PHC.
- The National Treatment Strategy has developed a framework that defines the critical role of PHC services in a continuum of care for people who have substance use problems.

At the provincial level in Ontario:

- Two PHC models which are showing promising results can provide a foundation for the development of new approaches:
 - Many Family Health Teams have incorporated mental health and some have incorporated addiction services in the range of programs they provide. The development of service agreements and protocols between the FHTs and community mental health and addiction providers would strengthen inter-sectoral linkages.
 - Many Community Health Centres (CHCs) deliver mental health and addiction services. CHCs utilize best practices such as low threshold approaches, harm reduction, and attention to the determinants of health to deliver effective services for the most vulnerable members of their population who experience poverty and social disadvantage as well as significant health problems.

Whatever the model, it is critically important that strategies for strengthening the interface between the PHC, mental health, and addiction sectors build on the foundation provided by the existing system of specialty services, rather than creating a PHC system that operates in isolation or creates parallel services (e.g. through the addition of mental health or addiction specialists to Family Health Teams).

Implementing Best Practices in Clinical Services

Adherence to established best practices should be a central focus of all models, regardless of the variations required to respond to the specific needs of any given community. In the addiction sector:

Best practices in collaborative primary health care for substance use are available in abundance. They emphasize universal screening, brief interventions, assessing and managing motivation for change, close liaison with relevant specialists, integrated management of concurrent health and psychological problems, and continuity of care.⁴³

For the mental health sector, best practices have been identified by the World Health Organization (WHO). A WHO report identifies essential mental health services at the primary care level and key elements of the continuum of community and specialist mental health services that should be provided in a well-functioning health care system.⁴⁴ It provides detailed examples of best practices and outlines 10 broad principles which were derived from an analysis of best practices.

The direction of the Regulatory Health Colleges will be essential to setting clear expectations for implementation of best practices. At a minimum, their leadership will be required to set standards of practice and guidelines for:

- PHC providers in respect to mental illness and addiction (e.g. for universal screening, brief intervention, and collaboration with community addiction and mental health services)
- community addiction and mental health services in respect to primary health issues (e.g. identification, referral to PHC providers)

Implementing Best Practices to Support Collaboration

Any effort to enhance intersectoral collaboration must support the development and implementation of best practices at the organizational level, including:

- shared service protocols and common service pathways
- clear definition of roles, responsibilities, and scopes of practice for each professional participating in the collaboration, including community-based providers
- practices and mechanisms that enable sharing of information, joint planning and decision-making, and conflict resolution
- organizational, leadership and administrative support
- integrated processes for intake, referral and/or case management
- a commitment to shared care (i.e. rather than ‘handing off’ clients, providers remain engaged within their defined roles)
- co-location – which allows for an experience of “seamless” care for physical and mental health/addiction issues

Collaborative practices also require significant support at the system level. Leadership, funding, and clinical practice support needs have already been identified in this document. Support at the system level is required in several other areas, including:

- *Dissemination of promising practices:* Knowledge resources should be developed to disseminate “ideas that work”. The collection and dissemination of information about promising practices will generate interest and build on the work of ‘champions’ and ‘early adopters’.
- *Outcome evaluation:* Collaborative initiatives will only be seen to bring value when their benefits in terms of clinical outcomes and organizational success can be measured and clearly articulated. Evaluation of collaborative practices will enable practitioners, policy makers, and researchers to consolidate improvements, draw guidance based on hard information, and establish credibility to leverage further support for collaboration.
- *Learning tools:* Existing resources can also be used to promote knowledge development - learning collaboratives (such as those organized by QIIP for PHC providers) could be used to address mental health and addiction issues, and could be expanded to include professionals from addiction and mental health agencies as well as other sectors.

- *Information sharing:* The development of a provincial electronic health record could significantly enhance collaboration among service providers.
- *Liability and regulation:* Collaborative initiatives can be impeded by real and perceived professional liability issues in inter-professional practice. Regulatory Health Colleges are positioned to lead the way in addressing those issues by working with relevant government bodies.

Developing Workforce Competencies

Requiring that all PHC providers have a baseline level of expertise in mental health and addictions would help to ensure that they provide effective and appropriate care to patients who present with those issues. Strategies to develop that baseline expertise include:

- Enhanced mental health and addictions content in the curriculum of professional schools
- Recognition of addiction medicine as a specialty supported by certification processes (as it is in other jurisdictions⁴⁵) for both new graduates and currently practicing physicians.
- Accessible opportunities for continuing education, including:
 - Delivery of training and knowledge in accessible venues
 - Implementation of registration/accreditation requirements
 - Provision of incentives for training

The baseline expertise that PHC providers have developed through education and training can be augmented by skills and knowledge drawn from community addiction and mental health services (e.g. through consultation, collaborative relationships, and/or purchase of services).

For both PHC providers and others, the Regulatory Health Colleges will play a critical role in supporting the development of workforce competencies. Core clinical competency requirements and continuing education requirements for professionals working in PHC, mental health, and addiction services are required.

In addition to clinical competencies, mental health, addiction and PHC providers must develop the attitudes and skills necessary for collaboration. Professional education, clinical training and subsequent professional development should promote understanding of the complementary value of various disciplines, and support approaches that are discipline-based but not discipline-bound. The educational system represents the principal lever for promoting collaborative values among health care providers. Inter-disciplinary educational approaches and continuing education strategies that incorporate inter-professional learning can help to equip providers from all disciplines for collaboration.

Developing Core Principles

Planning and development of collaborative service relationships between community addiction and mental health agencies and PHC providers should be guided by a shared commitment to core principles. As a starting point, the following principles were identified from the literature and the input of stakeholder groups:

- Mental illness and addiction are significant health issues, and as such, must be given the same weight and attention in the PHC system as other health issues.
- People who have addiction and/or mental health problems are not a homogenous group. People's mental health and addiction needs are affected by diverse factors including: age, language, gender, race, migration, sexual orientation, culture and geographic location⁴⁶.
- Effective services – whether delivered by PHC providers or by community mental health and addiction agencies – must recognize and respond to the diversity of experience and needs presented by consumers.
- Effective services for people who have mental health and addiction problems must consider the impact of the determinants of health.
- Access to effective services is a health equity issue that must be addressed jointly by mental health, addiction, and PHC providers.⁴⁷
- Mental health, addiction, and PHC providers hold shared responsibility to ensure that the most appropriate care is provided by the 'right provider' at the 'right time'
- Community mental health/addiction services and PHC providers must work in concert with the continuum of services provided by hospitals, psychiatrists, and other health care services, as well as other systems from which people who have mental health and/or addiction problems require services.
- Enhanced health outcomes require collaboration, coordination and continuity of care among health care providers.
- 'Acting early' (i.e. through early identification and intervention) will reduce harms associated with mental illness and addiction and enhance health outcomes.
- Services are more effective when the client is actively involved in his/her own care and their ability to self-manage is respected and supported by all service providers.
- All PHC providers should have at least a baseline capacity to competently provide screening, brief intervention, and referral for mental health and addiction problems, and some should have an enhanced capacity to address those issues.

G. RECOMMENDATIONS

Our recommended actions are aligned with Ontario's anticipated directions for mental health and addictions, as articulated in *Every Door is The Right Door*. They build upon a solid foundation of lessons learned from the literature and the input received from experts within Ontario's mental health, addictions, and PHC systems.

By necessity, the approach we are recommending is comprehensive – stakeholders agree that one-off actions will not adequately address this complex issue. Consequently, our recommendations build on one another and thus must be considered as a 'whole'. They can, however be implemented using a phased approach.

We recommend that the MOHLTC:

1. Develop a policy statement with respect to mental health, addictions and primary health care.

The policy should be consistent with Ontario's Chronic Disease Prevention and Management Framework and should:

- Enshrine mental health and addictions as health issues to be addressed within the scope of PHC
- Establish principles for models of effective practice

2. Adopt a 10-year strategy to enhance the interface between the addition/mental health and primary health care systems.

The strategy should:

- Provide clear leadership and direction
- Specify actions to be taken by the MOHLTC and LHINs; Professional Colleges, certification and/or accreditation bodies; educational institutions; the primary health care system; and transfer payment agencies with respect to:
 - defining core competencies and requirements for ongoing professional development
 - identifying standards of practice
 - specifying organizational and provider mandates and expectations
 - developing funding and compensation mechanisms that support collaboration
 - setting minimum specifications for collaboration, including targets
- Convene an Implementation Group, comprised of key stakeholders representing the mental health and addiction sectors, PHC providers, regulatory colleges, government, and people with lived experience to shepherd the implementation of the new Strategy and support the fulfillment of its vision.

3. Launch a campaign to reduce stigma and discrimination on the part of PHC, mental health and addiction providers.

The campaign should:

- Utilize best practices and lessons learned from other successful anti-stigma initiatives
- Build on opportunities provided by the Opening Minds Campaign being developed by the Mental Health Commission of Canada and ensure that addiction-related stigma is addressed.

4. Provide funding to support collaboration.

- Provide time-limited funding to allow PHC and mental health/addictions providers to engage in cross-sector dialogue, build relationships and linkages, and develop shared goals and strategies at the 'ground level'
- Provide on-going funding for the instrumental supports required for collaboration and partnership (i.e. space for service delivery and team meetings, records, administration, start-up requirements)
- Compensate and/or provide incentives for PHC providers to:
 - universally implement SBIRT protocols
 - engage in consultation and case coordination with community mental health and addiction agencies
- Strengthen the capacity of the PHC system (e.g. by engaging staff from community mental health/addiction agencies to provide services in PHC settings)
- Build additional capacity in the mental health and/or addiction systems to:
 - reduce wait times and eliminate service gaps
 - enable outreach and consultation to PHC providers
 - provide services for people with mild and moderate mental illness
- Expand availability and criteria for the use of sessional fees to permit consultation from PHC providers (including nurses and nurse practitioners as well as physicians)

5. Collect and disseminate information about innovative models and promising practices.

- Engage the community mental health and addictions sectors and the PHC system to jointly develop and implement a framework for evaluation
- Evaluate models to identify their benefits (i.e. improved health outcomes and reduction of health care costs)
- Create an inventory of promising practices and evaluation results
 - disseminate information about promising practices
 - disseminate results of evaluation and research
 - support communities of practice and mentoring programs

6. Facilitate the development of working models of collaboration

- Support communities in identifying common ground and committing to joint action
- Utilize champions to spark community awareness of needs, issues, and opportunities
- Generate opportunities for knowledge exchange by fostering cross-sector and inter-disciplinary relationships
- Provide resources and tools that can be adapted to address the varying needs of each community including:
 - templates for collaboration and shared accountability (e.g. service agreements)
 - decision support tools:
 - tools and resources to facilitate communication across sectors
 - Technology resources (tele-health, shared information systems, and other technology-assisted tools)
 - procedures and tools for universal screening
 - tools and protocols for brief intervention
 - tools to facilitate referral to community mental health and addiction providers

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- ³ *Every Door is the Right Door*, Ministry of Health and Long-Term Care, 2009 (Discussion Paper) p 9
- ⁴ *Every Door is the Right Door*, Ministry of Health and Long-Term Care, 2009 (Discussion Paper) p 9
- ⁵ Peer support may take a variety of forms. It can be provided by paid peer support workers or by consumer/client volunteers; in support groups or through mutual aid/self-help programs.
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- ⁷ *Toward Recovery and Well Being: A Framework for a Mental Health Strategy for Canada*. Mental health Commission of Canada. November 2009. Accessed January 20/10 at: www.mentalhealthcommission.ca/SiteCollectionDocuments/boarddocs/15507_MHCC_EN_final.pdf
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- ⁹ *Every Door is the Right Door*, Ministry of Health and Long-Term Care, 2009 (Discussion Paper), p. 9.
- ¹⁰ *Every Door is the Right Door*, Ministry of Health and Long-Term Care, 2009 (Discussion Paper), p.11.
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¹⁹ The MHCC is sufficiently concerned about stigma and discriminatory behaviour on the part of health care providers that it has recently identified that group as one of two priority ‘targets’ for its anti-stigma initiative “Opening Minds”.

²⁰ Saitz, R.; Horton, N.J.; Winter, M.; Samet, J.H. *Primary medical care and reductions in addiction severity: a prospective cohort study*. *Addiction*. 100(1):70-78. 2005.

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²² *Every Door is the Right Door*, Ministry of Health and Long-Term Care, 2009 (Discussion paper) p. 11.

²³ *Every Door, is the Right Door*, Ministry of Health and Long-Term Care, 2009 (Discussion paper) p. 29.

²⁴ *Submission to the Select Committee on Mental Health and Addictions*, Presented by Paul Garfinkel, MD, FRCP(C), President and CEO, Centre for Addiction and Mental Health, June 3, 2009

²⁵ Centre for Addiction and Mental Health. (2006). *The Economic Cost of Mental Disorders and Alcohol, Tobacco and Illicit Drug Abuse in Ontario, 2000: A Cost of illness Study*; Alberta Mental health Board and the Institute of Health Economics. (2007). *Mental Health Economic Statistics: In your Pocket*, Alberta Canada; and Ministry of Health and Long-Term Care. (2007). *Public Expenditure Analysis* cited in *Every Door is the Right Door*, Ministry of Health and Long-Term Care, July 2009 (Discussion Paper), pp 14-15.

²⁶ *Every Door is the Right Door*, Ministry of Health and Long-Term Care, 2009 (Discussion Paper), p. 23.

²⁷ “The staggering costs of mental illness and addictions were clearly articulated in the November 2008 report of the Auditor General, costs that are multiplied in their contribution to the communities’ and individuals’ burden of illness. The possibilities for turning those costs into savings ...in health care, corrections, law enforcement, crime, and incarceration are equally impressive: spend a dollar on prevention and treatment and \$7.00 returns” (AOHC *Every Door and the Community Health Centre Model of Care: A Dynamic Synergy*, p 5)

²⁸ *Every Door is the Right Door*, Ministry of Health and Long-Term Care, 2009 (Discussion Paper), p. 36.

²⁹ *Every Door is the Right Door*, Ministry of Health and Long-Term Care, 2009 (Discussion Paper), p. 39.

³⁰ *Every Door is the Right Door*, Ministry of Health and Long-Term Care, 2009 (Discussion Paper), p. 48.

³¹ A recent publication of the Institute for Evaluative Clinical Study suggests that Ontario physicians are ‘doing more’ at each visit – as a result, many may be reluctant to add even the briefest screening activity to an already heavy workload.

³² Martin, Neasa and Valerie Johnston. *A time for Action: A Report to the Mental Health Commission of Canada*, September 2007.

³³ Findings of the Primary Health Care Transition Fund reported in: *Collaborative Care*, Health Canada, March 2007.

³⁴ The EnHANCE project is developing a range of research, evaluation, education, and other resources to support the development of inter-organizational partnerships and enhance capacity for the delivery of inter-professional care (IPC) for people seeking access to services across primary care, mental health and addiction organizations.

³⁵ The Institute for Clinical Evaluative Sciences (ICES) Atlas, Primary Care in Ontario, raises questions about both fee for service funding and capitation payment: “while fee-for-service payment systems are thought to limit the amount of time a provider spends with a client, capitation payment systems could decrease any contact. Capitation may encourage primary care providers to select healthier patients or “cream skim” unless payers are successful in adjusting budgetary allocations for more complex and ill respondents” Douglas G. et. al., *Primary Care in the Health Care System* in: Jaakkimainen L, et. al. Primary Care in Ontario: ICES Atlas. Toronto: Institute for Clinical Evaluative Sciences; 2006.

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³⁷ *Every Door is the Right Door*, Ministry of Health and Long-Term Care, 2009 (Discussion Paper), p. 49.

³⁸ Martin, Neasa and Valerie Johnston. *A time for Action: A Report to the Mental Health Commission of Canada, September 2007*.

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⁴⁰ *Every Door is the Right Door*, Ministry of Health and Long-Term Care, 2009 (Discussion Paper), pp 31-32).

⁴¹ Association of Ontario Health Centres, *Every Door and the Community Health Centre Model of Care: A Dynamic Synergy*, September 2009, pp 11-12.

⁴² A comprehensive discussion of models of integration is provided in CCMHI toolkits.

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⁴⁴ World Health Organization and World Organization of Family Doctors (Wonca), *Integrating Mental Health into Primary Care: a Global Perspective*, New York, 2008, p. 49.

⁴⁵ (Certification processes for addictions medicine are in place in Australia, New Zealand, and the United States)

⁴⁶ *Every Door is the Right Door*, Ministry of Health and Long-Term Care, 2009 (Discussion Paper), p 23

⁴⁷ *Every Door is the Right Door* emphasizes the “Ontarians and their Government believe that the health system should be guided by a commitment to equity and respect for diversity in communities in service to the people of Ontario”, p. 19.

APPENDIX I: MENTAL HEALTH AND PRIMARY HEALTH CARE

A Rapid Review of the Literature: Barriers and Opportunities in Developing the Interface between Community Mental Health and Primary Health Care

Introduction

Primary health care reform in Canada has led to considerable investigation into the provision of multidisciplinary health care (*cf.* Deber and Baumann 2005; Nolte and Tremblay 2005; Prada *et al* 2006; Watson and Wong 2005). Several research initiatives have focused on how mental health providers can support people with mental health needs within primary care settings (Craven and Bland 2006; Gagne 2005; Mulvale *et al* 2008; Minore *et al* 2005). There has been less research on how primary health care can support community mental health agencies in providing a continuum of services and supports to clients.

Community mental health agencies and primary health care practitioners can support one another in providing comprehensive and coordinated physical and mental health services and supports to people with a broad range of mental and physical health needs.

Up to 86% of family doctors in Ontario provide care for patients with serious mental illness (Arnold 2008); many may spend up to 25-50% of their workweek identifying and managing patients' psychosocial and mental health problems (Craven *et al* 1997). Yet family physicians and family medicine residents report feeling inadequately trained to provide mental health care in their practices as well as dissatisfaction with their access to mental health specialists (Kirby and Keon 2004; NPS 2007a; NPS 2007b).

Communication from the field suggests that in under-serviced communities primary health care providers may be screening out potential patients with a mental illness (CMHA 2009a). Many people with a serious mental illness also face challenges in accessing an OHIP card or making an appointment to see a health care provider, which act as barriers to care (McKee 2006).

People with physical or mental health challenges are at greater risk of experiencing a co-morbid illness (CMHA 2008a). People with mental illnesses who have access to primary health care are less likely to receive preventive health checks, access specialist care, or receive surgical treatments, yet face significantly increased risk of developing a range of chronic physical conditions (CMHA 2008a; Kisely *et al* 2007). People who experience untreated depression or anxiety alongside a chronic physical condition face worse health outcomes and illness recovery rates (Patten 1999; CMHA 2008a).

Currently, community mental health agencies are funded to provide services and support to people with serious mental illnesses. Primary care physicians may be seeing patients who have mental health challenges serious enough to hamper their functional ability, but who may not meet intake requirements for some specialist services. Providing adequate support to people with mild to moderate mental illnesses in primary health care settings has the potential to reduce demand on mental health programs, allowing them to provide more intensive or specialised care (Kates *et al* 2008.)

Developing the Interface Between Community Mental Health and Primary Care Providers

Challenges at the Service Level

Differing practice cultures, styles and modalities can preclude collaboration

Collaboration between primary health care and other health sectors is most likely to be successful when organizational and professional cultures align through a common vision (Nolte and Tremblay 2005; Mulvale *et al* 2008; Minore *et al* 2005). Differing philosophies of treatment and recovery can preclude the development of an effective collaboration or coordination of services.

A recent study of family health team collaboration with mental health services identified that physicians may find it challenging to work as a member of a collaborative team, as they are more accustomed to one-to-one consultative or practice relationships with specialists or other health care providers in their practice (Mulvale *et al* 2008). Similarly, physicians can also find it a challenge to shift from self-employment to team-based and client-driven care models (Mulvale *et al* 2008).

Differing organizational practices can also preclude successful collaboration. For example, primary health care providers tend to keep short health records, while client records kept by community mental health agencies tend to be long (Bazelon 2004). Different sectors or organizations may also have different information-sharing or confidentiality practices that may not be compatible (Bazelon 2004).

Research suggests that primary health care providers may believe that people with serious mental illness are not capable of making decisions regarding their own health care, and as a result, may not involve them in discussions about alternative treatments or weighing risks and benefits of particular courses of treatment (Everett *et al* 2008). A medical perspective on mental illness is often associated with a more pessimistic view of recovery (CAMIMH, 2007). These attitudes can preclude effective collaboration with community mental health providers, who are oriented towards a client-centred recovery approach.

Coordination and collaboration requires the support of management/leadership teams

Successful collaboration and coordination requires leadership support and management involvement (Nolte and Tremblay 2005.) A supportive management team can provide the collaboration or coordination effort with administrative support, work to minimize ideological differences across collaborating organizations, or discourage “turf wars” for clients/patients across health disciplines and organizations. This “commitment from the top” authorizes staff to set aside time to build relationships and explore collaborative functioning (Minore *et al* 2005).

Collaboration and coordination initiatives require resources and infrastructure

Collaboration and coordination requires appropriate physical space, dedicated staff at both the administrative and service delivery levels, and established processes and infrastructure (Nolte and Tremblay 2005; Mulvale *et al* 2008). The co-location of services, involving adequate and shared physical space, increases opportunities for staff from collaborating organizations to come into contact with one another, which in turn can support coordination of care (Minore *et al* 2005; Mulvale *et al* 2008).

Electronic health records are essential for improving the continuity of care and reducing duplication of services. However, introducing new health information tools can be costly to install and monitor (Deber and Baumann 2005). Small community-based agencies and solo providers may not have the resources, space or staff available for this type of infrastructure.

Collaboration and coordination activities increase workload

Collaboration and coordination among service providers can increase workload, due to the time involved in sharing information, preparing the documentation, required by regulatory bodies and funders; and collecting and reporting service statistics (Deber and Baumann 2005; Rees *et al* 2004). Primary care practitioners may not be remunerated for these additional activities. (Bazelon 2004; Everett 2008)

Historical lack of capacity is a disincentive to collaboration

If primary health care providers have historically lacked success in securing mental health services for their patients due to lack of availability; or have been hindered in accessing mental health care due to wait times, they may presume collaboration with mental health services is not feasible. Similarly, a historical lack of access to primary health care for people with mental illness can discourage mental health agencies from seeking opportunities to collaborate with primary care providers (Bazelon 2004).

Stigma is a barrier to facilitating service collaboration

People with lived experience may not want their primary care practitioner to have information about their mental health problems due to fears that physical health symptoms may be dismissed or such information may be used against them (Bazelon 2004). Consequently, individuals may not wish the two sectors to interface regarding their needs and care.

Challenges at the System Level

Regulatory and legal frameworks can discourage collaboration across disciplines

Accreditation and licensure bodies set scopes of practice and self-regulation of the various health disciplines. Implicit in the professional model is the opportunity to protect occupational 'turf'. This can serve as a barrier to collaboration (Nolte and Tremblay 2005; Watson and Wong 2005). However, research in Canada suggests the opposite - that regulatory colleges currently are promoting collaboration (Prada *et al* 2006).

Physicians have raised concerns in some jurisdictions that offering non-physician services in their practices can raise the risk of malpractice litigation if a collaborative team on which they participate underperforms (Watson and Wong 2005). This concern may be overrated - case studies suggest this may not be a major barrier to interdisciplinary care in the researched programs across Canada (Prada *et al* 2006).

Multiple policy jurisdictions impact inter-sectoral coordination and collaboration

Primary health care and community mental health services are accountable to disparate government departments. For example, the planning, monitoring and funding of community health centres (CHCs) and community mental health fall under the jurisdiction of local health integration networks (LHINs); while other Ministry of Health and Long-Term Care units provide direction for health human resources, regulation of health professionals, family health teams, nurse practitioners and physician remuneration. Mental health and primary health care services in northern communities require navigating across multiple jurisdictional policies, such as for First Nations people receiving services both on and off reserve (Minore *et al* 2005). This array of governmental departments have differing mandates, priorities, reporting and monitoring requirements that can result in barriers to collaboration. Strategies to enhance the interface between mental health and primary care providers will need to find mechanisms to address these inter-jurisdictional issues (Macfarlane, 2005).

Financing and funding mechanisms are not designed for coordination and collaboration

Most physician compensation mechanisms do not provide remuneration for consultation and collaboration. In Ontario, community mental health agencies are not funded to provide services for mild to moderate mental illnesses (Gagne, 2005). A Canadian review indicates that the majority of primary health care providers did not have adequate funding to purchase services from other health disciplines or agencies (Watson and Wong 2005).

A shortage of health human resources is both a barrier and facilitator to coordination and collaboration

Health human resources shortages are a significant barrier to facilitating the interface between primary health care and community mental health, particularly in underserved rural and northern areas (Minore *et al*. 2005). Shortages of both service providers and administrative staff make it difficult for organizations and service providers to coordinate and collaborate.

Paradoxically, human resources challenges can also facilitate collaboration as providers with high caseloads are likely less threatened by colleagues performing some of their work (Deber and Baumann 2005; Minore *et al* 2005).

Challenges in providing inter-professional education

Interdisciplinary training programs are a key recommendation for developing collaboration and coordination in both primary and mental health care (Kirby and Keon 2004). Provincial governments in Saskatchewan and Quebec have introduced programs that train primary health care providers to work in teams (Minore *et al* 2005). However, there is a lack of access to funding for continuing education for many health providers (Minore *et al* 2005). Many small community-based organizations are unable to budget for professional development activities for their staff.

Instructors in inter-professional programs also face challenges in receiving tenure, promotion, or other merit increases when their performance is measured based on assuming responsibilities in a single discipline (Watson and Wong 2005).

Addressing Challenges: Findings and Lessons Learned

Canadian

Several literature reviews have been conducted that identify key tools and strategies for successful collaboration with primary health care. Although not specific to the interface with community mental health agencies, these findings should be considered in the development of specific initiatives linking community mental health agencies with primary care providers. The findings from key Canadian reports are summarized below:

The Canadian Collaborative Mental Health Initiative (CCMHI) conducted a systematic review of the experimental literature to identify best practices in collaborative mental health care in the primary care setting (Craven and Bland 2006). The findings that are generalizable to the community mental health/primary care interface are:

- Collaborative relationships between individuals and at the system level require preparation, time and supportive structures. Staff buy-in, institutional leadership, formal policy change and performance monitoring are key to success.
- Collaboration is most likely to be most developed when clinicians are co-located and most effective when the location is familiar and non-stigmatizing for service-users.
- The degree of collaboration does not in itself appear to predict clinical outcome.
- Client outcomes are better when collaboration and treatment guidelines are combined and when systematic follow-up is included.
- Collaboration that involves changes in the way primary care providers practice should include service restructuring designed to support those changes. Collaboration alone doesn't produce enduring change in physician skill, knowledge or behaviour. Changes in service structure are needed to produce a lasting positive effect on the process of care.
- Enhanced patient education about mental disorder and their treatment (usually by a health professional other than the primary care physician) is a component of many successful studies.

The Enhancing Interdisciplinary Collaboration in Primary Health Care (EICP) Initiative's literature reviews and final case study report identified a broad range of supports and enablers for interdisciplinary collaboration in the primary health care setting. (Nolte and Tremblay 2005; Prada *et al* 2006; Deber and Baumann 2005)

- *Health Human Resources*: An effective team organization with delineated roles, responsibilities and scopes of practice is important. Training and development in interdisciplinary care protocols, practices and competencies should also be incorporated.
- *Funding and financing*: Interdisciplinary collaboration occurs when it's paid to happen. Health professionals need to be appropriately remunerated for their collaborative initiatives. Funding should include incentives and inducements to collaborate and consider the time required for primary health care collaboration to develop and provide results. It does not appear to matter which financing mechanisms are used.
- *Information and Communications Technology* greatly facilitates the provision of collaborative care. The provision of up-to-date tools such as shared health records and appointment booking mechanisms can improve continuity of care, while reducing duplication and the likelihood of adverse events.
- *Supportive institutional culture*: The endorsement and leadership of management at both the clinical and administrative levels is an important driver for collaborative care. Successful interfaces with primary health care are supported through teamwork and shared vision and goals across organizations about the purpose and anticipated outcomes of the collaboration initiative.
- *Open, transparent communication*: Honest and clear communication across collaborators builds trust and understanding about one another's roles. In particular, open communication about each team member's role may help reduce confusion or any potential competition around shared clients/patients (Nolte and Tremblay 2005). Clear decision-making processes are also critical.
- *Planning and Evaluation processes* are needed that empower staff in collaborative primary care programs to try new processes to improve service outcomes and client satisfaction.

Toward Using Family Health Teams to Care for Chronic Mental Health Clients in Northern Ontario: Barriers, Opportunities and Training Needs was an analysis of barriers and enablers impacting upon the development of collaboration between family health teams and community mental health service providers in rural and northern Ontario. The report concluded that integration strategies must be flexible to meet the composition and competencies of local service providers and local needs. (Minore *et al* 2005). Findings were categorized into four themes:

- *Resource issues* determine how and what approaches will be tried. The scarcity of human and financial resources can preclude the development of team-based care while paradoxically encouraging team-based approaches to overcome shared resource barriers.

- *Organizational factors* impact upon the development of collaboration. Organizations that foster partnership and networking through their mandates or co-locate are more amenable to collaboration and coordination. Organizations that target similar client populations and share a common understanding of local needs and service issues are more amenable to developing inclusive and coordinated practices to meet client needs.
- *Management and policy supports* provide the consistent leadership and vision to maintain commitment among staff foster collaboration. Regular team meetings, and the development of clinical guidelines, referral protocols, and dispute resolution methods enhance collaboration.
- *Training initiatives* should focus on broadening each sectors' skills and knowledge base (e.g., mental health training for primary care providers); and on team-building processes and competencies.

Keynote at Canadian Collaborative Care conference

In his keynote address to the 10th Annual Canadian Collaborative Care conference, Nick Kates provided an analysis of how far collaborative care has come in ten years and what the challenges are for the future. Both practice and organizational systems must be redesigned to support collaboration. Kates recommended implementation of the chronic care model of care and of the Plan, Do, Study, Act (PDSA) model of continuous quality improvement (Kates, 2009).

Advancing Community-Based Collaborative Mental Health Care through Interdisciplinary Family Health Teams was an examination of collaborative mental health care within family health teams across Ontario. It examined factors that can advance collaborative mental health care. (Mulvale *et al*, 2008) The study found:

- Mental health professionals working in collaborative care must have experience to function effectively in an interdisciplinary primary health care environment. Remuneration to mental health professionals should reflect the level of experience required.
- Critical features of good collaboration were: a good understanding of the scope of practice of other providers; a clearly defined team vision of collaboration; electronic medical records and messaging systems; and case conferencing experience.
- Teams should be trained in:
 - roles for mental health providers in primary care teams and their scope of practice
 - guidelines for frequency and content of team meeting, especially how and when to use case conferencing
 - how to develop a strong vision for collaboration
 - how to work collaboratively given differences in organizational and professional cultures
 - using an electronic medical record for collaboration
 - guidelines for space allocation and sample office layouts

Ontario's Chronic Disease Prevention and Management Framework is an approach to health care that provides an opportunity to enhance primary care and community mental health collaboration. Improving chronic disease prevention and management (CDPM) is a priority in Ontario's current health care agenda (MOHLTC 2007). One of the strengths of the CDPM approach is its potential for integrating physical and mental health care for people with serious mental illnesses (a population at high risk of chronic physical conditions), for people with chronic physical conditions (a population at high risk of mental health problems) and for the recognition and treatment of depression and other mental health problems. (CMHA 2008b)

CDPM approaches can support improvements in primary health care, better linkages to community-based care and provide guidance to support patient self-management (CMHA 2008b, Kreindler 2008, Coleman and Newton 2005). An emphasis on improved coordination, and collaboration between health sectors through CDPM has the potential to improve health care outcomes for people with mental illness and chronic diseases. (CMHA 2009c)

A recent think tank explored how to increase collaboration between the community mental health, primary care and diabetes sectors to improve diabetes prevention and management for people with serious mental illnesses (CMHA 2009c). Recommendations from the think tank included:

- Support knowledge exchange between primary care, mental health and diabetes specialists, including the values and principles under which sector provides care
- Evaluate existing initiatives that address diabetes and mental illness; share information about promising practices; and provide support for the transfer of knowledge into practice, such as currently exists for Family Health Teams in Ontario (the QIIP Learning Collaborative).
- Improve collaboration between the sectors through creating regional leads for diabetes and serious mental illness, improving funding models to promote integrated care, and expanding access to primary care through incentives, efficient use of health human resources and more funding for team-based primary care.
- Engage and involve peer support programs, social recreation programs, and public health providers in providing support to individuals living with a serious mental illness to adopt healthy behavior.

Lessons Learned from Other Jurisdictions

Involve Primary Care representatives in planning collaborative initiatives

The Joint Commissioning Board of Somerset, UK, formed as a joint planning body in 1999. Primary care representatives were initially non-voting members, along with the service user and informal caregivers. Primary care representatives criticized their ex-officio status and successfully argued that they should have a voice in earlier stages of decision-making. (Peck *et al* 2002). Clinician representatives were also dissatisfied that the governance role did not meet expectations.

Consider regulatory requirements of individual disciplines when planning coordinated service delivery models

An Integrated Care Pathway (ICP) for mental health services in a rural region in Scotland was established as a mechanism to formalize multi-agency work at the operational level (Rees et al 2004). The ICP mapped clinical and administrative activities to support delivery of care by community mental health and primary care trust staff. The ICP offered a single point of access to a streamlined service, however concern was expressed that many of the tasks were generic and did not take advantage of the multidisciplinary nature of the team. Also of concern was the fact that care pathways did not map some of the discipline-specific obligations required by professional colleges.

Shared recognition of local needs and capacities drive collaboration

Studies in Britain and Italy have found that collaboration is best developed based on shared recognition of local need and using a model that is customized to local needs. (Berardi *et al* 1999) and (Byng and Jones 2004)

Current State of Community Mental Health and Primary Health Care Collaboration in Ontario

In Ontario, there are many examples of community mental health agencies and primary health care working together (CMHA Ontario 2008c).

Governance and planning levels

Community mental health agencies are involved on steering committees, advisory bodies and boards of primary care organizations. In some cases, family health teams and community health centres (CHCs) have adopted a priority focus on mental health care and/or on serving people with a serious mental illness. The community mental health sector's participation in governance and planning can serve to familiarize primary health care providers with community mental health intake protocols and programs, and has the potential to enhance linkages across sectors.

Shared care programs and primary care staff support

Shared care programs can include community mental health agencies providing services to primary health care in order to be improve care to patients with mental illnesses. Such programs may include training for primary health care professionals in the assessment, diagnosis and treatment of mental illness; information regarding the availability of community services; o review of cases; and providing short-term counseling and/or treatment services.

Shared intake and referral

Shared care programs in some Ontario communities include shared intake, referral and/or case management services that are intended to enhance continuity of care for individuals who utilize multiple services. These types of services are also intended to

assist primary care providers in navigating complex intake processes across services and organizations.

Co-location of services or shared staff

Some community mental health agencies and primary health care organizations share facilities or staff (Reville 2006). A community mental health agency may co-locate services within a Family Health Team (CMHA Ontario 2008c). Alternatively, primary health care providers may be located within a community mental health agency. Staff may be shared through a purchase of service agreement or may be sponsored by the agency. Co-located staff may be fully integrated with the staff of the hosting organization while retaining affiliation with their sponsoring organization. The co-location of services can provide enhanced continuity of care for people receiving both physical and mental health care at a single location.

Integrated/collaborative provision of care

The Canadian Mental Health Association, Windsor-Essex Branch has fully integrated primary health care and mental health services through the development of a satellite community health centre on-site. (Doey *et al* 2008)

Key Resources to Guide Primary Care and Mental Health Collaboration in Ontario

- The Canadian Collaborative Mental Health Initiative produced a series of 12 toolkits to support collaborative mental health care, There is a toolkit for health care providers and planners to help them plan, implement and evaluate collaborative initiatives in primary care in general and eight toolkits for specific populations including one for individuals with mental illness and one for individuals with substance use disorders.
(<http://www.ccmhi.ca/en/products/toolkits.html>)
- “Community Partnerships: Supporting Ontario’s Family Health Teams” (QIIP, March 2009) provide tools for Family Health Teams (FHTs) to create or expand partnerships. The guide discusses different levels and types of community partnerships with current examples from FHTs in Ontario. It includes resources and tools for developing community collaboration.
(http://www.qiip.ca/user_files/communitypartnershipsrg.pdf)
- “Guide to Community Funding Partnerships and Program/Service Integration” (MOHLTC, January 2006) is one of a series of guides for FHTs. The guide provides suggestions for partnerships between FHTs and community agencies. The suggested partnerships with community mental health and addictions are limited to referrals through the provincial information lines (MHSIAO, DART and OPGH all of whom are administered through Connex Ontario although that is not mentioned). All of the provincial mental health and addiction organizations are also listed as sources of information. A summary of mental health and addictions services is also included.
(http://www.health.gov.on.ca/transformation/fht/guides/fht_community_funding.pdf)

Promising Practices

South West LHIN's Primary Care and Mental Health Priority Action Team

The South West LHIN has established a Priority Action Team in Primary Health Care and Mental Health and Addictions (South West LHIN, 2008). While the Priority Action Team was originally mandated to focus on the coordination of services for people with mild to moderate mental illnesses, the Team indicates that primary health care for people with mental health needs requires a systemic perspective that expands beyond the direct primary health care setting.

Mental health and primary care in British Columbia

Bounce Back is a government-funded self-management support program for people with chronic diseases experiencing mild to moderate anxiety or depression in British Columbia. It offers two levels of low-intensity, cognitive-behavioural intervention. The first is a self-help psycho-educational intervention provided through a DVD. The second level is a guided, structured short-term self-help program available in manual and web-based formats. Working in cooperation with primary health care providers and mental health specialists in community mental health agencies, lay coaches provide motivational support, program instruction, and follow-up.

The Bounce Back program is based on a Scottish program, "Overcoming Depression: A Five Areas Approach", which demonstrated that supported self-help approaches to cognitive behavioural therapy in primary care is more effective and no more expensive for the treatment of depression, than usual practices (Williams, 2007).

Collaboration between peer supporters, mental health services and primary care in Australia

A peer support service was developed in Western Australia as a component of an initiative to improve the physical health of people living with mental illness. Peers work collaboratively with mental health and primary care providers to encourage lifestyle change. The most successful collaborations were found to receive a high level of management support, as well as peer involvement as staff. Successful projects involved a clear delineation of roles and responsibilities between the peer support workers and the other staff involved in the collaboration. (Bates *et al* 2008)

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APPENDIX II: ADDICTION AND PRIMARY HEALTH CARE

Literature Scan: Interface between Addiction Services And Primary Health Care

Rationale for Addressing This Issue

Introduction

Addiction affects the physical and mental health of individual Canadians, families, and the communities in which they live. A number of government policy, control, and service areas attempt to moderate and deal with the impacts of addiction at federal, provincial, and local community levels. This literature scan focuses on publicly funded addiction services and specifically, on the interface between those services and primary health care. It describes gaps, barriers, and promising practices at the interface between those areas of health care.

Scope and Limitations of the Scan

Addiction services typically provide treatment for problematic use of both alcohol and other drugs; many also provide services for problem gambling, co-occurring mental health issues, and/or smoking cessation. To develop a manageable base-line, this scan considered findings from literature related to use of alcohol and other drugs only. Concurrent addiction and mental health disorders, problem gambling, and tobacco addiction should be the subject of further study.

Problem substance use can occur at levels ranging from misuse to abuse to dependence, and a broad range of risks, harms, and costs is associated with each level. This scan will consider literature in relation to the full range of problem substance use (including various levels of alcohol, illicit drugs, and licit drugs use). Terminology used to describe levels of problematic use varies among the research and other literature reviewed; generally this scan uses terminology that reflects source documents.

Problematic use of alcohol has been the subject of a significantly greater portion of research and other literature. As a result, the scan provides more evidence-based data in relation to alcohol than it does to other psychoactive drugs. Findings related to alcohol may at times be generalizable to other addictions, since there are many common features, mechanisms, and processes common to problematic use of most or all psychoactive substances.

When considering collaborative service strategies, it is critical to understand and respond to the diverse issues presented by people who will receive services. Problem substance use is a multi-dimensional behaviour that is influenced by complex factors. On the whole, the scope of this literature scan did not allow a discussion of specific gaps, barriers, and promising practices that reflect the diverse needs related to gender, age, ethnicity and cultural affiliation, ability, and other diversity issues, however the importance of those factors must not be discounted.

Harms, risks, and costs associated with problematic substance use

Substance use, abuse, and dependence result in significant economic and health care costs in Canada. The National Treatment Strategy Working Group estimates that in 2002, the total annual economic costs of substance abuse were \$39 billion, and the cost to the Canadian

health care system was \$3.5 billion. In a report for the College of Family Physicians of Canada, the financial burden of alcohol-related harm in 2002 was estimated at \$14.6 billion in Canada (Watts 2008). The lifetime costs of care for a person with fetal alcohol syndrome (FAS) have been estimated to be US \$2 million (Lupton et al. 2002).

Recent studies by the World Health Organization (WHO) identify alcohol consumption as a leading contributor to chronic disease and a significant risk factor affecting health in developed countries such as the United States and Canada (Rehm et al. 2006). The World Health Report (WHO in Rehm et al. 2006) estimated that alcohol was responsible for 9.2% of burden of disease in developed countries compared with 12.2% from tobacco and 10.9% from high blood pressure. Use of alcohol was estimated to contribute more to the burden of disease than high cholesterol, high body mass, low fruit and vegetable intake, or physical inactivity (WHO in Rehm et al. 2006).

Rush et al prepared a report in 2008 that summarizes significant research regarding physical comorbidities. He notes that “alcohol is a known risk factor for accidental injury and many illnesses (Room et al. 2005 in Rush et al. 2008); and that the use of other drugs is also well-established risk factor for a variety of illnesses and physical conditions including but not limited to sexually transmitted disease, other infectious diseases such as HIV and AIDS, and Hepatitis, pulmonary-related problems, skin and dental-related disorders, to name just a few strong causal associations” (Lowinson 2005 in Rush et al. 2008). Rehm identifies the association of alcohol use with a host of chronic diseases such as cancer, liver cirrhosis, cardiovascular diseases, neuropsychiatric conditions, and gastrointestinal diseases are affected by alcohol consumption (Rehm et al. 2003, 2004, 2006).

A study of associations between alcohol and chronic disease identifies heavy tolls in mortality, lost years of live and hospitalizations (Rehm 2006). For example, in Canada in 2002, among adults aged 69 and younger there were:

- an estimated 42,996 years of life lost prematurely
- 91,970 net chronic disease hospitalizations
- 1631 chronic disease deaths

Use of alcohol during pregnancy can result in a range of fetal alcohol effects that may include physical, mental, behavioural and learning disabilities, with lifelong implications. FASD is an umbrella terms encompassing fetal alcohol syndrome (FAS), fetal alcohol effects (FAE), alcohol-related neuro-developmental disorder (ARND), and alcohol-related birth defects. Due to current limitations of diagnostic capacity it is difficult to estimate the actual number of children born in Canada with FAS or with FASD. FAS is estimated to occur at a rate of one to two per 1,000 live births; while FASD rates are less clear, in Health Canada's Framework for Action on FASD, the incidence is estimated to be nine in 1,000 live births (Health Canada 2001).

Impacts of substance abuse on children can extend beyond the impacts of fetal alcohol exposure. An analysis of Canadian data (excluding Quebec) for caregiver functioning in substantiated child maltreatment cases indicated that parental substance use was a precipitant

or contributing factor to abuse and neglect in a significant percentage of cases; alcohol abuse was identified in 30% of male caregivers and 18% of female caregivers, and drug abuse was identified in 17% of both male and female caregivers (Trocmé et al. 2005). Similarly, the Ontario Incidence Study of Reported Child Abuse and Neglect (1995), which examined the incidence and characteristics of reported child maltreatment, reported that alcohol abuse was identified in 38% per cent of substantiated cases and drug abuse was reported in 31 % of substantiated cases (Tomison 1996). Australian research which analyzed child maltreatment data for correlations with substance abuse found similar significant correlations (Tomison 1996).

The pivotal role of Public Health Care providers as the first point of contact

The Enhancing Interdisciplinary Collaboration in Primary Health Care Initiative (EICP) identifies the role of primary health care as the “first level of contact with the health system, bringing health care as close as possible to where people live, learn and work” (Enhancing Interdisciplinary Collaboration in Primary Health Care 2006). Since family physicians provide up to 80% of mental health care and an even higher proportion of addiction care to their patient population (Rhodes et al. 2006), primary health care is more than one of many entry points – it is arguably the pivotal point of access to assistance with substance use problems. A discussion paper developed by the Advisory Committee to the Ontario Minister of Health and Long-Term Care observes that “*Although every door should be the right door to get people to the right services, some doors are better than others... family health providers – family doctors and nurse practitioners – are the first point of contact with the health care system for most people*” (Minister’s Advisory Committee 2009, p35).

Screening, brief intervention, and referral in public health care settings

It is widely recognized in the literature that public health care is well situated to provide care for people who have substance use problems. In a Critical Issues Consensus Conference on medical education, it was identified by participants that the skills used with patients who have substance use disorders (brief counselling, motivational interviewing, work with families, and lifestyle change counselling) are congruent with the core skills required of all primary care physicians (Watts 2008).

Screening for problematic substance use is the key to identifying needs for referral to specialist services. However screening will also inevitably identify a larger population of “at-risk” substance users who do not meet the clinical criteria for referral to specialist addiction services but who are candidates for brief interventions in primary care settings. Brief interventions are practices used to investigate a potential substance use problem and generate motivation to address potential problems – either by natural, client-directed means or by seeking treatment. Brief interventions can be used as an initial treatment for at-risk and hazardous substance users, or as an adjunct to specialized programs.

Research indicates that a significant portion of the health and economic cost associated with substance use is driven by harmful or risky use by individuals who will be seen in primary health care settings, but who may not meet criteria for referral to specialized addiction treatment

programs. In its toolkit for collaboration, the Canadian Collaborative Mental Health Initiative (CCMHI) conceptualizes primary health care as occupying a broad middle ground between population health and specialized treatment (Somers et al. 2006). In this middle ground, a number of patients with mild to moderate substance use problems can be treated quite successfully within their primary care setting, generating opportunities to reduce health costs and social costs associated with risky behaviours. It is widely recognized in the literature that screening, brief intervention, and referral (SBIR) have the potential to increase the ability of PHCs to improve overall health outcomes for patients.

The most powerful evidence to date supporting the training of health professionals in SBIR has been established by a large scale [US] study of patients who participated in substance abuse screening and interventions in a variety of medical settings study (Madras et al. 2009). The study identified clear benefits in clinical outcomes between intake and 6 month follow-up reports, including reductions in substance use and improvements in several functional domains (general health, mental health, employment, housing status, and criminal behaviour).

The case for collaboration

In 2008, the Minister of Health and Long-Term Care convened an Advisory Committee to develop a recommended framework for addiction and mental health service in Ontario. One of the central recommendations set out by the Minister's Advisory Committee is 'to act early' by building and strengthening collaboration between primary health care providers and addiction services. The CCMHI toolkit for supporting collaboration in relation to substance use disorders identifies primary health care as the "*most compelling hub around which to build a comprehensive series of substance related collaborations*". Primary health care providers are well positioned to provide the continuity that is frequently necessary for the management of chronic health concerns, including substance use. Currently, substance abuse clients often encounter a succession of acute services with limited follow-up. Collaboration between primary health care and specialized addictions services can effectively overcome many potential discontinuities through practices including universal screening, early intervention, and continuous and integrated record-keeping (Somers et al. 2006). Since primary care practitioners require the ability to work in teams, to ask for help from other health professionals, and to recognize the key roles various members of a team play, their core skills are congruent with a collaborative multidisciplinary team-based approach (Watts 2008).

Major Gaps & Challenges

There is significant literature describing the challenges that may be expected when working toward more collaborative relationships between addiction services and primary health care. To enhance the interface between the two systems, it is important to understand and address issues that may impair collaboration, consequently this section includes a sampling of detailed information about specific research in this area.

Challenges at the service level

Gaps in identification of problematic substance use

The literature identifies screening and intervention as a significant gap in the interface of primary health care and addiction services. Epidemiological and health services data consistently show that substance abuse tends to be under-recognized in primary health care settings (Parikh et al. 1997, Urbanoski et al. 2007 in Rush et al 2008).

Research suggests that physicians ask about and discuss use of alcohol less frequently than other health behaviours (Arndt et al, 2002). Many do not routinely inquire about alcohol consumption (Duszynski et al. 1995) or counsel problem drinkers. When they do screen, physicians tend to rely not on systematic screening but on specific patient characteristics, including gender and presenting symptoms (Kaner et al. 1999), and most do not use formal screening tools (Friedmann et al. 2000). When patients disclose information about drinking concerns without prompting, primary care providers often do not explore these disclosures [e.g., abruptly change the subject, downplay the significance of their patients' drinking] (McCormick et al. 2006 in Nova Scotia Department of Health Promotion and Protection 2008).

A Canadian study found that most drinkers with a positive CAGE had not sought help from physicians, underscoring the importance of screening and brief intervention by physicians (Poulin 1997). In absence of specific screening questions, patients with milder alcohol problems are less likely to be identified by a physician than patients with more severe alcohol dependence and women and the elderly are even less likely to receive screening and counseling from their physicians (Arndt et al, 2002). Inconsistent screening practices translate to lost opportunities for detection of and intervention in problematic substance use.

Gaps in identification of alcohol use during pregnancy

Lack of consistent screening is also a barrier to prevention and early identification of FAS and related fetal effects. In a report published by the Canadian Centre on Substance Abuse (CCSA) on enhancing FAS-related interventions, Leslie notes that screening of women with substance use problems is generally not routinely conducted (Leslie et al. 2001). Since fetal alcohol effects depend on a number of factors in addition to alcohol exposure (including prenatal health, nutrition, and other drug use, lifestyle and socio-economic factors), consistent screening and intervention at the primary care level can have a profound impact on the health of children who are substance-exposed in utero.

Impediments to screening and intervention

The CCMHI identifies several key factors that contribute to the gap in screening and interventions: inconsistent practice recommendations (Duszynski et al.); difficulties differentiating substance-related from somatic symptoms (Katon 1992 in Somers et al. 2006); perceived barriers to the implementation of care (Rush et al. 1995 in Somers et al. 2006); concerns about losing control of care to specialists (Roche et al. 1991 in Somers et al. 2006); or negative expectations regarding outcomes for substance use treatment (Van der Walde et al, 2002 in Somers et al. 2006).

Studies in North America, UK, and New Zealand have identified lack of time as a significant barrier to implementation of brief interventions in primary health care settings; however, some research suggests that primary care providers may overestimate the time and effort required to conduct screening and a brief intervention (Aalto et al. 2003; Babor et al. 2001, Heather et al. 2006; Sullivan et al. 2006 in Nova Scotia Department of Health Promotion and Protection 2008]. A recent publication of the Institute for Evaluative Clinical Study suggests that Ontario physicians are 'doing more' at each visit – in Ontario over a 10 year period, primary care physicians delivered an increased level of care to a larger and older population without increasing the number of annual visit rates. (Douglas et al. 2006).

Physician concerns about how their patients will respond to screening questions can present barriers. In a study by Brady, physicians reported that patients were often annoyed when issues such as their alcohol consumption were raised as they were most interested in having their immediate presenting problems addressed (Brady et al. 2002 in Nova Scotia Department of Health Promotion and Protection 2008). Many physicians find it challenging to raise issues related to gambling, drug and alcohol usage with their patients. Research has found that this discomfort is due, in part, to physicians fearing interfering or spoiling their relationships with patients as well as concerns around losing patients (Babor et al. 2001; Heather et al. 2006; McCormack et al. 2006; Brady et al. 2002 in Nova Scotia Department of Health Promotion and Protection 2008).

Barriers arise from physician perceptions and attitudes. A review of the literature by Roche & Freeman (2004 in Nova Scotia Department of Health Promotion and Protection 2008) revealed that attitudinal barriers by family physicians prevent them from engaging in screening and brief intervention. These barriers include perceptions that patients with substance use problems are difficult, aggressive, demanding, manipulative, deceitful, unmotivated and unwilling to change. Misconceptions and discomfort around discussing substance use and problem gambling with patients were also documented in research by Babor (2001) and McCormack (2006) (in Nova Scotia Department of Health Promotion and Protection 2008).

Inadequate training coupled with lack of knowledge, skills and confidence has been identified as a common barrier to brief intervention. Roche notes that physician confidence in screening and intervening tends to be especially low for patients dealing with illicit drug related problems compared with patients with smoking related issues (Aalto et al. 2001, Roche et al. 2004, in Nova Scotia Department of Health Promotion and Protection 2008).

Challenges at the system level

Need for a conceptual shift

The delivery of primary care services in Ontario has been in transition over the past decade. Health promotion and prevention in primary health care have traditionally focused on visible, symptomatic physical medical conditions (as opposed to risk factors and early stage health issues). Recent and ongoing changes in Ontario's primary health care system may make this an opportune time to expand that focus to include substance use-related risk factors. Screening for problematic substance use will allow identification and intervention with patients who are in the early phase of problematic substance use or who are at risk for developing such problems – before they start manifesting serious harms. The CCMHI identifies significant potential for more inclusive and comprehensive primary health care practices: *“the emergence of new models of primary health care presents immense scope for integrating behavioural, pharmacologic and lifestyle-change approaches to the treatment of substance use disorders. Multidisciplinary primary health care teams, which might include physicians, nurses, social workers, dieticians, rehabilitation specialists, pharmacists, psychologists, psychiatrists, consumers/families/caregivers, etc., have the potential to provide cost-effective treatment based on principles of stepped care, escalating the intensity of interventions as indicated based on the consumer's response. Such teams are also well positioned to address the myriad medical and psychological problems affecting substance-dependent individuals, including HIV infection, hepatitis C, anxiety and mood disorders, poor nutrition, lapses in use, and relapse”* (Somers et al. 2006). Successful early detection of and intervention in problematic substance use is likely to result in reduced needs for acute care, better health outcomes, and reduction of related health care costs.

Lack of attention to problematic substance use

Addiction appears to be ‘off the radar screen’ in much of the literature, as well as in collaborative project work being undertaken with primary health care. Specific substance abuse data is rarely presented in the research and other literature related to primary care renewal or potential collaboration. When literature refers to ‘mental health and addiction’ as a unified area, there is a risk that important differences in patient characteristics and service needs will not be identified. Literature that focuses on mental health sometimes includes substance abuse data, thereby implying that problematic substance use is a sub-set of mental health data. However, since services for these populations in Ontario remain largely separate in funding, planning, and delivery, addiction-specific data is needed. In some documents it is not clear whether substance use data has been included. For example, the Institute for Evaluative Clinical Study (ICES) Atlas, Primary Care in Ontario (2006) includes a chapter on Primary Mental Health Care. It is unclear whether mental health data includes data about problematic substance abuse, since data was drawn from Statistics Canada's 2001/02 Canadian Community Health Survey in which respondents were asked questions about “help with emotions, mental problems or use of alcohol or drugs.”

Problematic substance use also appears to lack profile in staffing templates that are being implemented in family health teams. Mental health services have been identified as a priority in a number of family health teams however few teams are reported to include addiction specialists. Not surprisingly given their service mandate, Community Health Centres are reported to be significantly more involved in providing substance abuse and problem gambling services.

The impact of funding structures

The CCMHI substance abuse toolkit notes that integrated practice is currently complicated by administrative 'silos' and lack of integrated funding. The fragmentation of funding is associated with disparate performance mandates and service targets across service providers. (Somers et al. 2006). In Ontario addiction services are funded by Local Health Integration Networks (LHINs), while primary health care services are outside of LHIN responsibility. That separation of planning and accountability structures can undermine collaboration by making it difficult to harmonize practices, bring relevant stakeholders together, and address funding and resource issues between the sectors. In some cases, LHINs have taken a lead in bridging this divide: for example, by supporting and sponsoring the development of affiliated local family health teams and CHCs.

Primary health care system capacity issues

The government of Ontario has been working to address capacity issues by increasing physician supply while also funding innovative models such as Family Health Teams. Although solo practice remains the most common venue of care, group practice models are becoming more common. Starting early 2009, 1.9 million patients (16% of Ontario's population of 12 million) were enrolled as patients of 150 Family Health Teams, which provide a model of interdisciplinary care. CHCs are also being funded as an alternative method of health delivery for high risk populations that may have difficulty accessing health services because of language, culture, disability, socio-economic status, or geographic challenges. In spite of these efforts, primary care services are in short supply in many areas of the province; some communities are competing to attract new graduates or physicians who are willing to set up new practices. Findings from a recent study indicate that the current primary care system is at full capacity and has been for some time (Douglas et al. 2006).

Gaps in sector to sector communication

Poor communication between addiction services and family physicians has been identified as a barrier to referral. In focus groups at the Centre for Addiction and Mental Health family physicians described feeling as though they are 'throwing a ball into a black hole' when referring patients to addiction services. They emphasized the need for more open and relevant communication with addiction specialists, as with any other specialists involved in the care of their patients (Centre for Addiction and Mental Health, undated). Significant challenges also arise from inadequate systems to coordinate patient records, share information, and track outcomes across and within systems.

The structure and capacity of the addiction service system

The structure of the addiction system may present barriers to collaboration in some communities. Where multiple addiction agencies provide varied types of services for substance use problems in a single community, potential collaborators may be confused about roles, responsibilities, and scopes of practice of the addictions service providers (Somers et al. 2006). This difficulty may be compounded by philosophical and practice differences among addiction services: for example, implementation of harm reduction approaches can vary significantly among addiction services.

Conversely, in some communities, gaps in the range of available addiction services may confound efforts of primary care providers to make referrals and develop collaborative relationships. Lack of capacity and insufficient addiction system resources for service delivery can result in excessive wait times for a variety of substance abuse services (e.g. assessment,

residential treatment), again discouraging referrals and potentially undermining efforts at collaborative care.

Gaps in training and credentialing of physicians

The literature identifies multiple concerns about how well physician training prepares them to work with patients who are at-risk or have substance abuse problems. Research suggests that primary care providers feel there is a need for increased formal training (e.g., university medical education and training) and continuing education related to substance use and gambling problems (Aalto et al. 2003, Rowan 2000 et al. in Nova Scotia Department of Health Promotion and Protection).

In a report to the College of Family Physicians of Canada, the need for enhanced substance abuse training in Canadian residency programs was identified. Physicians receive little training in the treatment of substance abuse during medical school and residency and express a clear interest in receiving more training. In spite of efforts to enhance Canadian curriculum in the late 1990's, stigma, negative attitudes, and lack of understanding still undermine the Canadian medical community's response to substance abuse disorders as part of a spectrum of substance use disorders that represent treatable chronic diseases (Watts 2008).

The British Columbia Medical Association (BCMA) has emphasized the importance of recognizing addiction medicine as a specialty and providing certification processes, as is done in other jurisdictions (e.g. Australia, New Zealand, United States). The Canadian Society of Addiction Medicine (CSAM) offers a certification process; however CSAM certifications are not formally recognized by the Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada. Given the burden of disease from problematic substance abuse and the fact that physicians from all fields of medicine will encounter patients with addiction throughout their careers, the BCMA calls for expanded training and certification for currently practicing physicians, as well as education and resources specifically targeted to prescription practices for sedatives, narcotics, and stimulants for patients who have a personal risk or family history of addiction (British Columbia Medical Association 2009).

Potential impact of physician payment methods

Funding arrangements for primary health care are based on either compensation for specific clinical activities or on budgets required to fund specific health care programs and services. Concerns have been expressed that existing compensation schemes may fail to promote or adequately support the provision of care to patients who have substance use problems and related chronic care issues and complex care needs. Negative impacts on access for these vulnerable populations may be an unintended consequence of payment and rostering models that encourage physicians to sign up healthy patients rather than individuals with more complex health care needs. The recently published Institute for Clinical Evaluative Sciences (ICES) Atlas, Primary Care in Ontario, raises questions about potential negative impact of capitation payment systems on access to primary care for some patients: "*while fee-for-service payment systems are thought to limit the amount of time a provider spends with a client, capitation payment systems could decrease any contact. Capitation may encourage primary care providers to select healthier patients or "cream skim" unless payers are successful in adjusting budgetary allocations for more complex and ill respondents*" (Douglas et al. 2006).

Stigma and systemic bias

Stigma (negative attitudes) leads to discrimination (associated negative behaviour), which prevents people from getting the services & supports they need. In its eighth Annual National Report Card on Health Care 2008, the Canadian Medical Association revealed startling information on Canadian attitudes toward addiction. Among the negative attitudes identified were: widespread perceptions that addictions are not serious illnesses and even more widely held biases against social or professional interaction with people who have substance use disorders (British Columbia Medical Association 2009).

The Ontario Minister's Advisory Committee observes that the structural separation of mental health and addiction services from the rest of the health care system may perpetuate stigma by reinforcing that mental illness and addictions are 'different' and "somehow more shameful" than other health problems (Minister's Advisory Committee 2009). Similarly, the BCMA observes that: *"One of the greatest challenges of addiction is the significant stigma attached to it. The truly unfortunate consequence of this stigma is that it reinforces a sense of this issue being a lower priority than other health challenges"* (British Columbia Medical Association 2009).

As already noted, the ICES report on Primary Care identifies concerns about funding mechanisms that may reduce access to primary care for people who have more complex health care needs. If, as feared, funding mechanisms generate inadvertent barriers to care for individuals with addictions and related complex care needs, opportunities for collaboration between primary health care and addiction services will also be inhibited or reduced.

Recommendations from the Literature

There is a significant body of literature that calls for collaboration among primary health care providers and other health care, health promotion, and prevention services and recommends overarching principles and broad strategies. This literature scan will consider recommendations that can speak specifically to the interface between substance abuse services and primary health care, however the information presented here should be considered in the context of the broader literature on collaboration and change management.

New conceptual thinking about how services for problematic substance use are delivered

The concept of collaborative care has been gaining currency in service and system planning. Over the last several years, Health Canada has supported a number of initiatives – such as the Canadian Collaborative Mental Health Initiative and the Transition Fund Report on Integrated Service Delivery – which are yielding promising findings. Active collaboration between disciplines has the potential to allow various skills to be brought together when needed by an individual, rather than requiring patients to move among various services and levels of care. Supported by collaboration, care pathways within and across sectors can support continuity of care by providing integrated, person-centred services.

Recent recommendations from the National Treatment Strategy Working Group provide a conceptual framework for a continuum of substance abuse services and supports that defines critical roles for primary health care. The framework proposes a tiered continuum of services & supports that will address a broad spectrum of substance abuse-related risks and harms by matching levels and types of services with acuity, chronicity & complexity of risks and harms associated with substance abuse. The model is based on the principle that ‘every door is the right door’ – upon entry, people would be linked with services and supports within and across tiers in line with their needs. Primary health care services would typically provide screening, intervention, referral, and continuing care. The model has the potential to coordinate services, make better use of existing investments, and facilitate sharing of information (National Treatment Strategy Working Group 2008). This conceptual framework has been well received, and is already being used to inform planning in some provinces.

There is support in the literature for application of a chronic disease model for problematic substance use and related health issues. Views have historically differed as to whether addiction is a disease (chronic or otherwise). Regardless of any remaining debate on this subject, there are distinct benefits to the use of a chronic disease model in treating problematic substance use. Elements of chronic disease management used in addiction services have already proven effective. For example: patients who received both regular addiction and medical care were less likely to be hospitalized than those who received one or neither service; and on-site primary care at addiction programs has been associated with reduced addiction severity (Saitz 2005).

In a recent policy paper, the BCMA strongly advocates for formal recognition of addiction as a chronic disease: *“To create a system where those [Health Care/Acute Care] pressures can be reduced and those resources can be allocated to other problems requires that we change our thinking in a fundamental way. We must begin to think of addiction as a chronic disease and invest our health care dollars accordingly, much in the same way as we have begun to do for diabetes and heart disease”*. The policy paper argues that use of a chronic care model would facilitate linkage of addiction professionals to existing structures (e.g. collaborative care teams,

data collection mechanisms) and would enhance care for associated health problems (British Columbia Medical Association 2009).

Enablers of interdisciplinary collaboration

The CCMHI has developed a toolkit for establishing collaborative initiatives between mental health and primary care for individuals who have substance use disorders (one of several toolkits developed by the CCMHI as companions to the CCMHI planning and implementation toolkit for health care providers and planners). The goal of the substance abuse toolkit is to support the transfer of knowledge and enhance care for individuals who have substance use disorders through improved inter-professional collaboration. The toolkit emphasizes the importance of both service-level and administrative or system-level supports to collaboration. At the service level, clear roles, responsibilities and scopes of practice between primary health care and other service settings (i.e. addiction services) must be clarified, and consistent practices and documentation strategies must be established and implemented across the range of addiction and primary health care services in a given community (e.g., approaches to screening and assessment). The toolkit also highlights the need to build a common foundation of expertise across primary health care providers, which can be augmented by skills drawn from specialized addiction services. At the administrative or system level, the support of administrators and policy makers is needed to overcome legal and organizational hurdles that may arise (Somers et al. 2006).

System-level structural supports

Collaboration between primary health care and addiction services requires structural supports at both system and service levels. The literature widely identifies that system-level supports – such as standardized screening tools and protocols and mechanisms for sharing information between systems – are needed to provide a consistent foundation across the boundaries of communities. The BCMA recommends that standards of care be developed for addiction medicine, including clearly defined wait times for addiction services across the continuum of care and clinical guidelines and protocols for addiction care (British Columbia Medical Association 2009).

Strategies to enhance education, training, credentialing and knowledge exchange are needed at the system level. The BCMA has recommended expanded training and support for physicians in addiction medicine including formal recognition of addiction medicine as a specialty by provincial and national medical, nursing, and other health profession education bodies (British Columbia Medical Association 2009). Medical professionals have identified needs for both core competency development and enhanced specialty education in addictions training: *“Only with trained addiction faculty based in postgraduate primary care training sites can we hope to give students, and faculty, adequate experience and the backup that is required to build skills and confidence. And it is only with confident faculty that we are going to be able to ask residents to see this as part of the work of family physicians”* (Watts 2008).

The EICP Initiative has developed a set of principles and a framework that identify policies and operational infrastructures needed to support engagement of primary health care providers in interdisciplinary collaboration. The framework includes the following high-level elements required to sustain interdisciplinary collaboration (Enhancing Interdisciplinary Collaboration in Primary Health Care):

- **Health Human Resources:** strategies (recruitment, retention, role definition, skill development) to ensure the supply of professionals required by interdisciplinary teams approaches
- **Funding:** innovative funding models and payment methods that facilitate and promote interdisciplinary collaboration
- **Liability:** strategies to ensure appropriate protection for health professions working in interdisciplinary relationships, whether through individual coverage, protective associations, or legislation that clearly defines scope of practice
- **Regulation:** support from regulatory colleges for interdisciplinary approaches
- **Information and communications technology:** implementation of tools that create critical information paths and support continuity of information
- **Management and leadership:** support for the change process at governance and administrative levels
- **Planning and evaluation:** use of tools and strategies that respond to the needs of relevant populations and effectively track quality and organizational and service outcomes of interdisciplinary relationships

Service-level structural supports

To facilitate a coordinated multidisciplinary approach at the service level, supports should include both clinical components and organizational components (National Treatment Strategy Working Group 2008). Clinical components may include: development of shared service protocols and agreed service pathways; interdisciplinary collaborative models of planning and delivering services and supports; definition of roles for each professional on the team; strategies for decision-making and resolving conflicts; and mechanisms for ensuring continuity of information.

The CCMHI suggests that developing collaborative relationships will, by necessity, require a paced community-level process: *“At this stage, it would be premature to commend a particular structural model of collaborative care for substance use problems. Instead, we advise beginning with an environmental scan of prospective collaborators – both individuals and agencies. Over time, a dominant structural model of primary health care for substance use may emerge in Canada, perhaps in the form of an integrated primary health care centre, or, following the National Health Service’s example, Mental Health Trusts. However, the majority of Canadian communities are at the beginning stages of collaborative care for substance use”* (Somers et al. 2006).

Strategies for supporting implementation of screening, brief intervention, and referral in primary health care settings

Canadian resources have been developed to support primary care providers in working with problematic substance use; a sample of such resources includes:

- Essentials of ... Screening, Brief Intervention and Referral for Alcohol Use. (Canadian Network of Substance Abuse and Allied Professionals)
- Continuing Medical Education; Opioid Dependence Treatment Certificate Program; Classroom and on-line courses, workshops and events; Publications and resources for professionals, Clinical consultation line. (Centre for Addiction and Mental Health, Ontario)
- The SMART Guide: Motivational Approaches Within the Stages of Change for Pregnant Women Who Use Alcohol. (Action on Women's Addiction – Research and Education, and Mothercraft)
- Family Physician Guide: for Depression, Anxiety Disorders, Early Psychosis, and Substance Use Disorders. (Centre for Applied Research and Mental Health and Addiction, Simon Fraser University, BC)
- Best Practices, Early Intervention, Outreach and Community Linkages for Women with Substance Use Problems. (Health Canada)

Significant resources have also been developed in other jurisdictions. Examples include:

- The National Institute on Alcohol Abuse and Alcoholism, United States
 - Assessing Alcohol problems: A Guide for Clinicians and Researchers
 - Helping Patients Who Drink Too Much—A Clinician's Guide
 - Clinical Guidelines, Training and Support for Health Professionals
- US Substance Abuse and Mental Health Services Administration
 - SAMHSA/CSAT Treatment Improvement Protocols
- World Health Organization
 - Brief Intervention For Hazardous and Harmful Drinking: A Manual for Use in Primary Care
 - Drink-Less Program

Although best practices have been identified and tools are available, feasible models for engagement, training, and development of workable on-the-ground protocols are needed at the community level before consistent screening, brief intervention, and referral (SBIR) can be implemented in primary health care practice. Research and consultation with primary health professionals indicate that effective physician training strategies: skills-based role playing; performance feedback; access to clinical guidelines; clinic based education; and training by credible experts (Fleming 2004/5, Aalto et al. 2003 in Nova Scotia Department of Health Promotion and Protection). Although training is a recognized facilitator in the use of SBIR, competing educational needs and priorities among physicians and nurses must be addressed. Participation in learning opportunities must be supported by availability of training sites, faculty expertise, institutional support, and funding support (Roche et al. 2004 in Nova Scotia Department of Health Promotion and Protection).

Research indicates that nurse practitioners can play an important role in addressing time pressures that are barriers to screening and intervention (Nova Scotia Department of Health Promotion and Protection). Research has also demonstrated that nurse practitioners are capable of providing effective screening and brief interventions which help to decrease the time burden on physicians, and that use of technology (such as computerized tools designed for screening) can be a 'time-saving' tool in primary care practice (Ockene et al. 1999, Moyer et al. 2004 in Nova Scotia Department of Health Promotion and Protection).

Population-specific screening, brief intervention, and referral practices

A Research Update from the Public Health Agency of Canada recommends that pregnant women be screened for alcohol use in primary health care settings as part of routine prenatal health care. It is noted that screening should be universal and non-discretionary, and that it should occur in a supportive milieu that is sensitive to the circumstances of pregnant women who are substance users. The Update also encourages use of brief intervention with this population in primary health care settings: "*There is now good evidence that a brief intervention can be effective for non-dependent women of childbearing age. Brief interventions have also been shown to reduce alcohol consumption among pregnant drinkers who were not alcohol dependent*" (Public Health Agency of Canada, undated).

The Methadone Maintenance Treatment Practices Taskforce, which was convened by the Ontario MOH-LTC to provide advice on how to improve MMT in Ontario, recommends that MMT be provided by Family Health Teams and Community Health Centres. The task force emphasizes that people who receive MMT have complex needs and require access to interdisciplinary care that includes primary care counselling and case management. The task force emphasized the importance of transparent community engagement processes in planning and developing MMT services (Methadone Maintenance Treatment Practices Task Force 2007).

Addressing stigma

Finally, the importance of continuing work to reduce stigma is widely noted in the literature. The BCMA emphasizes that addressing stigma must be a critical consideration of any approach to improving addiction care. The Association suggests that strategies to overcome addiction-related stigma should be implemented at research, education, and treatment levels. Anti-stigma campaigns, similar to past successful campaigns used in respect to other illnesses such as cancer and HIV, would provide effective strategies for addressing stigma (British Columbia Medical Association 2009).

Promising Practices

The literature scan did not identify centralized sources information about promising practices in Ontario for collaboration between addiction services and primary health care, however anecdotal reports indicate that promising practices are being implemented. Examples of types of collaboration are presented in section 4.1 (Ontario), 4.2 (other jurisdictions in Canada), and 4.3(Europe).

Possible factors inhibiting development and documentation of promising practices include:

- Mechanisms are needed for methodically collecting information about promising practices at the interface between addictions services and primary health care (including but not limited to collaborative relationships) and for making that available to practitioners, policy makers, and researchers. Although the Connex data base provides comprehensive and current information about addiction services, including data about partnerships and sponsorship relationships, the data base is not designed to collect information about promising practices in specific areas like collaboration with primary health care.
- Analysis of a Connex data report of service relationships between addiction services and health care providers indicates that the vast majority of sponsorship and partnership arrangements are made with hospitals. Service relationships also exist with CHCs, CCACs, and Public Health Units, however these represent a small percentage of the sponsorship and partnership arrangements identified in the report. This is not surprising, considering that hospitals provide sponsorship for withdrawal management services across the province. These long-standing sponsorship relationships appear to have paved the way for other partnerships between these two sectors (Connex 2009).
- As has already been noted, addiction services are 'on the radar screen' to a lesser degree than mental health services. Addiction services have not received the level of support for developing collaboration that has been evidenced in initiatives like the Canadian Collaborative Mental Health Initiative. While the projects undertaken within mental health initiatives include services for people who have concurrent disorders, and some may also include addictions as a 'sub-set' of mental health, linkages between primary health care and addiction services as a distinct discipline have not yet been directly or systematically supported.
- Addiction services may be seen as less professionally-oriented or evidence-based than mental health services because of their grass roots origins in self-help programs and their historic non-medical orientation. Self-help programs pre-date the publicly funded addiction system and have had significant influence on the development of addiction services.

Examples and types of collaboration in Ontario communities

Integrated Addiction Services in a Family Health Team

The Hamilton Family Health Team (HFHT) is a long-standing health service group which operates in several locations across the city of Hamilton. The team is comprised of almost 300 health care professionals from a variety of disciplines (family doctors, nurses and nurse practitioners, psychiatrists and pharmacists, registered dieticians, and mental health counsellors). Of the seventy-five (75) mental health counsellors on staff at HFHT, two (2) are specialists in addiction (substance abuse and problem gambling). To meet the needs of multiple sites, the time of these two specialist counsellors is distributed among multiple service delivery locations. (Sources: Hamilton Family Health Team website, brief information interview).

Internal addiction-specific activities and functions include:

- **Consultation:** addictions-specialist staff provide internal consultation to other mental health counsellors and to their patients
- **Implementation of screening practices:** all professionals are asked to do a very brief (two question) screening with patients. Where the screen has not been used, barriers are lack of time and too many other issues to cover.
- **Brief intervention:** For patients identified through screening, psychoeducational materials are provided and information about a group program (DrinkWise) or referral to other addiction resources is provided. Connections to these resources can be made by the client/patient, or by the professional. Where brief interventions have not been delivered, barriers are lack of time and/or confidence to deliver Motivational Interviewing and psycho-educational materials.
- **Group programming:** DrinkWise is provided for FHT patients who have mild to moderate substance abuse problems. This program was formerly provided at local addictions community treatment (outpatient) program – it was deemed to be better situated in a primary care setting. Staff of the local addictions program assisted in training and piloting the program, which is now delivered by addiction specialists from the FHT.
- **Programming for family members:** in conjunction with the local addictions community treatment program, a 1 day education session is delivered for family members, with a focus on self care, coping, and understanding substance use and recovery.
- **Professional development:** sessions to build addictions awareness and/or skills provided to the team at least twice a year

Interface with external addictions community treatment program(s) consists of:

- *Referral for specialized services*
- *Consultation when developing programs, addressing complex needs/cases, and developing or delivering education*

Addiction Shared Care Program, St. Joseph's Health Centre, Toronto

The Addiction Shared Care (ASC) Program is a model of collaboration, providing Primary Care Physicians with clinical advice including assessment and support of their patients. The multidisciplinary team includes Addiction Medicine Physicians, Family Medicine Residents, a Nurse Clinician and an Addiction Clinician. Features and strengths of the ASC Program include (Source: Making Gains Conference [2006] presentation slides):

- The program is delivered in a primary care setting. Since there is evidence that patients prefer this setting, treatment retention rates may be higher
- The program is fully integrated into the hospital, enabling resource sharing (e.g. clinical management, education and program planning)
- The multidisciplinary team consists of primary care physicians, nurse clinicians, and addiction counsellors
- The program provides comprehensive feedback to the referring family physician
- Follow-up interviews, performed by telephone, are helpful to patients
- Research on shared care and addictions is limited. The results of this project will be valuable in determining how effective a shared care model works in Addictions. If proven to be successful, this program could be implemented for other primary care settings in Ontario and elsewhere.

Addiction Services in a Community Health Centre (CHC)

Data obtained from Connex indicates that four CHCs are delivering addiction services (in Ottawa, Kingston, and Windsor), however this data does not represent all the CHCs that provide these services, or all the service provided. Connex is developing a new reporting strategy that will allow collection of comprehensive data (Connex 2009). Addiction services in CHCs can be delivered using a variety of models including: integrated service delivery by CHC staff; service delivery by external specialist staff from community addiction services; and/or development of separate addiction services within the CHC.

Street Health Centre (SHC) is one example of how a comprehensive range of services for substance abuse and related issues is provided as a separate service under the sponsorship of North Kingston Community Health Centre (Sources: SHC website, brief interview).

- The Street Health Centre (SHC) is a harm reduction program that provides accessible, responsive health services to communities that are often marginalized from mainstream health services.
- From an original mandate as a health education outreach program founded in the early 1990s within an AIDS service organization, SHC has evolved into a “one-stop shopping” model, providing multiple health, disease prevention, primary care and treatment services.
- In early 2000, North Kingston Community Health Centre (NKCHC) seconded a nurse practitioner to a partnership project with SCH. In 2004, funding was approved for SCH to become a satellite of NKCHC.

- SCH works with several priority populations including: people who use injection and illicit drugs; people involved in the sex trade; high-risk youth; people who are homeless; and people recently released from incarceration

A Community-based Methadone Maintenance Therapy (MMT) Service

Although the majority of clients who receive MMT in Ontario are seen through private (for profit) clinics, a small number of community-based clinics provide on-site medical and counselling services along with MMT. These community-based clinics are regarded as important models of effective services because the provision of adjunctive services has been shown to improve the health status and quality of life of the client population.

One example of a CHC sponsored MMT program is the Street Health Centre (SHC) in Kingston (Sources: SHC website, brief interview).

- SHC's methadone clinic is a satellite of the North Kingston Community Health Centre (NKCHC) where services and medications (substitution therapy) are provided on-site for people who are using illicit opioids such as morphine, heroin, Dilaudid® or Oxycontin®.
- SHC counsellors work with people on a variety of issues, including basic needs, referrals, life skills, support and individual counselling related to drug use, addictions, sexual health, mental health, practical needs.
- Staff from local addictions and mental health agencies work out of SHC on a weekly basis and are available to work with SHC clients.
- Primary care is provided at SHC by a team of registered nurses, nurse practitioners and physicians; primary care is available to clients who do not have a family doctor. Health assessments, treatment for acute health problems and routine care management are provided on an appointment or walk-in basis.
- SHC also manages the Ontario Harm Reduction Distribution Program (OHRDP), which provides harm reduction materials, information, and support to Ontario's needle exchange and harm reduction programs.

A Model Program for Pregnant and Parenting Women and Their Children

The Public Health Agency of Canada has identified two Canadian Model programs in its Research Update on Alcohol Use and Pregnancy: Breaking the Cycle in Toronto, and the Sheway Program in Vancouver (Public Health Agency of Canada).

Breaking the Cycle (BTC) is one of Canada's first early identification and prevention programs for pregnant women and mothers who are using alcohol or other substances, and their young children. Typically, clients have experienced complex conditions of health and social risk, exacerbated by alienation from health and social supports. BTC provides a single-access model that coordinates services to adapt to the needs of these families rather than families having to adapt to multiple agencies. Within that framework, comprehensive care (including medical services and FASD Diagnostic Services) is provided by a multidisciplinary team. The breadth and depth of services provided by BTC is achieved through the collaboration of Partners

including: Mothercraft, Motherisk-Hospital for Sick Children, Children's Aid Society of Toronto, Catholic Children's Aid Society, Toronto Public Health and St. Joseph's Health Centre. In 2004, BTC was recognized as the Canadian case study illustrating best practices by the United Nations Office on Drugs and Crime publication *Substance abuse treatment and care for women: Case studies and lessons learned* (Leslie et al. 2006).

Promising Canadian initiatives outside of Ontario

The BC/Yukon Collaborative Care Initiative

The BC/Yukon Collaborative Care Initiative (BCYCCI) is designed to improve primary health care for substance abuse disorders. In a discussion of collaborative structures in relation to substance use disorders, the CCMHI provided a brief overview of the BCYCCI; it also highlighted strategies used in this initiative to respond to the challenges of developing collaborative structures (Somers et al. 2006).

- Strategies for engagement and planning included both 'top down' and 'bottom up' approaches. Top-down leadership was provided by the agencies responsible for primary health care reform, physician and nursing services, and hospital and community addictions and mental health services, including federal, provincial/territorial and regional bodies. Bottom-up leadership was provided by working groups consisting of local champions representing inter-professional contributors to primary health care for substance use disorders. The combination of top-down and bottom-up processes were deemed to be a practical necessity, given the importance of working through variations in practice and cultural differences between different provider groups at 'ground level', while also maintaining high-level 'drivers' of the change process.
- With those leadership components in place, each region undertook the initial step of harmonizing the services provided by leading publicly funded agencies, including alcohol and drug and mental health services. Harmonization involved adopting consistent approaches to screening and assessment and procedures for sharing information; and making a long-term commitment to joint training and staff development activities.

National initiative: Renewal of tools for Screening, Brief Intervention, and Referral (SBIR)

The CCSA is working with the College of Family Physicians of Canada and British Columbia Mental Health and Addictions Services in extensively revising and updating the Alcohol Risk assessment and Intervention (ARAI) resource package for family physicians. The ARAI continuing medical education renewal project is intended to build upon the earlier materials developed by the College of Family Physicians of Canada (CFPC) in the early 1990s. The new set of resources will focus primarily on alcohol screening, brief intervention and referrals for risky, non-dependent drinking. However, it is intended that some resources will also be included on how to address cases of alcohol dependence. It is anticipated that the new package will be primarily a web-based source of information and tools. SBIR will equip primary health care providers with tools to intervene in risky drinking behaviour well before a patient needs specialized referral, and has the potential to increase collaboration between PHC and substance abuse professionals. The project will provide physicians and other health care providers with clear, evidence-based risk guidelines and screening tools. It is projected that the project will be

completed by the end of 2009 and will be followed by interventions and training to encourage uptake (Canadian Network of Substance Abuse and Allied Professionals, undated).

National Initiative: Proposal for development of a Canadian Brief Intervention Network Project

A proposal has been submitted to the federal government (DTPF) for development of a Canadian Brief Intervention Network. The network would serve as a vehicle for (1) pooling expertise on evidence-informed screening, brief intervention and shared-care practices; (2) assessing strategies for more broadly implementing these practices within health systems; and (3) extending these practices and strategies to include illicit drugs such as cannabis.

The network would facilitate expanded practice of screening, brief intervention and shared-care for problematic substance use through the collaborative activities (e.g. regional communities of practice linking practitioners across general health and specialized addiction treatment sectors.) The network would be populated by organizations, groups and individuals from across Canada engaged in clinical practice, education or research on problematic substance use screening and brief intervention (Brown 2009).

European Initiative: Implementation of a National Framework in England

The 'Models of Care' framework

In a background paper prepared for the National Treatment Strategy Working Group, Ross et al. (2007) identified the *Models of Care* framework that has been implemented in Leeds, England as a source of promising practices for developing integrated treatment pathways for substance use issues.

The *Models of Care* framework was developed by the National Treatment Agency in England (in 2002). The framework utilizes a four-tiered model of service provision in local systems to meet the multiple needs of drug and alcohol misusers. Primary health care providers provide interventions in all four tiers, where appropriate and provided the practitioners have the required competencies.

The National Treatment Agency published an Update in 2006, which discusses the role(s) of primary health care providers that evolved in the context of local communities (National Treatment Agency 2006). It was noted that the roles of primary health care models vary in response to local resources and needs. In shared care models, substance use services may be delivered in a primary care setting by physicians who have the required competencies or by members of a multidisciplinary primary care team.

Specialist services may provide support or play a collaborative care role - particularly for more severe or complex cases. Shared care models also can involve service delivery by staff of specialist addictions services in the primary health care setting. It was noted that in of the above (and other) shared care models, patients should have access to long-term care and community-based multi-disciplinary support in the primary care setting, and flow of patients between the services sharing their care should be unobstructed (National Treatment Agency 2006).

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APPENDIX III: ROUNDTABLE DISCUSSION NOTES

PRIMARY CARE, MENTAL HEALTH AND ADDICTIONS INTERFACE

November 24, 2009

I. Background

The roundtable discussion provided an opportunity for representatives of the primary health care, mental health, and addictions sectors to:

- Review and comment on findings from literature searches and key informant interviews in relation to challenges of cross-sector collaboration
- Generate strategies to address challenges

Participants comprised a cross section of 'thought leaders' from all three sectors.

II. Caveats

Outputs of the roundtable discussion should be reviewed with the understanding that the roundtable session was not intended to produce a comprehensive array of strategies to address challenges – rather, the purpose of the session was to generate 'top of mind' ideas, based on cross-sector dialogue, in response to a presentation of limited data, and in a time-limited discussion. Literature reviews and key informant interviews conducted for this project yielded a more comprehensive snapshot of both challenges and strategies to address them. The outputs of the roundtable session, while consistent with the literature and key informant input, should be considered preliminary indicators of strategies that can be employed to address challenges in the interface between primary health care, mental health, and addictions service systems.

III. Recommended strategies to address challenges

As a baseline for discussion, a brief presentation identified and described six major areas of challenges of collaboration:

1. Identification and Access
2. Capacity
3. Knowledge and Competencies
4. Resources and Funding
5. Scope of Practice, 'Turf' Issues, and Trust/Respect
6. Impact of Stigma and Discrimination

Participants were asked to work in small groups to identify strategies could be used to address the above challenge areas, including actions that can be undertaken:

- by each sector
- at both system and practice levels
- with or without funding support

Participants recommended the following strategies in respect to each challenge, however they noted that, since challenges are inter-related, comprehensive strategies are required.

1. Identification and Access

- Integrate services:
 - Include Primary Care as a component of mental health and addiction services (e.g. salaried positions, nurse practitioners)
 - Integrate addictions and mental health services into primary care through purchase of service arrangements
 - Embed mental health and addiction services in primary health care settings (e.g. Family Health Teams)
- Implement strategies to help Primary Care providers identify early stage mental health and addiction problems:
- Provide early identification tools and resources
- Provide guidelines (OMA)
 - Provide education/consultation and support
 - Improve information and access (e.g. by introducing system navigation function that will allow MDs to call one number to connect with system navigator/lead agency tasked to receive information and make referrals)

2. Impact of Stigma and Discrimination

- Reduce stigma among professionals:
 - Provide intensive training, including job shadowing, cross training
 - Exercise caution re: use of language (not “addictions” – which is illness-based – but “substance use”)
 - Encourage use of strengths-based model to counter tendency among PC providers to equate addiction and mental illness with hopelessness
 - Engage clients/consumers:
 - Increased exposure reduces stigma
 - Use clients’ knowledge and skills :
 - Increase use of peer support workers with compensation
 - Engage the Dream Team, or similar educational models
 - Support individuals to participate in and manage their own care
 - Develop tools to support self-management and disseminate to consumers
 - Diversify workforce – reach out to pluralistic communities to reduce stigma

3. Knowledge and Competency

- Enhance Professional Education:
 - Start where each profession is at
 - Increase focus on Addiction and Mental Health in curricula of professional schools
 - Define core competencies related to addiction and mental health
 - Ensure that medical residents have experience with MH and addiction services
 - Include a focus on attitudes, values and diversity
 - Attitudinal and behavioural change is required – no amount of knowledge and competence will make a difference without them
 - Provide ongoing training

4. Scope of Practice, 'Turf', and Trust/Respect Issues

- Establish collaborative interagency teams based on:
 - Shared goals
 - Clearly defined roles, responsibilities and core competencies
 - Clear professional practice requirements
 - Clear expectations and accountabilities
 - Jointly determined targets and goals for care planning/case coordination
 - Common language, definitions
 - Systematic approaches, models, values
 - Shared protocols
 - Strategies for measuring success of collaboration
 - Respect, acceptance and valuing of the contribution of all team members and of the client
- End "handing off":
 - Reinforce expectation that all sectors remain involved with client/consumer
 - Ensure clear role definition through development of collaboratively care plan
- Develop shared health records and address related privacy concerns
- Promote "upstream" approaches in primary health care by implementing early identification/early intervention strategies

5. System Capacity

- Use collaboration and partnership to enhance/extend capacity
- Recognize that collaboration requires a real shift in paradigm/culture
- Support the change process
 - Support development/dissemination of effective partnership models (e.g. co-location , back office integration)
 - Identify opportunities to bring together organizations, integrate processes, and link resources
 - Bring stakeholders to common tables
 - Look at mandate and exclusionary issues/practices
 - Use 'champions' (who think outside the box/mandate) to 'jump start' change
 - Make collaboration an expectation
 - Disseminate promising practices across LHINs and document successes (e.g. North Bay)

6. Resources and Funding

- Consider and document outcomes for a) individuals and b) the system (in terms of cost)
- Develop effective responses for those who are expensive to serve (e.g. service resolution tables)
- Identify savings – e.g.:
 - Diversion from ER
 - Cost avoidance (e.g. through early identification)
- Invest savings in system capacity
- Ensure that 'the basics' remain in place: services in areas of choice and options for types of services (i.e. delivered in PHC and in mental health/addictions agencies)

IV. Identification of Priority Actions

The Consultants reviewed and consolidated the strategies identified in the previous exercise under six broad theme headings:

1. Reduce Stigma and Discrimination
2. Integrate Services
3. Facilitate a Paradigm Shift
4. Enhance Knowledge/Facilitate Knowledge Exchange across Sectors
5. Build Capability of Primary Health Care to Screen, Identify and Refer
6. Build Collaboration Skills and Provide Resources

Participants were asked to indicate (with voting dots) what strategies should be pursued first – i.e. those which should be priority actions because they would have the most immediate impact or be most critical to moving forward. The outcome of that exercise appears below. The total number of votes for each category is shown as [x].

1. Reduce Stigma and Discrimination [33]

- Address stigma among professionals in PHC. MH and Add with intensive, integrated training – including job shadowing
- Engage clients and consumers in all aspects of the system
- Develop protocols which mandate collaborative behavior, which may lead to change in attitudes
- Use consumer/client skills and knowledge (e.g. peer support)
- Address use of language
- *Make sure that referrals aren't just "hand-offs", but that people actually get connected and that follow up includes shared care*

2. Integrate Services [31]

- Integrate Mental Health and Addictions services into Primary Health Care and/or provide PHC (without using MDs only) as a component of MH & Add services
- Integration at system level, service level (and policy/funder level)
- *Specialized mental health and primary care settings in community should play a lead role in:*
 - *Shared care*
 - *Coaching, support and consultation re: collaborative MH and primary care in the community*
- Model can be virtual or physical (co-locate, back office integration)

3. Facilitate a Paradigm Shift [29]

- Expectations/incentives required to motivate the shift
- Focus upstream – start earlier and from a holistic point of view
- Plan to meet diverse needs, not just those of a homogenous population
- New ways of doing business/ culture shift on all sides
- Think of PHC in terms of the whole range of multi-disciplinary teams
- Paradigm shift already happening in CHC – expand and enable them, support this commitment tenfold
- Identify specific implementation steps for change –including who, what and how
- Important not to create yet another planning/strategy document

4. Enhance Knowledge/Facilitate Knowledge Exchange across Sectors [20]

- Assess outcomes
- Document successes (including savings)
- Support and disseminate information about work of “champions”
- Identify core competencies in mental health and addictions for all providers

5. Building Capability of Primary Health Care to Screen 18]

- Target nurses and nurse practitioners
- Facilitate system navigation - create one # to connect people to service
- Create tools and resources
- Identify early stage problems and refer

6. Build Collaboration Skills and Provide Resources [12]

- Ensure that people with lived experience are at the table
- Disseminate information about models and support their implementation
- Differentiate roles and responsibilities of various professional groups
- Disseminate information about “other sector” team members’ roles and approaches
- Specify goals for contact/collaboration across sectors
- Focus on continuity of care

V. Comments and observations from plenary discussion:

In plenary discussion, participants were invited to comment on the results of small group discussion and the voting dots exercise; key observations included:

- Reducing the disability of people with mental health and addiction problems requires:
 - a strong focus on primary care
 - a focus on the strengths and resiliency of mental health and addiction services, not just that of consumers/clients
 - ability to seize opportunities to think upstream – primary, secondary and tertiary prevention
 - Attention to client strengths, not just deficits - important to tap clients’ own assets
- Important considerations for planning:
 - Diversity of the population – we can’t build effective responses based on planning that does not consider class, gender, and race/culture right from the beginning
 - Impact of poverty
 - The need for dental services as an essential health services
 - The critical role of settlement workers and other allied services
- Current system focus and paradigm present challenges:
 - The health care system is based on acuity and is not sustainable
 - We are still very focused on the medical model, must take a more holistic view and provide broader, more comprehensive support
 - It’s rare to get a holistic assessment - from patient perspective, this is a problem whether or not you have a mental health addiction problem
- Current funding strategies present challenges:
 - New funding tends to be designated for targeted programs – we need to take a holistic (rather than targeted) approach

- Communities are not homogenous – differing needs and community resources mean that workable strategies may differ radically from community to community
- New inter-disciplinary models having mixed outcomes in respect to this population
 - Some of the new models work well but still, the average length of a visit under the fee for service system is six minutes
 - PHC patient selection practices that tend to exclude people with more complex needs happen when reward mechanisms support them
- Champions among us have moved forward on this issue because:
 - It's good for our clients
 - It's a business imperative
- Strategies to get to the desired end state
 - Challenges (and the strategies to address them) are all inter-dependent
 - Start by addressing stigma and take a holistic approach
 - Need to ensure implementation of screening protocols for mental health and addictions issues in PHC
 - We must help funders set targets and expectations
 - Should develop relationship with PHC as it is, not as it should be - need to identify ways which will allow PHC providers to embrace new approaches
 - Look to the CHC model
 - We, as service providers, have to believe that people (including each other) can do better - must check our own attitudes and behaviour for stigma and discrimination
 - Changing the system is everybody's responsibility (including consumers and families)
 - Paradigm shift must be accompanied by funding shift

APPENDIX IV: ROUNDTABLE ATTENDEES

Name		Association
Jean	Beckett	Consumer, Parry Sound
Nancy	Bradley	The Jean Tweed Centre
Raymond	Chung	Hong Fook Mental Health Association, Toronto
Laura	Cowan	Street Health, Toronto
Mary	Crompton	Saint Elizabeth Health Care, Toronto
Mary	Davies	North Bay Mental Health Housing and Support
Michael	Dean	St. Joseph's Health Centre, Toronto
Renee	Desmond	Centre for Addiction and Mental Health, Toronto
Lisa	Droppo	Ontario Association of Community Care Access Centres
Debbie	Ernest	Centre for Addiction and Mental Health, Toronto
Lana	Frado	Sound Times Support Services, Toronto
David	Gibson	Sandy Hill Community Health Centre, Ottawa
Michelle	Gold	Canadian Mental Health Association Ontario
Pam	Hines	Canadian Mental Health Association, Windsor
Sulekha	Jama	Across Boundaries, Toronto
David	Kelly	Ontario Federation of Community Mental Health and Addiction Programs
Marianne	Kobus-Matthews	Centre for Addiction and Mental Health, Toronto
Margaret	Leslie	Breaking the Cycle/Mothercraft, Toronto
Joan	Lesmond	OAHC, OCSA and Saint Elizabeth Health Care
Dennis	Long	Addictions Ontario
Nancy	Lum-Wilson	Ministry of Health and Long-Term Care
Scott	Macpherson	Consumer, Port Hope
Lee	McKenna	Association of Ontario Health Centres
Susan	Morris	Centre for Addiction and Mental Health, Toronto
Susan	Paetkau	Ministry of Health and Long-Term Care
Emma	Pereira	Centre for Addiction and Mental Health, Toronto
Donna	Rogers	Fourcast, Peterborough

Christine	Samson	WOTCH, London
Barney	Savage	Centre for Addiction and Mental Health, Toronto
Peter	Selby	Centre for Addiction and Mental Health, Toronto
Angela	Shaw	St. Jude Community Homes, Toronto
Liana	Sikharulidze	Saint Elizabeth Health Centre, Toronto
Brent	Stein	Canadian Mental Health Association, Simcoe
Linda	Stevens	Kingston Community Health Centre
Linda	Stewart	Association of Local Public Health Agencies

APPENDIX V: KEY INFORMANTS INTERVIEWED

Nancy Bradley, The Jean Tweed Centre

Michelle Gold, Canadian Mental Health Association, Ontario

Betty Harvey, St. Joseph's Health Centre (London, ON)

Jan Kasperski, Ontario College of Family Physicians

Dr. Nick Kates, Hamilton Family Health Team

Laura Kokocinski and Jim Restall, North West Local Health Integration Network

Lee McKenna, Association of Ontario Health Centres

Dr. Bruce Minore, Lakehead University

Margaret Mottershead and Lisa Droppo, Ontario Association of Community Care Access Centres

Dr. Peter Selby, Centre for Addiction and Mental Health and St. Joseph's Health Centre (Toronto)

Dr. Wayne Skinner, Centre for Addiction and Mental Health

APPENDIX VI: KEY INFORMANT INTERVIEW GUIDE

Interface Between Primary Health Care and Mental Health and/or Addictions Services Key Informant Interview Guide

Thank you for agreeing to be interviewed as a key informant. We are forwarding this Interview Guide to you to provide information about the project purpose and approach, the focus of the upcoming interview, and the interview questions.

Purpose

The Ontario Federation of Community Mental Health and Addictions Programs and the Canadian Mental Health Association Ontario are working together to develop a joint policy document for submission to key MOHLTC and LHIN decision makers regarding how to improve collaboration and coordination between primary health care and community mental health and addictions providers.

Approach

To develop the policy paper, the project will involve:

- scanning the literature re: gaps, challenges and promising practices in the interface between primary health care and mental health and/or addiction services
- interviews with a cross-section of key informants who are ‘thought leaders’ in the primary health care, mental health, and/or addiction sectors.
- a roundtable meeting that will bring together stakeholders from the three sectors to identify priorities for action

Focus of the upcoming interview

The questions below are designed to obtain your perspectives on readiness and capacity for change to support the interface between primary health care providers and community mental health and addiction agencies.

Interview Questions

1) *for Primary Health Care Sector:*

What are the priority needs of providers in your sector for collaboration with community mental health/ addiction providers in order to meet the needs of people with mental health problems or addictions?

for Community Mental Health and Addictions Sector:

What are the priority needs of providers in your sector for collaboration with primary health care providers in order to meet the needs of people with mental health problems or addictions?

- 2) What is the extent of collaboration and coordination between primary health care and community mental health and/or addictions providers currently in Ontario? What benefits and results from this collaboration and coordination, if any, are you aware of?
- 3) What are the most significant barriers to collaboration and coordination between primary health care and community mental health and/or addictions services in Ontario?
- 4) What can be done to address sector barriers to collaboration and coordination in Ontario?
- 5) What would enable collaboration and coordination between primary health care providers and community mental health and addiction services?
 - at the service level
 - at the system level
 - at the policy level
- 6) Which actions should be pursued first (i.e. *which are likely to yield immediate results, have the most critical impacts, or be met with readiness from primary care, mental health, and/or addictions service providers*), and why?