



Canadian
Collaborative
Mental Health
Initiative

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CCMHI MEMBERS

Canadian Alliance on Mental
Illness and Mental Health

Canadian Association of
Occupational Therapists

Canadian Association of Social
Workers

Canadian Federation of Mental
Health Nurses

Canadian Mental Health
Association

Canadian Nurses Association

Canadian Pharmacists
Association

Canadian Psychiatric
Association

Canadian Psychological
Association

Dietitians of Canada

Registered Psychiatric Nurses
of Canada

The College of Family
Physicians of Canada

CCMHI

Provincial Consultations

Nova Scotia Manitoba Saskatchewan



FINAL REPORT

December 2007

&

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May 5, 2008

As chair of the Canadian Collaborative Mental Health Initiative (CCMHI), a consortium of 12 national organizations representing community services, consumers, families and caregivers, self-help groups, dietitians, physicians, nurses, occupational therapists, pharmacists, psychologists, psychiatrists and social workers, I invite you to read the enclosed report.

CCMHI is committed to strengthening the relationships between mental health and primary care services, and the consumers using these services – what we refer to as collaborative mental health care. As part of our work we recently conducted consultations in the provinces of Manitoba, Nova Scotia, and Saskatchewan that involved key leaders of government, provincial organizations, and consumer and community groups. This report summarises the themes and messages arising during these sessions.

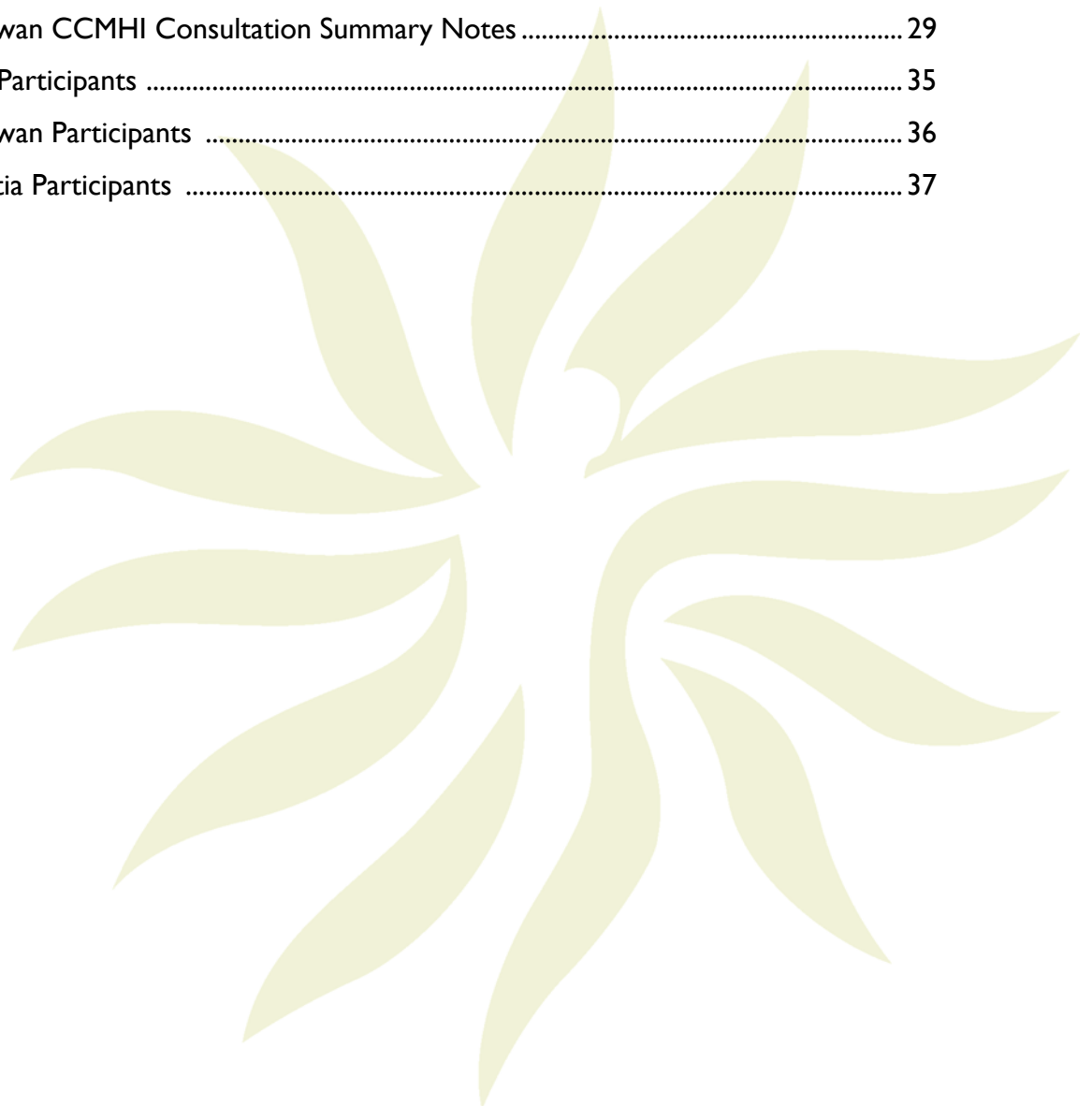
These meetings not only highlighted the enthusiasm for greater inclusion of projects that forge stronger links between mental health and primary care providers and consumers and families but also the very similar reactions and interest in three different parts of the country.

As collaborative mental health is increasingly seen as an important component of redesigning our health care systems to better meet the needs of consumers, this document provides important evidence as to the interest across Canada in advancing these concepts.

Nick Kates
Chair CCMHI

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Background

CCMHI is a national primary health care reform initiative comprising twelve national associations including two community / consumer associations and ten professions active in aspects of mental health services. During Phase One of its mandate, CCMHI developed a comprehensive resource package including 12 implementation toolkits targeting health service providers and planners, consumers, families, caregivers, and educators. Phase One concluded with the signing by the Presidents of the twelve associations of a CCMHI Charter of principles and commitments among the associations elaborating a model of professional and consumer / family collaboration.

Phase Two for CCMHI focuses on dissemination of these resources and promotion of collaborative mental health care at the local, regional, and provincial levels. The purpose of the consultations was to promote collaborative mental health care among professionals, policy makers/funders and consumers/family members in the primary care setting in Nova Scotia, Manitoba and Saskatchewan.

Format of Consultations

Separate agendas were developed for each of the provincial consultations. Each of the sessions began with welcoming and introductory remarks from host CCMHI Steering Committee members:

Nova Scotia:	Elaine Campbell and Dr. David Gardner
Manitoba:	Annette Osted and Dr. Keith Lowe
Saskatchewan:	Bob Allen

- This was followed by a presentation from Scott Dudgeon (Former CCMHI Executive Director) who provided attendees with an overview of CCMHI Phase One. Phil Upshall, Project Manager provided a summary of the major goals and expectations of Phase Two he indicated that the main goal of the consultations was to assess the utility of the CCMHI products, the appetite for forward movement in collaborative mental health care and suggested methodologies for

implementation. Each of the meetings was meant to advance collaborative mental health care in the provinces inclusive of consumer/family interests and the range of professions active in mental health services, by focusing on the following questions:

- What is the present status and interest in collaborative care in your province? Relationship to other mental health and primary care reform initiatives?
- Feedback on toolkits and other resources - what is their value and utility?
- What are the advantages of moving forward with collaborative care in your province?
- What would successful collaborative mental health care in the primary care setting look like in your province?
- What are the most pressing common issues and barriers to moving forward with collaborative care, and potential solutions?
- What are the possible next steps?
- Is your province ready for a Collaborative Mental Health Initiative?
- What needs to be done in the short-term and in the long-term?
- Do we need more information and how do we get it?
- Do we need to engage other stakeholders? If so, with whom and how?
- Do we need to seek resources and if so, how/from where?

Summary of Major Findings

Overall the consultations revealed strong support for collaborative mental health services in primary care. Detailed summary notes for each of the provincial consultations are attached and attest to the interest from the majority of targeted stakeholders. Specifically, consultation findings showed that the following initiatives would be highly valued by primary care and mental health providers, mental health professionals, health educators, policy makers and consumer and family representatives:

- Consultations were well attended and revealed substantial support for a national collaborative mental health care movement, accompanied by provincial and territorial programs. Lists of participants by province are attached as appendices.
- National leadership was seen as necessary for success in that it would unite isolated groups desiring to engage in collaborative mental health care and provide them (and interested others) with much needed knowledge exchange both at the macro-level policy and funding change strategies and micro-level best practice materials for clinical and programmatic change.
- Recognition that collaborative mental health is a ‘work in progress’, that the materials developed by CCMHI represent knowledge organized a few years ago and that many stakeholder groups and delivery agencies have been actively engaged in developing knowledge and practice.
- Need to produce toolkits in print form – as well as in electronic form: Another finding was that the audience for the toolkits, while computer literate, made most use of the available hardcopy versions – now in high demand but with no remaining inventory to respond to the volume of requests. The electronic versions, while accessible, proved to be the lesser-used conduit for dissemination.
- A demonstrated need to map innovative Canadian collaborative mental care projects for dissemination and replication. The consultations also revealed numerous grassroots collaborative initiatives that built upon and went beyond the original inventory completed in Phase I of the CCMHI project. Many of these are at the regional and rural levels. Many involve formal teamwork, and structured roles for consumers and their representatives. Participants felt that mapping these projects and disseminating this information broadly would further decision makers’ awareness, but also offer examples that could be replicated locally. Thus, in addition to the toolkits, participants want real life illustrations of collaborative care at work and ways to stay in contact with one another.
- In some instances there was support for building the inclusive collaborative model into service standards and accreditation processes, with the idea that to be adopted meaningfully and broadly some kind of framework of standards and accountability was necessary. Examples were given of other care standards in accreditation policies.

- A need to examine and report on enablers and barriers to access to collaborative mental health care, including service provider compensation reforms. Barriers to care include professional compensation patterns, wait lists and limited publicly funded professional and agency services.
- There is also a corresponding shortage of trained human resources. Of special note is the fact that much of specialized mental health care is provided privately outside of the public system. Many jurisdictions in Canada have begun – or are planning – to address these barriers. An example of an enabler is the recent development of 30 consensus measurements for quality primary mental health care. Participants felt that a national collation of these enablers, as well as barriers, along with an assessment of readiness for health provider compensation reform would drive collaborative mental health care forward.
- Consumer inclusion and participation in the collaborative model needs to be encouraged and supported formally and informally at all levels of service delivery and policy.
- Develop inclusive training modules focused on collaborative mental health care: Inter-professional education for health care providers has enjoyed substantial financial support from federal sources and is the focus of health system reform in a number of jurisdictions. The role of consumers and families in professional training is a critical but under-explored area. Inter-professional education is aimed at giving service/health providers experiences of working together – a collaborative practice that is not, as of yet, widespread. Thus, participants felt that a specific focus on collaborative mental health care is required, beginning with training modules for post-licensure professionals in active practice that would help them learn ways of working together, and working with consumers and families. While there is no doubt that college and university curricula are undergoing change, professional development training is well placed to obtain more immediate results for consumers and families.
- The view that the collaborative model is logical to deal with such issues as co-occurring conditions, e.g. addictions and mental illness and mental health implications of serious medical conditions, as well as with promotion and prevention, and the reinforcement of a broad public health approach.
- The findings from these consultations, as outlined above, translate into the components of a practical and multi-level framework for implementation aimed at addressing macro-level policy and funding enablers and barriers, as well as

- micro-level best practice models that speak directly to implementers' needs. Attendees were clearly seeking further networking opportunities and *an effective step-by-step implementation framework* that they can take forward to their respective policy-makers to persuade them to draft policies, enact legislation and fund projects – all of which will provide the necessary foundation for implementing collaborative mental health care regionally and locally.
- It became readily apparent to the CCMHI Team that consultations should be conducted in the remaining provinces and territories. The consultations in Phase 2 proved enormously fruitful and in many instances uncovered strong support, coupled with commitment and energy, for implementing collaborative mental health care. Providing a focus for this energy in the remaining jurisdictions would develop critical mass for implementation and ensure a national network for collaborative mental health care.
 - The enclosed Summary notes from each province provide valuable insight into the following barriers and opportunities that were identified in each of the provincial jurisdictions:
 - Advantages of moving forward
 - Common issues and barriers
 - Possible next steps
 - Short and long term measures to move forward
 - Engagement of other stakeholders

Feedback from Provincial Consultations

Post-consultation evaluations were sent out to all participants. Forty-eight evaluations were returned. The following represents comments received from some of the attendees in the three provinces:

“If anything is taken back- this should remain a national initiative- keep momentum going- if sunset clause says this is over- third phase- profile that it is happening all over Canada- get on the bandwagon- without a national picture- no bandwagon- just local thinking- finding serious paradigms here that have been professional practice for centuries- without

external or national level, difficult to sell the concepts at the provincial levels". Professional Manitoba

"I found the consultation quite informative and the CCMHI team very receptive to feedback from the audience. Certainly there was a very palpable sense of excitement and enthusiasm among the group for this initiative within Manitoba. I believe people here are quite motivated to move forward and fully embrace collaborative mental health care".

Professional – Manitoba

"The toolkits and other CCMHI resources are important for the expansion of collaborative mental health care in primary care". Professional Manitoba.

"Continued CCMHI activities are important to the future expansion of collaborative mental health services in primary care in Canada". Professional Manitoba

"Need to be clear about the scope of CCMHI's concept of 'collaborative' relative to other narrower concepts of shared care among professionals only. The audience seemed to accept the clarification, but the broad concept (consumers, families and all allied professions) will require nurturing and support relative to narrower concepts, since it doesn't have a long history in practice, it requires re-thinking roles, especially the consumer's role, at a higher level, and it will require supportive policies, funding and planning, governance and training mechanisms to be effective. The discussion of embedding collaborative mechanisms in standards and accreditation policies was extremely positive". Service Provider-Manitoba

"The most valuable aspect of this consultation was beginning to get on the same page with regards to collaborative mental health with the Regional Health Authorities and the professional bodies. At the very least the conversation has begun". Professional – Manitoba.

"I would like to see us reach a common understanding of the role of the consumer in the new paradigm. Forging an agreement to that is an essential first step". Service Provider – Manitoba

"Bringing provinces together to exchange collaborative best practice models is key. Otherwise people will not necessarily take the time nor do they have the resources to research these. Also, too much time could be spent reinventing the wheel of a project that

someone is working on and happy to share with other provinces. Official – Manitoba Health and Healthy Living

“Great job! It has prompted a de-brief meeting here between Primary Care and Mental Health which is a good sign”. Official – Manitoba Health and Healthy Living

“I would very much be interested in being part of the CCMHI committee in Manitoba; I believe we need to ensure we have rural regional representation at the table in all initiatives. Service Provider – Manitoba

“I would like to see collaborative care between formal mental health resources and the emergency systems, in particular the emergency room. There continues to be a significant wall, different mindset between hospital services and community services particularly in mental health”. Service Provider – Manitoba

“I want to thank you and your colleagues for the consultation. When I began this journey into the maze called Mental Health I began to realize that the health system was created in two parts; 1) from the neck down (primary care) and, 2) the head (mental health). During the consultation I heard for the first time in eleven years that Mental Health should embrace the body, mind and soul. In other words, the ‘whole’ person’. There is hope for the mentally ill and their families through the pursuit of the Collaborative Model for Mental Health. Keep up your good work”. Family Member – Manitoba

“We must talk about collaborative care in practice among different professions- we don’t teach how to be a member of a team- if yes- usually within that profession – so when they get out to practice- they are starting from scratch. We will continue to experience difficulties until we have education about true interprofessional practice” Professional – Manitoba

“The most valuable aspect of the meeting was having the leaders (decision-makers) at the table”. Consumer – Nova Scotia

“It would have been good to have more time to discuss the local follow- ups with the whole group present. I wouldn’t want to lose any of the momentum of this important initiative”. Professional – Nova Scotia

“I was delighted with the turnout, and think the meeting was a great success on both fronts”. Senior official – Ministry of Health – Nova Scotia.

“We must make space for consumers to be heard by society”. Consumer – Nova Scotia

“CCMHI has the best structure and materials to support implementation but the issue is the will to proceed and leadership”. Professional – Nova Scotia

“I would like to see the identification of specific barriers and opportunities for implementation in more detail in the future as well as specific implementation success stories from other communities.” Professional – Nova Scotia

“We should learn more about the priority focus of service in the context of primary care. This has the most promise because of the broader definition of primary health care means a more interdisciplinary and intersectoral way to meet health and population health needs”. Professional Saskatchewan

“I would like to see more success stories, demonstration models and best or good practices in the integration of mental health services with primary health care services”. Professional – Saskatchewan

“A toolkit on children’s mental health would be very helpful”. Professional – Saskatchewan

“Given that we have a very limited number of Psychiatrists in either fee for service practices, or RHA contractual services, and also given the average age of our Psychiatrists is high, we need to better consider the use of allied Mental Health and Addiction staff in any collaboration with Primary healthcare Physicians”. Director – Health Region – Saskatchewan

“Consumers and family members need to be involved in promoting the toolkits, developing CME opportunities based on the research and action plans of the toolkits”. Consumer – Saskatchewan

“If CCMHI is not sustained after this funding period, thought should be given to integrating its materials, processes, and mandate into the Mental Health Commission’s work”. Consumer – Saskatchewan

“I was encouraged by the fact that participants came from the level of Regional Health Districts and professional associations where their leadership could make a difference in moving forward the Collaborative Mental Health agenda”. Consumer – Saskatchewan

Follow-up since Provincial Consultations (as of April/08)

Saskatchewan: There has been a follow-up meeting of stakeholders in Saskatchewan in March 2008. A second (larger meeting) has been scheduled for May 2008. The purpose of these meetings is to lead to the development of a Saskatchewan Collaborative Mental Health Initiative.

Nova Scotia: Two members of the CCMHI Steering Committee have been invited to a follow-up meeting with senior officials with both mental health and primary care of the Nova Scotia Ministry of Health in May 2008. One CCMHI Steering Committee member has subsequently been invited to participate in the Provincial Mental Health Standards Review where collaborative principles have been added to the most recent draft of these standards.

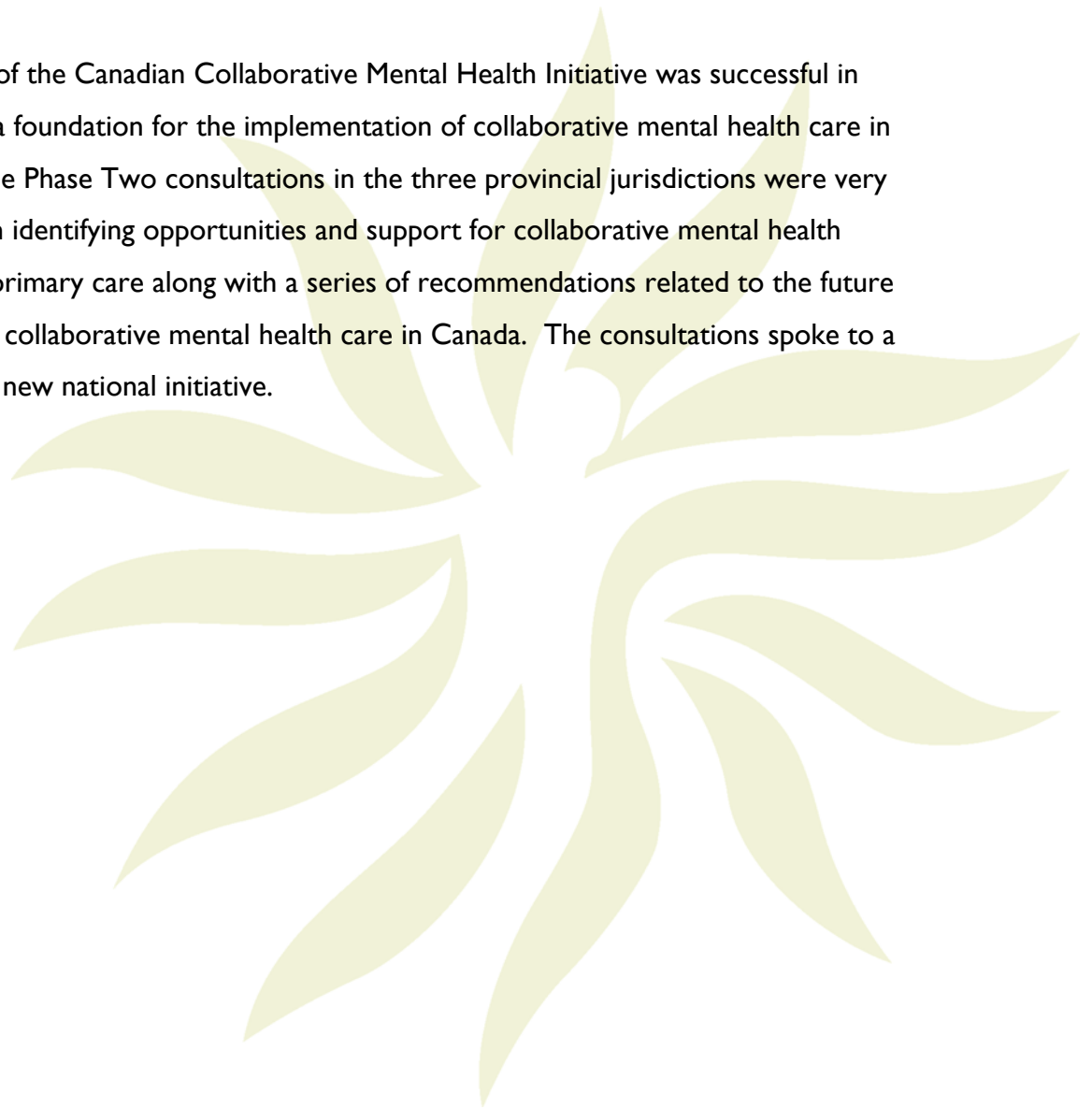
Manitoba: A joint debriefing meeting between Mental Health and Primary Care within the Manitoba Ministry of Health was convened. In addition, the Alliance on Mental Illness and Mental Health of Manitoba are planning to meet in the spring of for follow-up purposes.

Quebec: A preliminary discussion has taken place between the Chair of CCMHI and the Director of Mental Health for the Province of Quebec. Interest has been expressed by Quebec and CCMHI expects to conduct a formal provincial consultation process in the next stage of the initiative.

First Nations and Inuit Health Branch (Health Canada): The Project Manager of CCMHI Phase Two has had some preliminary discussions with officials of FNIHB. There is considerable interest in looking at mental health collaboration from an Aboriginal perspective. An agreement has been reached to follow up as part of the next iteration of CCMHI.

Conclusion

Phase One of the Canadian Collaborative Mental Health Initiative was successful in developing a foundation for the implementation of collaborative mental health care in Canada. The Phase Two consultations in the three provincial jurisdictions were very successful in identifying opportunities and support for collaborative mental health services in primary care along with a series of recommendations related to the future direction of collaborative mental health care in Canada. The consultations spoke to a desire for a new national initiative.



Manitoba CCMHI Consultation Summary Notes

Present Status and Relationship to Other Mental Health and Primary Care Initiatives

- Winnipeg has a shared care initiative – includes psychiatry, other doctors, Nurse Practitioners, RNs, RPNs, BSW, psychologist. Hope to add more resources to increase the initiative.
- In primary care – different models under study/use
- Rural areas with different needs – examine service provision
- Urban (WRHA) could learn from rural care model
- Need to reconnect all the chronic disease areas (including mental health) to broaden the collaborative model away from disease-specific modeling for primary care reform
- Mental health as ‘secret’, may restrict framework of teamwork and collaboration
- Successes have originated when client/patient/consumer is at the centre of care and there is effective communication with families
- Recognize need to focus on prevention not only treatment
- We must engage in meaningful discussions as to how Manitoba Health can support collaborative practice – definitely an area for RHA’s to pursue – needs to be nurtured – multiple initiatives
- Discussion as to “who’s in charge” – need to remember that consumer is at the centre
- Link between educational institutions, care sites, policy agencies – include professional colleges and evaluation standards in thinking about where and how collaboration is really working – we don’t know the places/ways collaboration is working
- IECPCP of interest as helping know about collaboration
- Need mechanism to evaluate patient centredness – there are many activities where different professional groups and client/consumer groups are getting together for mutual benefit/learning

- Who is at the table at these discussions and how to ensure consumer centredness
- Consumer centred direct care is OK but at education and policy levels
- The consumer-centred focus is lacking and need to lead

CCMHI Toolkits and Web Resources

- Comprehensive, practical and user friendly
- Promotes thinking of issues
- Would be very useful in the Arctic and other rural and remote areas of Canada
- Could use updates that speak to what is happening currently
- As time goes on, hope that that toolkits will be updated with evolving information and highlight pearls of collaboration
- Discussion on consumers not having directly contributed to toolkit development – some opportunities but segmented. Should be considered as works in progress
- Central Region has circulated the information to clinicians and program managers although this has not yet affected policy change at the regional level
- Front line may have received initial communication about resource without time/opportunity or informed motivation to really use/read as a working resource
- Need to build awareness further to disseminate the kits/resource/website as an effective tool
- Still need toolkits in a structured manner to involve consumers in evaluation of services and collaborative care. **Possible subject for Phase Three**
- Train the trainer concept may be useful to disseminate the translation/dissemination of the resources to patient/client benefit
- A question of revisions for the toolkits – marketable as a ‘hard copy’ attractive items for general use/distribution → future possibility
- There are other tool kits in primary health care field- health care, scope of practice, CCFP (teams) → so look for other tool kits
- Kirby Commission – knowledge exchange centre- the aim that the MHCC may undertake to support revision & dissemination of resources/tools

- Kits in synch with CCHSA standards of care need to be – need to remember accreditation standards are being revised to or already include ‘collaborator’ & therefore need to be able to measure collaborative care in order to keep patient/client focus
- Repeat, revise, collect resources & model their use/application at care & policy level

Barriers

- System demands
- Elitism – people will often refer to the highest level of credential irrespective of need
- Profit-driven mind set vs. reality
- Adequate compensation for work
- Explore incentive funding
- Money
- Location of providers
- Distance between providers
- Training
- Lack of attention to transitory process that would include need for increased dollars and ability to increase education spaces
- Professional silos
- Policy re who provides prescriptions- i.e. only MDs- we need to expand this
- Role of consumer- approach from mindset that we are all consumers
- Lack of user friendly system
- Stigma

Next Steps

- Go forward on collaboration in care at RHA/policy level – e.g. linking housing, health
- MB going forward with other proposals at national level- need to engage ‘folks’ in what that would look like
- Needs to be clear to funders that collaboration can work better for public
- Begin breaking down barriers
- Multi-professional Act at provincial level
- Ongoing connections between provinces re: crisis mgmt, often with justice issues related to MH
- Need to include consumer voice - partly included in legislators as elected
- PHIA/FIPPA reps – has + and - → focus on
- Commitment to reliable care
- Useful – a local alliance of consumer/client input – don’t hide behind confidentiality
- Today’s discussion could be useful to develop an initiative “compendium” – federal proposal for an Access between primary and specialist care – to put people/place/time together optimally at early stage, aim to include several sectors to decrease the chance of people ending up in the wrong office
- Fear of loss of power as the elephant in the room
- Need balance b/w public rights and professional duties (scope of practice – don’t see self as a threat)
- Collaboration has advantages and also takes time
- Need to be able to collaborate properly and recognize the outputs
- Need to recognize fears and address them rather than avoiding the discussion
- Enhanced communication about initiatives that are already taking place
- Valuing all providers and what they provide
- Simplifying access
- Educate professionals (includes inter-professional)
- Government leadership

- Address RHA disparities
- \$\$\$ directed to desired MH clinical activities
- ** Advocacy to ensure that political WILL develops (\$)
- Strategy for change (Social Change)
- Accreditation
- Professional bodies identify specific thresholds of desired behaviour (e.g. 3 mo. Minimum share care exposure)
- Top down and bottom up
- Increased specialization = increased need for collaboration
- Training in collaboration for both current and training professionals
- Match workplace expectations to collaborative training
- Change performance measures to measure attainment of desired goals (e.g. – better health outcomes)
- Research ethics
- Balance outcome measures with client-specific goal attainment
- Enriches clinical environment by having “other” disciplines’ trainees
- Reconcile professionals working together more effectively with engaging consumers in re-shaping service delivery
- Measurement considerations:
- MH as a determinant of attainment of broader health care goals (i.e.- wait time)
- MCPA- mental health consumers disproportionate use of Health care services
- Community pressure → politicians
- Involve MDs
- MDs, community MH- unity

Engage other public policy stakeholders

- Public Health
- Consumer groups (e.g. parent organizations)
- Addictions

- DHACs
- RHA Boards
- Child poverty groups
- CMHA MB
- Municipalities
- MHA Councils (provincial and regional)
- First Nations
- Corrections

Alliance on MIMH of Manitoba – agreed to organize follow-up discussions

Discussion and Feedback

- Unless we collaborate well, we lose the energy of any specialization that can help improve/benefit patient care
- We need national profile to support provincial uptake
- Need to know how/improve how we teach collaboration to training of students
- Too much of professional training puts blinders on “identity” to potential exclusion of other professions
- Government needs to model collaboration, including from client/consumers – professionals- mid mgmt- policy makers – RHAs can lead by figuring out how to collaborate
- The failure of mental health programs in MB can partially be measured by the number of consumers of mental health services needing emergency services
- Recipients of care could have important input into standards of care (and the evaluation of care over and above accreditation)
- CHSA accreditation model is a good way to involve all aspects and recipients/participants in care – “teeth” important
- May see change to an almost entirely patient/client-based accreditation of institutions/ programs
- Need to be able to ‘see’ where client/consumer is giving real input to accreditation processes and standards
- Collaboration as a lofty goal

- What it looks like – build capacity to include and collect patient/consumer experience as input to broad consumer perspective
- What does collaboration achieve? Need to know that from client, family, financial, etc... perspectives - need to know ‘what will I get, re: improved quality, if I buy in.’ The ‘why’ is not marketed well
- Patient/client focus is non communication & function with them not on organizational structure of “team” – how will client/patient have input – policy and practice
- National priorities that would help provinces
- Research, NCC, CIHR
- Healthy living strategy – include MH
- Organizational health
- National public health network
- These ideas should be advocated at the Mental Health Commission of Canada level- might have support at provincial level in next 2 to 3 years
- What needs to be promoted at provincial gov’t level- are there areas where prov. govt could take action or promote issues at MHCC level
- Need to make room for the voices- i.e. breast cancer has high profile- persons speak for themselves a lot- mh/mi still seems stuck where individual & family members can’t do that- need to make space for people to be heard- people don’t know basics & fundamentals of mental health or mental illness- MH awareness week only one week, not 52- Need recovery stories told by people who are recovering- one small step towards that happening
- Need to involve people who have the illness when promoting issues at govt level- when consumers speak, even govt people stopped playing with blackberries
- Of all the coll work- let’s not duplicate- research is important- partnerships in research- what about new collaborative centres- can that be broadened
- Something that’s been around- national healthy living strategy- in initial formation- tended to be broader & deeper than it ended up being- the actual document says soon to be involved with injury prevention & mental health. There is an opportunity for re-injection of mental health in there

- Organizational- national public health network- relatively new- public health agency- senior public health from all prov-fed-terr- if look at issues for other diseases- partnerships –disease and even organ initiatives- we are going narrower as we go forward instead of broader- mental health may be a connector- we can't do our work in MB without the support from those initiatives
- Marrying stories of consumers – also need to marry stories of families- almost a guarantee of continuing mh problems
- We need action research that engages consumers as well as other stakeholders. Another piece, the way that we as professionals forget our own consumer or family roles and maybe need to bring that in.
- We just completed participatory action research- interviewing service providers- we are still writing report- next step is to really explore some the questions that we didn't get to ask in the research to find out what mindsets are so when we do go forward
- Partnership in Consumer Involvement- have consumers make presentations to police, nursing, Participatory Action Research Groups also part of CMHA
- Issue of mental health care- being outcast cousin of health services in general- have good research in MB from Health Policy re use of health care services- people with mh problems use the system far more frequently than those without mi. So all of us are already service people with mh problems – why not build on that – public health and primary health care initiatives & chronic health care are all geared towards people with mi because they are the least healthy- have least healthy lifestyle- far more negatively impacted- could we begin to reframe the issue so that it becomes a part of general health services planning.
- Point about mh and wellness for aboriginal peoples- needs to be integrated in any go-forward state- forensics, etc
- If you have identified psych problem have less chance of getting appropriate treatment when you have a heart attack or other medical emergency
- Cardiac disease is high cost as is mental illness- how do we marry those two to decrease impact
- Kind of hard to know what is going on in govt- important part is dialogue- what are
- NOR-MAN health care centres –embedding mental health services

- Need to help consumers with care by involving them in an understandable care plan to which they agree and can take home
- Consumer perspective is not well defined. Need to define collaborative care, especially to inform consumers/families in need of care
- In Manitoba there are different professionals and professions are doing different pieces of collaborative care
- As educators, Manitoba health professionals (i.e. OT) there is some collaboration that is leading – there are some successes, although there is room to grow
- It would be very helpful if mental health policy makers would lead by collaborating across the sectors – we need policies and structures to support collaborative practice
- Need to pay more attention to mental health as possible co-morbid condition at acute/chronic client presentations for care
- Other initiatives in Manitoba include the Co-occurring Disorders Initiative (CODI).
- South Eastman hopes to start a Children and Adolescents Collaborative Model.
- Strong interest in Winnipeg, South Eastman and Westman (Brandon)
- Chronic Disease Management – the notion of mental health is only brought to light through intentionality.
- Need to work together to ensure decreased compartmentalization of mental health.
- Avoid distinguishing between chronic illness and mental illness.
- Push to promote mental health promotion alongside of IN MOTION Campaign.
- Region-wide Mental Health Promotion Initiative to link with chronic disease prevention (in South Eastman).
- Need to distinguish between shared-care and collaborative care and establish liaison with several funded projects that involve only service deliverers, not consumers, in the shared care model
- University of Manitoba teaching – inter-disciplinary/inter-professional education (medicine/OT, pharmacy/nursing, dentistry – includes Projects/Grand Rounds

Advantages in Moving Forward

- Increase availability/accessibility of appropriate health care provider – one-stop shop
- Thought to have annual mental health assessment done by SW, NP – screening tool
- Teaching family docs to ask more appropriate/specific questions
- Look at ways to use existing resources more efficiently
- Causes people to shift their focus on strategizing to look at provision of collaborative care
- Reinforces a broad population or public health perspective
- Rural – has been happening for some time due to necessity (less resources) but have gotten away from this
- Need to regenerate this - revisit the collaborative aspects and make it an expectation
- Facilitate to decrease morale problems
- Psychiatry becoming more approachable? Accessible
- Notion that a virtual team can become and remain a functional team
- Demystifying MI – these are the things known and unknown – share with community
- Supports/enhances outcomes
- Capitalize on telehealth

What would successful collaborative health care look like in Manitoba?

- Shared care is one model but collaborative practice encompasses a variety of models
- People getting together to build relationships
- Supportive policy perspective
- Transition funding and funding framework to support initiatives

- Built-in Quality Assurance element into the policy framework enhanced communication among team- increase in team building exercises
- Role of peer support specialist (includes navigator/support)
- True focus on client centered model (not just rhetoric)
- Full engagement of partners and team work – connecting people who are working in parallel now
- Streamlined intake with multiple entry points
- Organizational-level to mandate collaboration

1. Is Manitoba ready?

YES

2. What needs to be done?

- Communication structure – mailing list
- Political horizons – goals that survive political terms
- Transition plan and transition money for people to focus on leading change

Need more info?

Impact of spirituality

Need to engage other stakeholders

- Public health commits to being at the table
- Faith communities (clergy)
- Child and family services
- Aboriginal communities
- Provincial professional associations
- Voluntary agencies- consumers- peer support
- Marginalized groups
- Walk the talk
- Reflect our value of CMHC in plans, actions
- Context – societal change

- Training
- Pre and post licensure
- In a variety of work environments
- Holistic
- Multiple approaches
- Pamphlet on modeling behaviour
- Review job descriptions
- Include collaborative practice as part of performance management'
- Toolkits – systematize – organizations sign on
- See collaboration as client/consumer to have some control of care process
- For consumer to sit with a multi-disciplinary team can be terrifying, so need to attend to preventing “involvement per se” vs. input that a client can feel comfortable providing when in need of care
- Need teams to understand the many issues that can affect mental health – **be aware of the big picture** – professionals in health care need to know about impact of current & changing policy issues on their clients (i.e. impact of changes in financial supports, not only health care policy)
- Support system needs to be flexible to include a range of services/ **connect** health to broader determinants (outcomes of health & wellness) at individual consumer level & at policy level
- Goals of access to care & medially oriented care may need revision as wellness and quality of life in **broad context** to maintain client/patient focus/goals – **focus of quality of life as well as illness**
- Upcoming possibility of a 3rd call for proposal that will be Phase 3 about collaborative practice and patient/client centered care to connect RHAs, provincial health bodies and education/training institutions and practice sites.
- Unless we collaborate well, we lose the energy of any specialization that can help improve/benefit patient care
- Need to know how/improve how we teach collaboration to training of students
- Too much of professional training puts blinders on “identity” to potential exclusion of other professions

- Gov't needs to model collaboration, including from client/consumers – professionals- mid mgmt- policy makers – RHAs can lead by figuring out how to collaborate
- Need teams to understand the many issues that can affect mental health – **be aware of the big picture** – professionals in health care need to know about impact of current and changing policy issues on their clients (e.g. impact of changes in financial supports, not only health care policy)
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- Upcoming possibility of a 3rd call for proposal that will be Phase 3 about collaborative practice & patient/client centered care to connect RHAs, provincial health bodies and education/training institutions and practice sites.
- Issue of consumer representation- pioneering work in citizen democracy- in education systems- have PTA- how do we fully integrate consumers into decision-making processes --- know what we'd like to achieve but don't know what processes to use
- Re public consultation- don't have a separate mh – district health - advisory committees are mandated under law- boards of RHAs are appointed- mostly from non-professional groups- majority of rural & urban RHAs have consultation meetings with councils of municipalities
- Also have mh advisory councils in most regions and at provincial level
- Addictions and spirituality- some models to look at- one first nation place(Nelson House) looks at spirituality in their treatment centre – Also need to look at broader social issues – social planning council and others
- Priorities - what are initiatives - timing is right - lot of things going on- it's about influence at this point- primary health care is a priority for the province at this time- working with family services and housing, department of culture, etc... There are things that are happening and if we can have dialogue we can enhance, leverage or influence

- Great value in being clear in MB that there is a collaborative org interested in mh to go to for the dialogue and the conversation- I hadn't even thought of mh being at the table- now need it even if a heart health strategy- even if only to look at what determines motivation for ppl to look after themselves- this is a complex issue-might go to CMHA but that leaves out psychiatry- tipping point philosophy- all of a sudden a whole bunch of things tip so that mh gets recognized.
- AMIMH has some of the right ppl at the table- looking at who else needs to be there to look at next steps to pick up on this piece of work that
- AMIMH has had an advocate role – what happens when there are govt representatives. This can be worked through
- We need a summary of best practices- learned today about initiatives in MB.

Nova Scotia Consultation Summary Notes

Present Status and Relationship to Other Mental Health and Primary Care Initiatives

- Capital Health has a new expansion, multi service center; this could lead to ongoing collaborative care. This leads to such issues to look at like landlords, traffic, commercialism, cost, finance
- Primary health care is the right setting for collaborative care
- What may work elsewhere may not work in Nova Scotia
- Getting people in rural and urban areas interested in shared care, there is a potential base there to build on
- Psychiatrists willing to help physicians to make their jobs easier. Providing more effective resources for colleagues. Partnership between medical/mental care needs to be brought to Nova Scotia
- Doctors already deal with mental health issues. How can they be helped and supported to deal with this by psychiatrists
- Physicians would be more comfortable with access to mental health resources
- Psychiatrists want more medical information when seeing patients. They want more help for them to do their job

Discussion and Feedback

- Everyone has good intentions but there are built in “disincentives” like billing codes across Canada are nonexistent for Collaborative Care
- Time to get into masses, accept resistance but ignore it and push forward
- Varying levels on interest. Lots of fear/uncertainty if there are no incentives following will be too slow
- No incentives: How can we make this happen with what we have already in Nova Scotia?
- What can we do besides the funding because this is not the only issue
- Endorse “shine the light” on collaborative care resources

- We need to broaden and look at all health services and how mental health patients access medical services and vice versa
- \$\$ dance between community care and acute care. Where is the family physician? Who has the power/authority?
- You can't give a good education without a good working system
- We have great opportunities and we just have to connect them
- When you run into barriers you must turn to communities for help
- "We" have no training in Collaborative Care and need local

Next Steps

- The existing system isn't going anywhere, we're losing people instead of gaining
- Each district should make an immediate plan to go forward for collaborative practice to get it moving. Small plan/large plan
- Develop and implement strategies to get the District Health Boards to take part
- Better training and resources, not everyone may be properly informed
- Help the professions figure out what they need to ask for
- Capital Health has a new expansion, multi service center; this could lead to ongoing collaborative care. This leads to such issues to look at like landlords, traffic, commercialism, cost, finance
- Creating collaborative care practice outside of this one time only meeting
- Comments need to go to local District Health Boards
- Using directors table/forum to progress, information to spread through communities
- There has to be a policy through legislature
- Keep looking for opportunities to continue the progress of collaborative care through chronic disease management, psychiatric, and primary health care

Barriers

- Family physician: supporting the time the physician puts in to this initiative (fee code). While it is voluntary it may not be so quick to move forward
- Advanced share care provinces have a fee code and Nova Scotia does not at the present time

- Nothing pays you to consult with a psychiatrist unless you have a patient right in front of you
- Fee for service/contracts/negotiations are in progress but there is no current compensation
- What really is the interest for physicians/psychiatrists?
- Everyone's fear is based on lack of knowledge. Increased access, knowledge, and resources would be supportive and efficient
- People will find it hard to change when they haven't worked in this way in the past and have a lack of engagement and vision
- Need for psychiatric care is great in many areas. Qualified people just aren't available. The waiting time for developmental disabilities, behavioural issues is very slow due to the lack of qualified professions in these field
- Nurses aren't trained in mental health until their fourth year. Sooner, more effective training would allow for more effective recruitment
- We are not training professionals collaboratively. Where can they get the necessary training and education
- Current students want to practice collaboratively but communities show them an older world
- Doctors have to deal with liability. They can be liable for law suits if they receive wrong or vague information from another professional and provide advice based on this information. Some body must take responsibility for overseeing liability and finance for collaborative care
- Government needs to resolve funding issues with provincial organizations
- Collaboration is an ongoing need to be supported. We need projects that require shared budgets
- Training for people and professionals
- Basic funding, where is the money?
- Any steps toward collaborative care will create an immense relief on either side of health care
- Challenge in changing of behaviour, need to address our own departments about change and leaving tradition behind

- Partnerships of substance abuse to take part? A variety of exclusions were made. Groups were chosen by who wants to move forward, there are lots of opportunities for more groups and people to join
- Addiction/Substance/mental should interact more
- Federal bodies can only do so much, add provincial charters
- Support by Policy/Resources, integrating health services in all nine provinces where they are separate institutions is variable from province to province
- Smoke free areas have not dissipated, everyone has followed suit. Chronic disease management is related to this promotion
- Health care can provide these resources but won't have the resources to do their core job
- There is a need for commitment, boundaries, and resources to keep workers in their place
- Community agencies provide significant services without compensation or Federal funding
- Training needs to be improved. Professions need to get behind officials and tell them their issues to get some clear direction so we can move forward
- Mental health resources need to be organized so medical professionals can be brought in and use these resources
- Sense of direction, how to enable what collaboration means?
- Communities are a big part, how do we address their issues to best serve these people?
- Any steps toward collaborative care will create a huge relief on either sides of health care
- Collaborative care is still in its early days, stepping in the right direction with how people are planning and acting when put together will help
- Time to get into masses – accept resistance and push forward

Saskatchewan CCMHI Consultation Summary Notes

Present Status and Relationship to Other Mental Health and Primary Care Initiatives

- The interest is high, if it was integrated it would help – there is too much demand
- University of Sask- strong interest – a web site for GP's to ask questions of the psychiatrist – Beyond Blue in Australia a model on site support and telephone
- If we are lucky to obtain resources we want to develop this for all of Sask
- Feel isolated
- We are new to this
- Most of the patients from rural areas
- Team oriented
- Ministry of Health – Primary Care Branch – provides incremental funding to health authorities – have introduced service practitioners - 56 established teams – very successful (primary health teams) – 13 new teams this year – currently at about 26%
- The mental health core component of the health line is not known – in its infancy
- One psychiatrist visits rural areas twice a month
- Psychiatry – in collaboration with family medicine unit
- Clinical and educational components
- In the process of evaluating it from an economic perspective
- Problem in marketing the good ideas and projects
- One FP is unaware of psychiatry services in Saskatoon
- First Nations people are not accessing primary health care teams. No one has ever met with First Nations people to talk about this. Plans are in place to present CCMHI toolkits at an upcoming conference of several FN communities on March 11/12

- Telehealth has helped changed things – we have a ways to go but it has made a big difference
- Some of our psychiatrists are champions of telehealth
- ABI – Community based treatment
- Assertive community based treatment/MD (psychiatrist)
- Relations positive, attitude, respect critical factors
- Assertive community treatment has broad application
- Collaborative outreach between Health Regions - Telehealth
- Shortage of psychiatrists and other health professionals

CCMHI Toolkits and Web Resources

- Useful as a secondary resource
- We need the same material from stigma to respect as our made from illness to recovery

What would successful collaborative health care look like In Saskatchewan?

- Service connections from prevention addiction treatment
- It appears there is good raw material to work with in Saskatchewan
- Decentralize services
- Who should be on this train or team
- Consumers
- Community mental health nurses – can be well linked to GP's and psychiatrists
- Discrimination against the worker as well
- Pharmacists
- Family and caregivers
- Psychologists, social workers OT's
- One number that gives GP's access to all other mental health services
- No wrong door

- Need to take services to the clients
- User friendly
- We need more psychiatrists

Next Steps

- Needs to be a long term commitment
- Mental health should be a provincial issue – weakness in mental health
- Marketing this to government, users and colleagues
- Electronic record is the key
- Regulatory bodies to educate members – collaboration - stigma
- Make case for provincial mental health priority not RHA priority
- Electronic record keeping – key to collaboration
- 15- 20 minute video
- What is collaboration
- Multiple audiences, clinicians, policy makers, consumers
- Health Regions recognize value of time for planning purposes
- Service connections – start to finish
- Promotion – screening detection
- Decentralize Regina Mental Health Services
- No wrong door
- TEAM: Consumers, community mh nurses, pharmacists, family caregivers, telephone access to multiple resources, FP's, psychologists, social workers, psychiatrists, OT's, dieticians, admin staff
- Web – Communication – Clearinghouse
- Look at CPLA specialists
- MHCC – Knowledge Exchange Centre
- Expectation is to build up a network – need improved communication
- Share contact information – another meeting
- Clearinghouse and website

- Indications are primary health care will continue in Sask. and incorporating mental health makes sense
- Develop the website to function as an online knowledge exchange center – with provincial and national rooms

Agreement to meet again – to move forward

Janice Burgess will email participants

Dave Nelson – meeting

Regional directors meet quarterly

Invite Ministry of Health and mental health directors

- Rural – out of necessity, MD, Public Health Nurse, Dietician
- Interest is high – resources needed
- Integrate with chronic disease management
- Department of Psychiatry supporting rural clinics – introduce helpful resources i.e. Australian website on depression plus email support
- Isolated team oriented, community RN'S
- 24/7 Help Line – RN triage mental health and addictions component
- Primary Health Care Coordinators – i.e. teleconference with Dr. Nick Kates
- Mental health and addictions team (multi-disciplinary) – outreach to 50,000 people
- Satellite from University of Saskatchewan services 14,000 rural residents – support to family medicine.
- Proposal for evaluation
- Good projects – marketing problem with low uptake from FP's
- FP'S Are treating sometime need specialist confirmation
- Mental health intake – available to MD's, patients, consumers – one number to call
- Scarcity of services available to First Nations people
- People not accessing mh specialized services
- FP'S overprescribing drugs

- Inter-jurisdictional off-loading
- Stigma and labeling not helpful

Barriers

- Dollars
- Health care human resource shortage
- Balancing wait times/activity/ resources
- Issue of confidentiality “don’t talk to my mother”
- a question of organizing the consent – how you structure the team
- Location and transportation
- Concern about reconfiguring – currently screening at a high level – would not want to lose the centralized resources – need both
- Education: a need to train our new graduates how to collaborate
- Leadership
- Low population density – remoteness
- Difficult to operate at scale
- Difficult to reach services
- Staff spread too thinly
- Transportation
- Resources organized for high level of screening to sign pointing above, need to identify what we would be able to stop doing
- Need to invest resources as part of transition
- Time
- Evidence
- Education – pre-licensure and post-licensure

Discussion and Feedback

- Level of interest, commitment is encouraging
- CCMHI resources materials will be useful
- Affirmation of good work already underway in Saskatchewan
- Need/service gap – important to acknowledge – need to consider impact of (up sign) on time to treatment
- Need to figure out ideal system for short-term first – improving access to care
- Current reality – 5 minute consult
- Community agencies prepare consumers to effectively engage
- Peer support
- Like the idea of doing something about stigma and discrimination
- Concrete idea of collaborative care was helpful
- Expectation of meeting was to build network and share participant list
- Consumers need to monitor to ensure forward progress
- How to communicate with government
- Where should the leadership come from in Saskatchewan
- CMHA, Family Physicians, local PHC teams
- Ministry of Health: use primary care system as a vehicle for improving services
- The gap is so large – we need to find the way to shorten the time for access
- Allocating patients to underused service providers
- Stigma is really discrimination and a human rights violation
- There is a need to invent a Saskatchewan model
- PHC – Key facilitators - emulate
- PHC AS a Saskatchewan policy arena
- Leverage current initiatives – PHC teams
- Regions now have structure to support PHC coordinated approach (agreement on priorities) from regions
- Chronic disease management as a vehicle

Consultation Participants

Manitoba Participants

Dr. Liz	Adkins		
Dr. Judy	Anderson	Principal Investigator	Faculty of Med. University of Manitoba
Dr. Frances	Berard		Manitoba College of Family Physicians
Sharon	Bissonnette		North Eastman Regional Health Authority
Dawn	Bollman	President	College of Registered Psychiatric Nurses MB
Tara	Brousseau	Executive Director	Mood Disorders Association of Manitoba
Sean	Brygidyr	Health Labour Relations Officer	Manitoba Health
Dr. Chris	Burnett	Medical Director	Physician Resources
Debra	Carnegie	Program Manager	Assiniboine Regional Health Authority
Gary	Cavanagh	Past President	The Manitoba Pharmaceutical Association
Nicole	Chammartin	Executive Director	CMHA - Winnipeg
Marion	Cooper		Winnipeg Regional Health Authority
Gina	De Vos	President	Manitoba Society of Occupational Therapists
Rob	Desrochers	Nurse Therapist	Canadian Federation of Mental Health Nurses
Dr. James	Ediger	Coordinator, Clinical Services, Assistant Professor	Community Residential Program, St. Amant, University of Manitoba
Dr. Murray W.	Enns	Psych. Acad. Head, Associate Head	Health Sciences Centre
Marcelle	Falk	Supervisor – Community Mental Health	South Eastman Health
Ross	Forsyth	Assistant Registrar	The Manitoba Pharmaceutical Association
James	Friesen	CEO	Eden Health Care Services
Shannon	Gander	Policy Analyst	Mental Health and Addictions Branch, MB Health and Healthy Living
Bev	Goodwin	Family Member	
Ron	Guse	Exec. Director/Registrar	Manitoba Pharmaceutical Association
Rudy	Ambtman	A/Exec. Director	Canadian Mental Health Association (Manitoba)
Kim	Heidinger	Consumer / Outreach Worker	Manitoba Schizophrenia Society
Carol	Hiscock	Executive Director	CMHA -Manitoba
Dr. Joel	Kettner	Chief Public Health Officer	Office of the Chief Medical Officer of Health
Ken	Kroeker	Program Leader - Mental Health	Regional Health Authority - Central Manitoba Inc.
Tammy	Lambert	Consumer	Manitoba Schizophrenia Society
Dr. Keith	Lowe	CMHA MB member of CMHA National	Manitoba Education, Citizenship and Youth
Garry	Meadows	Director of Mental Health Services	Parkland Regional Health Authority
Pat	Olafson	Program Manager	IRHA Mental Health Crisis Services
Annette	Osted	Exec. Director	College of Registered Psychiatric Nurses MB

Michael	Petit	Community Wellness Manager	Churchill Regional Health Authority
Brandi	Randell	Consumer	Manitoba Schizophrenia Society
Gayle	Restall	Assistant Professor	Department of Occupational Therapy, School of Medical Rehabilitation, University of Manitoba
W. Gail	Richardson	Program Consultant	Manitoba Health Wait Time Task Force/Regional Affairs
Kim	Ryan-Nicholls	Associate Professor	Department of Psychiatric Nursing, Brandon University
Dr. Jitender	Sareen	Research/Epidemiology	PsychHealth Centre
Karen	Serwonka	Policy Analyst	Population Health Promotion
Tim	Shewchuk	Consumer	Manitoba Schizophrenia Society
Elly	Spencer		Nor-Man RHA
Lynda	Stiles	Coordinator, Mental Health Programs	Brandon Regional Health Authority
Carolyn	Strutt	Director of Mental Health	Winnipeg Regional Health Authority
Chris	Summerville	Executive Director	Manitoba Schizophrenia Society
Deb	Taillefer	Mental Health Program Manager / Chair	South Eastman Health / Provincial Network-MH Managers
Dr. Michael	Van Vliet	Family Medicine Resident	
Barbara	Wasilewski	Director	Primary Health Care, Manitoba Health and Healthy Living
Pam	Wener	Coordinator/ Assistant Professor	Department of Occupational Therapy, U of Manitoba
Maureen	Koblun	Consumer	
Gerry	Duguay	Consumer	
Joanne	Winsor	Consultant, Nursing Practice	College of Registered Nurses of Manitoba

Saskatchewan Participants

Robert	Allen	Executive Director	Reg. Psych. Nurses Assoc. of Sask.
Doreen	Bell	Consumer	
Carla	Bolen	Nurse	Health Promotion in Mental Health & Addictions
Janice	Burgess	Director of Professional Practice	The Pharmacists' Association of Saskatchewan
Dr. Donna	Cameron	Family Physician	Lakeside Medical Clinic
Roger	Carriere	Program Lead Mental Health	Community Care Branch, Saskatchewan Ministry of Health
Shari	Cherepacha	Board Member	Sask. Society of Occupational Therapists
Brett	Enns	Director	Health Region
Dr. Mohamed	Gheis	Shared Care Champion	
Cheryl	Hamilton	Regulatory Services	Sask. Registered Nurses Association
Richard	Hazel	Executive Director	Sask. Association of Social Workers
Dave	Hedlund	Exec. Dir. MH/Addiction	Regina Qu'Appelle Health Region
Anita	Hopkauf	Executive Director	Schizophrenia Society of Canada of Saskatchewan
Dr. Micheal	Howard-Tripp	Supervisor	Shared Mental Health Program at the Family Med. Department
Terry	Hutchinson	Executive Director	Mental Health/Addictions Services, Five Hills Health Reg.

R.J. (Ray)	Jourbert	Registrar	Sask. College of Pharmacists
Maureen	Kachor	Clinical Coordinator	Health Service Task Team, Saskatchewan Association of Social Workers
Carol	Mann	Aboriginal Chronic Disease Consultant	Primary Health Services Branch Saskatchewan Health
Karen	Messer-Engel	Registrar	Sask. College of Psychologists
Colleen	Molnar	Manager	Mental Health Clinic
David	Nelson	Executive Director	CMHA - Saskatchewan
Duane	Schultz	Regional Director	Mental Health & Addiction Services
Michael	Seiferling	Practicum Student	Canadian Mental Health Association (Saskatchewan Division) Inc.
Fay	Shuster	Director of Primary Health Services Branch	Saskatchewan Health
Dr. Raymond	Tempier	Chair - Psychiatry	University of Saskatchewan
Marlene	Weston	Director	Health Region
Beverley	Whitehawk	Mental Health Policy Analyst	Federation of Saskatchewan Indian Nations
Loraine	Whitehead	Director	Health Region
Jayne	Whyte	Consumer	
Kathy	Willerth	Dir. Mental Health	Ministry of Health, Community Care Branch, Saskatchewan

Nova Scotia Participants

Cheryl	Billard	Program Mgr. Comm. Care	Capital District
Dr. Ian	Bower	Physician Services	Nova Scotia Department of Health
Elaine	Campbell	Clinical Social Worker	Canadian Association of Social Workers
Cathie	Carroll	Executive Director	NS College - Family Physicians
Richard	Chenier	Consultant	Chenier Consulting Canada
Pam	Chisholm	Shared Care Nurse – Member of marg. adults toolkit	
Andy	Cox	Board Member	Mental Health Comm. of Canada
Peter	Croxall	Director	Capital District Mental Health Program DHA 9
Dr. Nicholas	Delva	Head of Psychiatry	Dalhousie University
Scott	Dudgeon	National Executive Director	Alzheimer Society of Canada
Dianna	Fortnum	Director, Mental Health Services	Colchester East Hants Health Authority DHA 4
Dr. David	Gardner	Associate Professor	Dalhousie University
Dr. David	Gass	Director, Primary Health Care	Primary Health Care Section, Nova Scotia Dept of Health
Dr. Rick	Gibson	Dist. Chief Family Practice	
Paul	Helwig	Manager	Specialty Teams and CORE
Dr. Brian	Hennen		
Dani-Sue	Himmelman	Leader	CCMHI NS Consultation

Dr. Alec	Hipwell	Staff Psychiatrist	Department of Psychiatry, Nova Scotia Hospital
Kristi	Kempton		College of Registered Nurses of Nova Scotia
Dr. Risk	Kronfli	President	N.S. Assoc. of Psychiatrists
Maria	Kuttner	Director	N.S. Department of Health
Peggy	MacCormack	Senior Coordinator	Adult Mental Health (DOH)
Dr. Philip	Mills		
Joyce	Morouney	Clinical Social Worker	Shelburne Mental Health Centre
Charlene	Murphy	Coordinator of the Inverness Mental Health Clinic	Cape Breton District Health Authority DHA 8
Patricia	Murray	Director, Children's Services	Mental Health, Children's Services, NS Dept. of Health
Josephine	Muxlow		First Nations Inuit Health Branch - Atlantic Region
Faizal	Nanji	Director, Adult Mental Health	Department of Health
Susan	Nasser	Executive Director	NS Assoc. of Social Workers
Dr. Herb	Orlik	Clinical Director	Chief of Psychiatry
Dr. David	Pilon	Psychologist	Association of Psychologists of Nova Scotia
Tony	Prime	Chair (MOH)	NS Seniors MH Network
Heather	Sandeson		Clinical Nutrition Services, Nova Scotia Hospital
Susan	Shaddick	Manager	Halifax Mental Health Clinic
Dr. Ian	Slater		
Linda	Smith	Executive Director	Mental Health, Children's Services, and Addiction Treatment
Charlene	Thomas	Senior Director	Pictou County Health Authority & Guysborough Antigonish Strait Health Authority DHA 6 & DHA 7
Linda	Thompson	Manager, Mental Health Promotion and Prevention	Mental Health Program, South Shore Health
Heather	Thompson	Representative and clinician	Canadian and Nova Scotia Association of Occupational Therapists
Carol	Tooton	Executive Director	CMHA - Nova Scotia
Merv	Ungurain	Senior Consultant	Primary Health Care
Phil	Upshall	National Executive Director	Mood Disorders Society of Canada
Anne	Godden-Webster	Health Professor	Dean's Office, Dalhousie University