National Conference on Shared Mental Health Care

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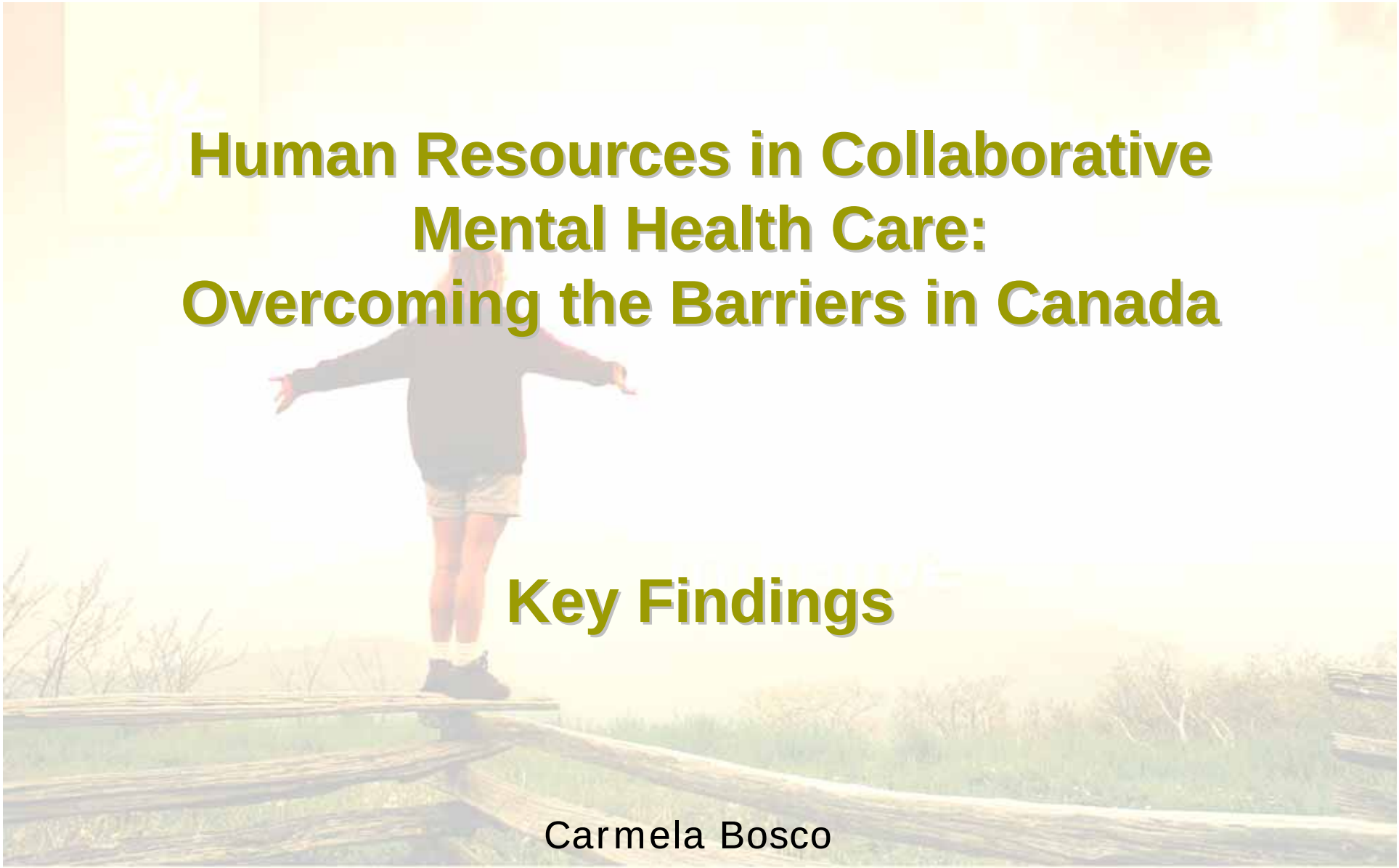

Human Resources in Collaborative Mental Health Care: Overcoming the Barriers in Canada

Key Findings

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Objectives

- Gain understanding of MHHR issues in Canada and abroad.
- In-depth analysis of the issues on the barriers to collaborative mental health care.
- Identify approaches/solutions to overcome barriers.

Key Findings - Trends

- Fragmented mental health delivery system at all levels.
- Funding for CMHC delivery is needed.
- The need to build a stronger mental health workforce.
- Scope of practice is inconsistent for mental health providers.
- Support for interprofessional education and training.
- Success of CMHC examples internationally.
- Understanding of mental health sector – need for comprehensive data.

Specific MHHR Trends

Theme	Problem	Solution
Coherent mental health system	Inconsistent and lack of services and support	Replace ‘silos’ with integrated health care delivery
Additional funding for CMHC	❖ Under-funding ❖ Limited coverage ❖ No incentives	Short-term funding through projects
Implement strategies for mental health workforce	❖ Shortage of mental health providers ❖ Challenges in recruitment and retention ❖ Lack of planning ❖ Overworked providers – no time to learn about change	❖ Increase workforce ❖ Link supply to population needs for mental health and addiction ❖ Improve working conditions ❖ Create/innovate mechanisms to facilitate collaboration

Specific MHHR Trends

Theme	Problem	Solution
Facilitate CMHC through scope of practice	❖ Consensus on standards and competencies for CMHC ❖ Defined roles ❖ Lack of clarity about accountability and liability of team practice	❖ Define scope of practice for CMHC ❖ Harmonize legislation ❖ New models for collaboration through liability
Support IPE and training	❖ Lack of understanding of mental health issues ❖ Limited training	❖ Educate and train health care providers on CMHC benefits ❖ Standardized credential ❖ Bridge programs ❖ Integrate culturally curriculum and training opportunities

International Trends

- Traditional profession-specific approaches to HHR planning and deployment.
- Reported shortages of mental health providers (i.e. Australia, US).
- Focus on physician workforce planning.
- Early stages at total workforce and integrated workforce-wide planning.
- “Shared-care” team approaches to CMHC (i.e. US, UK).

Barriers and Approaches

- Legislation, regulation and policy
- Remuneration
- Scope of Practice
- Liability
- Interprofessional Education
- Peer Support

Legislation and Policy Findings

Issues

- Self-regulation laws impacting on functioning of workplaces
- Boundaries between workplaces and health care settings
- Standards of practice in “silos”
- Multiplicity of regulators
- Regulatory “turf protection”
- Regulatory fragmentation
- Inflexible legal infrastructure
- Restrictions placed by privacy legislation on sharing of patient information

Approaches

- Review and eliminate unnecessary legislative rigidity
- Encourage administrative flexibility
- Comprehensive legislative reforms
- Mandate accountability for interprofessional practice
- Develop integrated system of regulation
- Develop collaborative regulatory culture
- Linkages with broader reforms and system changes
- Learn from reform in other countries

Remuneration Findings

Issues

- Fee-for-service structure primarily for physicians
- Insufficient funding for CMHC providers at IPE and CP levels
- Project funding for CMHC but is limited
- Lack of incentives to encourage collaboration
- Lack of resources to develop funding models
- Reluctance to change funding schemes
- Budgetary constraints through health care reforms
- Clarity as to what services are being provided by specific CMHC providers

Approaches

- Explore alternative funding models (i.e. Group Health Centre)
- Create “intermediary” organizations (i.e. family health teams)
- Policy innovation to facilitate reimbursement models
- In-depth analysis of payment schemes (i.e. capitation and blended)
- Adapt models proven to be successful in other jurisdictions (i.e. UK)

Scope of Practice Findings

Issues

- Inconsistencies as to how scope of practice is defined that encompass competencies and standards across F/P/T
- Viewed as problem but evidence is limited
- Highly valued by providers
- Professions protect their scopes
- Regulatory independence
- Differentiation between overlap or shared competencies
- No allowance for collaboration
- Lack of understanding scope of practice boundaries
- Reviews are underway but process is slow

Approaches

- Develop national standards for scope of practice
- Review frameworks in hospital settings that allow collaborative practice
- Role substitution as proven successful in the UK
- Expanded roles of CMHC providers where appropriate
- Addressing health care reforms (i.e. HHR shortages)
- Incentives for providers to work in rural and remote communities
- Encourage HHR planners on co-ordination on health care delivery

Liability Findings

Issues

- Emphasis on individual accountability
- Uncertain to adjust to collaborative practice in accountability and standards of care
- Create liability exposure especially in transition phase (i.e. non-physicians and institutions)
- Difficulty to implement malpractice law reform
- Clarification on professions' role in collaborative practice
- Mental health court case – first test model for collaboration – all members of team were liable

Approaches

- Tailor collaborative practice to requirements of tort law
- Promotion and education to courts
- Legislative change
- Common insurer for all providers in collaborative practice
- Increase focus on health outcomes and best practices
- Effective communications (i.e. patient record management)
- More research in collaborative work

Interprofessional Education Findings

Issues

- IPE as a priority
- Minimal activity of IPE incorporated into CMHC
- Funding available at macro level by research grants or university budgets
- Leadership support not available
- Lack of support, resources and funding
- IPE was established in responding to health needs
- Commitment from faculty and educators (i.e. buy-in)
- No incentives for IPE at the practice level
- Competing for time and curriculum in education sector

Approaches

- Research on CMHC in IPE
- Requirements of professions (i.e. standard of practice, competencies)
- Select champion/leader in CMHC
- Accreditation recognition
- Knowledge transfer
- Address systemic issues
- Conduct IPE sessions
- Incentives for IPE at practice level

Peer Support Findings

Issues

- Offer services that are not recognized by health care providers
- Lack of remuneration for volunteers, caregivers
- Ensure access to health care services for recovery in communities
- Limited funding for peer support programs
- Peer support not engaged in dialogue and reforms
- Address attitudes towards mental health
- Not considered as an important resource for patients recovering in communities

Approaches

- Participant in CMHC reforms
- Increased funding for health and wellness programs provided by peer support

Information Gaps

- Interaction between mental health providers and other professions.
- Effects of reimbursement in collaborative service delivery in health care settings.
- Comparative scope of practice inventories (i.e. overlap).
- Legislative review and impact on MHHR.
- Impact on new models of collaborative health care delivery in IPE.
- Best practices on CMHC.
- Access to comprehensive mental health human resource data.
- Role and level of interaction of peer support with health care providers in recovery.

Lessons to be Learned

- Build from policy framework and leadership of other countries proven successful.
- Effective use of resources.
- Provide supportive infrastructure for providers (i.e. team protocols).
- Effective communications among providers – better patient outcomes.
- Risk management tool – for design and implementation of CMHC.
- Expanded scopes of practices – clarity of roles.
- Evidence-based best practices.

What We Know

Successful

- Priority
- Funding
- Commitment/ support
- Servicing a need
- Mindset
- Opportunities
- Linkage with health reforms/agenda

Unsuccessful

- Limited funding/resources
- Systematic
- Regulatory issues
- Knowledge of professional cultures
- Lack of support
- Time constraints

What Can Be Done

- Supportive policy and legislation.
- Special remuneration and incentives.
- More training of primary and mental health providers in benefits of CMHC.
- More research in CMHC effectiveness towards patient and provider care.
- Redefine roles.
- Build provider and consumer awareness and understanding of CMHC.

Recommendations

1. Implement effective CMHC HHR planning.
2. Establish reimbursement and funding priorities.
3. Develop comprehensive legislative framework.
4. Develop CMHC policy framework.
5. Build case for IPE in mental health and addiction.

Final Thoughts

- CMHC is achievable.
- Commitment and support for change at practice, government and organizational levels.
- Need for leadership to address barriers.
- Need for awareness on mental health and addiction.

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