Canadian
Collaborative
Mental Health
Initiative

Initiative
canadienne de
collaboration en
santé mentale

The Toolkit Series

For

~ Providers and Planners ~

~ Consumers, Families and Caregivers ~

~ Educators ~

A Document Summary

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Introduction
Collaboration between mental health and primary health care services: A CCMHI planning and implementation toolkit for health care providers

What is collaborative mental health care?

Collaborative mental health care describes models of practice in which consumers, their families and caregivers, together with health care providers from a variety of primary health care and mental health settings – each with different experience, training, knowledge and expertise – work together to provide better co-ordinated and more effective services for individuals with mental health needs. These services include mental health promotion, illness prevention, detection and treatment of mental illnesses, rehabilitation and recovery support.

Collaborative mental health care can encompass a broad range of activities, such as regular visits by a mental health care worker to a primary health care setting; unified programs that offer mental health and physical health care through one administrative and financial entity; regular telephone consultations between primary health care and mental health care providers; the integration of specialized care providers such as psychiatrists, psychologists, nurses, social workers, occupational therapists, dietitians and pharmacists within primary health care settings; development of treatment plans jointly by consumers and providers; incorporating mental health interventions into the management of general medical conditions such as diabetes; meeting the primary health care needs of individuals with a severe and persistent mental illness; and strategies to improve access to community mental health services.

Collaborative mental health care can take place in a variety of settings including community health centres, health care providers' offices, mental health clinics, homes, schools, correctional institutions and community locations such as shelters. Collaborative mental health care can be based on a number of different models depending on the providers involved, the services provided and the degree of collaboration. (For a comparison of different models of collaborative mental health care, please see Appendix A. of this toolkit) Providers may be co-located and able to meet face-to-face but even if that is not the case, collaboration can still take place via telephone, fax, Internet, teleconferencing, videoconferencing or educational interventions. Providers may offer joint assessments, case discussions and advice, educational opportunities, consultation, back-up/support or direct care to consumers. The Canadian Collaborative Mental Health Initiative has published *Collaborative mental health care in primary health care: a review of Canadian initiatives Vol II: Resource Guide* (Pauzé and Gagné, 2005) which describes and synthesizes approximately 90 collaborative initiatives in Canada; the publication is available on their Web site, www.ccmhi.ca.

Key elements

Collaborative mental health care is characterized by four key elements:

- Accessibility
- Structures and systems which support collaboration
- Richness of collaboration
- Consumer-centredness

Fundamentals

The success and ease of implementation of collaborative mental health care will be determined, in part, by four external factors:

- Congruent policies, legislation and funding regulations
- Sufficient funds
- The current evidence base
- Community needs

More detailed information about the key elements and fundamentals may be found in Appendix A (of this toolkit) and in the Canadian Collaborative Mental Health Initiative document *What is collaborative mental health care? An introduction to the collaborative mental health care framework* (Gagné, 2005) available on their Web site, www.ccmhi.ca.

Basics of collaboration

In collaborative partnerships, mental health and primary care providers and consumers share:

- Common goals or purpose
- A common language
- A recognition of and respect for respective strengths and differences
- Equitable decision-making
- Clear and regular communication

Benefits of collaborative mental health care

Federal, provincial and territorial jurisdictions across Canada have recognized the importance of improving the organization and delivery of primary health care: making it more accessible, comprehensive, interdisciplinary, co-ordinated and oriented to health promotion. This is particularly critical for mental health services, which are often poorly co-ordinated, stigmatized and not easily accessible.

An increasing body of evidence accumulated over the last 10 years indicates that collaboration can improve access to mental health care, especially for populations who traditionally underutilize mental health services; improve continuity of care; increase communication and co-ordination of care; potentially reduce mental health costs (although this may be offset by finding new cases); reduce the use of other health services; make more efficient use of available resources; and increase the capacity of both the mental health and primary health care systems.

Satisfaction ratings with such services are high on the part of primary health care providers, mental health care providers and consumers using the services. There is also evidence that outcomes are better than routine care by the family physician and equivalent to outcomes delivered in mental health services for many but not all populations seen. For a comprehensive annotated bibliography of research publications (2000 - 2004) related to the integration of mental health and primary health care, please see *Annotated bibliography of collaborative mental health care.* (Pautler and Gagné, 2005), available at www.ccmhi.ca.

Limitations of collaborative mental health care

Collaborative mental health care should be seen as part of a continuum of care, with a smooth flow between primary, secondary and tertiary services. Some kinds of problems may be treated more effectively in specialized mental health services which have access to a wider range of resources. These can include individuals with complex diagnostic or management needs, or who require a specific treatment such as CBT, more comprehensive rehabilitation services or more intensive case management. Some services for children and adolescents and for seniors may also require more comprehensive resources. There is also likely to be variation in the comfort of family physicians in managing specific problems in their office, even with the support of a mental health care provider. Supporting a comprehensive range of mental health services or providers may be challenging for smaller initiatives.

Other possible limitations include available space, time constraints and the readiness of all partners to participate in collaborative models.

Barriers to collaborative mental health care and strategies to address them are explored in the Canadian Collaborative Mental Health Initiative document *Collaborative mental health care in primary health care: a review of Canadian initiatives Vol. I: Analysis of initiatives* (Pauzé et al, 2005) and *Vol. II: Resource guide* (Pauzé and Gagné, 2005), available at www.ccmhi.ca. Barriers cited by the approximately 90 Canadian collaborative mental health initiatives surveyed include funding/remuneration, structures/systems, buy-in, human resources, skill, geography, evaluation, and policy and legislation.

About this toolkit

This toolkit has been developed to assist health care providers, managers, consumers and community services interested in developing and implementing collaborative mental health care initiatives, primarily through the integration of specialized services in primary health care settings. It offers practical advice on different aspects of establishing a successful collaborative initiative from identifying need to evaluation and includes checklists, work pages and resources. It may be used by individuals or groups interested in starting an initiative "from scratch" or wishing to change or expand an existing initiative. It is not intended as a guide to clinical practice or management.

Central to the approaches suggested in this toolkit is an understanding of the principles of managing "chronic" diseases in primary care settings and the need for system changes if these problems are to be managed optimally.

Common to models of chronic disease management (also known as the chronic care model or the comprehensive care model) are six key functions, which need to be in place to deliver optimal care. These are:

- A comprehensive range of available services in a well-co-ordinated service delivery model
- A strong emphasis on self-management and a new partnership between an informed and empowered consumer and a well-prepared and supportive provider
- Evidence-based guidelines incorporated into a treatment setting through treatment algorithms or the presence of a specialist
- Information systems that allow records to be shared easily between different providers involved with an individual's care and enable individuals at risk of developing a problem to be monitored over time
- Organizational changes that share the vision and support the goals of the initiatives being developed, including the provision of adequate resources
- The integration of health services with community resources, looking at health from a population as well as an individual perspective

Central to the success of any initiative, therefore, is the ability to recognize that any specific intervention needs to be seen as part of a system of care, and to consider other system adjustments or changes that need to be made to support the planned initiative. This should always be borne in mind when contemplating any of the guidelines outlined in this toolkit.

Collaborative mental health care is an emerging area of practice with a need for guidelines based, as much as possible, on the best available evidence (best practices). The advice and recommendations contained in this toolkit are based on a review of the current literature, reports from successful initiatives and interviews with individuals who have been involved with collaborative initiatives.

While this toolkit is designed in a sequential, step-by-step format, change is not always linear. You may find that some steps do not apply to your initiative or need to be approached in a different sequence. This toolkit is intended to be a guide and to suggest options, rather than present the one and only way to do things.

The resources and capacity of health care providers, the needs of consumers and the specific problems presented will vary by initiative. The toolkit will offer a range of options that bridge the "ideal" (what could be achieved if funding/resource availability were not an issue) and the "reality" (what can be done with available resources).

We hope this toolkit will also serve as a resource for health care planners and funders as primary health care and mental health care reforms proceed. The implementation of collaborative mental health care can be significantly facilitated by reform strategies and policies which are co-ordinated across jurisdictions and by the availability of adequate and sustained funding.

This toolkit is intended for use with a general population. It has eight companion toolkits, each of which looks at issues to consider when planning, implementing and evaluating collaborative mental health care initiatives involving eight specific populations: Aboriginal peoples; children and adolescents; ethnocultural communities; rural and isolated communities; seniors; individuals with serious mental illness; individuals with substance use disorders; and urban, marginalized populations. The complete toolkits are available at the Canadian Collaborative Mental Health Initiative Web site, www.ccmhi.ca.

The information in the population-specific toolkits complements and augments that in the general toolkit; it does not repeat or replace it. The general and population-specific toolkits should be used together.

A Glossary of terms used in this toolkit may be found in Appendix C of this toolkit. We have used the term "consumer" rather than "patient" or "client" to refer to individuals (and their families/caregivers, where applicable) who either directly or indirectly make use of health care or related support services. A toolkit by and for consumers, *Working together towards recovery: Consumers, families, caregivers and providers* (Canadian Collaborative Mental Health Initiative, February 2006) is available on the Canadian Collaborative Mental Health Initiative Web site, www.ccmhi.ca.

Toolkits for providers and policy makers

Executive summary
Establishing collaborative initiatives between mental health and primary care services for Aboriginal peoples

Introduction

Persistent socioeconomic inequities and continued marginalization have taken a toll on the mental health of many Aboriginal people. Although they suffer many of the same mental health problems as the general population, rates of mental health problems such as suicide, depression, substance abuse and domestic violence are significantly higher in many Aboriginal communities. The overall mental health status of Aboriginal Peoples is markedly worse than that of non-Aboriginal people by almost any measure. The rate of suicide among First Nations is 2.1 times the Canadian rate. Mental health problems need to be located within the context of intergenerational trauma and grief due to extensive losses of land, language and livelihood, and the legacy of residential schools.

The purpose of this toolkit is to assist health care providers and others to work collaboratively to best meet the mental health needs of Aboriginal Peoples. Highlights of this toolkit include: seven key issues for consideration when planning and implementing an initiative; six key recommendations; and brief descriptions of five positive practice initiatives.

Defining the population

According to Canada's Constitution Act, 1982, the Aboriginal Peoples of Canada include Indians, Métis and Inuit. The term 'First Nations' is now widely used instead of 'Indian'.

Consultation process

Consultation focused on members of the Expert Panel (composed of representatives from across the country) and their colleagues and networks.

Key messages

- **The traditional Aboriginal concept of 'health' is holistic**. Although access to high-quality medical services is important, Aboriginal health caregivers see 'health' as an outcome of many things besides services, including early childhood experiences, poverty, personal and political self-determination (Mussell & Stevenson, 1999).
- **Accessibility is a critical issue**. A systematic and organized national mental health program does not currently exist in Canada, and at the national and regional levels, existing mental health services (e.g., access to assessment, consultation and treatment) are inadequate and poorly integrated.
- **Resource distribution is not equitable or consistent**. Funding mandates do not respond to communities in crisis.
- **There is a lack of integrated health services that are holistic** (physical, emotional, mental, and spiritual) and they are not well linked to other services such as social services, education, etc. Services provided through various federal and provincial departments are fragmented, and funding is allocated separately.
- **Training of service providers is inadequate**. There is a need for training for non-Aboriginal mental health care providers, e.g., family physicians, psychologists and psychiatrists, in Aboriginal realities and mental health issues that would support collaboration strategies. Training for traditional Aboriginal elders in mental health care has been carried out and is

being suggested as a useful collaborative technique.

- **There are few models of shared/collaborative mental health care for Aboriginal Peoples** in which consumers, primary care providers, mental health care providers and allied health professionals work together in an integrated approach.
- The ongoing lack of clarity regarding responsibility of federal or provincial governments for provision of comprehensive mental health care highlights the need for the **development of a national mental health framework for Aboriginal Peoples in Canada**. Other countries, e.g., New Zealand, have developed such frameworks.
- **It is essential to include Aboriginal communities in the planning of mental health services** to ensure appropriateness and accessibility of such services. Active community participation in planning of mental health services with a focus on capacity-building is highly recommended.
- **Stable funding for mental health services** would significantly improve service delivery. Funding must be sought for new collaborative initiatives from a variety of sources, including federal and provincial/territorial governments, and Band Council/Tribal Council budgets.
- **Key principles** that are critical to collaborative mental health care initiatives for Aboriginal Peoples are: mutual recognition, mutual respect, sharing, and reciprocal relationships and responsibility.
- **Examples of collaboration** include:
    - Dilico Ojibway First Nations: Family physicians, nurse practitioners and mental health clinicians collaborating, psychologist and psychiatrists available on a consultation basis, and telepsychiatry with specialists available
    - Muskiki Mental Health Program: Counselling and other services that incorporate Medicine Wheel teachings; traditional medicine healer available
    - Waadiziwin Health Access Centre, Mental Health Program, Fort Frances, Ontario: Fly-in service, interdisciplinary team with family physicians, nurse practitioners, mental health workers, FAS (Fetal Alcohol Syndrome)/FAE (Fetal Alcohol Effect) co-ordinator, traditional healer.
    - In the new paradigm collaboration model, traditional and biomedical practitioners would work together to develop techniques and practices to promote and restore health, using the best elements from both systems or recombining those elements into wholly new ways of approaching health and healing (RCAP, 1996). This model calls for new and/or modified roles and responsibilities of community-based health personnel, family, peers and other social groups serving as therapeutic support for the consumer to gain the most from therapy. In many communities today, the paid workers are the major supports for the consumer. Under the new model, increased levels of involvement on the part of peers, family and other members of an individual's support network is desired for best outcomes. Indigenous spirituality and knowledge are important elements.

Copies of this CCMHI toolkit and companion documents are available at www.ccmhi.ca.

Executive summary
Establishing collaborative initiatives between mental health and primary care services for children and adolescents

Introduction

Mental health services for children and adolescents have often been developed as an adjunct to adult services. However, the needs of this population are unique and require specialized skills to accurately diagnose and treat.

The purpose of this toolkit is to assist service providers, managers, consumers and other community services in developing and advocating for collaborative primary care initiatives involving mental health services for children and adolescents. Highlights of this toolkit include: suggestions for physician education; special needs of transitional youth; issues in rural and remote family medicine; key points to consider; descriptions of positive practice initiatives; key websites; and useful tools and resources.

Defining the population

This toolkit defines children and youth by age (0-18 years). The prevalence rate of mental health concerns in children and youth is approximately 20%. Close to 10% of children attending primary care present with mental health concerns as their chief complaint. One youth in ten contemplates suicide. Up to 80% of children with mental health needs will not receive any mental health services.

Consultation process

An Expert Panel with expertise in collaborative mental health services for children and adolescents gathered information and sought feedback from a variety of sources, both lay and professional, from across the country representing a wide range of disciplines including psychology, social work, nursing, dietetics, child and adolescent psychiatry, pediatric and family medicine, as well as police youth services, teachers and youth.

Key messages

- **Primary care is an important setting for serving children and adolescents with mental health needs** because most children are seen by a primary health care provider at least once each year. The advantages of providing mental health care within primary health care include knowledge of the family, reduced stigma and consumer preference.
- **Children and adolescents present some unique access issues**. Children and adolescents are typically not self-identifying and are usually brought to the attention of services by others, such as parents, guardians, social service agencies, schools, etc. Services need to include these significant others in order to obtain complete diagnostic information, which, in turn, requires consideration of privacy issues and logistical challenges, e.g., scheduling, location, co-operation of parties who may sometimes be in contentious relationships.
- **Adolescents with mental health needs may be the least well served**. They often do not have much regular contact with the health care system, tending to see health care professionals only for sports injuries or camp physicals, rarely seeking care for mental health problems. In addition, there are few professionals specializing in adolescent mental health.
- **To conduct a comprehensive assessment involves** more than one clinician, and traditional medical fee structures such as fee-for-service do not recognize this.
- **Older youth between the ages of 16 and 24, referred to as 'transitional youth', often 'fall between the cracks' of youth and adult**

services, and much remains to be done to effectively respond to them.

- **Youth-centred mental health care is considered a best practice approach and means:** involving youth in care decisions and program design; integrating peer support; recognizing developmental issues and the impact of mental illness on normal development; avoiding treatment-related trauma attached to first diagnosis and hospitalization; identifying the special effects of stigma on youth; focusing on home and community-based care; developing age- and stage-appropriate education about mental illness; addressing the social determinants of health (e.g., gender, education and social support networks); and focusing on wellness and ability.
- **Policies and legislation** have an impact on issues such as confidentiality, privacy, sharing of information and treatment consent, and often present contradictions and inconsistencies in the way services are provided. There is a need for agreements and protocols to enhance collaboration.
- **The educational needs of primary health care practitioners working with children and youth with mental health concerns cannot be met completely with generic training or Continuing Medical Education**. Engaging with this special population, assessing them appropriately and developing appropriate intervention plans all require specific approaches. Educational activities need to commence at the professional training level for all primary/mental health care disciplines and continue throughout the careers of those who work with children and youth.
- **Policy-makers and decision-makers need to be involved** at the beginning in identifying community needs, available resources and gaps in services, and in developing plans and strategies for increasing appropriate services and enhancing collaborative strategies.
- **Issues in rural and remote family medicine** such as supply and demand, lack of training and problems with remuneration create further difficulties in addressing child and adolescent mental health needs.
- **Best practice is facilitated by the involvement of a multidisciplinary team**, with members each having particular tasks and functions, e.g., pediatrician, family physician, nurse, psychiatrist, psychologist, dietitian, pharmacist, social worker, occupational therapist, etc.
- **Collaborative care programs for children and youth need to develop working relationships with other service sectors supporting children,** e.g., child welfare, special needs, education, health, schools, justice, social services, recreation, other community agencies.
- **Pediatric collaborative care programs will be quite different from adult services and different processes need to be used**.
- Examples of **models in child and youth collaborative primary/mental health care** include:
  - Telepsychiatry consultations using multidisciplinary virtual teams
  - Support for rural practitioners and mental health agencies
  - Co-ordinated involvement with other sectors such as education and children's services
  - Care management by specialists that work in primary care settings
  - Care management by primary health care practitioners with specialist support
  - Primary health care interdisciplinary teams

Executive summary
Establishing collaborative initiatives between mental health and primary care services for ethnocultural populations

Introduction

Ethnocultural groups are not in essence a 'special' population but rather a population at risk because of poor access to the specific and/or unique services they may require. Consumer and community consultation with this population is paramount to determine if potential approaches are culturally appropriate and relevant, and to assist with providing appropriate linguistic supports. There remains significant stigma within some ethnocultural populations in approaching mental health services or admitting to their potential need. In addition, the concept of mental health will vary among cultural groups, and guidance from its members is necessary.

The purpose of this toolkit is to assist service providers and other key stakeholders to work collaboratively to meet the mental health needs of ethnocultural populations. Highlights of the toolkit include: ten key issues for consideration when planning and implementing an initiative; descriptions of two positive practice initiatives; and a list of key websites.

Defining the population

Included in the working definition of this 'special' population are immigrants, refugees, and second- and third-generation Canadians of minority groups.

Consultation process

The Expert Panel employed several strategies in the development of this toolkit, including conducting surveys, questionnaires and interviews with a range of service providers, health care providers and consumers; involving settlement organizations and interpreters; and consulting community representatives.

Key issues for consideration

- **Accessibility is a key issue**. Services must be culturally and linguistically appropriate; translators must be available; information needs to be in multiple languages and formats; service providers must understand racial and systemic barriers; having one location for multiple services is beneficial.
- **Primary health care providers need to develop an increased awareness of somatization of complaints as individuals may not express mental health issues as such**.
- **Cultural competency is pivotal for services to be useful**. Cultural competency involves providing equal access, removing barriers and being inclusive (Sue, 2001). It also refers to an awareness of contextual and nonverbal signals; differences in communication styles; and power, role, gender and age factors (Gorman, 2001).
- **Awareness of poverty issues and how they may affect those receiving services is important.** These issues could include cost of transportation, cost of medication, cost of basic items such as food and clothing, and availability of appointments outside of regular working hours.
- **One major barrier to gaining access to successful and appropriate services is a lack of awareness (on the part of providers and consumers) of culturally specific services.**
- **Involvement of consumers requires greater attention.** Consumer centredness means there are formal avenues of review, revision,

consultation and feedback. The right to self-determination must be respected and there must be education regarding decision-making and options.

- **A greater understanding of the policies and legislation that impact ethnocultural populations is required.** The issues are vast and include numerous disparities and lack of awareness of the needs to be addressed.
- **It is necessary to secure funding for interpreters, advocates and culturally appropriate material and financial supports for immigrants and refugees during resettlement.**
- **There are no valid measurement or evaluation tools applicable to this population as a whole**, nor any significant evidence-based research upon which to develop guidelines for ethnocultural services. Evidence-based screening and health maintenance guidelines relevant to the patterns of illness in different immigrant groups should be developed.
- **Service providers involved in collaborative care** may include physicians, settlement workers, advocates, religious and community groups, nurses, physiotherapists, psychologists, clinical counsellors, health brokers, interpreters, psychiatrists, lawyers, mental health workers, dietitians, addictions counsellors, pharmacists and community liaisons. Provisions should be made for interpreters and health brokers to act as liaisons in the community.
- **Collaborative care structures must include rapport-building and establishment of trust before any significant issues can be addressed.**
- **Two types of collaborative models currently exist for this population**: Ethnocultural-inclusive models address the needs of multiple ethnicities and cultures in one setting, while ethnocultural-specific models address and provide services to a particular cultural group or ethnicity.

Executive summary
Establishing collaborative initiatives between mental health and primary care services for seniors

Introduction

Seniors aged 65 and over accounted for 13% of Canada's population in the 2001 census, up from almost 12% in 1991 (Statistics Canada, 2002). It is projected that by the year 2016, more than 16% of Canada's population will be 65 years of age or older (National Advisory Council on Aging, 1999). A greater proportion of Canada's older adult population is also living longer: Those aged 85 and over represent the fastest growing segment of the senior population (Statistics Canada, 2002).

It is estimated that 20% of adults over age 65 have a mental disorder (Jeste et al, 1999), yet there are shortages of family physicians and specialized mental health services for seniors. There is an escalating need to develop new service delivery models to better address the interdependent biomedical, psychological, social, functional and environmental needs of seniors experiencing mental health issues.

The purpose of this toolkit is to assist health care providers to work collaboratively to best meet the unique health care needs of seniors experiencing mental health issues. Highlights of the toolkit include: an overview of an 'ideal' geriatric primary mental health care collaboration; key issues for consideration when planning and implementing an initiative; an extended literature review; descriptions of more then 20 positive practice initiatives; and key websites.

Defining the population

Age is a primary factor in defining this population but not in itself sufficient. Although age 65 is often used as a benchmark, individuals under 65 may be considered part of this population if they experience age-related mental health issues. The definition used in this toolkit includes: primary mental illness with age-related primary health concerns, including individuals with late onset depression or schizophrenia-like syndromes and longstanding psychiatric illness with age-related complication such as stroke, mobility problems or dementia; complex dementia/neurological/medical conditions with associated or comorbid psychiatric illness; forensic patients; and individuals with substance use disorders, concurrent disorders or those with developmental delays who are growing old. Individuals with a longstanding mental illness who grow old with no major age-related issues are not included in this population. The primary mental health care provider must be the ultimate judge of who amongst his or her population is likely to benefit most from collaborative mental health care initiatives.

Consultation process

The members of the Expert Panel have varied personal and professional backgrounds including caregiving, social work, community nursing, geriatric psychiatry, family medicine, policy analysis and program evaluation. The development of this toolkit involved four key steps: a literature review; 23 in-depth interviews (qualitative); 30 interviews (quantitative survey design); and presentation of drafts of this toolkit at a number of workshops and conferences.

Key messages

- **Access barriers** include factors relating to age, attitudes and values; eligibility criteria; physical mobility; funding issues; and lack of knowledge of options. Access issues are further compounded by difficulties faced by senior caregivers in managing their own health needs; financial issues; and the complex co-ordination required to arrange necessary supports and resources.

- **Accessibility can be enhanced** through greater awareness among consumers and caregivers of available services; increased health professional home visits; co-ordination of transportation and respite care; support to caregivers; and enhanced capacity to advocate with a strong voice.
- **A limited number of primary and mental health care providers have specialized formal training in seniors' health.**
- **Consumer centredness includes** improved access to collaborative services and supports for consumers/family/caregivers with sufficient time to interact and engage meaningfully with providers; enhanced education and counselling; home-based care as needed; and opportunities for input and participation as consumer representatives.
- **Polices, legislation and funding** need to support cohesion among services essential to seniors (e.g. health, transportation and social services); improve the portability of health services; address inconsistent eligibility criteria; and create flexibility in service models so that primary health care providers can adequately address the unique and complex needs of seniors with mental health needs.
- **Evidence-based research** points to best practices that include: consumer centredness; collaboration with health care providers (professionals and non-professionals) and with health and social services; care provided through the primary health care system; the use of interdisciplinary teams and case managers; outcome-based treatment planning; the use of a biopsychosocial model of care; use of established guidelines for care; community outreach, including home visits; and support and education of caregivers.
- **Collaborative structures need to ensure that seniors have time to interact and engage meaningfully and that their care providers are not too busy to address their concerns**. Equally meaningful input from a diversity of stakeholders is needed to ensure the varied needs of seniors are met. Seniors with mental health needs must be represented on collaborative care advisory groups dealing with policy development, planning and service implementation, and support given to building capacity within the community to ensure the diverse needs of seniors are identified and addressed.
- **How the diverse group of stakeholders relate to and work with each other are critical to the quality or richness of the collaboration**. Meaningful stakeholders can include: (geriatric) psychiatrists; (geriatric) internists; neurologists; geriatric psychiatry outreach teams; family physicians, nurses, psychiatric nurses; practical nurses; psychologists; neuropsychologists; social workers; bereavement counsellors; specialty mood case managers; pharmacists; occupational therapists; liaison and education workers; physiotherapists; dietitians; non-professional health care providers (care aides, home support workers, paid live-in support); informal supports (families, peer support personnel, cultural peer groups, friends, neighbours); a wide range of community health care resources (care facilities, day care, seniors support services); and 'outside-the-health-care-box' supports (police, clergy, coffee shops, libraries, banks, lawyers, etc.).
- **Examples of positive practices** in collaborative mental health for seniors are numerous and take many forms. .

Executive summary

Establishing collaborative initiatives between mental health and primary care services for rural and isolated populations

Introduction

Individuals living in rural and isolated areas are a culturally unique and diverse population. Despite this diversity, rural and isolated communities share common problems in terms of health status and access to health care. Most provinces and territories show a trend towards progressive deterioration of health the greater the distance from urban areas: lower life expectancy than the national average; higher rates of disability, violence, poisoning, suicide and accidental death; and more mental and physical health issues than their urban counterparts. When considering rural and isolated populations in Canada, it is particularly important to look at the needs of Aboriginal Peoples since they constitute one of the largest segments of isolated populations.

The purpose of this toolkit is to encourage greater collaboration among primary health care professionals, mental health care professionals, consumers, families and community organizations in addressing the primary mental health care needs of individuals living in rural and isolated parts of Canada. Highlights of the toolkit include: a guide to providing effective collaborative mental health care in rural and isolated areas; seven key points for consideration; descriptions of six positive practice initiatives; and key tools and resources.

Defining the population

There is no standardized definition of rural and isolated populations. Aspects relating to the quality of life in rural and isolated populations are seldom incorporated in current definitions. For the purpose of this toolkit, the following definition was used proposed: *Rural and small-town communities are those that have 10,000 or fewer residents and are situated outside commuting zones of large metropolitan areas and cities. 'Isolated' implies having limited or no road access nor ready access to specialized services.*

Consultation process

Members of the Expert Panel were selected on the basis of their involvement with primary health care and mental health care in rural and isolated areas across Canada. Strategies used in the development of the toolkit included a survey (over 30 responses received from a range of providers) and several focus groups (reaching consumers, families and caregivers, and providers and members of various associations).

Key messages

- **Numerous access issues exist** including insufficient numbers of health care professionals and resources, and travel barriers and costs created by the distance from health care professionals in urban centres. **Strategies for improving access include:** using diverse channels of communication (such as radio, television, newspaper and the Internet) to disseminate health care information; creating regional health authority sub-organizations or other bodies to help high-risk groups; developing self-help manuals for consumers to foster health promotion and prevention; using telemedicine to overcome distance and isolation from service; and providing transportation.

- **Consumer centredness** can involve having inclusive meetings between consumers and providers; providing consumer/client advocate/complaints officers to address consumers' needs; enabling consumers to make self-referrals to mental health; and supporting transportation to mental health services outside of rural areas.

- **Policy and legislative issues reflect discrepancies** between federal and provincial jurisdictions, particularly for Aboriginal Peoples, and put limits on service delivery. There is a need to mandate core competencies for mental health care providers in rural and isolated areas.

- **Funding issues are critical**: Resources to provide basic care are not adequate, and additional funds are needed to provide financial incentives to attract health professionals. Funding is also needed to provide resources directed to consumers who need and utilize higher levels of mental health care to prevent more costly service utilization.

- **Evidence-based research is needed** to assist in better planning and service delivery for rural and isolated populations, and creativity is required to plan and support this type of research. This is required within a context of involving community members in a way that will ensure community needs are being addressed.

- **Showing success in terms of evaluation is a necessity** in creating leverage for change. Particular care needs to be taken to ensure evaluation tools are appropriate to rural and isolated populations.

- Although there are a number of 'best practice' approaches, critical to the success of rural and isolated collaborative initiatives appears to be **flexibility and local adaptations that make each effort unique**, such as two clinicians working locally, fly-in visits, or distance video conferencing. Each are attempts to bridge gaps in providing clinical service that otherwise would not be present.

- **Collaborative approaches need to consider the following:**
  - Using multidisciplinary teams which include community advisory committee members and consumers
  - Accrediting key stakeholders such as family doctors and other mental health providers to provide mental health care
  - Starting collaborative partnerships informally and involving non-clinicians (e.g., clergy, teachers, care providers)
  - Providing core training to health care professionals
  - Ensuring a network of formal and informal supports to clinicians providing primary mental health care

- **Collaborative strategies to improve effectiveness include:**
  - Enhancing the richness of the collaboration to improve overall co-ordination of services among providers and decrease the burden of care for family physicians and other first-line providers
  - Using a pyramid model of health care provision to serve a greater number of consumers more effectively, i.e., have proctors and supervisors for community health workers so that psychiatrists are not the first point of contact
  - Enabling flexibility in role assignments in order to 'get the job done'
  - Facilitating access to clinical supervision or peer supervision for 'back-up' even if this involves a long-distance relationship
  - Training in 'collaboration' for those working in the area

Executive summary
Establishing collaborative initiatives between mental health and primary care services for individuals with substance use disorders

Introduction

Problems involving drugs and alcohol are invariably intertwined with a wide range of health and social factors, requiring an integrated perspective on prevention and care. While there is considerable evidence that primary health care providers can positively impact substance use in their practice setting, low rates of detection and treatment through primary health care underscore the need for greater co-ordination and collaboration in the provision of care.

The goal of this toolkit is to describe opportunities to accelerate the transfer of knowledge and the enhancement of care for individuals with substance use disorders through improved interprofessional collaboration. Highlights of the toolkit include nine key issues for consideration; eight steps to implement collaborative care for this population; and key tools and resources.

Defining the population

This toolkit focuses on those individuals that have substance use disorders stemming from the use of licit and illicit drugs. The use of psychoactive substances including alcohol, tobacco and illicit drugs contributed to 12.4% of deaths worldwide in the year 2000 (World Health Organization, 2002). Alcohol alone is estimated to be responsible for 4% of the global burden of disease.

Consultation process

An Expert Panel representing diverse professions across Canada was established. There was intensive study of collaborative primary health care in other jurisdictions, including the UK, and input from three interprofessional groups that are currently leading the implementation of collaborative care in British Columbia and the Yukon. In addition, a 'think tank' took place during a conference in Whitehorse supporting regional implementation of collaborative primary health care for substance use problems.

Key messages

- **Improving access to treatment** will require not only increasing the availability of services but changing practices that take place once the threshold of care has been crossed. Universal screening is necessary to identify substance-related health needs because people with these problems (or risks) often do not present for treatment of the substance problem *per se*. Therefore, universal screening is necessary to identify substance-related health needs. Professionals and consumers alike need greater access to information concerning best practices. The administration of services must be reformed so that consumers have access to the blend of primary health care supports that are appropriate for them.

- A given Canadian community may have a dozen or more agencies that provide services for substance use problems. **There is a need to clarify the roles, responsibilities and scopes of practice** between primary health care and other service settings and to establish practices and documentation strategies that can be implemented consistently across different services, e.g., complementary approaches to screening and assessment. Consideration should also be given to developing a common foundation of expertise across health care providers, which can be augmented by particular specialized skills.

- **All successful treatment for substance use**

problems is consumer-centred. Consumer-centred care can be organized around the principles of timeliness, appropriateness, continuity and inclusiveness of services. Effective collaboration requires that relevant information must travel faster than the consumer. Health professionals should examine the possibility of harmonizing practices concerning the ascertainment and exchange of information (e.g., informed consent) so that each professional has a complete health record, and so that the demands on consumers are minimized (e.g., retelling their history to different providers).

- **Policies and legislation may require reform in order to support collaborative care models.** Health care providers can play an important role in identifying needed policy reforms. Potential areas of reform include policies concerning smoking cessation, impaired driving and methadone maintenance, and practices regarding informed consent, sharing of consumer information and record-keeping.

- **Integrated practice is impeded by a lack of integrated funding**. The impetus to create collaborative primary health care for substance use must follow a strategic plan, and funding must be allocated in a manner that supports the strategic plan, including the integration of physician and other health services, interprofessional education and other supports such as effectiveness research and common information systems.

- **Evidence-based collaborative care must be developed and refined through continuous and meaningful evaluation**. This requires ongoing partnerships between clinicians, policy makers, administrators and researchers.

- **Two general models** for integrating the services of primary health care, mental health and substance use services are presented: centralized models bring providers and consumers together under a single site; decentralized models involve the development of linkages and shared practices across separate providers.

- **Models of interprofessional care present opportunities** to better co-ordinate referrals from primary health care to specialized services; to improve transitions from specialized services to primary health care settings (e.g., using a multidisciplinary team located in a detoxification centre); and to integrate behavioural and pharmacological approaches to the treatment of substance use disorders.

- **Administrators must support ongoing discussion** among primary health care providers and other clinicians, consumers and the community to ensure that health resources are attuned to the changing needs of consumers with substance use problems.

- **Steps to implementing collaborative care** for substance use disorders, based on Kotter (1998) include:
  - Establish a sense of urgency.
  - Form a powerful guiding coalition.
  - Create a vision.
  - Communicate the vision.
  - Empower others to act on the vision.
  - Plan for and create short-term wins.
  - Consolidate improvements and produce still more change.
  - Institutionalize new approaches.

Executive summary
Establishing collaborative initiatives between mental health and primary care services for individuals with serious mental illness

Introduction

Much has already been accomplished, through the work of consumer advocates, family organizations and mental health organizations, in re-defining issues relevant to people with serious mental illness (SMI). Historically, this population has often been stigmatized and dehumanized. By contrast, it is now assumed that consumers with SMI will be supported to attain and maintain normal roles within the context of living with a serious illness and that services will be organized and delivered to support these roles. The emphasis is on citizenship, empowerment, community integration and recovery.

The purpose of this toolkit is to assist service providers and other key stakeholders to work collaboratively to meet the mental health needs of individuals with SMI. Highlights of the toolkit include: a list of recommended articles; descriptions of four positive practice initiatives; key websites, tools and resources; and 10 key issues for consideration when planning and implementing an initiative.

Defining the population

Serious mental illness is the presence of a mental health problem that is serious enough to significantly disable a person across a number of social and functional domains and that requires significant system resources to enable the person to set and achieve fulfilling life goals and successful community integration. This toolkit is focused on people with SMI such as schizophrenia and bipolar affective disorder and two other groups that have been identified as meeting the criteria for this population: individuals with borderline personality disorder and aging individuals with psychotic disorders.

Consultation process

An Expert Panel was established and prepared a draft document which was reviewed by a consumer advisory committee, consumer, family members and a range of providers. In addition, a focus group with consumers was held, and 12 shared/collaborative care programs providing services to this population were consulted.

Key issues for consideration

- In developing collaborative projects, **providers need to have a conceptual framework** for understanding what is needed to support people with SMI to live fully and successfully in their community. This framework needs to situate the consumer at the centre of care, promote consumer recovery and integrate not only medical/ psychiatric care but linkage with other providers, e.g., housing, income, education.

- The **recovery paradigm** assumes that people with SMI are citizens with rights and responsibilities, and services should be organized to support full community integration.

- **Key challenges** include accessibility, working with individuals with addiction/substance use disorders and/or personality disorders, communication between providers, language/cultural issues, poverty/homelessness, physical health comorbidity, complexity of needs and engagement with services.

- **Consumer involvement in the design of programs** is fundamental to ensuring that their needs are met (e.g., input about where they are comfortable receiving services and what kinds of services they have had difficulty obtaining).

- **Relationship-building amongst the wide range of providers** who can support the individual is key.
- **Both process and outcome evaluations need to be considered**.
- **The literature describes four approaches** to improving physical and mental health care for people with SMI:
  - Shifting the locus of mental health care into the primary care setting
  - Providing primary care within a mental health setting
  - Providing a fully integrated continuum of mental health and primary care within the same organization and/or location
  - Increasing the connections between mental health and primary care providers where such services jointly have responsibility for individual consumers
- **Local conditions have helped shape existing models**, e.g., factors such as the availability of resources, desire to collaborate and capacity of organizations with a commitment to working with people with SMI.
- **Unique functions of successful collaborative models** for people with SMI include self-management support, advocacy, rapid access, case management/system navigation; outreach/engagement, individualized care/treatment plan, concurrent disorders capable (i.e. ability to screen, assess and treat concurrent substance use problems) and rehabilitation supports (such as housing, vocational and educational).
- **Examples of collaborative initiatives** include:
  - Specific clinics and physicians designated to provide primary care to people with SMI within a large mental health system
  - Nursing-based primary care centres within a large rehabilitation-focused mental health centre
  - A multidisciplinary mental health team providing services within a primary care setting
- **Key elements** in building a collaborative service for people with SMI include:
  - Common vision and clearly articulated ‘shared’ goals for collaboration
  - Involvement of all partners as equals in the collaboration
  - Mutual respect for the roles of each provider and the consumer
  - Strong linkages to hospital programs
  - Clear memoranda of understanding/agreement
  - Clear roles and responsibilities of team members
  - Ensuring staff have strong commitment to, and experience working with, people with SMI
  - Clear protocols for sharing information

These elements should be in place prior to any delivery of services.

Executive summary
Establishing collaborative initiatives between mental health and primary care services for urban marginalized populations

Introduction

When one is marginalized from normal supportive structures mentally, physically, socially, spiritually and financially, the social determinants of health are all detrimentally affected. The published literature is replete with findings linking urban marginalization and poor health outcomes. When a service provider is concerned with the health and well-being of the urban marginalized consumer, it is essential to view the consumer as a whole and to take a collaborative approach to primary health care service delivery.

This toolkit is focused on aiding the development of collaborative mental health care for the urban marginalized, to spur the creation of new initiatives, share the teaching of leaders in the field and ultimately provide more relevant, equitable, cost-effective, quality care to this population. Highlights of the toolkit include: ten key issues for consideration when planning and implementing an initiative; descriptions of five positive practice initiatives; key websites (Canadian, American and international); and important tools and resources.

Defining the population

The urban marginalized are an extremely heterogeneous population. This toolkit defines urban marginalized as including individuals who are homeless, living with addiction, living with disabilities, street youth, sole support parents, Aboriginal Peoples, mentally ill persons, gay/lesbian/bisexual/transgendered individuals, and racial minorities (including immigrants and refugees), who live in an urban setting and share the common determinants related to social exclusion and poverty. Not all members of these groups are necessarily marginalized but they have a higher likelihood of marginalization than others.

Consultation process

An Expert Panel was formed with representatives from across Canada, which included leaders in collaborative mental health care for this population. Consumer input was obtained and community agencies were consulted.

Key messages

- **Barriers to appropriate health care for this population occur at both 'macro' and 'micro' levels.**
    - Lack of address, identification, transportation, telephone, social support to negotiate layers of red tape and minimal control over activities of daily living, along with the complication of fee-for-service payments that require a health card number for billing, and lack of drug coverage all hinder access and treatment options for this population. The need for advocates for this population is paramount.
    - Funding is one of the most frequently reported barriers and points to the need to broaden the base of funding by establishing key partnerships and ensuring the involvement of the entire community.
    - Other factors complicate the therapeutic relationship and referrals of the marginalized including high susceptibility to ailments, severity of ailments, unintentional injury, prevalence of concurrent disorders, lack of a social support network, history of violence, distrust and feelings of powerlessness.

- **Elements that maximize successful outcomes** include strong reciprocal communication and linkages through formal or informal partnerships with all pertinent supportive structures/services such as shelters, outreach, housing, social services, pharmacy and addiction services.

- **Treatment stability is facilitated when staff members working directly with consumers develop a high level of trust and social history.** Consumers must be placed at the centre of treatment planning to ensure they are willing, capable, understanding and supportive of all aspects of the proposed strategy.

- **Accessibility to services is a key element that needs to be considered when developing policies at the program level.** Consumers must be involved as equal partners in the development process. Because the services of many agencies need to become intertwined, memoranda of understanding and service agreements need to be considered.

- **The collaborative team may include a wide range of individuals, and its composition should be tailored to the unique needs of the consumer.** Common team members could include: nurse/nurse practitioner with mental health/public health expertise; outreach worker with mental health expertise; social worker; translator; counsellor (addiction); housing worker; case manager; family therapist; peer support worker; pharmacist; occupational/physical therapist; dietitian; psychologist; volunteers; dentist; family physician/psychiatrist.

- **The most effective collaborations** are formal, institutionalized interprofessional/ interdisciplinary care teams which tend to work best when team members are co-located under one roof with satellite outreach arms. Services should be provided in a location which maximizes consumer access, such as at an inner-city community health centre with outreach components or shelter-/drop-in-based initiatives with links to primary care providers. An assertive outreach interdisciplinary component can bring hard-to-reach consumers into treatment.

- **Building a collaborative foundation of care for the urban marginalized requires**:
  - Consumer-centred, holistic integrated care built upon trust and consumer input
  - Service delivery design including multiple sites
  - Interdisciplinary teams
  - Flexibility of service in components and intensity, and access to mainstream health services
  - Outreach and engagement including outreach on the streets and to other places where services are received
  - Outreach workers and case managers to promote engagement of the consumer
  - Nonjudgmental and supportive consumer interactions with the team
  - Incentives to promote consumer engagement
  - Evidence-based standard of care as provided to those who have more resources

Toolkits for consumers, families and caregivers

Introduction
Working together towards recovery: Consumers, families, caregivers and providers

> *"When I was first diagnosed, the idea that I could recover was the furthest thing from my mind. I thought I had dropped into a deep pit and would never get out. But I did - bit by bit by bit – with a lot of help. My life is not all roses now, but it's a whole lot better than I ever thought it could be."*

When you first recognized that you, or someone you love, might have a mental illness, you probably felt a lot of emotions; shock, fear, sadness, anger. You also likely felt all alone. You are not. In any given year, one in five Canadians will experience a mental illness.

A team of experts (people who've experienced mental illness themselves, family members and caregivers) have come together to provide you with this toolkit so you won't feel so alone. It is intended to offer you the information they wished they'd had right from the beginning.

Recovery from mental illness is the guiding light of this toolkit. Recovery is living life to the fullest – despite a mental illness. At first, recovery may seem like just too BIG of a mountain to climb – but it is really about finding hope and holding onto it.

Working together towards recovery describes the best sources of information we could find. Many are on the internet because it is accessible – from the privacy of your home - whenever you want and the resources are free. If you don't have a computer – or access to one - your local library has free Internet service. If available, we have included the addresses and phone numbers of organizations who host the recommended sites. We have also recommended books and pamphlets but they have to be ordered at a cost.

The goals of ***Working together towards recovery*** are:

1. To provide easy to find information you can trust so you and your family can be effective partners in your treatment and recovery.
2. To make sure you know it is OK to ask that the professionals you see work as a team – if this would work best for you.
3. To assure you that the most important members of the team are you and those who love you.
4. To help you or your family become involved, if ready and interested, in creating a collaborative care initiative or other mental health service in your community.

We have tried to give you the most up-to-date information possible – noting that new resources are being published daily. Overtime, there will be new and useful books and websites for you to find.

And finally, the biggest concern of the hundreds of people that were consulted by the Canadian Collaborative Mental Health Initiative was that they plan, *in advance*, for crises. If this is your concern as well, please go to Appendix 2 for a **Crisis Plan**.

A word about the Internet

The Internet used to be considered the way of the future but it is now the reality of today. Canadians use the Internet most often to find health information.

The Canadian Health Network (http://www.canadian-health-network.ca) offers advice on what to look for when you are deciding whether or not a health website is trustworthy.

Is the source credible?

- Is the organization who hosts the site well-known and reputable?
- If it is an individual, do they identify themselves and do they have the appropriate credentials to provide mental health and mental illness information?
- If the site is hosted by someone who has had a mental illness or who is a family member, is this clearly stated? Experiential information is valuable but it is different than medical information or information from other professional sources.

Is the information relevant?

- Does the site have Canadian content? A lot of health information is borderless - it remains the same no matter what country hosts the website. But there can be substantial differences in medication names, legislation and other facts if the site is not from Canada.
- Does the information appear superficial or seem like someone's individual opinion? It may still be helpful but it is not the same as scientific research or information from an organization known to specialize in mental health and mental illness information.

Is the information timely?

- Has the site recently been updated?
- Is the information it provides identified by the date so that you know it is current?
- Are the links to other sites active?

Is there disclosure?

- If the site wants to sell you something, has that been made clear? Can you still access valuable information without purchasing?
- Are both sides of an issue presented or do the site authors seem to be trying to convince you to believe only what they believe?
- If the site is sponsored, is it clear who the sponsor is? For example, one source of information on mental health and mental illness are pharmaceutical manufacturers' sites. The information may be helpful but you must be aware that the host is selling a product.
- If you have to register to use the site, is it clear why, and how your privacy will be preserved?

Introduction
Pathways to healing: Mental health guide for First Nations people

About pathways to healing

The purpose of this toolkit is to assist First Nations people who are considering taking action to help themselves or others to heal:

- To make sense of their history and the emotional pain caused by colonization.
- To help build self-awareness and understanding of how the past affects us as individuals, families and as a community. How traditional knowledge, ways of knowing, beliefs, values, language and cultural ways support renewal, healing and wellness.
- To begin to see how unspoken grief hurts our children, our young people, and our ability to form healthy relationships as adults with our partners, as parents and with our elders.

This toolkit is also written for family, friends, and caregivers because the lack of balance for one - affects us all. Because we know, families, caregivers and the community can play a key role in recovery.

The information shared comes from the wisdom of people who: have journeyed through the effects of colonization: understand their cultural foundation and how to build upon it and/or improve their self-awareness: have learned to grieve, and found the red road to recovery; have conducted the best Aboriginal and Western research available today.

What we hope to pass on is:

- Knowing the link between our current life choices, First Nations history, and the relation this has to our understanding of balance and health.
- Hope for a better future through healing
- That help is often hard to find - but is worth seeking,
- That working together with health professionals, family, Elders and peers can enhance the healing journey,
- That good mental health is a shared concern, and
- That you are not alone.

This toolkit written for First Nation people regardless of where you live. No matter where you live, be it in an urban, rural, semi-isolated, or isolated setting, this toolkit will be useful. It will provide practical advice on how to build supports and find competent and skilful help when the journey is difficult. It will guide you to where you can find more information. It is a starting point for change.

Toolkits for educators

Introduction

Strengthening Collaboration through interprofessional education: A resource for collaborative mental health care educators

The training and education techniques of health care professionals are key determinants of their willingness to collaborate. In order to assess the prevelance of current Canadian interprofessional education programs that address collaborative mental health care, McVicar et al. (2005) conducted two surveys. Findings at the pre- and post-licensure levels suggest that there is a paucity of programs in this area, prompting the development of this toolkit.

The goal of this toolkit is to improve the mental health of people living in Canada by enhancing the interprofessional education and training of key stakeholders. For the purpose of this toolkit, key stakeholders are *not* limited to individuals holding professional designations, and may include: a broad range of primary health and mental health care providers; consumers, families and caregivers; community agencies; pre-licensure students; policy makers; administrators; and other individuals who do not necessarily hold a professional designation. Collaboration in the context of collaobrative mental health care emphasizes the important role that consumers, families and caregivers have as part of an effective collaborative team.

This toolkit includes:

1. A **theoretical section** (Section A) – provides background information on the application of interprofessional education within the context of collaborative mental health care.
2. An **implementation section** (Section B) – provides concrete information and activities to support the implementation of an interprofessional education workshop within the context of collaborative mental health care.
3. A **decision guide** (Appendix B) – provides questions to help workshop facilitators identify their organization's needs and readiness to engage in an interprofessional education workshop to enhance the delivery of collaborative mental health care in primary health care settings.

How to use the toolkit:

- If you are a **general interest reader**:
    - Section A provides a brief overview and discussion of the key concepts and principles of interprofessional education, as they relate to the integration of primary health and mental health care.

- If you are a potential workshop **facilitator**:
    - Section B explains how to organize and facilitate a workshop.
    - A thorough understanding of the contents of Sections A and B is essential to have prior to implementing the workshop.
    - You may consider reading additional materials, depending on your comfort level with the concepts and principles presented in Section A.

- If you are going to be a workshop **participant**:
    - You may benefit from reading through Section A prior to attending the workshop.
    - You may consider reviewing the activities in Section B.

Why interprofessional education?

Traditionally, health professionals have trained in isolation from other professionals. The curriculum content and structure follow strict disciplinary lines. Students from different professions may have a clinical practicum at the same location, but training schedules, length of time at the location, supervision, and agreements with the academic health centre are all negotiated independently.

A variety of forces are encouraging the move toward interprofessional education. First, students must be able to work as members of a team after graduation. For example, the Royal College of Physicians and Surgeons of Canada has recognized the importance of the role of "collaborator" as a key competency, which all post-graduate residents must demonstrate upon graduation. Second, a number of key reports concerning the Canadian health system have also stressed the need for greater collaboration involving interprofessional teams of health care providers (Kirby, 2002; Romanow, 2002; Health Council of Canada, 2005).

What is collaborative mental health care?
Collaborative mental health care describes a range of models of practice in which consumers and their families and caregivers, together with health care providers from both mental health and primary health care settings—each with different experience, training, knowledge and expertise—work together to promote mental health and provide more coordinated and effective services for individuals with mental health needs.

Similar to engaging in collaborative mental health care activities, opportunities to include consumers, families and caregivers, and other individuals who do not necessarily hold professional designations, should be explored and encouraged when designing, implementing and evaluating interprofessional workshops or programs.

Toolkit Series

Implementation toolkits for providers and planners

1. Collaboration between mental health and primary care services. A planning and implementation toolkit for health care providers and planners

Companion Toolkits

2. Aboriginal peoples
3. Children and adolescents
4. Ethnocultural populations
5. Individuals with serious mental illness
6. Individuals with substance use disorders
7. Rural and isolated populations
8. Seniors
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Toolkits for consumers, families and caregivers

10. Working together towards recovery: Consumers, families, caregivers, and providers.
11. Pathways to healing: A mental health guide for First Nations people

A toolkit for educators

12. Strengthening collaboration through interprofessional education: A resource for collaborative mental health care educators

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