

Collaboration for Addiction and Mental Health Care: Best Advice

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Executive Summary

Background

Collaboration among providers, both within and across service sectors, has been established as a best practice to address a variety of health issues more effectively. This fact is also true for addiction and mental health services where the co-occurrence of addiction, mental health problems and physical co-morbidity are very common and particularly challenging to address. While Canada has seen substantial momentum at the systems level toward improved collaboration between the mental health and addiction sectors, effective strategies for collaboration at the practice level have not yet been systematically developed, evaluated, documented and shared.

In response to this gap, the Canadian Executive Council on Addictions (CECA), the Mental Health Commission of Canada (MHCC) and the Canadian Centre on Substance Abuse (CCSA) embarked on a partnership in 2012–2013 to consolidate knowledge and generate consensus on effective strategies for collaboration between mental health and addiction services. The partnership's efforts were supported by a Scientific Advisory Committee (SAC) that identified key areas of focus. When summarizing the evidence related to these key areas, the SAC was challenged by the diversity of the available literature, which focused on different sectors and services, varying forms or models of collaboration, and assorted targeted outcomes. Given this mix, it was not possible to identify tidy “proof points” of what works best under specific programmatic and contextual conditions. Rather, the evidence, with all its challenges and nuances in interpretation, points to key principles, considerations and elements of collaboration that can successfully support service providers.

Collaboration:
Any form of cooperative enterprise, whether it be shared or collaborative care, a partnership, a network, a community coalition or various forms of integration, that aims to increase the chances of achieving some common objective compared to acting alone as an individual or organization.

The SAC presented its work at the May 2013 Leaders' Forum to a range of stakeholders from across Canada, including researchers, administrators, direct service providers and persons with lived experience of mental illness or addiction. Forum participants discussed the implications of the available evidence in the context of their own experience and jurisdictions, and suggested additional strategies for practice and research. Forum participants also made individual and collective commitments to maintain the momentum generated by this work by supporting collaborative efforts in their own local, provincial/territorial and national contexts. A key theme that emerged from the Leaders' Forum was that everyone, across multiple sectors and at all levels, has a role and responsibility to support and advocate for collaboration to improve access to services and outcomes for people with mental health and addiction-related problems.

This document presents the best advice distilled from these efforts, as well as a call to action for stakeholders at the pan-Canadian, system and service levels to meet these goals.



Potential Benefits of Collaboration

Collaboration is important not only to increase the effectiveness of services at the **individual level** to address the full range of needs and treatment trajectories, but also at the **population level** to maximize societal impact. The literature highlights the following key benefits expected from collaboration:

- Enhanced capacity to support people with complex conditions;
- Enhanced capacity in collaborating partners;
- Improved access to services;
- Earlier detection and intervention;
- Clinical value in integrated care;
- Improved continuity of care;
- More satisfied healthcare consumers; and
- Improved client–patient outcomes and reduced costs.

Models of Collaboration

This document describes specific models and approaches for collaboration that have had some traction in the research literature, including the model presented by the Canadian Collaborative Working Group on Shared Mental Health Care, the Chronic Care Model and the Tiered Model. These models have several features in common that are specific to collaborative efforts. The commonalities include:

- A need for effective linkages;
- A high level of trust and reciprocity among participants;
- A focus on a broad continuum of severity;
- Multi-sectoral involvement;
- Multiple levels of collaboration that align with different types of needs and levels of severity; and
- A distinction between service- and system-level initiatives.

Key Considerations for Action

This document presents key considerations for action in support of collaborative work. These considerations are based on the research evidence presented in background papers, as well as practice experience and recommendations from participants in the Leaders' Forum. In the main report, key considerations are accompanied by one or more illustrative examples to describe real-life instances of successful incorporation of collaboration into mental health and addiction service delivery. Examples of resources that are specific to each key consideration are also provided. The six key considerations for action are summarized below.

Supporting Change

Collaboration between the mental health and addiction sectors requires changes — some significant — in the ways that service providers do business. Unfortunately, most change initiatives fail, either at the implementation stage or over the longer term, because many barriers to change are not adequately addressed. Decision makers and leaders are encouraged to approach collaboration as a formal change initiative. Ideally, change should be guided by a formal change management model and strategy, and informed by best practice principles and interventions based on implementation science.



Engagement and Relationship Building

Effective working relationships are a key component of collaboration and are associated with positive health outcomes. It is critical for funders and policy makers to identify and give priority to initiatives that build collaborative relationships. This activity includes building relationships across sectors and ministries, among service providers, between service providers and people with lived experience (and other clients), among clients (e.g., mutual support), and even involving community members in general. Developing relationships can be very challenging: it requires preparation, time and supportive structures (e.g., funding, time and venues). People with lived experience and their families and supports should be meaningfully engaged to design — or redesign — collaborative care processes that adequately address their needs and build upon their strengths. These individuals are an invaluable resource with unique perspectives and experiences to contribute.

Screening and Assessment

Only a small minority of people with mental health and addiction-related concerns seek help from specialized services. Most of those who seek help do so from other community services such as primary healthcare providers or other health and social service professionals. And although these people are in contact with various service providers, their mental health and substance use risks or problems, including addiction, are often not identified. These contacts are missed opportunities for prevention, offering advice, further consultation and referral for additional support. Given these realities, the need to extend the service delivery network well beyond the specialized sector of mental health and addiction services has become clear. Also evident is the importance of other community service providers — such as those in primary care, hospitals, social services, schools and justice-related settings — to proactively ask questions about mental health, substance use and addiction-related issues and to have a fully articulated response protocol in place.

Treatment and Recovery

Health services, while sharing a common goal to improve the health and functioning of the whole person, are too often compartmentalized, fragmented and disconnected. They often lack a coherent understanding and plan to address the broader picture. Viewing treatment through an integrated, holistic lens of helping those affected by mental health, addiction or both enables a more comprehensive view of illness, treatment and recovery. This expanded view emphasizes the need for collaboration to ensure that the necessary resources and expertise are available for treatment to be effective. Collaborative connections are also required to coordinate care in active, complementary ways across the stages and phases of care. Collaborative treatment is **client-centred**, with an adequate understanding of clients and their strengths and needs, and **person-directed**, such that clients have the ultimate responsibility for the direction of their own care. These concepts place the client at the centre of treatment and support planning, and recognize that the quality of the client's participation is the most important determinant of treatment outcome. The collaborative task in treatment is therefore to reinforce and enhance the client's capacities for self-directed recovery and to mobilize social resources toward improved functioning and recovery.

Building Capacity for Collaboration

Building appropriate capacity for collaboration is an important component of supporting change. Two major areas of focus can build capacity: human resources and technology. Most stakeholders involved in collaborative work have not received any formal training on collaboration. Indeed, lack of human resource capacity, including familiarity with collaborative practices as well as knowledge and necessary skills, has been identified as an important barrier to collaboration and integration. This document describes several strategies to build human resource capacity to support collaboration at



both the system and service levels. Technology has also proven to be effective in enhancing access to services and supports, especially in the context of health care professional shortages and in linking service providers, enhancing collaboration and providing consultation to underserved jurisdictions. Technology also offers other options for the delivery of primary care and managing and planning services. Sharing information across functional boundaries is challenging; adequate time and attention should be dedicated to this work, including management of privacy issues. Privacy concerns are particularly important to address in the context of collaborative care.

Evaluation

Interpretation of the overall body of evidence on collaboration is challenged by methodological issues, including the wide variation in scope and nature of the collaborative or service integration initiatives being studied. These challenges notwithstanding, some evidence supports collaborative mental health care in the context of primary care and collaborative screening, brief intervention and referral (SBIR) to treatment and other forms of addiction consultation and liaison in healthcare settings. More research, however, is clearly needed. Many collaborative efforts are already underway at various levels in the mental health and addiction sectors in Canada. It is critical that these and other models of collaboration be evaluated to confirm their impact and to ensure that results are shared broadly. If supported by a formal knowledge exchange strategy, this information can contribute to the larger body of evidence regarding what works (and what does not) with collaborative efforts. As with planning and implementing collaborative care, no standard formula for evaluation exists owing to the many levels and forms that collaborative activities can take. This document presents some common considerations for decision makers to keep in mind.

Call to Action

People with lived experience, families and other supports, service providers, administrators and decision makers, all have a role to play in translating this document's advice and key considerations into action. Stakeholders can accelerate the momentum by taking action at the pan-Canadian, systems and practice levels.

At the Pan-Canadian Level

- Get the word out and promote this document and its related products.
- Develop and share a speaking toolkit that presents this document's context and highlights.
- Explore sources of funding to promote knowledge exchange and action.
- Explore sources of funding to develop and measure indicators of short-, medium- and long-term progress toward collaboration.
- Explore the creation of an online repository to house information, case examples, and research and evaluation on collaboration.
- Promote opportunities to advance collaborative work.

At the Systems Level

- Spread the word about the initiative and this document in local contexts.
- Share lessons learned, resources and tools from collaborative efforts.



- Incorporate an evaluation component in collaborative efforts and commit to share the results with a broader audience.
- Adopt language that is supportive of collaborative efforts and capitalize on opportunities to advocate for collaboration at grassroots levels.
- Share this document with individuals who can influence decisions.

At the Practice Level

Clients, Families and Supports

- Share this document with service providers and emphasize how its key considerations are important to one's treatment and recovery experience.
- Share this document with one's patient or client advisory council and ask that specific actions be prioritized for implementation and advocacy.
- Share one's own care experience as it relates to collaboration.
- Advocate for enhanced collaboration where gaps or opportunities are evident.
- Advocate for client and family involvement in planning processes and evaluations that aim to develop and assess the impact of collaborative efforts.

Service Providers

- Distribute and present relevant content from this document to team members.
- Assess the addiction and mental health services offered by the provider in relation to the concepts outlined in this document, and develop a strategy to address identified gaps or opportunities to enhance collaboration.
- Examine services and identify which models of collaboration are currently in use and which could potentially be applied, and then share these findings.
- Review the best advice presented in this document and identify any opportunities to further advance collaboration with addiction and mental health services.
- Conduct a client perspective walkthrough of services to identify gaps or opportunities for enhancement as they relate to collaboration.
- Collect client stories of their experience in treatment and other services, review these stories relative to this document and identify areas for enhancement.
- Plan and conduct an evaluation related to collaboration, making sure that clients and families are involved in these processes.
- Share this document with provincial professional associations and encourage discussion at that level on ways and means to support these collaboration efforts.





Introduction

Background

It is now common practice in the planning, delivery and evaluation of mental health and addiction¹ services and supports to see collaboration as a solution (or at least a partial one) to challenges related to access and delivery of care for individuals with substance use and mental health problems. Collaboration among sectors and services is particularly important, given the fact that only a minority of individuals with mental health and addiction challenges seek help from specialized mental health and addiction services (Urbanoski, Rush, Wild, Bassani, & Castel, 2007; Kohn, Saxena, Levav, & Sacareno, 2004). Of those who do, most approach other community service providers, such as primary care physicians (Shapiro et al., 1984; Kessler et al., 1996).

As in the broader healthcare system, the need for better collaboration of addiction and mental health services is becoming clear. This awareness has been bolstered by an emerging body of literature on the benefits of mental health and addiction services working together. Indeed, many jurisdictions in Canada have already moved toward bringing together mental health and addiction services under one administrative umbrella. Less is known, however, about what collaboration should look like and which strategies are most effective at the point of direct service delivery to improve access and client outcomes.

In response to this gap in knowledge, the Canadian Executive Council on Addictions (CECA), the Mental Health Commission of Canada (MHCC) and the Canadian Centre on Substance Abuse (CCSA) embarked on a partnership in 2012–2013 to consolidate knowledge and generate consensus on effective strategies for collaboration between mental health and addiction services. This partnership's first task was to create a Scientific Advisory Committee (SAC) comprised of individuals with expertise in addiction, concurrent disorders, community mental health and collaborative mental health care (refer to Acknowledgements section for a list of SAC members). The SAC identified key areas of focus related to effective collaboration² and developed background papers that synthesized the available evidence in these key areas (Rush & Reist, 2013; Rush & Chaim, 2013; Selby, Skinner, Reist, & Ivanova, 2013; Reimer, Reist, Rush, & Bland, 2013).

The background papers were summarized and presented at a Leaders' Forum in May 2013 to a range of stakeholders from across Canada, including researchers, administrators, direct service providers and persons with lived experience of mental illness or addiction (see Appendix A for a list of Leaders' Forum participants). Forum participants discussed the implications of the background paper findings in the context of their own experience and jurisdictions. They recommended additional strategies for practice and research to improve client care and client outcomes through more effective collaboration. Participants also provided examples of collaborative efforts that may shed further light on key ingredients of effective collaborative initiatives. Forum participants also made individual and collective commitments to maintain the momentum generated and to support collaborative efforts in their own local, provincial/territorial and national contexts.

Scope and Objectives

A challenge in summarizing the evidence about strategies for effective collaboration is that the body of knowledge is spread across a range of literature and deals with various sectors, including addiction, mental health, primary care, and generalist and specialist health care. This growing body

¹ Since no term in the field of addiction yet spans the full continuum of risk and harm as well as the spectrum of different substances and potentially addictive behaviours, we use the term "addiction" as a convenience term only.

² These key areas include screening and assessment; collaborative care pathways for treatment and recovery; system-level supports; and actions for achieving collaboration.



of literature speaks to many forms of collaboration, concerns a variety of settings and sub-populations, investigates different types of outcomes, and offers many lessons learned. This diversity made it too complex to synthesize the work tidily into “proof points” about what works best under particular conditions. In addition, it remains unknown if collaboration actually has a direct impact on improving client and family outcomes and, if it does, which areas are most affected.

Questions of what works best, where, when and how must be reframed to ask what the body of knowledge can contribute to the work of decision makers who are funding, administering, providing or evaluating services. A shift toward collaboration has begun and evidence needs to guide all efforts in a common direction. To that end, summarizing the evidence with its challenges and nuances has value, as does extracting key principles, considerations and critical elements of collaboration to support those charged with implementation. Both scientific and practice-based evidence are essential. For this reason, participants in the Leaders’ Forum, which included individuals with lived experience, frontline practitioners, administrators and researchers, were essential in shaping advice to decision makers on how to enhance collaboration between mental health and addiction services, and with other health services.

This document borrows the conceptualization of collaboration and evidence for it, from a range of sectors and settings; however, to make its scope manageable, this document focuses on strategies and key considerations for achieving effective collaborative relationships specifically between mental health and addiction services **at the point of contact** with people who need help. In some cases, this point might also include primary care settings where mental health and substance use services have an increasing presence (e.g., in Ontario in the context of Family Health Teams). To meet client needs, mental health and addiction service providers need to be able to work in a range of collaborative arrangements along the continuum of services and supports with other health and social service sectors (e.g., primary care, social services, criminal justice). Many of the key considerations presented here and in future related products will be broadly relevant and applicable to these various service delivery interfaces.

This report does not focus solely on people with co-occurring mental health and addiction challenges. It advocates for holistic, collaborative approaches that support people with mental health and addiction-related concerns, but also recognizes the unique and significant challenges of people experiencing co-occurring disorders that require significant collaboration across many services and sectors. For more information about this specific population, refer to key documents on co-occurring disorders (Health Canada, 2002; Canadian Centre on Substance Abuse, 2009).

What does “collaboration” really mean? One difficulty in synthesizing material about the collaborative delivery of mental health and addiction services and supports is the many terms and concepts used in the literature. “Collaboration” is sometimes used synonymously with “service/system integration,” “partnerships,” “shared care,” “disease management,” “networks and network analysis,” and “coalitions and community development.” The terms “collaboration” and “integration” are most commonly interchanged and frequently assigned the same meaning, while at other times “collaboration” is seen as a less formal, less structured level of “integration.” For the purposes of this document, integration is considered to be one form of collaboration, which is defined as:

Any form of cooperative enterprise, whether it be shared or collaborative care, a partnership, a network, a community coalition or various forms of integration, that aims to increase the chances of achieving some common objective compared to acting alone as an individual or organization.

Analysis must distinguish between **system** and **service** levels (Rush & Nadeau, 2011; Voyandoff, 1995; Minkoff, 2007) because some of the key considerations, strategies and ingredients related to collaboration might be different. **Service-level collaboration** relates directly to the interface between service providers and their clients, families and supports. Collaboration at this level can include collaborative assessment, treatment planning, case consultations, transition and linkage



management, multi-disciplinary clinical teams, and collaborative service networks. **System-level collaboration** is more about administration or management where linkages are made to improve planning, budgeting and operations. Collaboration at this level can involve common or joint clinical information systems and electronic records, structural or functional linkage in policy development, strategic and budget planning, co-location, and organizational culture and leadership. This document focuses on collaboration at the service level, although work at the system level (e.g., joint planning, shared data systems, policy) can be necessary to facilitate collaboration at the service level.

Finally, it must be acknowledged that a focus on collaboration in the context of health service delivery will have a relatively small impact compared with efforts to address the environmental and social determinants of health, which have a larger impact on population health. Nevertheless, the delivery of mental health and addiction services consumes a significant share of public resources. It is critical that these resources be accessible, effective and responsive to clients' needs and strengths.

Potential Benefits of Collaboration

Collaboration can increase the effectiveness of services at the **individual level** to address the full range of needs and treatment trajectories, but at the **population level** collaboration can maximize social impact. The rest of this section outlines the key benefits expected from collaboration as highlighted in the literature.

Enhanced Capacity to Support People with Complex Conditions

Efforts to strengthen the health system have traditionally been aimed at the acute care system. Despite widespread and longstanding recognition of the value of improved collaboration — especially for people with complex, chronic conditions — change toward more collaborative practice has been slow. The increasingly complex needs of people who seek help compound this issue; service providers face numerous challenges in identifying and working with this complexity in a comprehensive manner. As a result, many people with complex chronic conditions are not being well served and, indeed, are cycling through the acute care system (RAND Europe & Ernst and Young, 2012). These trends apply within the fields of mental health and addiction, especially for those people with complex profiles of addiction, mental health problems and physical co-morbidity (Health Canada, 2002; Canadian Centre on Substance Abuse, 2009; Rush & Nadeau, 2011). Evidence also shows that most people are not receiving the appropriate level of care, particularly those with co-occurring disorders (Koegl & Rush, 2011). A recent report from the Canadian Institute for Health Information (CIHI) shows that among admissions to inpatient mental health facilities, a high percentage have co-occurring mental and substance use disorders (35.6 percent) (CIHI, 2013). The data also show that these individuals are routinely in contact with multiple service providers from different programs and sectors who typically have little contact or information sharing with each other. Through collaboration, people with complex conditions can be treated and supported more effectively — a key factor that promotes collaborative activity.

Enhanced Capacity in Collaborating Partners

Collaborative partnerships can enhance professional or organizational capacity. For example, participants can have greater knowledge of services available in a community and how and when to engage them. Collaborative activity can improve the skills of managers and staff, either indirectly through opportunities for observation and information-sharing (e.g., case conferences, shared care) or more directly through organized education events, cross-training and mentoring. At a program or organizational level, participation in collaborative partnerships can lead to, for example, improved policies and practices that increase client inflow and operational efficiency or that enhance the services being offered.



Improved Access to Services

It is widely believed that collaborative care arrangements between specialist and generic mental health and addiction service providers will expand coverage of the network of services as a whole, especially for populations that tend to underuse services. There is clear evidence that only a minority of individuals with mental health and substance use challenges, including addiction, seek help from specialist mental health and addiction services (Urbanoski et al., 2007); most are more likely to seek help from other community services such as primary care (Shapiro et al., 1984; Kessler et al., 1996). People are also engaged in multiple community services simultaneously or over time and report challenges in accessing specialist services (Health Canada, 2002).

Earlier Detection and Intervention

Collaborative care increases opportunities for earlier detection of mental health and addiction problems or high-risk situations. This benefit can, for example, be supported by proactive screening initiatives – either broad or targeted – provided through generic services with well-communicated protocols for referral to more specialized services (Babor et al., 2007; Pignone et al., 2002). Many people with mental health or substance use problems have co-occurring physical health problems such as cardiovascular or pulmonary disease, diabetes or arthritis (Stang et al., 2006) and are therefore already in contact with primary care services.

Clinical Value in Integrated Care

Co-morbidity of mental health and substance use problems is common in Canada (Rush et al., 2008), as in other jurisdictions such as the United States and Australia (Andrews, Henderson, & Hall, 2001; Kessler et al., 1996). The co-occurrence of these problems is particularly high in people seeking treatment for substance use concerns (Chan, Dennis, & Funk, 2008) and mental health issues (Koegl & Rush, 2011). Clients with co-occurring disorders have been difficult to engage and maintain in treatment, although integrated care models have shown some success in this regard (Donald, Dower, & Kavanagh, 2005). Persons with severe substance use problems often do not have their general medical needs adequately addressed and are at higher risk for infections and infectious diseases, cardiovascular disease and other chronic diseases such as diabetes (Donald et al., 2005; Dickey, Normand, Weiss, Drake, & Azeni, 2002). Many of the most effective treatments for severe substance use problems involve pharmacotherapy, such as methadone maintenance treatment for opioid dependence (Amato et al., 2005; Mattick, Breen, Kimber, & Davoli, 2009), and medication management is also important for the treatment of mental disorders. With many people experiencing interrelated physical and mental health and addiction challenges concurrently, clinical value can be added by co-locating and coordinating health services with mental health and addiction services, and treating issues simultaneously.

Improved Continuity of Care

Across health care generally, and certainly with respect to mental health and addiction services, individuals report major challenges in making the transition through various types of care both horizontally (e.g., across different levels of mental health or addiction care and support) and vertically (e.g., across sectors, such as from a hospital stay to the community; from emergency care to community crisis response; from primary care to specialist care and back for longer-term recovery management; from youth to adult services). Some would say the issue of continuity of care is the “heart and soul” of collaborative care initiatives.



More Satisfied Health Care Consumers

Clients of healthcare services are often frustrated with having to access multiple service providers who are largely disconnected from each other. These changes among service providers often require clients to re-tell their story and adjust to a new way of business or value orientation. Clients want more centralized, coordinated services – including sharing of their information – that reflect a “one-stop shopping” or seamless approach, and that offer a wider array of choice. Such concerns are common in client and family satisfaction surveys and focus groups, especially among those managing concurrent mental health and addiction issues (Health Canada, 2002).

Improved Client-Patient Outcomes and Reduced Costs

The benefits of collaboration are expected to contribute to improved health outcomes. Even if costs initially increase owing to new service development, healthcare costs will decrease over time via reduced duplication of services and better matching clients to the right level of care. Some evidence suggests that treating mental health or substance use problems among patients with physical health problems might also reduce overall healthcare costs (Butler et al., 2008). It is also important to recognize potential cautions or challenges associated with collaborative care. Challenges include the dominance of one treatment and support paradigm over another without dialogue and sharing of inter-professional culture and practices; increased time and other resource investment during the planning and development of collaborative initiatives; lack of clarity in accountability for case management and outcomes; and risks associated with the choice of measures of impact that may not reflect intermediate or longer-term benefits.



Models of Collaboration

Given the broad definition of collaboration provided earlier, it is helpful to consider specific models and approaches for collaboration that have had some traction in the research literature. Nonetheless, no single model offers the optimal approach for all community contexts.

Canadian Collaborative Working Group on Shared Mental Health Care

The Collaborative Working Group on Shared Mental Health Care consists of members from the College of Family Physicians of Canada and the Canadian Psychiatric Association. Focusing on the service level, the Working Group describes collaborative mental health care as “care that is delivered by providers from different specialties, disciplines, or sectors working together to offer complementary services and mutual support” (Kates et al., 2011). It also summarizes several models of collaboration, adapted for this report for relevance beyond the primary care setting:

- **Effective communication:** Transmitting relevant information about individuals and programs in a timely, legible, relevant and understandable manner, including through electronic records.
- **Consultation:** Mental health and addiction professionals provide advice, guidance and follow-up to other service providers to supplement the care and support of their clients and families while sharing ongoing responsibility of care. Alternatively, other service providers offer advice to specialist service providers on the management of medical, psychosocial and spiritual needs of individuals with mental health and addiction problems.
- **Coordination:** Coordination of care plans (including discharge plans) and clinical activities (including screening, assessment, treatment and support planning) to avoid duplication, use resources efficiently and help transition people to the services they require. Coordination can also include inter-professional educational activities such as joint presentations, site visits, cross-training and webinars.
- **Co-location:** Mental health and addiction professionals working on location in other service delivery settings or, alternatively, the placement of other service providers within mental health and addiction services to help address physical, psychosocial and spiritual needs of people using those services.
- **Integration:** A single service or clinical team that brings together mental health, addiction, primary care and other relevant professionals for the purpose of shared planning of care and decision-making, documentation in a common or shared medical record, and collaborative intervention activities. This interdisciplinary clinical team can be tied together as a single administrative entity or be bound by service agreements and contracts.

Chronic Care Model

The Chronic Care Model (Wagner, 1998) was developed in response to the failure of traditional healthcare services to address the needs of individuals with chronic health conditions. Wagner advocated that clinical services and the required system-level supports need to be reconfigured to realize any meaningful improvement in health outcomes. The Chronic Care Model requires:

- Behaviourally sophisticated self-management support that gives priority to increasing clients' confidence and skills so that they can be the ultimate managers of their illness;



- Well-developed processes and incentives for making changes in the care delivery system;
- Reorganization of team functions and processes of practice (e.g., appointments and follow-up) to meet the needs of chronically ill patients;
- Development and implementation of evidence-based guidelines and support for those guidelines through provider education, reminders and increased interaction between generalists and specialists; and
- Enhanced information systems to facilitate the development of disease registries, tracking systems and reminders to give feedback on performance.

This model has been instrumental in articulating the need for a range of healthcare services to work collaboratively to better meet patient requirements. However, it falls short of taking into account the need for a broader base of coordinated services and supports, and collaboration across sectors – including health, legal, social services, housing, education and employment – to address the complexity of mental health and substance use problems.

Tiered Model

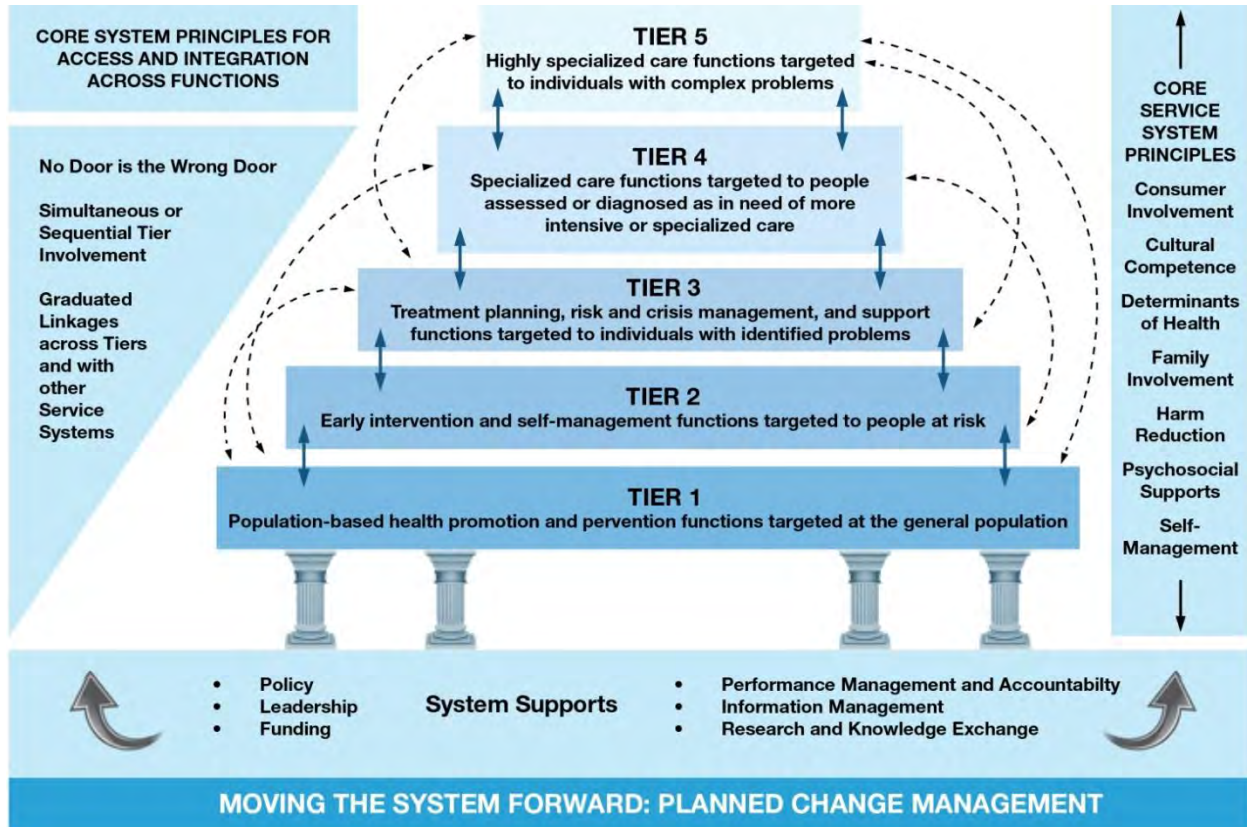
The Tiered Model is another conceptual approach that can support planning and implementation of mental health and addiction care, and that addresses the need for broader multi-sectoral collaboration. Derived from chronic care models for health service planning, the Tiered Model (see Figure 1) was initially advanced as a key element of the National Treatment Strategy for substance use services and supports (National Treatment Strategy Working Group, 2008). It has since been adapted several times in the Canadian context for addiction services and to support the coordination of services for people with co-occurring mental and addiction problems (National Treatment Strategy Working Group, 2008; Rush & Nadeau, 2011). The Tiered Model also builds upon the Stepped Care Model advocated by the National Health Service in the United Kingdom in its guidelines for the treatment of depression (see Appendix B).

The Tiered Model is grounded in a perspective of population health. The distribution of risks and harms (often referred to as “severity”) is presented in pyramid form, in layers or “tiers.” In the mental health field, this has been done traditionally with the classification of mild, moderate and serious mental illness. Building upon this Tiered Model of risks and harms, each of the five tiers reflects a class of functions aimed at achieving certain outcomes appropriate to the level of severity. A function is distinct from a type of program or service (e.g., a primary care setting), as a range of functions can be provided in a given service delivery setting. Further, the tiers reflect an increasing degree of specialization in the nature of the function provided and the expected competency of the service provider to address mental health, addiction and co-occurring conditions. This increased specialization corresponds to greater problem severity; the higher the tier, the fewer people in need of the service, but the greater the costs associated with service delivery across multiple sectors.

That individuals and their families can enter this comprehensive service delivery network at multiple points (i.e., the concept of “any door is the right door”) is critical to the Tiered Model. Upon entry, they should be linked to other functions within or across tiers according to their needs. Thus, the network of services must be operationalized and coordinated to facilitate transitions within and across the tiered functions as determined by the individual’s needs: no part of the network “owns the person”; each client is an individual of the entire network. The concept of graduated integration is essential here, when the need for specific collaborative strategies and their intensity is considered in relation to the severity of the needs of the individual (as in the Stepped Care Model).



Figure 1. The Tiered Model



From Rush (2010) and Rush & Nadeau (2011), building upon the Tiered Model described in the National Treatment Strategy of the National Treatment Strategy Working Group (2008).

The Tiered Model uses several core principles consistent with working toward collaborative mental health and addictions care and support (e.g., client-centred care, self-management and the role of families). At the bottom of the diagram are the core system-level supports required to create and sustain service-level collaborative processes and structures (e.g., shared information systems, policy and leadership). This positioning reflects the distinction between system- and service-level collaboration.

The Tiered Model has proven to be a useful conceptual framework for planning mental health and addiction services and system supports in many Canadian jurisdictions. The model's application, however, is not without challenges. For example, the model is a conceptual tool that needs to be operationalized with core features such as linkage managers, efficient intake, assessment and matching protocols, concrete harm reduction strategies, and multiple levels of care and support. Also, the model does not address the core competencies required to deliver high-quality services or the value that must be placed on strong, empathetic therapeutic relationships required at multiple junctures both within and across services and functions represented by the tiers.

Common Features

The models described above have several common features that are specific to collaborative efforts. These commonalities include:

- The need for effective linkages;
- A high level of trust and reciprocity among participants;



- A focus on a broad continuum of severity;
- Multi-sectoral involvement;
- Multiple levels of collaboration that align with different types of needs and levels of severity; and
- A distinction between service- and system-level initiatives.

Mechanisms to Support Collaborative Clinical Care Pathways

Other mechanisms have been described that support health service collaboration and integration in general, and are highly relevant to mental health and addiction collaborative care and support.

These mechanisms include:

- **Single assessment process incorporating multidisciplinary assessment:** Single assessment processes reduce the number of assessments between mental health, addiction and various health and social service professionals to enable a seamless care process. Another option is to use common screening and assessment tools across a network of providers, with electronic sharing of information and joint care planning.
- **Shared electronic medical record:** Keeping a shared record involves a common electronic platform to post and share health-related information; for example, results of screening and assessment tools, diagnoses, case notes and details of the continuing care plan.
- **Centralized access point to care:** This approach aims to reduce the number of entry points for users, in some cases to a single access point, to reduce the number of professionals and organizations that prospective clients and their families have to deal with.
- **Screening, brief intervention and referral (SBIR):** SBIR requires health and social service professionals to use common screening instruments to identify people at risk of mental health and addiction problems or experiencing them. People so identified then receive brief treatment on-site or are proactively linked to specialist providers, depending on needs and severity.
- **Linkage managers or system navigators:** Linkage managers or system navigators are assigned responsibility to support the transitions of an individual and family members and supporters across services and sectors to prevent them from being bounced between mental health, addiction and other service providers, and possibly becoming lost in the system.



Key Considerations for Action

This section presents six key considerations for action in support of collaborative work. These considerations are based on the research evidence presented in the background papers, as well as practice experience and recommendations from participants in the Leaders' Forum. For each key consideration, a real-life example is provided to illustrate how this consideration has been successfully incorporated into mental health and addiction service delivery. Resources specific to each key consideration are also provided.

Supporting Change

Collaboration between the mental health and addiction sectors requires changes — some significant — in how service providers do business. Unfortunately, the majority of change initiatives fail, either during implementation or over the longer term, because barriers to change are not addressed (Fixsen, Blase, Naoom, & Wallace, 2009; Grimshaw et al., 2006). While the focus of this report is on collaboration at the point of direct service delivery, the barriers identified in this section are at both the service and system levels. Most would acknowledge that systems are important when new approaches and innovations are implemented (Schmidt et al., 2012) and that interventions that support change are best implemented at multiple levels to impact direct care (Fixsen, Naoom, Blasé, Friedman, & Wallace, 2005). A variety of functional and structural supports must be in place at the system level to sustain changes initiated at the service level (e.g., accountability mechanisms, shared information systems, leadership).

There is abundant discussion in the literature of the many barriers and challenges to the development of collaborative care and support for people with mental health and addiction problems, including concurrent disorders (Kates et al., 2011; Chalk, Dilonardo, & Gelber Rinaldo, 2011; Rush & Nadeau, 2011). Many barriers are also identified with general health services integration, as well as collaborative primary care (RAND Europe & Ernst and Young, 2012; Hutchison, Levesque, Strumpf, & Coyle, 2011; Ivbijaro (Ed.), 2012). The challenges, many of which were also highlighted by Forum participants, include:

- Current models and levels of funding and remuneration;
- Time constraints;
- Lack of familiarity with evidence-based practice in this area;
- Lack of belief or confidence in the value to be added by collaboration;
- Lack of preparation through education and training for collaborative practice;
- Entrepreneurial culture of some professionals and organizations;
- Attitudes, stigma and discrimination working with people with mental health and addiction problems;
- Lack of incentives for change or presence of disincentives;
- Lack of access to key services required for a particular collaborative approach, including geographic disparities in accessing some services (e.g., psychiatrists, specialists in addiction medicine); and
- Fear of change in general and absence of an opinion leader to kick start and sustain change management process.

Decision makers and leaders are encouraged to approach collaboration as a formal change initiative, even when the targeted changes are relatively small in scope; these, too, can fail to gain traction without attention to appropriate supports. Ideally, change should be guided by a formal change management model and strategy and informed by best practice principles and interventions



based on implementation science.³ The strategy should include a process to assess barriers and readiness for change and develop specific strategies to address these issues. A number of models and resources are available (see Resources for Supporting Change) that may be tailored, depending on the scope and context for collaborative change.

The key considerations of engagement and relationship building, capacity building and evaluation are critical components of change management and are discussed in later sections. In addition to these considerations, the following strategies were highlighted both in the literature and in the experiences of Forum participants.

- **Take the time to plan and support change:** Collaborative relationships need preparation, time and supportive structures (Craven & Bland, 2006). It is critical not to oversell the ease of implementation; instead advocate a realistic, paced and well-managed approach to implementation. Forum participants reinforced this principle, highlighting the reality that collaborative relationships may in the beginning be inefficient: that is, the new processes involved in the collaborative arrangement might actually require more time and effort as compared to business as usual. In some cases, this inefficiency can be an ongoing trade-off for enhanced delivery of care. In other cases, inefficiencies will resolve themselves as collaborative partners get to know each other and the new processes.
- **Involve people with lived experience and their families and supports:** These core stakeholders need to be meaningfully engaged to design collaborative care processes that adequately address their needs and build upon their strengths. They are an invaluable resource with unique perspectives and experiences to contribute.
- **Develop a shared vision:** Collaborative partners must agree on the goals and philosophy of the targeted change (Kates et al., 2011). A shared vision among stakeholders at both system and service levels establishes an important foundation and rationale for subsequent changes in infrastructure and processes. This vision should be developed inclusively and communicated broadly.
- **Align funding and policies with collaboration efforts:** Funding models are generally not structured to support collaborative interdisciplinary approaches (Kates et al., 2011). For instance, a number of activities associated with integrated and collaborative care, such as case management, consultations and other communication activities between providers, are not traditionally reimbursed under typical fee-for-service care structures. This challenge will require policy changes and appropriate payment mechanisms that facilitate collaborative practice. Other regulatory and policy changes are levers for system change and often complement funding changes (Schmidt et al., 2012).
- **Be a leader for change and develop and support leadership at all levels:** Top-down management support and leadership is often cited as the key ingredient in the process of change toward collaborative services. So too is the need for a strong opinion leader or champion (Rush & Nadeau, 2011). Depending on the scope and nature of the collaborative effort, it could be helpful to ensure champions are in place at all levels. Champions are especially helpful in overcoming resistance or ambivalence toward change among their peer, particularly if they have strong social potency.
- **Engage those responsible for implementing the change early in the process:** Buy-in from stakeholders, particularly those who will be involved in actual implementation, is essential.

³ Implementation science is the “study of methods to promote the integration of research findings and evidence into health care policy and practice.” Frequently Asked Questions about Implementation Science (National Institutes of Health). Accessed July 25, 2013 from <http://www.fic.nih.gov/News/Events/implementation-science/Pages/faqs.aspx>. See also Fixsen, Naoom, Blase, Friedman, & Wallace 2005.



- **Adjust operational structures and practices:** Operational structures and practices form the backbone of service delivery. Assessing processes and developing strategies to support collaborative practices is critical for effective service delivery and system change. Collaborative practice alone has not been shown to produce skill transfer or enduring change in primary care physician knowledge or behaviour. Service restructuring to support changes in practice patterns is also required (Craven & Bland, 2006). A potential lever is for funders and policy makers to encourage operational analyses to identify issues and encourage multiple approaches to support collaboration.

Illustrative Example of Supporting Change

Family Health Team, Hamilton, Ontario

The Ontario government promotes Family Health Teams and has given them the mandate:

- To focus more on preventing illness and promoting health;
- To look at the best ways to manage chronic illnesses such as diabetes and depression;
- To provide care that is more accessible and comprehensive; and
- To give patients the opportunity to be more involved in decisions about their own health.

Since April 2005, the Ontario government has approved 200 Family Health Teams across the province. The Hamilton Family Health Team (HFHT) is the largest, serving more than 280,000 people, and was built on the foundations of the Hamilton-Wentworth Health Service Organization's Mental Health and Nutrition Program.

The HFHT, located in downtown Hamilton, serves part of the Hamilton Niagara Haldimand Brant Local Health Integration Network (LHIN). More than 400 clinicians work together in a collaborative environment to give patients the care they need and keep them healthy. The team including 150 physicians, as well as nurses and nurse practitioners, registered dietitians, counsellors, psychiatrists and pharmacists, serves approximately 280,000 patients.

The success of the HFHT is partly attributed to its patient centredness, facilitating chronic disease management initiatives and providing access to a range of care services. Efforts concentrate on helping patients get healthy and stay healthy by:

- Sharing up-to-date information about the best ways to prevent disease and promote health;
- Looking at risk factors and offering appropriate screening and follow-up;
- Detecting and addressing health (including mental health) problems earlier, when care is more effective and less costly;
- Increasing the range of health conditions that can be assessed and treated in the family doctor's office, where most patients first seek care;
- Offering support and strategies to better manage chronic illnesses; and
- Working with patients and their families to navigate the healthcare system so that care is better coordinated.

For more information about this project, please contact:

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Resources for Supporting Change

- Canadian Centre on Substance Abuse. *Systems planning*. (2014). Ottawa, ON: Author. Retrieved from <http://www.ccsa.ca/Eng/topics/Treatment-and-Supports/Systems-Planning/Pages/default.aspx>.
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- Reeler, D. (2007). *A three-fold theory of social change and implications for practice, planning, monitoring and evaluation*. Cape Town, South Africa: Community Development Resource Association. Retrieved from <http://www.cdra.org.za/articles/A%20Theory%20of%20Social%20Change%20by%20Doug%20Reeler.pdf>.

Engagement and Relationship Building

Effective working relationships are a key part of collaborations for positive health outcomes (Institute of Medicine, 2006; Assay & Lambert, 1999; Miller, Forcehimes & Zweben, 2011). Evidence from both research and practice highlights that it is critical for funders and policy makers to identify and give priority to initiatives that build collaborative relationships. This work includes building relationships across sectors and ministries, among service providers, between service providers and clients, among clients (e.g., mutual support), and with community members in general.

Forum participants emphasized that relationship building and personal contacts are foundations for any collaborative enterprise. They also cautioned that relationships are challenging to develop without dedicated supports (e.g., funding, time, venues). This caution is echoed in the research literature, which highlights that collaborative relationships require preparation, time and supportive structures (Craven & Bland, 2006). Some mechanisms to enhance communication and build relationships include:

- Providing opportunities to strengthen personal contacts and build relationships among service providers (e.g., holding meet-and-greets, practice observations and training sessions; establishing advisory committees to address particular issues) (Kates et al., 2011; Collins, Hewson, Munger, & Wade, 2010).
- Encouraging the development of networks that connect service providers, information technology experts, researchers and consumers interested in collaborative health care to exchange ideas, share experiences and develop initiatives (Kates et al., 2011).
- Promoting links among healthcare planners at provincial, territorial and regional levels, thereby increasing the likelihood of coordinated initiatives (e.g., developing networks of specialists to call on) (Kates et al., 2011).

Forum participants also cautioned that leaders must address structural barriers that often impede relationships, such as scopes of practice and medical or legal constraints. For example, when building collaboration across sectors, service providers often have different training, credentials and mandates. The differences can cause misunderstandings from the lack of a common language to describe observations, concerns and goals. Shelter workers, for example, might perceive an individual's chaotic behaviour as "bad" or "non-compliant," requiring punitive action such as a discharge from the shelter, whereas a mental health or addiction worker might understand that the



behaviour is related to a mental health or addiction problem that requires treatment. As an example of medical or legal constraints, a specialist might have concerns about liability when advising another clinician about management of a case without seeing the client personally. The specialist might be less likely to collaborate in shared care models or might insist on seeing the client, thus creating a waiting list, when a brief collaborative conversation could have sufficed.

When engaging people with lived experience and their families and supports, healthcare providers must acknowledge and respect the diversity among these groups. For example, some people with lived experience do not wish to have particular family members involved in their care, but may identify other family members and friends who should be engaged in their recovery journey. The family members who are not to be involved, however, might still be in need of services and supports and have much to contribute to planning around service delivery.

Care should also be taken to engage particular groups of people with lived experience who tend to be more marginalized from involvement in collaborative work; for example, those with active substance use problems and individuals receiving pharmacotherapies (e.g., opioid replacement therapy). Experiences of stigma and discrimination might lead some people with lived experience and their families and supports to choose not to have their lived experience identified when engaging in collaborative work. These wishes should be respected as much as possible.

The Canadian Centre on Substance Abuse (CCSA) and the Mental Health Commission of Canada (MHCC) have developed resources to support people with lived experience and their families and supports (see Resources for Engagement and Relationship Building). This support includes increasing their involvement in planning, implementation and evaluation of services. Their involvement can be encouraged by helping these individuals to participate in:

- Public consultations
- Advisory committees
- The design, implementation and interpretation of satisfaction surveys and accreditation processes
- Advocacy groups
- Training professionals by providing a lived experience perspective

Leaders are cautioned to carefully estimate the effort required to **meaningfully** engage and involve people with lived experience and their families and supports. Truly client-centred efforts involve these individuals at all stages and levels. Collaborative arrangements are optimized when clients and family are not only supported, but also have the ongoing experience of contributing to the design, delivery and evaluation of care that offers continuity and relevance to their situations. The MHCC recommends applying a “caregiver policy lens” to support engagement activities and the planning and review of programs and policies. Leaders are encouraged to develop a specific strategy to engage people with lived experience and their families and supports.

Engagement strategies should include practical considerations such as timing, location, venue and format of meetings or other forms of involvement. Leaders are also encouraged to develop standards of compensation that could include financial reimbursement, training or other innovative approaches such as “time banking” to encourage involvement of people with lived experience.⁴

⁴ Time banking is a means of exchange used to organize people and organizations around a purpose, where time is the principal currency. For every hour participants “deposit” in a time bank — perhaps by giving practical help and support to others — they are able to “withdraw” equivalent support in time when they themselves are in need. (See What is timebanking? Accessed April 23, 2014 from <http://www.timebanking.org/about/what-is-a-timebank/>).



Illustrative Examples of Engagement and Relationship Building

The Healthy Child Manitoba Strategy

What might happen if a province or territory realigned itself to put children and youth at the centre of public policy and community development? Over the last two decades, Manitoba has been building structures, processes and resources across sectors to improve outcomes for children and youth. In the 1990s, the Government of Manitoba established the Children and Youth Secretariat to work across the Ministries of Health, Education, Family Services and Justice (with additional Ministries joining over time). This Secretariat was formed in response to cross-departmental analyses that found the province spending \$1,000 per minute and \$1.4 million per day (in 1992 dollars) on the "top 200" most at-risk children and youth in Manitoba – defined as those served at greatest cost by multiple ministries. This analysis was accompanied by a sense that outcomes for the most vulnerable young people could be better than the status quo and that these 200 youngsters represented only a fraction of youth in need.

In 2000, the provincial government introduced new infrastructure, including the Healthy Child Manitoba Strategy, focused on cross-departmental, evidence-based prevention and early intervention for children and youth. It also included longitudinal outcome evaluation across sectors (e.g., health, education, social, justice) and across the life course (prenatal to 18 years). This infrastructure introduced new resources to develop and empower regional parent-child coalitions, and an independent Provincial Healthy Child Advisory Committee, representing the province's leading stakeholders for children.

In 2007, the Legislative Assembly of Manitoba proclaimed these core structures, processes and resources for children in *The Healthy Child Manitoba Act*. The Act included specific, new provisions for horizontal data collection and linkage (while maintaining the highest standards of privacy protection) for planning, monitoring and evaluation. It also required the government to report regularly to the public on progress in improving outcomes for children and youth.

Highlights of new changes since the implementation of the Health Child Manitoba Strategy include:

- Availability of population-based data on children and youth, linkable across the life course to measure progress and improve investments;
- Province-wide implementation of several internationally regarded, evidence-based preventive interventions;
- Rigorous evaluation of several made-in-Canada programs, including randomized controlled trials that showed measurable impacts on the health and wellbeing of young people; and
- Collaboration of ten ministers, deputies and partner departments under the Healthy Child Manitoba Strategy.

While much more work remains to be done, Manitoba has legislation to maintain the essential ingredients of the Strategy during economic crises, cabinet shuffles and changes of government. Manitoba now also has collaborative, cross-sectoral structures and processes in place to power community engagement, strengthen partnerships and expedite decision making. The province is also well positioned to rapidly find, fund, pilot, evaluate and scale-up the best practices that science and community knowledge have to offer to maximize opportunities for optimal child and youth development.



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The Canadian Collaborative Mental Health Initiative

The Canadian Collaborative Mental Health Initiative (CCMHI) was a consortium of 12 Canadian health and mental health organizations representing community services, consumers, families, caregivers, self-help groups, dietitians, physicians, nurses, occupational therapists, pharmacists, psychologists, psychiatrists and social workers. The 12 national organizations shared a focus on working together to enhance relationships and improve collaboration among healthcare providers, consumers, families and caregivers. They sought to improve consumer access to prevention, health promotion, treatment and intervention, and rehabilitation services in primary healthcare settings.

CCMHI secured a two-year Primary Health Transition grant (ended in 2006) through which it produced 10 evidence-based research papers, including *Better Practices in Collaborative Mental Health Care: An Analysis of the Evidence Base* and a series of toolkits. It developed a case for improving mental health care in the primary care setting through collaboration across disciplines, including healthcare providers, consumers and caregivers. Through its member organizations, CCMHI raised awareness of the benefits of collaborative mental health care and built enduring communities of interest committed to further efforts to improve mental health care.

Health Canada funded Phase 2 of CCMHI to ensure that Canadians with mental illness and their care providers have access to, and can benefit from, the knowledge generated through CCMHI. Through a consultative process, the CCMHI Steering Committee agreed that the best way to achieve broader uptake of the principles and practices of collaborative care was to develop selective provincial collaborative teams. By working with Charter members, the CCMHI Project Team identified potential champions and leaders in mental health care and brought them together to test and refine the knowledge generated during Phase 1. Using three pilot sites, the relevance and utility of the newly created toolkits were confirmed, and opportunities and barriers for developing collaborative care practices at the provincial and regional levels were better understood. These findings were summarized in a consultation report.

For more information about this project, please visit:

<http://www.shared-care.ca/page.aspx?menu=69&app=266&cat1=738&tp=2&lk=no>

Resources for Engagement and Relationship Building

- Canadian Centre on Substance Abuse. (2013). *Systems approach workbook: Valuing people with lived experience*. Ottawa, ON: Author. Available from <http://www.ccsa.ca/Resource%20Library/nts-systems-approach-lived-experience-2013-en.pdf>.



- The Canadian Collaborative Mental Health Initiative provided a series of toolkits for consumers, families, caregivers, health providers, planners and educators about collaborative care and the active role that consumers can play in the prevention and care. The series can be accessed at <http://www.shared-care.ca/page.aspx?menu=69&app=266&cat1=745&tp=2&lk=no>.
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Screening and Assessment

As previously discussed, it is recognized that only a small minority of people with mental health and addiction-related concerns seek help from specialized services. The majority of those who look for assistance do so from other community services, such as primary healthcare providers or other health and social service professionals. Even people in contact with these service providers might not have their mental health and substance use risks or problems, including addiction, identified (Barnaby, Drummond, McCloud, Burns, & Omu, 2003; Weaver et al., 2003; Mitchell, Meader, Bird, & Rizzo, 2012). This gap results in missed opportunities for offering professional advice, more extended consultations or referrals for additional support. These are also missed opportunities for preventing future problems, especially for children and youth, since mental health challenges often predate high-risk substance use and addiction in later adolescence or young adulthood (Adair, 2009).

In light of these realities, the service delivery network needs to be extended well beyond the specialized sector of mental health and addiction services (Institute of Medicine, 2006; Babor, Stenius, & Romelsjo, 2008; Ivbijaro (Ed.), 2012; Kates et al., 2011). Professionals in community services such as primary care, hospitals, social services, schools and justice-related settings must also be proactive in asking questions about mental health, substance use and addiction-related issues.



For people with low to moderate risk or less severe mental health and addiction problems, proactive, opportunistic screening and on-site brief intervention are intended to reduce risks and harms and have a positive impact on health-related outcomes. For those with higher risk or more severe and complex problems, opportunistic screening is intended to open a pathway to more comprehensive assessment, appropriate treatment and support, and improved health outcomes. For people with co-occurring addiction and other mental health challenges, proactive, systematic screening can identify a wide range of unidentified problems that can impact treatment engagement and outcome (e.g., health risks, thoughts of suicide, chronic health problems, psychosocial challenges). Savings are also anticipated in future medical, social and criminal justice costs.

In the selection and implementation of screening tools, considerable attention must be paid to the tools' psychometric performance: for example, sensitivity (ability to detect people with the index condition, such as depression) and specificity (ability to detect people who do not have the index condition). Ensuring a low false positive rate is especially important, given the additional resources required for comprehensive assessment and treatment planning. Current literature on screening and assessment recommends a staged approach, which can help with the selection of tools to minimize false positives in a given population (e.g., clients presenting to addiction services versus those presenting to primary care services). In a staged approach, the goal is to first cast a wide net (i.e., high sensitivity) with a brief screening tool and then, depending on the results, use a second, more detailed screening tool targeted to specific disorders or problem areas and that yields few false positives. This approach ensures efficient use of resources for subsequent assessment.

Screening and assessment must be seen as a process that continues over time as more information is shared and therapeutic relationships are strengthened. A collaborative, longitudinal approach is particularly critical for the assessment of complex, co-occurring disorders (Kranzler, Kadden, Babor, & Rounsaville, 1994), given the need to untangle etiological sequencing (e.g., depressive symptoms induced by heavy alcohol use) (Health Canada, 2002). In a collaborative approach to screening and assessment, sharing information among service providers is also essential.

Ideally, screening should occur at an individual's first point of contact with the system. This contact could be a provider at any level of care, from any discipline and in any one of multiple sectors (see also the Stepped Care or Tiered Model). Providers across sectors should have the knowledge, competencies and skills to implement appropriate screening processes. They should also have tools that are feasible to use in their context, are useful in identifying client needs and determining recommendations for further screening, assessment, treatment and support, and whose results can be shared with other service providers. Collaborative care models enable various service providers, other professionals and stakeholders to bring together their collective strengths and capabilities to construct a system in which individuals are screened and have seamless access to the full continuum of services and supports (Rush; in press).

The service providers and professionals involved could include those in specialized mental health and addiction services as well as primary care physicians, probation workers, guidance counsellors and others. This range of service providers and professionals highlights the diversity of settings and contexts that influence the choice of screening and assessment tools and related consultation and training needs. To be useful and effective, screening processes must be connected to fully articulated response protocols. These protocols should describe required actions based on positive screening tool results, including recommendations for further in-depth screening and assessment, and follow-up consultation and referrals. The response protocols could also include a referral resource guide customized for a local community. In collaborative models, each provider must be clear about its role in screening and assessment, including the response protocols, so that individuals get what they need from the most appropriate resource in a timely manner. This point was strongly reinforced by participants in the Leaders' Forum and is fundamental to the development of care pathways for people with a specific profile of needs and strengths.



Models of Collaboration for Improved Screening and Assessment

Collaborative Care through Integrated Treatment and Support

The high rate of co-morbidity among those presenting in either addiction or mental health settings is well known (Chan et al., 2008; Rush & Koegl, 2008; Virgo, Bennett, Higgins, Bennett, & Thomas, 2001). Because of co-morbidity, it is important to build capacity to screen for and assess substance use and addiction in mental health programs and vice versa. When screening occurs in mental health, addiction, primary care or other settings, it must be followed by a more comprehensive assessment, as according to the staged model. This staged approach links screening, assessment and outcome monitoring with a family of tools and related decision-making processes. These tools are developmentally appropriate and diversity-based to ensure fair and equal access and subsequent assessment and treatment.

The staged model framework assists in choosing the right tools and using them with the right people at the right time. The choice and use of tools can involve additional professionals and disciplines for a full bio-psycho-social-spiritual investigation and response. These supports might be internal or external to the service or agency where the initial screening is completed. Referral for complementary, integrated treatment and support (co-located or via service agreement) could also be required, depending on the severity and complexity of the individual's challenges and overall situation.

Cross-sectoral Collaboration through Screening and Intervention

Screening for substance use and addiction in generic or non-specialized settings can occur as part of a formal screening, brief intervention and referral (SBIR) intervention. This intervention can entail a collaborative arrangement for the provision of brief intervention and treatment, or more extended treatment depending on the specific results of the screening tools (Babor et al., 2007). SBIR interventions emphasize the role of the family physician or other primary care professionals as the first point of contact where problems can be detected and treatment initiated. Contact can also involve addiction specialists co-located within these generic settings. There is strong evidence that this approach is effective at identifying people at risk of future problems, providing brief but effective advice or counselling, and linking people to further assessment and treatment as indicated (Kaner et al., 2009; McQueen, Howe, Allan, Mains, & Hardy, 2011; Madras et al., 2009). The evidence of the effectiveness of SBIR in different settings for adolescents is also suggestive of positive impact and is growing (Mitchell, Gryczynski, O'Grady, & Schwartz, 2013). In Canada, this practice is now formally embodied in the SBIR protocol for family physicians and builds upon previously identified low-risk guidelines for alcohol use (Butt, Beirness, Gliksman, Paradis, & Stockwell, 2011; Canadian Centre on Substance Abuse, 2007, 2012).

Alternatively, screening can occur in a broader collaboration of multiple, cross-sectoral providers who offer different levels and types of care and who come together to implement a common screening tool, decision-rules and referral protocol. The protocol might include referral for further screening, assessment, brief treatment and support, or external referrals for intervention not available internally. In this collaborative approach, providers across different settings are trained to screen and respond, rather than delegating the task to addiction "specialists."

Collaboration between Addiction and Mental Health Specialists in Generic Settings

Screening and assessment in generic community settings can also be performed by in-house addiction or mental health "specialists," or by co-locating specialized addiction or mental health treatment service providers in the generic setting. Examples include addiction or mental health liaison nurses in emergency or hospital settings (D'Onofrio & Degutis, 2010; Sharrock, Grigg, Happell, Keeble-Devlin, & Jennings, 2006; Yakimo, Kurlowicz, & Murray, 2004) and mental health and addiction workers in



schools (Costello-Wells, McFarland, Reed, & Walton, 2003; Wei, Kutcher, & Szumilas, 2011). The addiction or mental health specialist co-located in the generic environment provides an important service to clients who might otherwise not have access to such resources. This co-location also enables important capacity-building activities with hospital, school and agency staff, which can include case-based consultation and planning for collaborative care, informal and formal education about addiction and mental health, and identifying and addressing a host of related needs.

A collaborative approach to screening and assessment requires mutual respect for the unique contributions that each service provider professional has to offer to a client-centred approach. The uniqueness of the various perspectives notwithstanding, common principles include:

- A whole-person perspective on strengths and needs, as well as contextual variables;
- Sensitivity to diversity and related equity issues;
- Strong emphasis on creating a welcoming, motivation-based therapeutic interface;
- Adherence to an evidence-based approach using psychometrically sound tools; and
- Consideration of personal and collateral information.

The context in which screening takes place must be carefully considered. The role and purpose of screening should be well understood and articulated in the context of an organization's mandate and objectives. Policy must support the implementation of screening and related protocols. Required staff competencies and program design should fit within clear protocols addressing where, when and how screening will be administered and how the information gathered will be used. The personnel who administer the tools must be trained to introduce, administer, score, discuss and take appropriate action based on screening results. All of this information should be clearly conveyed to individuals engaging with the service so that they understand how screening can help.

In models of collaboration across a continuum of services within or across sectors, partners' roles should be defined so that it is clear who will be screened, where screening will be administered (ranging from a single standardized question to a formal tool), who will administer which parts of the screening protocol, how and with whom the results will be shared, and where referrals based on the screening results can be made.

A number of potential risks must also be considered across settings on an individual- as well as setting-specific basis. The risks include stigma resulting from identification and labelling, social exclusion, limitation of opportunities, and false positives consuming scarce treatment resources. Risks associated with identification can be greater for certain individuals; for example, severe sanctions on those identified as being involved in substance using activities might be imposed by some schools, employment programs, shelter and housing providers, residential services in the mental health sector, long-term care facilities, families and specific ethno-cultural groups and communities. Input from people with lived experience and their family members can be extremely helpful in mapping out their journey and identifying where things are not working.

Illustrative Example of Screening and Assessment

National Youth Screening Project

The National Youth Screening Project involved collaborative work with cross-sectoral networks of youth-serving agencies in 10 communities across Canada. Service providers participated in a range of project activities including:

- Developing capacity related to co-occurring disorders;
- Implementing a common screening tool (GAIN-SS) for a six-month period with youth entering their services;



- Following a clinical and research protocol, including using the screening tool for clinical and research purposes;
- Implementing a response protocol agreed upon within the agency and the network;
- Developing customized referral resource guides that list local resources for consultation and for follow-up referrals;
- Completing pre- and post-project measurement of service providers' knowledge, attitudes and practices in addressing mental health, substance use and concurrent disorders amongst the people with whom they work; and
- Providing feedback about the screening tool and its use in the service providers' own context.

The project findings revealed details about the mental health and substance use concerns of participating youth, along with feedback that indicated most service providers found the common screening tool was useful and feasible in their practice, had an impact on treatment decisions and facilitated referrals. In addition, service providers reported higher levels of knowledge, increased engagement in practices to address co-occurring disorders, and a perception of increased cross-agency integration and collaboration. Overall, engaging in a new practice – in this case, the implementation of a screening tool – in the context of a supported collaborative endeavour increased uptake of that practice and provided a foundation for building collaborative relationships. Feedback from a number of project participants indicates that use of the tool is ongoing and relationships with project partners are being sustained.

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Addiction Liaison Nurses in Quebec Emergency Rooms

The Quebec health ministry expressed concern about the high use of emergency departments by people with substance use problems in many regions, including the Capitale-Nationale, Mauricie, Centre-du-Québec and Chaudière-Appalaches. Treatment centres in these regions (Centres de réadaptation en dépendance) established pilot projects to place addiction liaison nurses (LNAs) in select emergency departments. The treatment centres' co-location of LNAs not only addressed the high use of emergency departments, but also engaged more people by reaching out to those with substance use problems who were accessing healthcare services and who might have been receptive to information and advice to seek help. This strategic collaborative initiative had the explicit objective of engaging new clients with no previous history of treatment for substance use problems.



Different service organizations were involved; the LNA team in the Québec City area is presented as an example. The team provided services in three hospitals and was comprised of six nurses, two psychologists, a social worker and a psycho-educator. The LNAs have expertise and experience in the delivery of interventions specific to substance use disorders. Although employed at the specialized treatment facility, the majority of their time was spent at their respective hospital's emergency departments. Specifically, the role of the LNAs included:

- Receiving service requests from hospital staff (hospital physicians, psychiatrists, nurses and social workers);
- Connecting with the medical team;
- Completing patient assessments;
- Conducting brief motivational interventions; and
- Making referrals to the appropriate level of service at the treatment centre, based on client needs.

Patients were given the choice of whether to engage with the LNA and could exit the process at any point. After the LNA completed an assessment, the patient could be referred to the treatment centre for treatment. For patients not yet ready for treatment, the LNA delivered a brief motivational intervention.

Evaluation results in the Québec City area showed that a very high number of patients with substance use problems were identified through this process and the majority had no previous substance use treatment experience (similar results are observed in other areas). Over 75 percent of initial requests for an LNA assessment resulted in referral to the addiction program of the Centre de réadaptation en dépendance de Québec; over half actually attended and 80 percent of those who attended specialized services had no active treatment file. Identification and linkage to treatment was particularly effective for those with co-occurring mental health challenges. These results are similar to those reported in the wider literature on screening and addiction liaison initiatives in healthcare settings. Based on these results, the LNA initiative has now been implemented in 27 emergency departments in Quebec.

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Resources for Screening and Assessment

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Treatment and Recovery

Looking at treatment and recovery from a collaborative perspective serves as a reminder that health services, from primary to specialized care, share a common aim: to improve the health and functioning of the whole person. Yet service delivery can easily fall into compartmentalized, fragmented and disconnected bits of activity, each aimed at a targeted concern, without a coherent understanding of the whole picture. Using an integrated, holistic lens to view how to help people affected by mental health, addiction or both allows a comprehensive view of illness, treatment and recovery, and emphasizes the need for collaboration to bring about healthy change.

Biological, psychological, social, cultural, spiritual and other factors must be brought together to develop effective understanding of mental health and addiction problems (Substance Abuse and Mental Health Services Administration, 2002; Health Canada, 2002). These factors serve as effective branches of health along which care can be organized and recovery can be achieved. Because effective understanding and remediation of these problems requires such a comprehensive view, the work of helping is best accomplished through collaborative connections. This means that within teams, resources and expertise must exist to provide all the elements required for effective treatment. Collaborative connections need to be made to coordinate care in active, complementary ways across the stages and phases of care.

Increasingly, treatment and recovery are guided by two foundational concepts: care must be client-centred and person-directed (Corring & Cook, 1999; Stewart, 2001; Government of Ontario, 2011). **Client-centred** care is based on an adequate understanding of clients and their strengths and needs, while **person-directed** emphasizes that clients (or patients) have ultimate responsibility for the direction of their own care. Both concepts place the client at the centre of treatment and support planning and the overall process of care; both affirm that recovery is a process that is best directed by that person undergoing it. Evidence strongly suggests that client factors account for more variance in treatment outcome than any other factor (Norcross, 2010; Miller, Forchimes, & Zweben, 2011).

Clients: The Core of Collaboration

Seeing clients as co-creators and co-actors in the therapeutic process, as well as lead authors of their own recovery stories, creates an understanding of the helping process that is inherently collaborative. It recognizes that a key skill for helpers is their ability to draw out the collaborative potential in treatment, client by client, day by day. Indeed, it appears that the quality of a client's participation is the most important determinant of treatment outcome (Bohart & Tallman, 2010).



This dynamic, co-productive view of therapy contrasts with more traditional approaches in which therapists intervene and clients respond.

Seeing clients as active participants rather than passive recipients, and supporting and obtaining maximum client involvement and participation are tasks that require skill, but that make therapy more effective (Miller et al, 2011; Norcross, 2010). It is as much the client in collaboration with the therapist who makes treatment work, as it is the other way around. In this context, many individuals in most populations affected by mental health and addiction problems can improve and change without treatment (Miller & Carrol (Eds.), 2006). The collaborative task in treatment, therefore, is to reinforce and enhance the client's capacities for self-directed change and to mobilize social resources toward improved functioning and recovery (Norcross, 2010).

Key activities to support collaboration with clients are to:

- Support and enhance client agency, strengths and resources;
- Affirm client's ability to change;
- Promote client involvement;
- Listen to clients and respect their experiences and perspectives;
- Enlist social support; and
- Draw on client feedback to make care responsive to client needs and goals.

Collaborative Connections: A Multi-level Framework

If the core collaboration is between client and helper, one of the key functions for helpers is to ensure that they have collaborative connections with others who can support the client's holistic recovery. These connections should exist on a number of levels:

- Within the service in which the helper works;
- Within the sector in which the service is located (addiction, mental health or other);
- Across services and service sectors; and
- Within the community in which the client lives.

Fortunately, models can be employed to support planning, implementation and evaluation of collaborative connections in all of these levels. The Chronic Care Model and the Tiered Model are described in the Models of Collaboration section of this report. Integrated care pathways, the Stepped Care Model and the Quadrant Model are described in the following subsections.

Integrated Care Pathways for Teams and Services

For collaborations within teams and services, the concept of a care pathway offers a way to ensure basic standards of care are met, while allowing for enhancements in care for individuals who need more support to reach the desired health outcome. Often called integrated care pathways, these models describe anticipated courses of care that are delivered within given periods of time and are connected with client healing journeys (Jesseman, Brown, & Skinner, 2013; National Treatment Strategy Working Group, 2008; Mental Health Commission of Canada, 2009). Team members must be clear about their roles and those of other team members, and agree to perform them together in ways that are explicitly negotiated. While variations and enhancements occur based on feedback and evaluation, the care pathway approach aims to ensure that the basic standards of care are regularly provided. A principle of care pathways is to make all collaborative partners "owners" who are committed to working in explicitly collaborative pathways of care. These "owners" have all contributed to the planning, implementation and evaluation of these pathways (Kitchiner & Bundred, 1996; Gilbody et al., 2006; Schrijvers, Hoorn, & Huiskes, 2012).



In developing collaborative, client-centred care pathways it is important to:

- Be clear about the goal of the collaborative care pathway;
- Identify the functions that need to be accomplished for a client to move along the pathway;
- Specify the team members, what roles they will play and tasks they need to carry out;
- Negotiate when tasks need to be done and in what sequence; and
- Implement processes for team review of tasks completed, client progress and ongoing evaluation of the care plan.

The Stepped Care Model: Collaborative Connections within a System

Collaborative care pathways identify standard care algorithms for specific healthcare problems. These standard algorithms are anticipated to meet the needs of approximately 80 percent of relevant clients. About 20 percent will need additional help and support, some even needing to access different care pathways altogether. The Stepped Care Model is a pragmatic approach that seeks to help the client reach goals by matching the client to the minimum level of care needed, as suggested by the evidence, to produce the desired result. The model allows for care to be either **stepped up**, if after evaluation clients need additional or more substantial treatment and support to reach their goals, or **stepped down**, if less intensive treatment and support is indicated.

This collaborative model requires ease of access in a flexible system that supports shifts in care planning. For example, a treatment plan for a person with a complex profile of co-occurring mental health and addiction challenges would include admission to a concurrent-disorder specialized inpatient program, followed by post-discharge support through primary care, and an ongoing concurrent-disorder-capable community addiction program for relapse prevention.

In designing and implementing a stepped care approach it is important to:

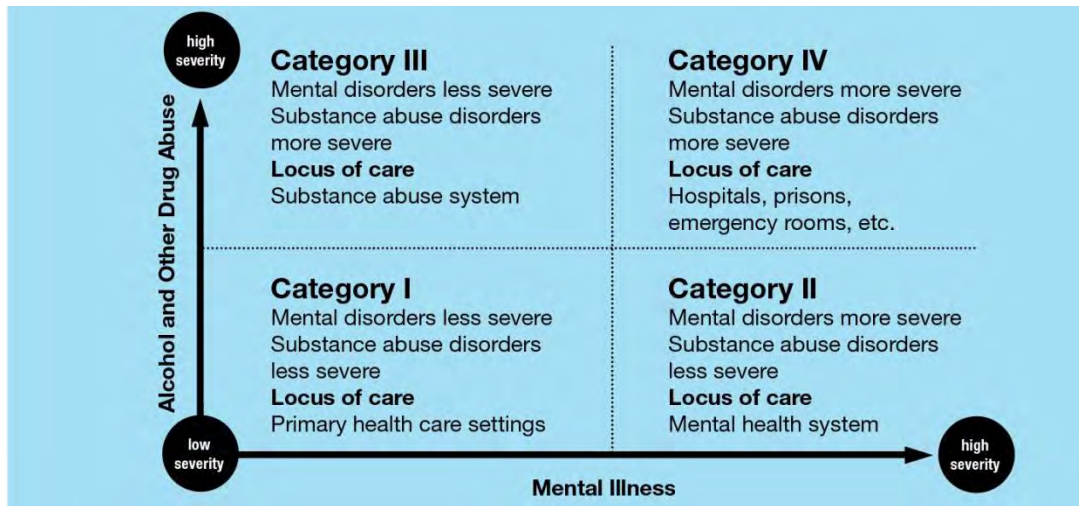
- Identify the care options for which a client is eligible;
- Determine the option that would be advised using the evidence base available;
- Discuss eligible options with the client and the implications involved for each;
- Support client choice;
- Monitor progress;
- Modify care by extending or stepping it up if the initial option is not producing the desired result;
- Initiate a process to conclude this episode of care, including options available for the client for next steps in care; and
- Evaluate course of care using client, collateral and objective measures of process and outcome variables.



The Quadrant Model: Collaborative Connections across Primary Care, Mental Health and Addiction Services and Systems

Clients with complex needs are among the hardest to help in specialized systems that lack ways of providing comprehensive care and that are poorly integrated with other service sectors.⁵ In response to this challenge, the Quadrant Model has emerged from the Substance Abuse and Mental Health Services Administration (SAMHSA) as a heuristic to guide more integrated and collaborative care (Center for Substance Abuse Treatment, 2005). By seeing both substance use disorders and mental disorders as existing along their own continuums, the model presents four categories, and assigns the corresponding responsibility for care based on a determination of severity (see Figure 2).

Figure 2. The Quadrant Model



Source: Center for Substance Abuse Treatment (2005).

In the Quadrant Model, clients with mild to moderately severe substance use and mental disorders are seen in primary and community healthcare settings. Clients with moderate to severe problems are eligible for specialized systems. Where the most severe problem is the substance use disorder, the addiction system is the clinical lead; where mental disorders are the most severe, the mental health system takes the lead, with collaborative connections with services in the other systems as needed. Where both addiction and mental illness are severe, the client is eligible for treatment with an integrated multidisciplinary care team. The Quadrant Model helps services assess where they are in the continuum of care and what their collaborative connections need to be with primary and community health care and other specialized systems.

To develop and implement collaborative connections across services and systems, service providers must:

- Identify client care needs that go beyond the resources of specific service providers;
- Identify resources that are able to respond to identified care needs;
- Make *ad hoc* collaborative connections to support clients in need of immediate care;
- Negotiate formal partnership agreements that clarify roles and responsibilities of each service involved in the collaboration;

⁵ Other helpful models that support cross-sectoral collaborative connections include the Chronic Care Model and the Tiered Model described in the Models of Collaboration section.



- Actively communicate to those who need to know about the scope and operational details of the partnership agreement;
- Review the effectiveness of collaborative connections, including connections with clients, staff, partners and stakeholders, with a focus on quality improvement and advocacy based on evidence of the effectiveness of collaborative care; and
- Ensure active support for collaboration at an administrative or management level, including, for example, support for joint or cross-training of providers across services and sectors, and development of protocols for consultation, referral and shared care.

Collaborative Connections: Building Recovery and Community Capital

Recovery is something each person seeking help will define in his or her own terms. **Recovery capital** is “the volume of internal and external assets that can be brought to bear to initiate and sustain recovery” from alcohol and other drug problems, as well as mental health challenges (Arah, Klazinga, Delnoij, Asbroek, & Custers, 2003). Recovery capital has both personal aspects (physical and mental health) as well as social dimensions (human connections and material resources) that can be called upon at the individual, family and community levels to promote growth and wellbeing. The relationship between “recovery capital” and “community capital” is close and together they tie in with community capacity-building initiatives. This relationship reminds us that effective population-level prevention and health promotion programs and policies will have a greater impact on the health of the population than investments in healthcare services aimed at those with identified challenges. Essentially, community improvement efforts, including affordable housing, employment and education options, access to healthy food choices, green space and other aspects of a healthy environment, will increase the chances of personal recovery for people at all levels of the severity continuum.

A person-centred model of treatment and recovery affirms the ability of people to make healthy changes in their lives and draws on evidence-based practices to support those changes. Access to treatment options is only one element in building recovery capital. If treatment is deployed in ways that assist and respond rather than frustrate and defer, its role can be powerful. Collaboration between the services provided in mental health and addiction treatment and other sectors is essential.

In building and sustaining recovery and community capital, it is important to:

- Shift the focus from treating illness to supporting recovery;
- Identify the client’s personal recovery capital (i.e., strengths and assets that can be applied to maintain and enhance wellbeing and healthy functioning);
- Draw on family and interpersonal social capital to mobilize others who can support the client’s recovery goals;
- Work at the community level to develop recovery capital by ending the stigma of mental illness and addiction;
- Identify role models and exemplars of recovery to endorse recovery as a viable goal;
- Promote peer support options that are available in neighborhoods and communities;
- Actively include people with addiction and mental health issues in everyday processes of community life; and
- Provide resources to support housing, education, leisure, employment and social engagement that are valued by the client.



Illustrative Examples of Treatment and Recovery

NAVNET: A Coordinated Systems Response for Clients with Complex Needs

NAVNET is a network of senior representatives from health, government and community organizations in St. John's, Newfoundland and Labrador, that meets to explore innovative solutions to barriers faced by individuals with mental health and substance use issues who have multiple and complex needs. NAVNET was formed in response to a recommendation of the Navigators and Networks Report to address the gaps and barriers that individuals with complex needs face in their attempts to secure services from a largely fragmented system of multiple government departments. NAVNET was sponsored by Eastern Health and the Department of Advanced Education and Skills, and is founded on evidence-based practice coming out of Australia.

Relationship building has been central to NAVNET's work. Collaboration between the health, government and community sectors has resulted in a shift away from a siloed, fragmented approach toward a more inclusive and collaborative response. NAVNET's efforts have included the development of an information-sharing protocol, a cost analysis (2010) and an evaluation.

Client referrals are made by NAVNET member organizations. Once accepted, the Project Coordinator determines which organizations are needed to form a multi-system team for the client. These teams, made up primarily of frontline workers from different departments and organizations, share information with one another (supported by a memorandum of understanding) and use an assessment matrix to identify baseline indicators. Preventative care planning occurs to help move the current eight NAVNET clients along this matrix. Plans are reviewed and outcomes are measured. Barriers encountered are brought to the NAVNET Steering Committee for a response.

In 2012, Eastern Health's Applied Health Research Division completed an evaluation of the NAVNET demonstration year. Using a mixed-method approach including client stories, interviews, results from the assessment matrix and service use data, the evaluation found improvements in client health and wellness, improved housing stability, reduced use of emergency services, fewer hospital admissions and less involvement with the criminal justice system. The indicators from service use data show promise with regards to overall cost reduction for these clients.

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Integrating Concurrent Services: A Frontline Experience

Frontenac Community Mental Health and Addictions Services (FCMHAS) in Kingston, Ontario, offers a range of services for individuals who have mental health, substance use and gambling problems. Services include assertive community treatment, case management, 24-hour crisis support for the community, court support services, and supported housing. Several challenges were identified related to service integration, including difficulties in accessing services; clients having to tell their story many times to access services; long wait times; stigma when accessing mental health and addiction services; and reported duplication and fragmentation of services.

To address these challenges, a leadership team was assembled, led by senior staff at FCMHAS, to better integrate services and ensure they were high-quality, client-centred and recovery-oriented. The leadership team also aimed to ensure that the process fully engaged staff and client members. Team consensus was developed around principles for implementing more integrated services,



informed by a literature review to determine the best evidence to use. The team drew significant ideas and material for implementation of a comprehensive and integrated system for those with mental health and addiction issues from the work of Minkoff and Cline (2004) and their Comprehensive Continuous Integrated System of Care.

Five service clusters were identified for planning purposes:

- The access cluster focused on access issues;
- The group development cluster to provide psycho-education and specialized training for community re-integration;
- The comprehensive intensive cluster focused on services for individuals with complex needs;
- The community support cluster designed for people requiring separate services such as court support; and
- The community integration cluster focused on plans for initiatives that promote full integration using the natural community supports held by each person.

Staff and clients used an appreciative inquiry process to identify needs and prepared options for consideration. World Café sessions were also held, which allowed a number of committees to come together and share what they learned.

This process identified opportunities to ease major bottlenecks that impede effective implementation and focused on the development of two integrated clusters: community support-community integration and comprehensive-intensive. In addition, several groups were developed to address specific issues related to contact with the organization. These included an access team whose members focused on the required triage and ensuring that services were made available as quickly as required. It is expected, although not required, that clients will be able to move through and between the clusters. While the entire system has yet to be implemented, initial evidence indicates reduced wait times for services. Further evidence will be collected to measure impact on client satisfaction.

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Enhancing Concurrent Capability across a System of Care: A Story of System Collaboration

In 2010, the Alberta Addiction and Mental Health (AMH) Provincial Clinical Network was formed to ensure Alberta Health Services (AHS) clinical staff are involved with patient safety and quality initiatives in meaningful and productive ways. One of the network's first priorities was to lead province-wide actions that support frontline practice changes to better address the needs of Albertans seeking help for co-occurring disorders. A multidisciplinary and multidepartment Enhancing Concurrent Capability Provincial Working Group was created.

In 2011, the Working Group released a consensus paper, *Enhancing Concurrent Capability: Foundational Concepts*, to define concurrent disorders and describe the essential components of capable care in the AHS integrated addiction and mental health service delivery system. The Working



Group also released Chapter One of the *Enhancing Concurrent Capability Toolkit: A Welcoming and Engaging Strategy* (ECC Toolkit). This practice resource was developed with patient and consumer input and includes self-reflection activities, anti-stigma vignettes, a walk-through checklist and other activities that help promote welcoming as a key strategy of enhanced care.

In 2012, the Working Group hosted the Enhancing Concurrent Capability Provincial Forum: Moving Forward. This forum brought together 150 champions and consumers from across the province to share practice improvements and lessons learned in enhancing concurrent disorder services. Dr. Robert Drake's keynote address set the tone for moving forward following the evidence.

In the same year, the Working Group released *A Standard Approach to Screening* for concurrent disorders in AMH Services, recommending the GAIN-SS and other instruments in addition to service- and system-level considerations in implementing this approach. This paper borrows heavily from the experience of the Centre for Addiction and Mental Health (CAMH) and formed the basis for Chapter Two of the ECC Toolkit, which addressed screening.

In late 2012, the AMH Clinical Network was transitioned into an AMH Strategic Clinical Network, thus wrapping up the Working Group's mandate. A new Enhancing Concurrent Capability Advisory Group has taken over and continues to guide implementation of practice changes, including ECC Toolkit chapters on assessment and concurrent capable competencies.

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Resources for Treatment and Recovery

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Building Capacity for Collaboration

Building appropriate capacity for collaboration is an important component of supporting change (see Key Consideration for Action, Supporting Change). This section presents two major areas of focus to build capacity, emphasized in both the research literature and by Forum participants: human



resources and technology. Both areas of focus are key considerations in comprehensive models and strategies for changing clinical practice and system-level supports to ensure sustainability of new practices. For example, quality improvement requires identification of incremental, feasible and measurable changes to service delivery processes and may require new skills and competencies, as well as technological supports to facilitate rapid cycles of problem identification, implementation, feedback and improvement.

Models of implementation science (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005; McCarty et al., 2007; Hoffman et al., 2012) also tap into many critical areas for assessing the need for change and offer a staged approach to change management, with a strong focus on sustainability. The broad stages of change management are exploration, installation, initial implementation and full implementation; again, human resources and information technology play key roles in this process. Both quality improvement and implementation science place heavy emphasis on evaluation and performance measurement (Watkins, Pincus, & Tanielian, 2001; Addington, Kyle, Desai, & Wang, 2010).

Human Resources

Most stakeholders involved in collaborative work have not received any formal training in collaboration. Indeed, lack of human resource capacity, including familiarity with collaborative practices (Kates et al., 2011) and knowledge and necessary skills (Collins, Hewson, Munger, & Wade, 2010; McCarty et al., 2007) have been identified as important barriers to collaboration and integration. As with other strategies, building human resource capacity in support of collaboration can be addressed at multiple levels.

At the system level, decision makers, leaders and professionals can influence academic institutions to develop content related to collaboration in professional curricula (Kates et al., 2011). Professional program buy-in could be more likely if a trend is established by embedding expectations for collaboration in hiring processes, job descriptions and deliverables. Ideally, academic curricula should be linked to core competencies specific to collaboration (e.g., competencies for inter-professional practice), either integrated in existing discipline-specific core competencies or developed as part of a national health human resources strategy specific to inter-professional collaboration. It may also be necessary to proactively engage labour relations groups and unions to navigate potential changes in scope of practice.

At the service level, enhanced capacity would naturally flow from building relationships (see Key Consideration for Action, Engagement and Relationship Building). In addition, leaders should support more formal cross-discipline education and skills training (Kates et al., 2011; Collins et al., 2010), such as inter-professional development sessions (e.g., skills related to use of screening, motivational interviewing, brief interventions and self-management tools), job shadowing and mentoring. Given the multicultural society in which we live, training and staff development must respect diversity, interpreted broadly to include, as examples, sexual orientation, gender, age and cultural competence. As emphasized earlier, it is also critical that service providers be granted the time, space and support to work through some of the challenges associated with change. One important mechanism for this work is dedicated, supportive clinical supervision. Service providers can also benefit from feedback from their clients, either as part of within-treatment monitoring (Rush, Rotondi et al., 2013) or through formal efforts to collect client perception of care (Rush, Hansson et al., 2013).

Technology

Technology has proven to be effective in enhancing access to services and supports, especially in the context of shortages in healthcare professionals in urban and rural settings (Kates et al., 2011). Telemedicine in particular has the potential to link service providers, enhance collaboration and provide consultation to underserved jurisdictions (Kates et al., 2011). Technology also offers other options for



the delivery of primary care through applications such as web-based self-management tools and telephone, text or email exchange as alternatives to or to supplement office visits (DeGruy & Etz, 2010).

In addition to supporting the delivery of services, information technology has the potential to support providers in managing and planning services (Collins et al., 2010). Indeed, it is hard to imagine collaborative initiatives without a strong information management and technology component (Protti, 2009). This component can include evidence-guided algorithms to enhance collaboration, data collection and analysis, as well the management and sharing of client information (Kates et al., 2011).

Sharing information across functional boundaries is challenging, in part because of the localized, contextual nature of information and because firm boundaries have developed over time. Adequate time and attention, and extensive stakeholder engagement should therefore be dedicated to this work, including management of issues related to privacy. Privacy issues, including a thorough assessment of privacy legislation and implications for collaborative initiatives, are critical, as concerns in this area have been identified as a major challenge to the development of effective collaboration. Even with adherence to privacy legislation and appropriate informed consent processes in place, service providers might still be reluctant to share information with others, for various reasons (for example, fear of unforeseen repercussions to the consumer such as increased stigma, restrictions that may be placed on accessing the complementary service or liability risk assessment). Advances in electronic medical records (EMRs) can serve to mitigate some of these concerns, as EMRs allow more selective information to be shared than, for example, detailed case notes. Further, service providers need to become very familiar with privacy legislation and examine their own challenges and biases when working within these legislative boundaries.

Close attention must be paid to how processes related to privacy of information, as well as all technological changes, will affect and be affected by the organization in which they become embedded, as well as their potential impact on clients. This area is another critical area in the change management process for a collaborative initiative that requires meaningful participation of people with lived experience and their family and supports in the planning and evaluation process.

Illustrative Examples of Building Capacity for Collaboration

Advancing Concurrent Capable Competencies through a Professional Development Network

The Alberta Health Services (AHS) *Addiction and Mental Health (AMH) Integrated Service Delivery Framework* (2009) set the stage for a single, province-wide continuum of addiction and mental health services. AHS also established a goal to improve client outcomes and experience by achieving concurrent capability across addiction and mental health services (Alberta Health Services, 2010). This goal is supported by the AHS-AMH Professional Development Strategy, which aims to ensure a diverse and well-trained addiction and mental health workforce that delivers concurrent capable care to clients, patients and their families who are experiencing addiction, mental health problems and concurrent disorders.

The Strategy is supported by the Professional Development Advisory Committee (PDAC), a provincial network of AHS zone and provincial representatives. PDAC serves as a hub for an extensive network of working and reference groups across the province. The network is working on three main priorities: the Concurrent Capable Competency Framework; the Readiness for Practice Education and Practice Support Outline; and the Clinical Supervision Guidance Framework.

Working from the Canadian Centre on Substance Abuse's (CCSA) *Competencies for Canada's Substance Abuse Workforce* (Canadian Centre on Substance Abuse, 2010), 100 operational managers and staff from all five AHS zones were consulted to determine the validity of the CCSA



competencies in their setting and to identify how the competencies should be modified. The most significant modification was to revise the competency definitions and behavioural indicators to be more inclusive of mental health service delivery. Based on this feedback, the Concurrent Capable Competency Framework (CCCF) was developed; it includes a set of behavioural and technical competency domains that range from novice to advanced practice levels. A national and international review of the literature on concurrent capability was also conducted to ensure that the feedback was conceptually aligned with research and current thinking. This work resulted in a competency framework that represents best practices in concurrent capable care.

Ongoing modifications based on emerging research and feedback from operational managers and staff will ensure continuing relevance. The CCCF provides a common language and point of reference for establishing consistent, high-quality performance among service providers in AHS – AMH.

Resources for Building Capacity for Collaboration

- Canadian Centre on Substance Abuse. (2010). *Competencies for Canada's substance abuse workforce*. Ottawa, ON: Author. Retrieved from <http://www.ccsa.ca/Resource%20Library/ccsa-011799-2010.pdf>.
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Evaluation

Interpretation of the overall body of evidence on collaboration is challenged by methodological issues in much of the relevant research. Many challenges are inherent in the wide variation in the scope and nature of the collaborative or service integration initiatives being studied. Despite these challenges, some evidence supports collaborative mental health care in the context of primary care. More work needs to be done in the area of collaborative addiction care and support (Chalk,



Dilonardo, & Gelber Rinaldo, 2011), although the evidence is quite strong with respect to collaborative screening, brief intervention and referral to treatment (SBIR) and other forms of addiction consultation and liaison in healthcare settings. Further economic evaluation also needs to be performed concerning various collaborative initiatives related to mental health and addiction care and support, including cost offset, cost-effectiveness and cost-benefit studies.

Examples presented during the Leaders' Forum and in response to the call for illustrative examples to include in this report, reinforced the perception that there is no shortage of collaborative efforts already underway at various levels in the mental health and addiction sectors in Canada. Examples include, work recently completed in New Brunswick to develop guidelines for a recovery-oriented approach in mental health and addiction program delivery; Family Health Care Teams in Ontario; the Alberta's Addiction and Mental Health Strategy; Saskatchewan's initiative on screening and brief intervention in primary care settings. It is critical that these and other models of collaboration be evaluated to confirm their impact and to ensure the results from these efforts are shared broadly. Ideally, a formal knowledge exchange strategy should be used to share this information and contribute to the larger body of evidence about what works with collaboration. Evaluation conducted in a research context or pilot project should also contribute concretely to the uptake of collaborative activity or innovation.

As with planning and implementing collaborative care, no standard recipe for evaluation exists, owing to the many levels and forms that collaborative activities can take (Rush, 2014). That said, decision makers should keep some common considerations in mind, the first being the importance of making a commitment to evaluation and using the resulting information for more than basic accountability purposes. Evaluation should contribute information to ongoing improvement and to sustain cost-effective collaborative efforts.

A written evaluation plan should be created, with specific questions to be addressed, measures and data collection strategies clearly articulated, and a description of the collaborative model or activity in terms of process and outcome objectives. The purposes of evaluation must be explicit about whether the collaboration is at the system or service level. Evaluation expectations and indicators of success need to be clear from the onset, particularly for system-level integration efforts and targets. The evaluation plan also needs to be flexible and open to emergent issues that are common in collaborative work.

The evaluation plan should also articulate the "theory of change" upon which the collaborative model or activity is based. This articulation can be done in part with a logic model supplemented with other kinds of evaluation planning strategies (e.g., concept mapping). The theory of change or logic model should be developed through a collaborative process with key stakeholders, including people with lived experience, to achieve consensus in understanding the collaborative intervention, as well as the expected outcomes and use of the information.

Evaluators and stakeholders must be open to exploring a full range of process, outcome and economic evaluation questions and issues, as described below, including assessing benefits to client and family perceptions of care. It can be helpful to think of the evaluation moving through stages consistent with the stages of development of the collaborative initiative itself. This approach would mean a regular refresh of the evaluation plan over the lifespan of a collaborative care initiative.

Process evaluation monitors and documents specific aspects of implementation to describe the intervention and help determine the relationships between elements of the collaborative initiative and outcomes produced. This form of evaluation can include a fidelity assessment to monitor the implementation and sustainability of collaborative activities or models and a partnership assessment to assess organizational and partnership readiness. This dual assessment reflects the fact that both factors internal to the collaboration (e.g., staff skills in inter-professional practice and degree of



implementation) and external factors (e.g., organizational readiness and previous history of collaboration in the community) will impact overall effectiveness.

Outcome evaluation assesses whether the collaborative activity has had an impact on targeted outcomes. The outcomes can include changes in client access to services, including penetration rate into the in-need population; service flow through the system and case-mix, including assessment of impact on vulnerable populations; reduced wait times; improved continuity of care; reduced healthcare use (e.g., emergency and hospital use); changes in staff attitudes, skills and behavioural engagement in screening and assessment practices; and health-related outcomes. The challenge of linking changes in the scope and nature of collaborative care, as measured in a process evaluation, to client health outcomes should be articulated and addressed in the evaluation design. In some instances, implementation of one component of a collaborative initiative might not impact client outcomes without the implementation of other components. For example, screening for mental health and substance use concerns is not likely to have an impact on client health outcomes without follow-up intervention (e.g., brief intervention, referral to treatment). Such expectations need to be established in while developing the initiative's theory of change during the evaluation planning phase.

Economic evaluation can include cost analyses of various collaborative care arrangements, changes in cost-efficiencies and productivity, cost-effectiveness of alternative collaborative care models and cost-benefit or cost-offset (e.g., reduced or more appropriate service use).

Lastly, it is important to think clearly about the overall model of evaluation that is most appropriate to the specific collaborative initiative and its context (Rush, 2014). Evaluation of collaborative care initiatives can benefit from newer models of evaluation such as developmental evaluation (Patton, 2011) and complexity-based and systems evaluation (Canadian Centre on Substance Abuse, 2010). Systems evaluation can include, for example, an assessment of power relationships in collaborative care models and their impact on services provided and population served or excluded; network analysis to assess relationship structures such as community- and hospital-based cliques; and the role of the evaluation process itself in implementing and sustaining a collaborative relationship.

Illustrative Examples of Evaluation

Evaluation of the National Youth Screening Project

In the National Youth Screening Project (see also the illustrative example in the Screening and Assessment section), pre-post measures (self-report) were used with participating service providers to look at their practices related to direct service with clients as well as their practices and perceptions related to collaborative practice. Pre-measures were administered prior to engaging in the project and before the first training on project protocol and on working with youth with co-occurring disorders. Post-measures were administered following completion of six months of data collection (i.e., six months of involvement in a project where the providers administered a screening tool to youth engaging in their services).

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Ontario's Systems Improvement through Service Collaboratives Initiative

To address the challenges of fragmented service transitions for children and youth with mental health problems, the Ontario Ministry of Children and Youth Services launched a Comprehensive Mental Health and Addictions Strategy in 2011. One of the initiatives in the strategy is Systems Improvement through Service Collaboratives (SISC), which aims to close critical service gaps for children and youth who are vulnerable, at key transition points or live in remote communities. The SISC initiative is collaboratively led by six provincial ministries, making it uniquely comprehensive and multi-sectoral. This initiative also has an additional focus on Aboriginal and Francophone populations as provincial priority groups.

A community Service Collaborative is a group of service providers and stakeholders from multiple sectors who work together to identify local service gaps and implement system-level changes. This work is done by selecting or adapting and implementing evidence-informed interventions that support children and youth with complex needs at key transition points. Starting with community engagement in February 2012, 18 Service Collaboratives were rolled out and are in various stages of development in communities across Ontario. Membership on collaboratives ranges from 20 to 100 people, depending on the community. The Centre for Addiction and Mental Health (CAMH), Canada's largest mental health and addiction teaching hospital, was commissioned to sponsor the implementation and evaluation of the SISC initiative.

Evaluation has been embedded in the SISC initiative from the beginning. Given the strong affect that context can have on practice, especially in complex interventions, the SISC initiative adopted a developmental evaluation approach, which allows for high sensitivity to context and veers away from the rigidity of measuring fidelity to interventions (Patton, 2011). The SISC evaluation engages Service Collaborative stakeholders as active participants in the planning, implementation and development of the evaluation plan. In addition to executing the components of the SISC evaluation plan discussed above and supporting the development of local evaluation plans, the SISC evaluation team has also supported Service Collaboratives across the province in the development of their local evaluation plans.

As a community-led initiative that infuses evidence and evaluation throughout, key lessons have been learned in achieving a balance between science and the practical needs of community initiatives. Pressure is ongoing to adapt the Service Collaborative model and select interventions based on community needs. Along the way, there has been an attempt to implement these interventions systematically and document the process. The evaluation component of the SISC initiative has had to evolve to meet the demands of the project. Stakeholder expectations and the realities of creating system-level change in a compressed timeframe have had to also be managed as part of this initiative. The SISC initiative has succeeded in balancing these challenges by ensuring fidelity through the application of the National Implementation Research Network (NIRN) Active Implementation Framework and through the integration of knowledge exchange and evaluation gathered from the initiative's early stages.

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Resources for Evaluation

- Krank, M. (2012). *Monitoring and evaluation toolkit: A resource to support the portfolio of Canadian standards for youth substance abuse prevention*. Ottawa, ON: Canadian Centre on Substance Abuse.
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Call to Action

People with lived experience, families and other supports, service providers, and administrators and decision makers, all have a role to play in translating the suggestions and considerations in this document into action. Stakeholders can accelerate the momentum for collaboration by taking concrete action at the pan-Canadian, systems and practice levels. Some actions described below are already underway and others are presented as future opportunities. All of them cut across sectors and are important and necessary for a fundamental shift in how we relate to each other and to the individuals we serve.

At the Pan-Canadian Level

The partnership between the three organizations that led to this joint initiative – the Canadian Centre on Substance Abuse (CCSA), the Canadian Executive Council on Addictions (CECA) and the Mental Health Commission of Canada (MHCC) – reflects collaboration in action. It also reflects each agency’s recognition of the importance of better collaboration across sectors, especially between mental health and addiction. These organizations have made an ongoing commitment at the senior leadership level to promoting the sharing and uptake of the advice contained in this report. This promotion will include:

- Getting the word out about this document and related products by making them available on CCSA, CECA and MHCC websites, and by promoting them at relevant networks, professional conferences and other venues.
- Exploring sources of funding for an annual or biannual Leaders’ Forum to promote the exchange of knowledge and action.
- Exploring sources of funding to develop and measure indicators of short-, medium- and long-term progress toward collaboration. Indicators of progress could include changes in policy and practice and an increase in evaluations of new collaborative practices.
- Exploring the creation of an online repository to house information, case examples, and research and evaluation on collaboration.
- Promoting opportunities within CCSA, CECA and MHCC and their networks to advance collaborative work.
- Developing and sharing a speaking toolkit so that leaders can present the context and highlights of this document at local agencies, committee meetings, conferences and any other venue where stakeholders can benefit from this resource.

In addition to these commitments, other pan-Canadian organizations and groups have a role and responsibility to share, advocate for and support the advice presented in this document. These organizations include:

- Government departments and ministries
- Professional associations and organizations
- Consumer and family advocacy groups and organizations



At the Systems Level

The Leaders' Forum held in May 2013 generated commitments from all participants to build upon the objectives of this initiative, to maintain the momentum generated from the event and to support collaborative efforts in their local contexts. Leaders from the Forum committed to a number of actions, many of which can serve as examples to all interested stakeholders. These actions include:

- Spreading the word about the initiative and this document in local contexts.
- Sharing lessons learned (e.g., effective change management strategies; management of privacy issues), resources and tools from their own collaborative efforts in the national repository developed by the joint partnership of CCSA, CECA and MHCC and at other relevant venues such as strategic planning meetings, committee meetings and conferences.
- Incorporating an evaluation component in collaborative efforts and committing to share the results with a broader audience, including by submitting them to the national repository.
- Adopting language that is supportive of collaborative efforts and advocating for collaboration at the grassroots level.
- Sharing this document with individuals who can influence decisions.

At the Practice Level

A number of opportunities exist to promote collaboration at the local, practice level. The following examples represent concrete steps that both clients and service providers can take.

Clients, Families and Supports

- Sharing this document with service providers and emphasizing how the key considerations presented are important to one's treatment and recovery experience.
- Sharing this document with one's patient or client advisory council and asking that specific actions be prioritized for implementation and advocacy.
- Sharing one's own care experience as it relates to collaboration within and across different service sectors.
- Advocating for enhanced collaboration where gaps or opportunities are evident.
- Advocating for client and family involvement in planning processes and evaluations that aim to develop and assess the impact of collaborative efforts, including collaboration with clients and families and supports.

Service Providers

- Distributing this document to team members, presenting an overview and identifying how the contents apply to the services offered by the provider.
- Assessing the addiction and mental health services provided by your organization or for which it is responsible and determining how those services compare to the concepts and principles in this document.
- Developing a strategy to initiate or enhance collaborative opportunities, including with primary care and other service delivery sectors.



- Examining services and identifying which models of collaboration are used and which could potentially be applied, and then sharing lessons learned for inclusion in the national repository.
- Reviewing this document's suggestions and concrete examples systematically, as a team, and identifying opportunities to further advance collaboration with addiction and mental health services.
- Conducting a client perspective walk-through of services, considering such indicators as:
 - When clients enter the service, are they asked about their mental health and substance use?
 - Are clients welcomed and assured that they are in the right place?
 - Are clients' addiction, mental health and other significant health needs addressed at the same time?
- Collecting client stories of their experience in treatment or other services, reviewing these stories relative to this document and identifying areas for enhancement.
- Planning and conducting an evaluation related to collaboration (e.g., an assessment of costs and benefits of collaboration and the comparative outcomes of different models of collaboration) and making sure that clients and families are involved in evaluation processes.
- Sharing this document with provincial professional associations and encouraging discussion at that level on ways and means to support collaboration efforts amongst all members.

Summary

Collaboration has been established as a best practice to address a variety of health issues more effectively. The same holds true for addiction and mental health services, where the complex profiles of co-occurring addiction, mental health problems and physical co-morbidity are common and challenging to address. While momentum has been generated at the systems level in Canada toward improved collaboration between the mental health and addiction sectors, effective strategies for collaboration at the practice level have not been systematically developed, evaluated, documented and shared. In response to this gap, this document presents advice and key considerations from research as well as from leadership, practice and lived experience about effective collaboration, including the key ingredients and how we can share and apply this knowledge to fill in the gaps.

Everyone, across multiple sectors and from all levels, has a role and responsibility to support and advocate for collaboration to achieve better access to services and to improve outcomes for people with mental health and addiction-related problems. This document will be a valuable resource and will contribute to the ongoing journey toward this end.



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Appendix A: Leaders' Forum Participants

May 2-3, 2013, Toronto

	Name	Title	Organization	City, Province
1	Monica Bull	Consultant, Access & Clinical Efficiency	Mental Health & Addictions Division, Department of Health and Community Services, Newfoundland and Labrador	St John's, NL
2	Margaret Kennedy	Director, Mental Health & Addictions	Health PEI	Charlottetown, PE
3	Linda Courey	Director, Mental Health and Addiction Services	Cape Breton District Health Authority	Sydney, NS
4	Elaine Campbell	1. Board member 2. Clinical Social Worker	1. Canadian Association of Social Workers 2. Nova Scotia	Onslow, NS
5	Barb Whitenect	Executive Director, Addictions and Mental Health Services	New Brunswick Health	Fredericton, NB
6	Catherine McPherson-Doe	Manager, Mental Health Services	Hamilton Family Health Team	Hamilton, ON
7	Dr. Tony George	1. Medical Director, Complex Mental Illness Program 2. Representative	1. CAMH 2. Addictions Section, Canadian Psychiatric Association	Toronto, ON
8	David Kelly	Executive Director	Ontario Federation of Community Mental Health and Addictions Programs	Toronto, ON
9	Neill Carson	Executive Director	Ambulatory Care and Structured Treatments Program	Toronto, ON
10	Anne Bowlby	Manager	Mental Health and Addictions Unit, Ministry of Health and Long Term Care Ontario	Toronto, ON
12	Aseefa Sarang	1. Executive Director 2. Committee Member	1. Across Boundaries 2. National Advisory Committee, Chez Soi/At Home	Toronto, ON
13	Dr. Sharon Cirone	Representative	The College of Family Physicians of Canada	Toronto, ON
14	Catherine Willinsky	Manager, National Programs and Projects	Schizophrenia Society of Canada	Toronto, ON
15	Kim Wilson	Executive Director	Canadian Coalition for Seniors' Mental Health	Toronto, ON
16	Vicky Huehn	1. President 2. Executive Director	1. Psychosocial Rehabilitation Canada 2. Frontenac Community Mental Health & Addictions Services	Kingston, ON
17	Dave Gallson	1. Co-chair 2. Associate National Executive Director	1. Canadian Alliance on Mental Health and Mental Illness 2. Mood Disorders Society of Canada	North Bay, ON
18	Jim Cincotta	Senior Policy Advisor	Inuit Tapiriit Kanatami	Ottawa, ON
19	Ian Manion	Executive Director	Ontario Centre of Excellence for Child and Youth Mental Health	Ottawa, ON



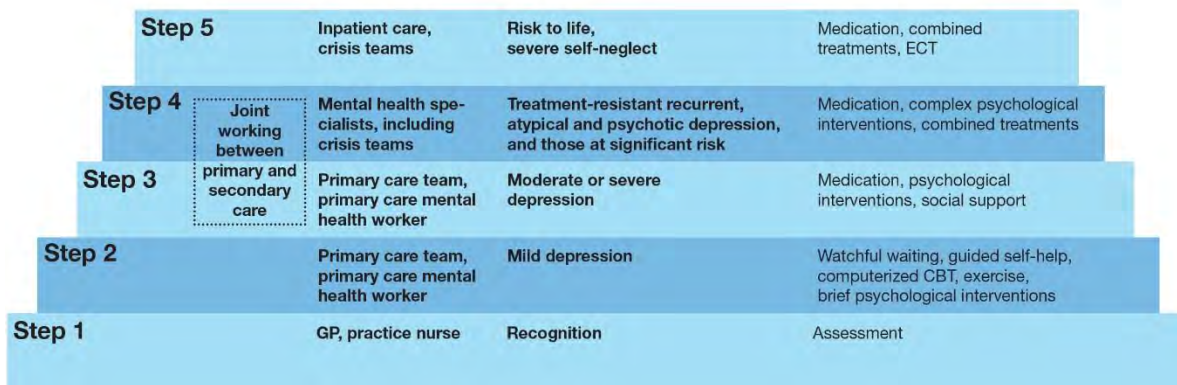
	Name	Title	Organization	City, Province
20	Mark Ferdinand	National Director, Public Policy	Canadian Mental Health Association	Ottawa, ON
21	Rose Sones	Manager	First Nations and Inuit Health Branch Health Canada	Ottawa, ON
22	Tina LeClair	Executive Director	Addictions Policy & Support Branch, Government of Manitoba	Winnipeg, MB
23	Kathy Willerth	Director	Mental Health and Addictions, Ministry of Health, Government of Saskatchewan	Regina, SK
24	Colleen Dell	Research Chair, Substance Abuse	University of Saskatchewan	Saskatoon, SK
25	Terry Gudmundson	Special Advisor to the Deputy Minister	Ministry of Health, Government of Saskatchewan	Regina, SK
26	Brett Enns	Regional Director	Community Services, Mental Health Centre, Prince Albert Parkland Health Region	Regina, SK
27	Silvia Vajushi	Executive Director	Community Health, Alberta Health	Edmonton, AB
28	Tom Shand	Executive Director	Alberta Division, Canadian Mental Health Association	Edmonton, AB
29	Shannon Griffin	Director	Planning and Strategy Development, BCMHAS & Strategy Planning for PHSA BC Mental Health & Addiction Services, an agency of the Provincial Health Services Authority	Vancouver, BC
30	Bill Nelles	Individual		Vancouver, BC
31	Amanee Elchehimi	Representative	MHCC Youth Council	Vancouver, BC
32	Barbara Lacey	Manager and Clinical Supervisor	Community Mental Health and Adult Services, Yellowknife Health and Social Services Authority	Yellowknife, NWT
34	Marie Fast	Manager	Mental Health, Yukon Health and Social Services	Whitehorse, YK
35	Brian Rush	Scientific Advisory Committee		Toronto, ON
36	Peter Selby	Scientific Advisory Committee		Toronto, ON
37	Gloria Chaim	Scientific Advisory Committee		Toronto, ON
38	Wayne Skinner	Scientific Advisory Committee		Toronto, ON
39	Peter Butt	Scientific Advisory Committee		Saskatoon, SK
41	April Furlong	Consultant – Science Advisory Committee		Toronto, ON
42	Rita Notarandrea	CCSA/Steering Committee		Ottawa, ON
43	Paula Robeson	CCSA		Ottawa, ON
44	Cheryl Arratoon	CCSA		Ottawa, ON
45	Francine Knoops	MHCC/Steering Committee		Ottawa, ON
46	Barry Andres	CECA/Steering Committee		Edmonton, AB
47	Beverley Clarke	CECA/Steering Committee		St. John's, NL
48	Louise Bradley	President & CEO	MHCC	Ottawa, ON
49	Michel Peron	CEO	CCSA	Ottawa, ON



Appendix B: Stepped Care Model

A stepped care framework for depression care pathways was developed in the United Kingdom by National Health Service (NHS) to match the needs of individuals with depression to the most appropriate services, depending on the characteristics of their illness and their personal and social circumstances. People enter the clinical pathway at different steps, depending on severity and previous history (see Figure 3). Lower steps represent services for less severe problems and each step increases the complexity of interventions in response to more complex problems. People move between steps depending on needs and progress toward recovery goals. As with the Chronic Care Model, the Stepped Care Model is primarily focused on the delivery of services and supports within the formal healthcare system and does not specifically account for other services and supports aimed more broadly at the social determinants of health implicit in the recovery pathways of clients.

Figure 3. The Stepped Care Model



Adapted from the UK National Institute for Health and Care Excellence (NICE) guidelines.

- Step 1: Recognition in primary care and general hospital settings.
- Step 2: Treatment of mild depression in primary care.
- Step 3: Treatment of moderate to severe depression in primary care.
- Step 4: Treatment of depression by mental health specialists.
- Step 5: Inpatient treatment for depression.



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