ACHIEVING COLLABORATION: SYSTEM LEVEL SUPPORTS AND ACTIONS

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INTRODUCTION

Implementing service delivery systems based on the bio-psycho-social model requires a collaborative approach. The model draws attention to the genetic, physiological, psychological, social and cultural elements that influence health. At its simplest, integration ensures a person receives care that addresses

The research literature on integration is complicated by this complexity and lack of definitional clarity. The term 'integrated care' is both broadly and narrowly defined. Definitions range from requiring only interactions among providers to requiring shared treatment plans. Nevertheless, common among the definitions is the requirement of some communication or coordination between providers to meet the mental health, substance use or general health needs of people presenting for care (Butler et al., 2008). Operational methods used to increase communication and collaboration between care providers include:

- Various communication mechanisms (e.g., a formal care manager role, consultations on an as-needed basis, regularly scheduled case reviews, formal protocols for information sharing)
- Co-located services designed to facilitate communication between providers and to increase access for clients

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effects of systematic care from an integrated approach suggests it is likely the quality of the treatment provided that contributes to the improvements observed rather than integration per se. However, the design and quality of the trials are inadequate to show this definitively.

HOW DO WE ACHIEVE COLLABORATIVE MENTAL HEALTH AND ADDICTION CARE AND SUPPORT?

There is no shortage of literature discussing the many barriers and challenges to the development of collaborative care and support for people with mental health addiction problems, including concurrent disorders (Kates et al., 2011; Chalk et al., 2011; Rush & Nadeau, 2011). Many barriers are also identified with respect to health services integration generally, and collaborative primary care specifically (Rand Europe, 2012; Hutchison et al., 2011; Ivbijara, 2012). The list of challenges commonly includes current levels of funding and funding/remuneration models; time constraints; 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/or addiction problems; lack of incentives for change; lack of access to key types of services required for a particular collaborative approach; geographic disparities in accessing some services (e.g. psychiatrists; specialists in addiction medicine); lack of belief/confidence in the value to be added by collaboration; fear of change generally and absence of an opinion leader to kick start and sustain a change management process; to name some of the more salient factors.

A consistent feature of effective healthcare systems is strong and integrated primary care (Kates et al., 2012; DeGruy & Etz, 2010; Dickinson & Miller, 2010). Kates and colleagues (2012) argue achieving primary care transformation will require a supportive healthcare environment, including policies and structures at a system-wide level. An approach to primary

program. For example, one can emphasize the benefits for health care providers in managing challenging patients or meeting performance or quality targets. It was also identified as critical not to "oversell" the ease of implementation but rather advocate a realistic, paced, and well-managed approach to implementation. Lastly, the literature on creating successful community partnerships (see Wildridge et al., 2004 for a comprehensive review) offers valuable information for planning and implementation of collaborative activity generally, as does some literature specific to collaboration (Fawcett et al., 2000). While this literature is closer to the area of community development and capacity building, it offers some important perspectives, for example, the need to incorporate technical assistance and resources in support of the collaborative process itself and the need to carefully document the process of change and, in particular, early successes.

Although each collaborative initiative is unique and context-dependent, some guidance for development and implementation may be derived from a "best practice" framework for organizing health care delivery systems for people with complex needs, including chronic mental health conditions. Hollander and Price (2008) articulated such a best practice framework derived from interviews with approximately 270 leading experts in the respective domains (the others being care for the elderly,

support collaborative practices across the system

appointment (Collins et al., 2010). Strosahl (2005) proposes the standard of care should not be defined by the practice of specialty mental healthcare but rather from the practice of primary care.

Training and education: Lack of familiarity with collaborative practices (Kates et al., 2011) and limited knowledge of necessary skills (Collins et al., 2010; Watkins et al., 2001) have been cited as barriers to integration and collaboration. Suggested strategies to address these obstacles include cross-discipline education and skills training (Kates et al., 2011; Collins et al., 2010), such as professional development sessions on implementing practices such as screening, motivational interviewing, brief interventions and self-management tools. Other mechanisms include supports from provincial and territorial governments and health authorities (e.g., access to relevant materials, support for visits to existing projects), and steps by academic institutions to prepare students to work in collaborative models (Kates et al., 2011).

Technology: Collaborative models supported by technology such as telemedicine have "demonstrated their value in addressing limited access, as well as shortages of healthcare professionals in urban and rural settings" (Kates et al., 2011). An innovation such as telemedicine has the potential to provide ways to link service providers, enhance collaboration and provide consultation to underserved jurisdictions (Kates et al., 2011). Technology also offers other options

The literature points to primary care as foundational to an effective healthcare delivery system. In tandem with this, observers argue achieving strong primary care requires the support of an integrated system. Therefore, creating high quality primary care with enhanced collaboration will require attention to both human-focused and infrastructure elements.

Evolving an integrated infrastructure

Several elements of the systems infrastructure can either promote or impair integration. Careful attention must be given to continuously assessing the impact of current elements and evolving structures that promote effective system operations and lead to improved outcomes.

Regulatory and policy changes are levers for system change and often complement changes in funding mechanisms. Financial management is associated with integrated systems and includes equitable funding distribution for different services or levels of service and mechanisms to promote inter-professional teamwork.

Well-designed computerized information systems are also associated with integrated healthcare. Information systems support operational practices such as managing client records, tracking service utilization and outcomes, as well as supporting service delivery (e.g., self-management tools, email exchange).

Clarity around practices and standards of care helps build understanding and trust within integrated healthcare. The differences between traditional general healthcare and behavioural health services need to be addressed through cross-discipline education and professional development. The importance of client efficacy should be paramount in development of this cross-disciplinary understanding.

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