ARTICLE 1 - COLLABORATIVE MENTAL HEALTH CARE

Milestones and historical perspective of its development in Canada

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Not so long ago, psychiatric hospitals were true fortresses with their walls erected for keeping insanity in the background. Built at the fringes of cities and society, they were autocratic social microcosms which provided all the necessary services to their inhabitants. With their adjacent cemeteries, these territories of social apartheid for the mentally ill turned out to offer a true all-inclusive journey.[1] The confinement of patients and caregivers within the hospital walls facilitated their ability to manage their surrounding in a relatively predictable way. The submission to the pre-established order of society was the necessary condition to live without being repressed. One need only recall the cult movie *One Flew Over the Cuckoo's Nest*[2] to visualize the institutional ambiance. The nurse Miss Ratched came across more as a guardian of the order than anything else. A good patient was a docile patient. In that respect, the paradigm of management of Henri Fayol was perfectly fit for that time: planning, organizing, commanding, coordinating and controlling.[3]

Following World War II and more precisely from the 1960s onward, an irresistible movement of deinstitutionalization, often associated with post-modernity, radically changed society in general and almost completely abolished psychiatric hospitals in particular. The psychiatric institution was seen as outdated, costly and inefficient. The implementation of mental health clinics within communities was supposed to provide care more responsive to the contemporary world and in a more humane fashion.[4, 5] We now know that the process of deinstitutionalization in psychiatry faced several pitfalls: the phenomenon of “transinstitutionalisation” (whereby patients moved from the dismantled psychiatric hospital only to end up in jail or in socio-economic ghettos), "criminalization" of mental illness, fragmentation of care delivery systems, etc. In short, too many patients failed to get access to the delivery of care and to receive treatments as expected.[6]

Obviously, something has gone wrong. Among all the pitfalls disabling the mental health care system, the communication between family physicians and psychiatrists was conflictual. For many years, their relationship looked very much like a dialogue of the deaf. In Canada, as in other countries (New Zealand, England, USA), this situation has been well described.

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[1] Gervais, Michel, Lucie Gauthier, Lise Gélinas 2000. La réhabilitation de l’hôpital psychiatrique – Une question d’audace et de synergie. *L’Information psychiatrique – Revue mensuelle des psychiatres des hôpitaux*, volume 76 no.7 (Juillet) : 787-795.
[2] Forman, Milos (movie director) 1975. Title of the movie: *One Flew Over the Cuckoo's Nest*.
[3] Fayol, Henri 1916. *General and Industrial Management*. London, Pitman, 1949. Translation of “Administration industrielle et générale » that was published in French in 1916.
[4] Grob, Gerald N 1992. Mental health policy in America: Myth and realities. *Health Affairs*, volume 11 no. 3 (Fall): 7-22.
[5] Lecomte, Yves 1988. Le processus de désinstitutionalisation aux États-Unis : première partie. *Santé mentale au Québec*, volume 13 no. 1 : 34-47.
[6] Torrey, Fuller 1988. *Nowhere to go, The Tragic Odyssey of the Homeless Mentally Ill*. Harper and Row (publisher), New-York.

On one hand, the family physicians felt abandoned: "...family physicians...reported problems accessing psychiatric consultation in a timely fashion, poor communication between psychiatrists and family physicians, and poor continuity of care ... Family physicians are not informed of changes to their patients' treatment ... not informed when their patients were admitted or discharged ... Family physicians felt that they were not recognized as part of the treatment team ... poor liaison with the mental health teams ... ."

On the other hand, the psychiatrists also had genuine concerns: " ... poor referral letters, inappropriate referrals, unrealistic expectations, inadequate evaluation of patients prior to referral, and family physician reluctance to follow patients after discharge ... ."[7]

In order to meet the conditions for a better collaboration between family physicians and psychiatrists, the College of Family Physicians of Canada (CFPC) and the Canadian Psychiatric Association (CPA) endorsed a common position paper, *Shared Mental Health Care in Canada*, published in 1997.[8] Already, the family physician was seen as the hub of the supply chain of mental health services. In the perspective of this irresistible trend of shifting resources from hospitals to communities, the managerial activities that had been confined to the hospital institution and led by its pyramidal hierarchy would give way to a network of interdependent resources. The citizen who knocked at the door of a health facility would henceforth have access to a comprehensive network of services that extends far beyond the borders of the organization. The sanitized world of Nurse Ratched had given up the ghost.

To follow up on this position paper, both organizations set up the CPA/CFPC Collaborative Working Group on Shared Mental Health Care which has been very productive since then. It is worth noting that this initiative of the two Canadian organizations was not driven by "strategic planning," Indeed, like the crew of the spaceship USS Enterprise in the television series *Star Trek*, this working group was mainly dedicated to "exploring the unknown." They were asked to discover models of organization, the equivalent of unfamiliar forms of life, which would be fit for this new world of integrated services. Although the strategy of the group had deliberate qualities, it relied most on informal learning. This "crafting strategy" was the ongoing formulation of an emergent vision created through venturing and learning.[9]

From 2004 to 2006, the Canadian Collaborative Mental Health Initiative (CCMHI) was funded by the Government of Canada's Primary Health Care Transitions Fund. The goal of the CCMHI was to provide " ... policy makers, and other interested groups and individuals with summary of the current experimental literature on the effectiveness of collaboration practices in the delivery of mental health care in the primary care setting" and its outcomes have been well-summarized by Bland and Craven.[10]

In 2004, when CCMHI began its activities, the extent of collaborative care had far exceeded the boundaries of the unique interface between family physicians and psychiatrists. Led by a strong working coalition of 12 national health organizations that was composed of consumers, families and caregivers, dieticians, family physicians, nurses, occupational therapists, pharmacists, psychologists, psychiatrists

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[7] Bland, Roger, Marilyn A Craven 2002. Shared Mental Health Care: Bibliography and Overview. *The Canadian Journal of Psychiatry*, volume 47 no. 2, Supplement 1 (April): 1S-104S.

[8] Canadian Psychiatric Association (CPA) and the College of Family Physicians of Canada (CFPC) 1997, Position Paper, written by Kates, Nick, Marilyn A Craven, Joan Bishop, Theresa Clinton, Danny Kraftcheck, Ken LeClair, John Leverette, Lynn Nash, Ty Turner. Shared Mental Health Care in Canada. *The Canadian Journal of Psychiatry*, volume 43 no. 8 (October): 1-12.

[9] Mintzberg, Henry 2009. *Managing*. Berrett-Koehler Publishers Inc., p. 162-163

[10] Bland, Roger, Marilyn A Craven 2006. Better Practices in Collaborative Mental Health Care: An Analysis of the Evidence Base. *The Canadian Journal of Psychiatry*, volume 51 no. 6, Supplement 1 (May): 1S-72S.

and social workers, CCMHI was inspired by the following strategic vision: "A well-integrated public health system with health care providers from a variety of backgrounds working in partnership with consumers and their families, communities and one another, to enable consumers to access prevention, health promotion, treatment/ intervention and rehabilitation services from the most appropriate provider: when they need it, in a location that is accessible, and with the fewest obstacles." CCMHI was a movement that designed a new world of possibilities. It reminds us that in its most crucial component, managing is necessarily creating.[11]

Similar to other forms of innovation, collaborative mental health care had its share of early adopters, but some important groups remained reluctant to proceed in a direction where the order of things appeared fuzzy. In this community-based approach, unlike within large provider organizations like hospitals where the specialized elites have a commanding role, the power structure is more diffused and may appear to be less prestigious.

Some medical associations saw a dramatic, even dangerous, departure from the essential role of physicians as providers to individual patients. Different stakeholders had doubts about the positive impacts of collaborative care and, in addition, they were concerned by legal issues. In particular, many psychiatrists feared that the interdisciplinary and the network approach would expose them to important risks in terms of medical liability.

In September 2007, the Canadian Medical Protective Association (CMPA) published a paper on this issue:[12] *Collaborative Care: A Medical Liability Perspective*. In many respects, the position of the CMPA challenged the fierce resistance of some medical organizations. The CMPA stated that "... the same medico-legal liability system that currently protects the interests of both patients and providers can also support collaborative practices."

Beyond its recommendations about the management of medico-legal risks, CMPA wrote that "Collaborative care has significant potential to greatly enhance the delivery of health care in Canada ... Collaborative care can be an important element of a more comprehensive solution to improving patient access to care ... CMPA is committed to identifying and reducing risks in collaborative care and ensuring discussions of medical liability are supported by fact so that innovative health delivery models, such as collaborative practice, are not hindered by lack of knowledge or unfounded fears."

This position dealt a serious blow to those who had strongly argued that collaborative care was to a large extent an unlawful practice.

The growth of collaborative care models has turned out to be so impressive, and their advances so promising, that the CPA and CFPC decided to endorse a new Position Paper in August 2010.[13] Several projects of collaborative mental health care –in Canada and elsewhere – showed clinical outcomes which were superior to traditional organizational models. Among those outcomes were "an improved access to mental health care and increased capacity of primary care to manage mental health and addiction (MH&A) problems...better clinical outcomes, a more efficient use of resources, and an

[11] Lapierre, Laurent 2005. Gérer, c'est créer. *Gestion*, volume 30 no.1 (Spring) : 10-15.

[12] Canadian Medical Protective Association (CMPA) 2007. *Collaborative Care: a Medical Liability Perspective* (September).

[13] Canadian Psychiatric Association (CPA) and the College of Family Physicians of Canada (CFPC) 2011, Position Paper, written by Kates, Nick; G Mazowita, F Lemire, A Jayabarathan, R Bland, P Selby, T Isomura, M Craven, M Gervais, D Audet. The Evolution of Collaborative Mental Health Care in Canada: A Shared Vision for the Future. *The Canadian Journal of Psychiatry*, volume 56 no.5 (May): 1-10.

enhanced experience of seeking and receiving care.” It is as if collaborative care has managed to square the circle.