In 1996, E. H. Wagner published an article entitled *Organizing Care for Patients with Chronic Illness* that was a turning point in care of people struggling with chronic illness.\(^1\) He pointed out the extent to which the health care system was especially designed to respond to the acute and urgent needs of the patients and that, in many respects, it proved ineffective in addressing chronic diseases.\(^2\)

From the outset, he described how the context of care of chronic diseases was different and argued that the organization of care should be redesigned accordingly: "Chronic illnesses confront patients and their caregivers with a restricted and uncertain future and the burdens associated with controlling the disease ... We have culled examples from the literature in order to examine comprehensive approaches to reorganizing care delivery that have improved the outcomes of patients with chronic illness." In short, the acute-care model was not designed for patients with chronic diseases.\(^3\)

Wagner enumerated a long list of pitfalls that undermined the capacity of the health care system to tackle chronic diseases: priority of "urgency over severity," poor compliance to evidence based clinical guidelines, failure to promote self-management of their care and wellbeing by the chronically ill patients, lack of training of the caregivers for providing comprehensive care to meet the needs of these patients and their family (systematic assessments, preventive interventions, psychosocial supports), delays in the "detection of complications or declines in the health status," lack of culture and structure of clinical practices that would allow a collaborative interdisciplinary approach, etc.

In accordance with Wagner’s observations, Holman and Lorig stated that “the present health care system, designed early in the last century to cope with acute disease, did not change when chronic disease became the major issue. As a consequence, discontinuity and fragmentation of care are widespread. Technology is often applied unnecessarily. Community and home-based care are poorly developed. Costs mount without obvious commensurate benefits for patients. And a large segment of the population is unable to obtain appropriate health care.”\(^4\) All those observations are especially important for the mental health care system.

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Wagner then proposed what is now referred to as the Wagner Model; that is to say, the Chronic Care Model (CCM). This model includes many of the key ingredients for the success of collaborative mental health care:

- Use of explicit plans and protocols: “The shift to evidence-based, planned care should be eased by working within a care system or group practice that values guidelines...”
- Practice redesign: interdisciplinary team approach, proactive and sustained follow-up of the patients (from acute and reactive to proactive), regular team meeting, clear allocation of tasks among the care providers, shared plan of care, etc.
- Patient education (assisting patients in managing their illness) and support: self-care, self-management, patient participation, psychosocial support, etc. This orientation is closely akin to the movement of recovery and empowerment of the consumers that is the prevailing strategic vision in mental health. The development of self-management competencies by the consumer and his family is a core component of collaborative mental health care as well.
- Expert support: access, in a timely fashion, to consultation by an expert (ex: a psychiatrist) and support by the expert that is available directly in the primary care setting. Wagner uses specifically the word “collaborative care” and points out the “potential risk of further fragmenting care”. He calls for “innovations in generalist-specialist interactions...whereby specialists and generalists manage patients together in the primary care setting.”
- Patient registries and other supportive information technology.
- A population-based perspective that leads to a more effective use of community resources. Example: peers-support group.

As with the case for collaborative care, the CCM cannot be managed through the “taylorisation” of work and cannot be easily replicated. In other words, CCM is not a fast-food restaurant. Although some key factors of success are found in the redesigning of care in each organization, there is no absolute uniform application of the CCM. Unlike fast food, CCM is a meal with a unique local flavour. The same rationale applies to the collaborative mental health care models.

Collaborative mental health care and CCM share common features that make them complementary. Collaborative care provides the strategic vision and the organizational culture that allow the CCM to be implemented and to deliver the expected outcomes: “The model (CCM) emphasizes informing and activating patients and positioning physicians within proactive and collaborative practice environments ... Productive interactions include regular assessment, tailoring of clinical management by protocol to specific patient needs, collaborative goal setting, a shared care plan, and sustained, tailored follow-up.” With the CCM, health care delivery goes much beyond the simple patient-doctor relationship and encompasses a "more collaborative process between an informed patient and a prepared, proactive health care team." There is no possible application of the CCM without the necessary collaboration among the stakeholders and the coordination of their activities towards common goals. Conversely,

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collaborative mental health care relies on, among other things, the principles of chronic disease management to achieve its goals.\textsuperscript{11}

This vision is also compatible with the dominant movement of recovery and empowerment that prevails in mental health. However, the word "chronic" may bother consumers. An editorial of the Canadian Journal of Psychiatry, published in 2002 and entitled "Chronic my ass", denounced the misuse of the word "chronic" which was associated with a form of stigma.\textsuperscript{12} Therefore, when it is used in mental health, perhaps the Chronic Care Model could be renamed the “Care Model adapted to complex context” or simply the “Care Model” in order to remove the stigma attached to the word “chronic.”

In mental health, many Canadian provinces are now working on implementing the CCM adapted to the local contexts. These actions will be embedded into a model of collaborative care designed to fit within comprehensive primary care settings. As recommended by many scholars and experts, the emphasis is on increasing high-quality primary care provided by multidisciplinary teams, and aims at achieving effective integration of primary care and specialist care.\textsuperscript{13} It is striking to notice the huge gap between the prevalent medical and managerial culture (more inclined to deal with the simple – complicated dimensions of the acute diseases in an ordered world) and the culture that remains to be created for sustaining the management of chronic diseases, so prevalent in mental health, in complex contexts In short, “… the link between the focus of clinical medicine, shifting from acute (simple or complicated) to chronic (complex) clinical challenges requires a rethinking of the management of health care … The interdependence of the clinical and the management or leadership aspects of health care is profound.”\textsuperscript{14} To give collaborative care a chance of being a success, managers and clinicians are condemned to get along and work together closely.

Glouberman and Mintzberg described how the health care network has become an extremely complex system that is characterized by a very important differentiation of its activities, particularly under the influence of the medical specialties that have developed in silos (chimneys), and suffers from a lack of mechanisms of integration.\textsuperscript{15} In this highly fragmented care system, the lion’s share of the budget is allocated to hospitals, to the "cure" of acute diseases and to the medical emergencies. Again, the resources that are invested in the “care” of the chronic diseases have been scarcer.

Incidentally, Glouberman and Mintzberg emphasized the need for “continuous, cooperative care, not just intermittent cure … the natural forces of cooperation must be exploited to bring integration to a level commensurate with the differentiation.” With these insights in mind, it is clear there is an added value of the CCM and of the mental health care collaborative models as mechanisms of integration in the health care system.


\textsuperscript{13} Ham, Chris 2010. The ten characteristics of the high-performing chronic care system. Health Economics, Policy and Law: 71-90.
