Mental Health in RAAM

June 6, 2023

Dr. Tanya Hauck MD PhD FRCPC
Psychiatrist, CAMH
Assistant Professor, University of Toronto

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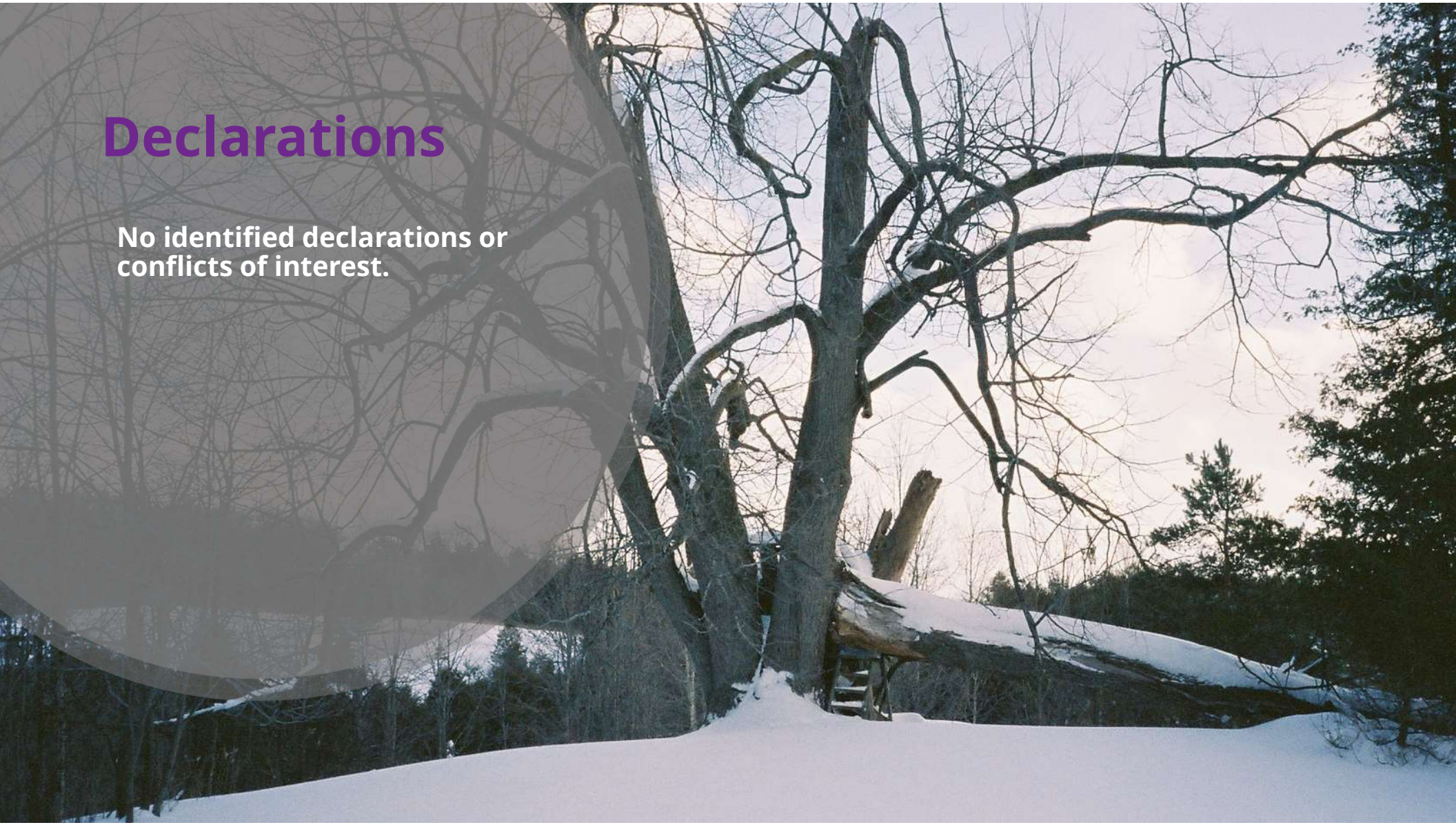
Declarations

No identified declarations or conflicts of interest.



Objectives

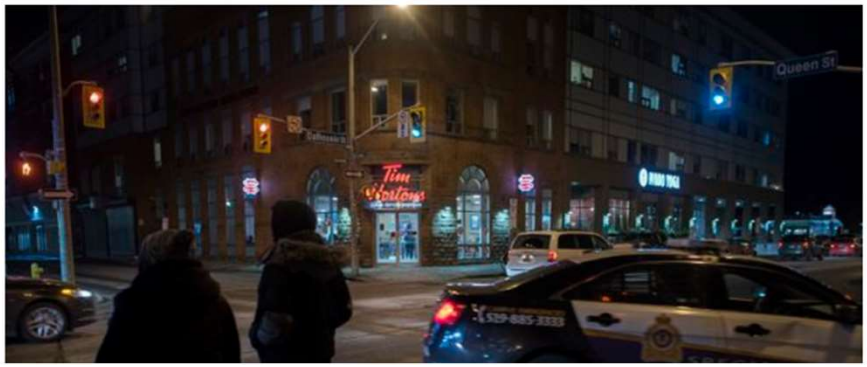
1. To provide an overview of mental health care in RAAMs and the background to this situation (and future)
2. To review the psychiatry resource tool developed for RAAM providers
3. To discuss and questions or concerns or recommendations arising from this tool

[1]

In a Brantford Tim Hortons, the toll of the opioid crisis is in full view

A 24-hour Tim Hortons in the Southwestern Ontario municipality has become an informal clubhouse: a place to get out of the cold, chat with friends and buy and use drugs

MARCUS GEE ›
PUBLISHED FEBRUARY 3, 2019
UPDATED FEBRUARY 4, 2019



[2]

In Brantford's opioid nightmare, a community sees more hopeful days ahead

A year of surging opioid deaths spurred this Ontario town to action. Now, signs of progress are appearing, though officials warn the crisis may be far from over

MARCUS GEE ›
INCLUDES CORRECTION
PUBLISHED FEBRUARY 24, 2019
UPDATED FEBRUARY 25, 2019
13 COMMENTS

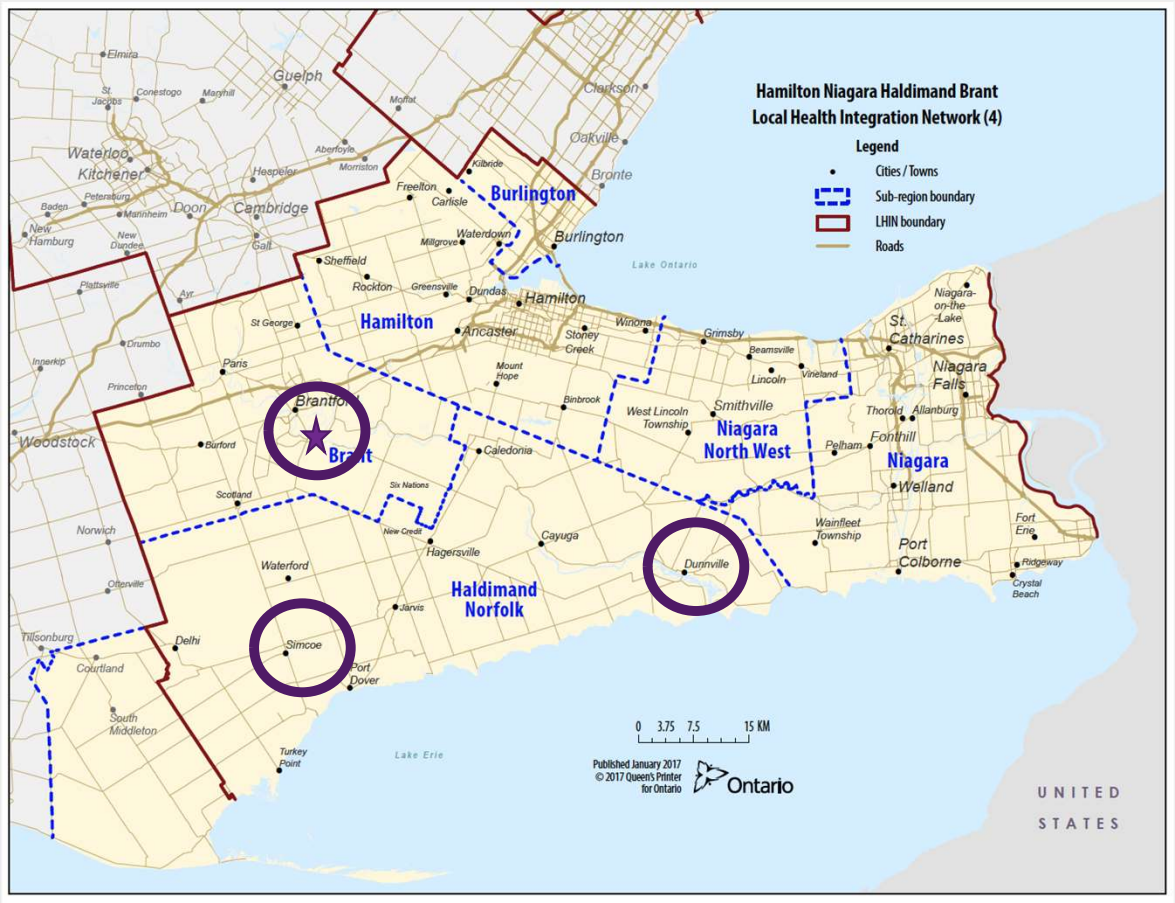
From META:PHI
Jan 23 2019

“Good Morning,

I wanted to inquire if any psychiatrists in the province are doing OTN consults. We are in short supply of psychiatrists in Brantford, and some of our doctors and nurse practitioners are just looking for consults and can follow the patient post consult. Thank you for any assistance.

Stephanie Rochon”

The Brant Haldimand Norfolk RAAM



[3] (Hamilton Niagara Haldimand Brant LHIN, 2014)

The Brantford RAAM

Clinic Background

- Opened September 28, 2018
- Tuesdays and Fridays from 9am-1pm
- 3 Physicians, NPs
- Concurrent Disorders Counsellors
- Mental Health Social Worker
- Case Managers
- Peer Support Workers
- Affiliations
  - > *St. Leonard's Community Services*
  - > *Canadian Mental Health Association - BHN*
  - > *Brantford General Hospital*
  - > *Grand River Community Health Centre*
  - > *De dwa da dehs nye s Aboriginal Health Centre*

The Brant Haldimand Norfolk RAAM

Psychiatric Comorbidities

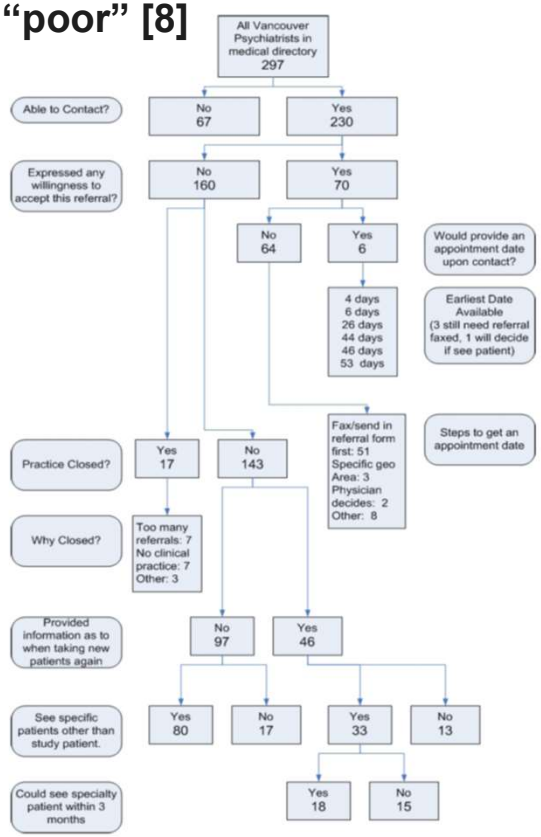
- Substance-induced psychosis
- Stimulant use disorders
- PTSD
- Bipolar disorder
- Psychotic disorders
- Major depressive disorder and generalized anxiety disorder

Access to Psychiatry Across Canada

Access to and waiting time for psychiatrist services in a Canadian urban area: a study in real time.

Goldner EM, Jones W, Fang ML. Can J Psychiatry. 2011 Aug;56(8):474-80. [9]

35.1% of all family physicians identify access to psychiatry as "poor" [8]



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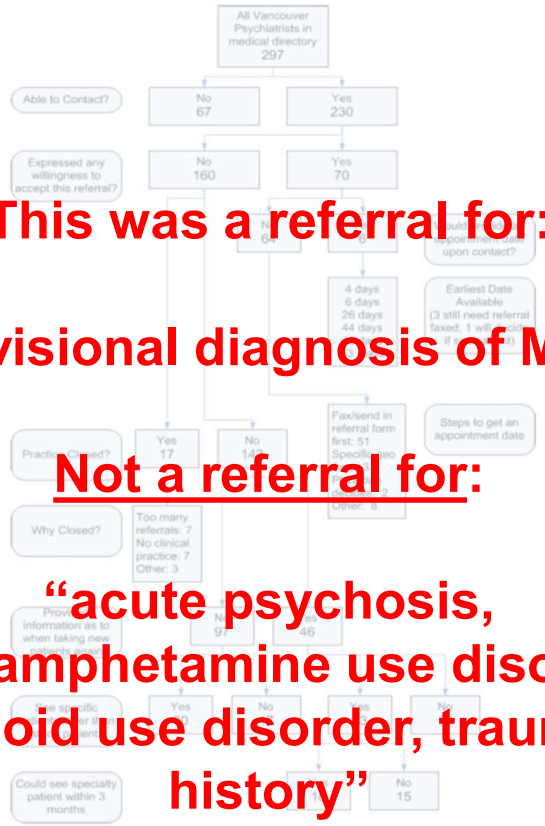
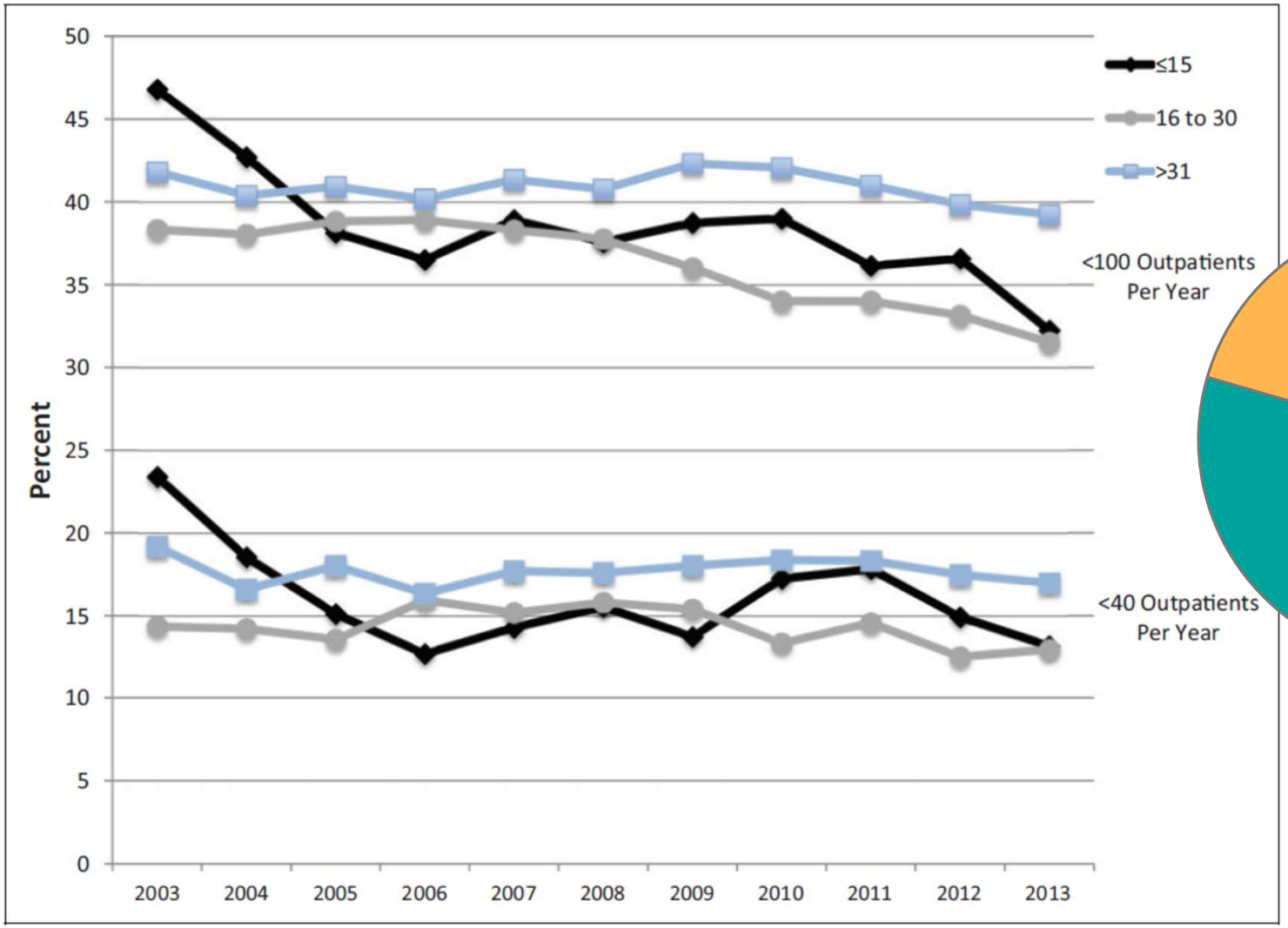


This was a referral for:

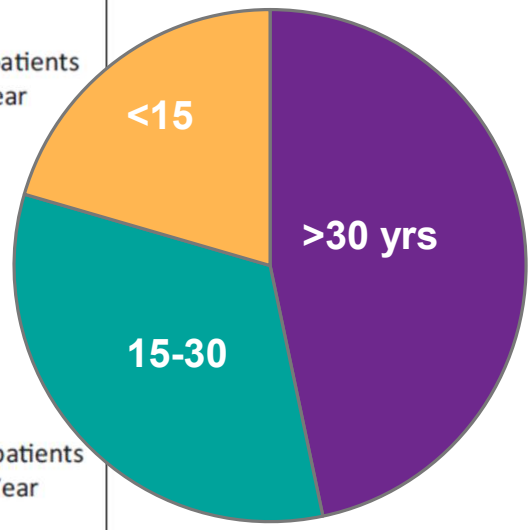
"provisional diagnosis of MDD"

<u>Not a referral for</u>:

"acute psychosis, methamphetamine use disorder, opioid use disorder, trauma history"



2070 Psychiatrists in Ontario in 2013
Years Since Graduation



Kurdyak et al, CJP 2017, Vol. 62(1) 40-47

Figure 1. Proportion of psychiatrists who see fewer than 40 and 100 outpatients total annually by years since medical school graduation, 2003-2013.

What about patients who use substances ?

"Controlling for sociodemographic characteristics, comorbidities and past-year service use, those with 1–4 ED visits for SUD and those with 5+ ED visits for SUD had reduced odds of being hospitalised or visiting a psychiatrist in the 30 days following their index ED visit, relative to those with no ED visits for SUD"

Urbanoski K, et al. Emerg Med J 2018;35:220–225 [11]

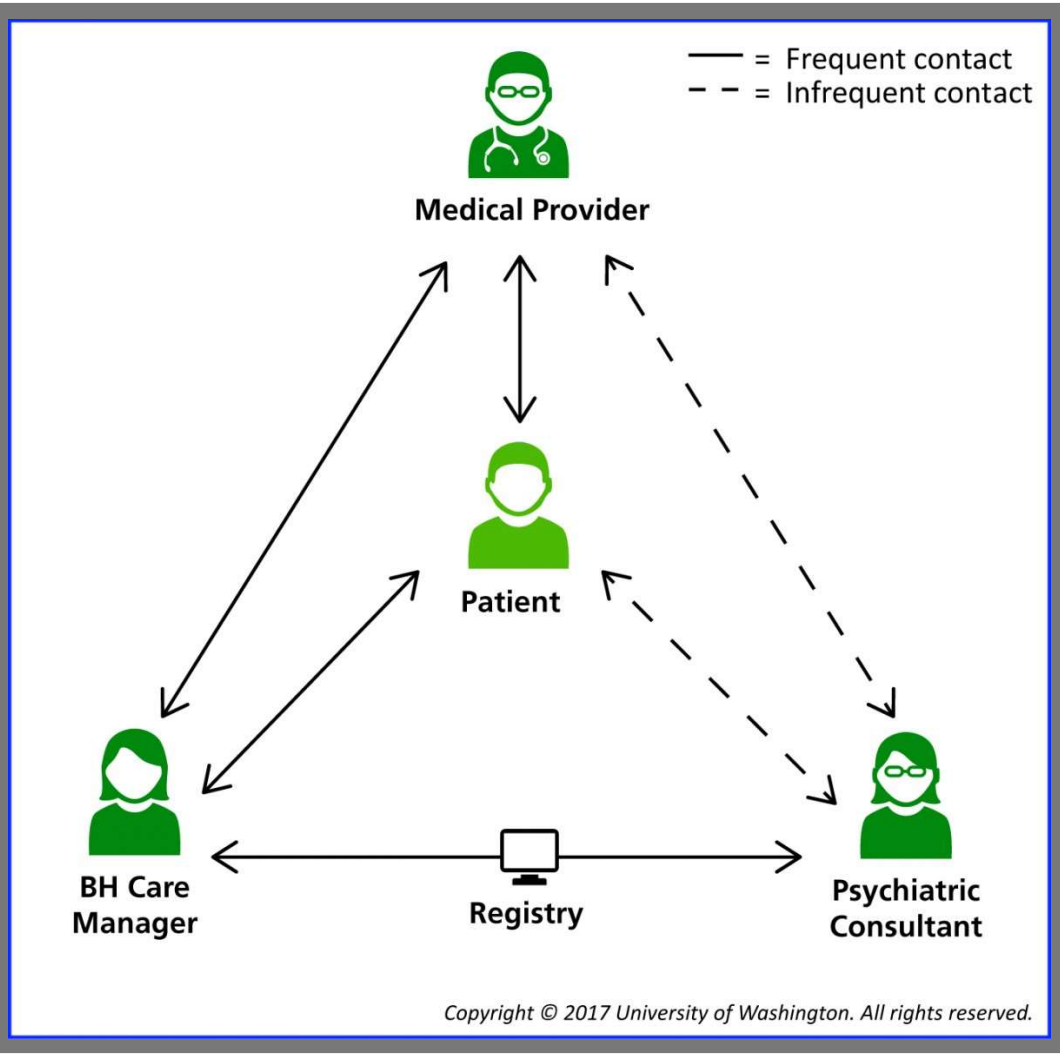
Table 4 Logistic regressions predicting the receipt of follow-up care* and 2-year mortality among frequent ED users for mental disorders†

	No of ED visits for substance use disorder			
	1–4 visits (vs 0) n=1319		5+ visits (vs 0) n=1573	
Outcome	OR (95% CI)	P	OR (95% CI)	P
Hospitalisation	0.555 (0.474 to 0.650)	<0.001	0.283 (0.237 to 0.339)	<0.001
Primary care	1.025 (0.883 to 1.189)	0.746	0.678 (0.580 to 0.792)	<0.001
Psychiatrist visits	0.692 (0.589 to 0.812)	<0.001	0.250 (0.206 to 0.304)	<0.001
2-year mortality	1.044 (0.635 to 1.715)	0.866	2.633 (1.813 to 3.825)	<0.001

- Concurrent disorders are a major problem
- Alcohol, opioid and other substances are a public health emergency
- Access to psychiatry is already problematic AND is expected to get worse in the future

Where do we go from here?

Evidence for Collaborative Care: The AIMS Center



Principles of Effective Integrated Health Care:
"co-location will not produce the same results"

Patient-Centered Team Care / Collaborative Care: Primary care and behavioral health providers collaborate effectively using shared care plans. It's important to remember that colocation does NOT mean collaboration, although it can.

Population-Based Care: Care team shares a defined group of patients tracked in a registry to ensure no one "falls through the cracks." Practices track and reach out to patients who are not improving and mental health specialists provide caseload-focused consultation, not just ad-hoc advice.

Measurement-Based Treatment to Target: Each patient's treatment plan clearly articulates personal goals and clinical outcomes that are routinely measured. Treatments are actively changed if patients are not improving as expected until the clinical goals are achieved.

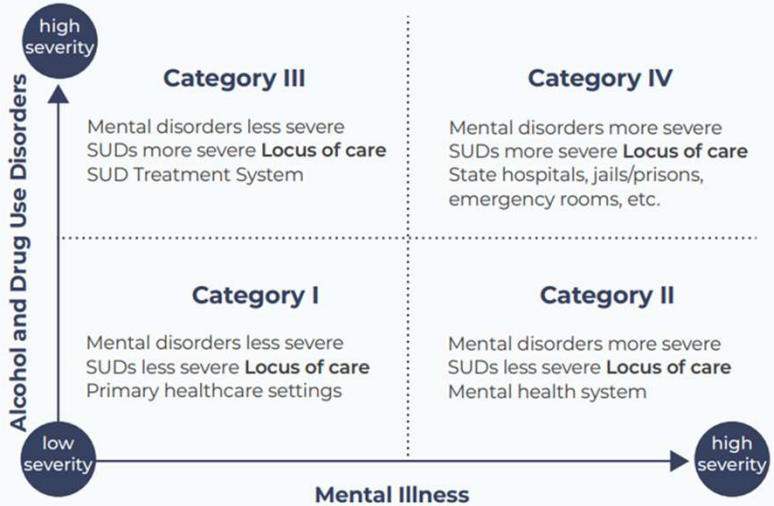
Evidence-Based Care: Patients are offered treatments for which there is credible research evidence to support their efficacy in treating the target condition.

Accountable Care: Providers are accountable and reimbursed for quality of care and clinical outcomes, not just the volume of care provided.

"Collaborative care is associated with significant improvement in depression and anxiety outcomes compared with usual care, and represents a useful addition to clinical pathways for adult patients with **depression and anxiety**."

Models are available to help counselors make treatment and referral decisions based on the severity and impact of each disorder. For instance, the quadrants of care (also called the Four Quadrants Model) is a conceptual framework that classifes clients in four basic groups based on relative symptom severity, not diagnosis (Exhibit 2.3). The quadrants of care were derived from a conference, the National Dialogue on CoOccurring Mental Health and Substance Abuse Disorders, which was supported by SAMHSA and two of its centers—CSAT and the Center for Mental Health Services—and co-sponsored by the National Association of State Mental Health Program Directors and the National Association of State Alcohol and Drug Abuse Directors. The quadrants of care is a model originally developed by Ries (1993).

EXHIBIT 3.8. Level of Care Quadrants



Substance Abuse Treatment for Persons With Co-Occurring Disorders (SAMHSA)

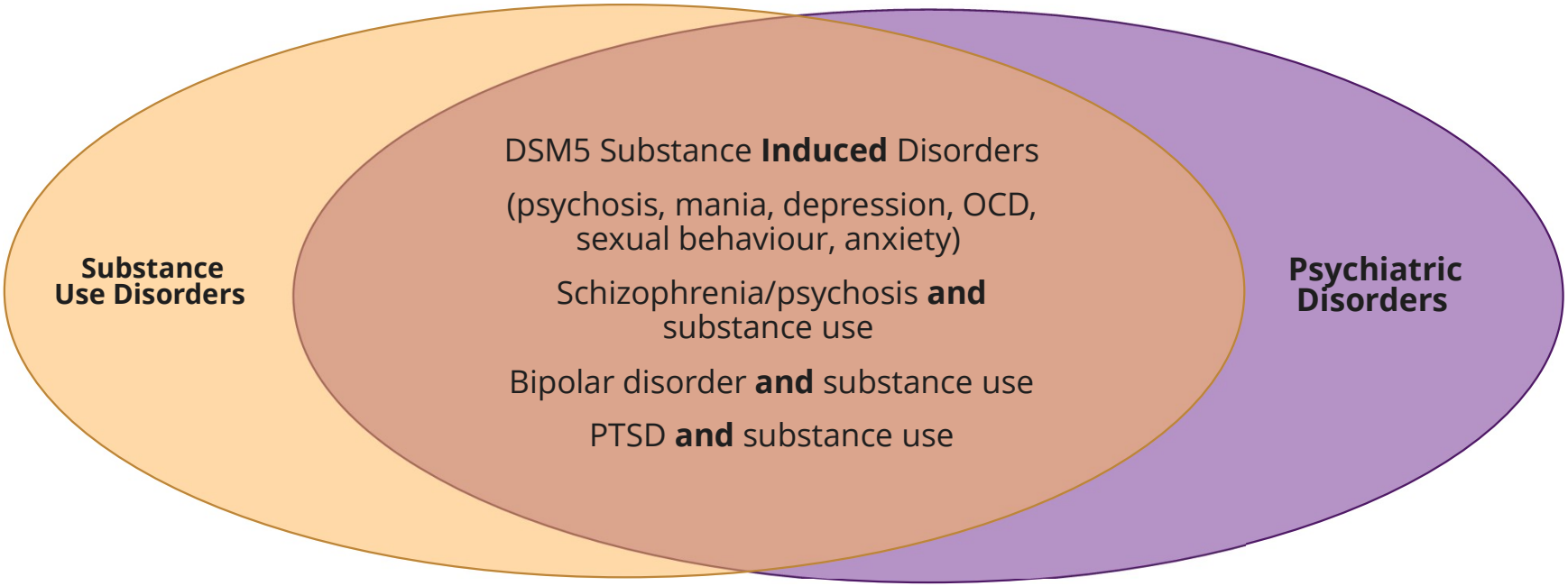
"**Quadrant IV:** Quadrant IV has two subgroups. One includes people with serious, persistent mental illness (SPMI) who also have severe and unstable SUDs. The other includes people with severe and unstable SUDs and severe and unstable behavioral problems (e.g., violence, suicidality) **who do not (yet) meet criteria for SPMI**. These individuals require intensive, comprehensive, and integrated services for both their SUDs and mental disorders. The locus of treatment can be specialized residential SUD treatment programs such as modified therapeutic communities in state hospitals, jails, or even in settings that provide acute care such as emergency departments (EDs)."

Concurrent disorders need different models of care

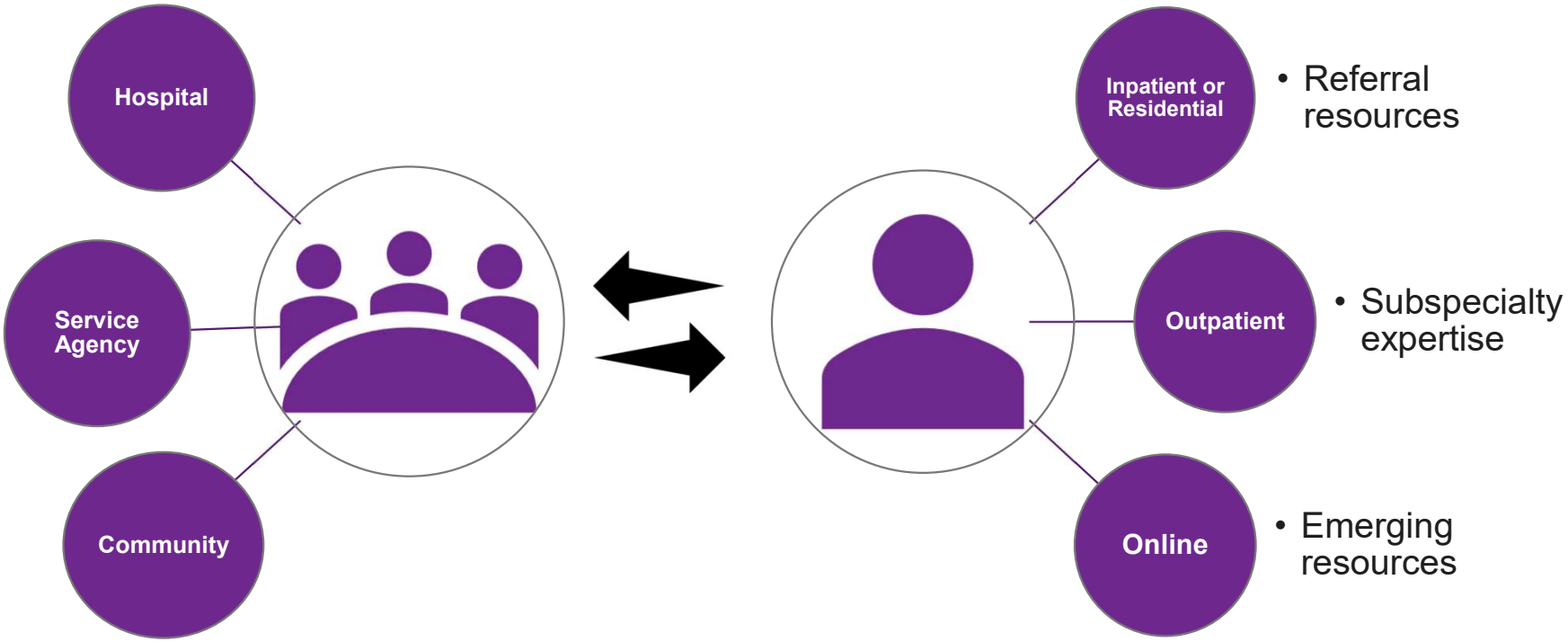
"The substance use service gap in rural communities results in clients having **extensive delays** for such care, which is a barrier for treatment success. As 1 client summarized: "A lot of people that are here for help today and then are put on a wait-list for a call next week, their mind has totally changed, 'I don't want the help or I don't need the help.'" "

Browne et al, The Journal of Rural Health 32 (2016) 92–101

The Brant Haldimand Norfolk RAAM: Embracing Complexity



Case consultation and capacity building



The “Psychiatry Tool”, a Work in Progress

- A work in progress!
- Developed through our model in the BHN RAAM, with input from Stephanie Rochon RPHT, Kelly Kokus DNP, NP-PHC, MScN, Ilan Nachim MD CCFP, and Leslie Buckley MD MPH FRCPC
- a “two pager” intended to support RAAM providers (MDs and NPs) who are caring for individuals along a spectrum of mental health and substance use (quadrants, I, III and IV) who are presenting to RAAM clinics
- Approaches to common disorders such as MDD, PTSD, GAD, psychosis
- Prescribing considerations with concurrent mental health
- Medical considerations relevant in RAAM clinics
- Recommendations about the Mental Health Act and certifiability
- **Not a replacement to consultation in many cases**

Treatment of Concurrent Disorders in RAAM Clinics

Concurrent Disorders in RAAM Clinics

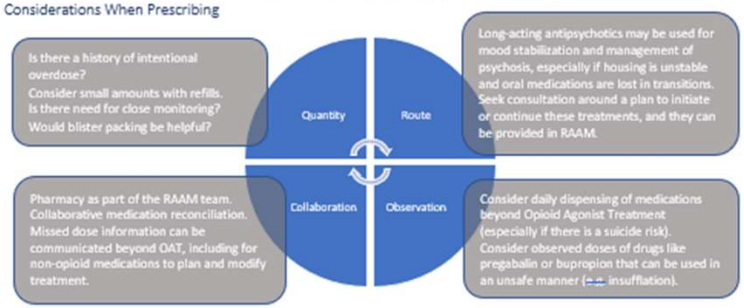
- Individuals with concurrent substance use disorder presenting to emergency departments are known to be **less likely to receive** outpatient or inpatient psychiatric care compared to individuals without addictions related emergency department visits.
- Wait lists for community resources including psychiatric consultations and Assertive Community Treatment (teams supporting individuals with schizophrenia and other disorder) are long throughout the province, ranging from months to over a year.
- RAAM clinics are meant to be low barrier, and patients are seen without appointments or referrals, making them an essential access point for individuals seeking care for mental health and addictions care.
- A core principle of a RAAM is to treat all substance use disorders and address mental health disorders.
- Concurrent psychiatric disorders are the rule, not the exception, in individuals presenting for addictions treatment.
- Concurrent treatment is essential, and treatment of mental health disorders also improves the substance use disorder, such as treatment of long-standing anxiety with antidepressant treatment during post-acute withdrawal from alcohol.
- Prescribers must practice within their training and experience and seek support and consultation when needed in diagnosis and treatment considerations. *E-consultation is another option available in Ontario through the Ontario Telehealth Network.*
- The purpose of these recommendations is to encourage treatment within the comfort and training of the prescriber, recognizing that many individuals will require psychiatric assessment and treatment planning.
- Psychotherapy is an essential component of treatment (in addition to substance use counselling) that is not covered here.

Common Concurrent Disorders, Assessment Tools and Guideline-Based Treatments

	Posttraumatic Stress Disorder (PTSD)	Major Depressive Disorder (MDD)	Generalized and Social Anxiety Disorder	Substance-Induced Psychosis/Schizophrenia
Tools to support diagnosis	PTSD Checklist for DSM-5 (PCL-5)	Patient Health Questionnaire (PHQ-9) Beck Depression Inventory (BDI)	General Anxiety Disorder-7 (GAD-7) Liebowitz Social Anxiety Scale (LSAS)	
Relevant guidelines	Canadian clinical practice guidelines for the management of anxiety, posttraumatic stress and obsessive-compulsive disorders.[1]	CANMAT Depression Work Group. Canadian Network for Mood and Anxiety Treatments (CANMAT) 2016 Clinical Guidelines for the Management of Adults with Major Depressive Disorder: Section 3. Pharmacological Treatments.[2]	Canadian clinical practice guidelines for the management of anxiety, posttraumatic stress and obsessive-compulsive disorders.[1]	Addington, D et al. Canadian Guidelines for the Assessment and Diagnosis of Patients with Schizophrenia Spectrum and Other Psychotic Disorders.[3]
Typical first-line pharmacological treatments	Fluoxetine, Sertraline Venlafaxine XR, Paroxetine. Prazosin for nightmares and alcohol use disorder[4]	Escitalopram[5], Sertraline, Duloxetine, Mirtazapine, Bupropion. Augmentation with quetiapine, risperidone, olanzapine	Escitalopram[5], Sertraline, Venlafaxine XR, Paroxetine Pregabalin, Gabapentin[6]	Risperidone, Olanzapine, Paliperidone, Aripiprazole[7] and long-acting injectable formulations

1. Katzman et al, BMC Psychiatry 14 (Suppl 1), S1 (2014).
2. Kennedy SH et al, Can J Psychiatry. 2016 Sep;61(9):540-60.
3. Addington, D et al, Can J Psychiatry. 2017 Sep;62(9):594-603.
4. Prazosin has some off-label evidence in the treatment of alcohol use disorder.
5. Escitalopram and citalopram have advisories related to QT prolongation, a particular concern if combined with methadone.
6. Pregabalin and gabapentin have potential for misuse and should be monitored and not prescribed in large amounts.
7. Aripiprazole labels have been updated to include a warning about risk of pathological gambling, hypersexuality and other impulsive behaviours.

Considerations When Prescribing



Tanya S. Hauck MD PhD FRCPC, Stephanie Rochon RPHT, Kelly Kokus DNP, NP-PHC, [illegible] Ilan [illegible] MD CCFP, Leslie Buckley MD MPH FRCPC

Medical Considerations with Psychiatric Prescribing

When prescribing substance use disorder treatments and psychiatric medications, a number of medical conditions, risk factors and drug-drug interactions should be considered. Some common concerns are presented here, although this is not an exhaustive list:

QT prolongation	Consider QT prolongation risk and relative benefits of medications, particularly when combining high dose methadone (>150 mg) with QT prolonging agents such as antipsychotics or antidepressants, or in alcohol withdrawal or with the use of cocaine or methamphetamine. Provide psychoeducation and monitor ECG (especially prior to and after medication initiation) and consider cardiology referral.
Bipolar disorder	Antidepressants can precipitate mania in bipolar disorder and should be avoided or only considered following comprehensive psychiatric assessment. Mood stabilizing medications such as valproate or lithium require careful monitoring and psychiatric assessment. Consider a medication safe for both prevention/treatment of mania and depression such as quetiapine or aripiprazole if mania is a concern.
Renal function	Drugs like lithium and pregabalin undergo renal clearance and require dose adjustment in renal impairment.
Hepatic function	Certain medications (e.g. duloxetine, valproate) undergo hepatic metabolism and are contraindicated in hepatic impairment or require dose adjustment (e.g. fluoxetine).
Drug-Drug interactions	It is essential to work with the patient's pharmacy team/pharmacist to identify relevant drug interactions, including those related to cytochrome P450 enzyme inhibition or induction (e.g. vortioxetine and bupropion).
Metabolic monitoring	All patients on antipsychotic medications, for any indication (psychosis, augmentation of mood, etc.) must receive monitoring for metabolic side effects and cardiometabolic risk management. The Early Psychosis Intervention Ontario Network has monitoring tools available: http://www.metabolic.help4psychosis.ca/#pdfs
Safety assessments	Patients with mental health and substance use are at risk of self harm, harm to others and reduced self care. Provide safety planning including reduced access to means such as medications used in an overdose. Free CAMH Safety Planning mobile app: https://www.camh.ca/hopebycamhapp
Neurocognitive disorders	Patients presenting to RAAM clinics may present with neurocognitive disorders (dementia) due to substance use such as alcohol, or other concurrent disorders (traumatic brain injuries, cardiovascular disorders). Referral to primary care, memory clinic and reversal of treatable causes (such as thiamine treatment) is essential. **It may be important to conduct a medication reconciliation and discontinue or taper any medications such as benzodiazepines or anticholinergic medications that increase the risk of delirium.** Seniors' mental health and medication resources: https://ccsmh.ca/ https://www.gerimedrisk.com/
Seizure history	Bupropion should not be used in patients with an elevated risk of seizures (significant alcohol use, sedative or hypnotic use disorder/withdrawal, history of seizures such as seizures from fentanyl).
Pregnancy	Psychopharmacology must be carefully considered in pregnancy in an informed consent discussion. The risks of the treatment versus the risks of the untreated mental health disorder must be considered. Consider the need for referral to perinatal mental health services and coordination of care with pregnancy care providers. Some medications have serious risks and are contraindicated in pregnancy (such as valproate). Best Use of Medicine in Pregnancy resource: https://www.medicinesinpregnancy.org/ Lactation and medication resource, LactMed®: https://www.ncbi.nlm.nih.gov/books/NBK501922/
Polypharmacy	Medication reconciliation is essential, as well as communication with primary care and other prescribers. Polypharmacy can lead to serotonin syndrome with multiple classes of medications (SSRIs, opioids, TCAs) contributing: https://crediblemeds.org/index.php/login/dicheckwonder

Consider Referral to Psychiatry for:

- Youth under 18 and especially under 16, and patients over 65 or with neurocognitive disorders (or memory clinic/geriatrics)
- Consideration of medications such as valproate, clozapine, lithium, initiation of long-acting antipsychotics
- Community Treatment Orders or the need for Assertive Community Treatment (ACT), usually for individuals with psychotic disorders and repeated hospitalizations, to support community living and to prevent rehospitalization
- Subspecialty care such as Obsessive-Compulsive Disorder that has not responded to first line management
- Perinatal mental health care (planning pregnancy, during pregnancy, or post-partum mental health concerns)

Acute Psychiatric Emergencies and Safety:

- Consider driving safety, including mandatory reporting for psychiatric symptoms or diagnoses (such as acute psychosis)
- Consider the need for a Form 1 – a Form 1 is an Application by Physician for Psychiatric Assessment and should be used if there a safety concern: any/multiple of threats to self/others or failure to care for self
  - Past/Present test: what is the **safety issue**, e.g., "ran into traffic", "attempted overdose", "waved knife in clinic"
  - Future test: what are the **symptoms of a mental health disorder**, e.g., yelling at wall, thought disorder, feels hopeless
- Consider the need for emergency services (EMS/police) if there is a hazard to staff or other clients, or the possible use of a police wellness check if it is not possible or appropriate to use a Form 1

Tanya S. Hauck MD PhD FRCPC, Stephanie Rochon RPHT, Kelly Kokus DNP, NP-PHC, [illegible] Ilan [illegible] MD CCFP, Leslie Buckley MD MPH FRCPC

Common Presentations: (DSM5 prevalence)

	Posttraumatic Stress Disorder (PTSD) (8.7% lifetime, 3.5% annual)	Major Depressive Disorder (MDD) (7% annual)	Generalized (2.9% annual) and Social Anxiety Disorder (7% annual)	Substance-Induced Psychosis/Schizophrenia (lifetime 0.3%–0.7% for schizophrenia)
Tools to support diagnosis	PTSD Checklist for DSM-5 (PCL-5)	Patient Health Questionnaire (PHQ-9) Beck Depression Inventory (BDI)	General Anxiety Disorder-7 (GAD-7) Liebowitz Social Anxiety Scale (LSAS)	Clinical assessment
Relevant guidelines	Canadian clinical practice guidelines for the management of anxiety, posttraumatic stress and obsessive-compulsive disorders.[1]	CANMAT Depression Work Group. Canadian Network for Mood and Anxiety Treatments (CANMAT) 2016 Clinical Guidelines for the Management of Adults with Major Depressive Disorder: Section 3. Pharmacological Treatments.[2]	Canadian clinical practice guidelines for the management of anxiety, posttraumatic stress and obsessive-compulsive disorders.[1]	Addington, D et al. Canadian Guidelines for the Assessment and Diagnosis of Patients with Schizophrenia Spectrum and Other Psychotic Disorders.[3]
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The fine print…

1. Katzman et al, BMC Psychiatry 14 (Suppl 1), S1 (2014).

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7. Aripiprazole labels have been updated to include a warning about risk of pathological gambling, hypersexuality and other impulsive behaviours.

Prescribing Considerations

1. **Quantity to prescribe?**
   - Consider any history of intentional or accidental overdose
   - Consider giving a small amount with refills
   - Blister packing may be helpful
2. **Route?**
   - Long-acting antipsychotics may be helpful, especially if housing is unstable
   - Consider consultation to initiate these medications
3. **Collaboration?**
   - Consider pharmacies to be part of your team
   - Consider requesting other missed dose information
4. **Observation?**
   - Consider daily dispensing of other medications, especially if there is high risk of suicide or loss
   - Consider observation of higher-risk psychiatric medications (bupropion, pregabalin)

As with all medications, this must be a discussion with the patient, and involve informed consent.

Medical considerations

1. QT prolongation: especially high risk with methadone
2. Bipolar disorder: antidepressants are likely contraindicated, mood stabilizers require significant monitoring
3. Renal function: lithium and pregabalin require particular consideration
4. Hepatic function: valproate and many antidepressants may need to be modified
5. Drug-Drug interactions: important to work with pharmacies (e.g. vortioxetine and bupropion)
6. Metabolic monitoring: **all antipsychotics, at all times**
7. Safety assessments: safety planning is the most evidence based intervention
8. Neurocognitive disorders: referral to primary care/memory clinics, providing thiamine if needed/possible, deprescribing sedatives/anticholinergic medications
9. Seizure history or risk: consider if bupropion is safe
10. Pregnancy: https://www.medicinesinpregnancy.org/ https://www.ncbi.nlm.nih.gov/books/NBK501922/
11. Polypharmacy: relationship with pharmacy and primary care, reconciliation

What is a form 1?

"Application for psychiatric assessment"

This assessment may take up to 72 hours, but the detention only commences at a "Schedule 1" facility

The patient receives a notification ("Form 42") *only* upon arrival at the Schedule 1 facility

Any physician may fill out a form 1 after performing an assessment

The physician has 7 days after an assessment to fill it out

The form gives authority for 7 days afterwards for police to apprehend the person

Upon arrival at the facility the detention lasts 72 hours

In general, there are two key concerns:

1. **Past/Present → what is the RISK to self or others?**
2. **Future → what are the SYMPTOMS of mental illness?**

Safety Assessments and Safety Planning

Safety Planning Intervention (SPI) developed by Stanley et al (Cognitive and Behavioural Practice, 2012, 19: 256-264)

Rationale:

Many patients don't seek care after an ED visit for suicidality (11-50% of attempters refuse care)

Suicidal crises are usually short-lived, ebb and flow, and crisis management is helpful

Clinical intervention is more helpful than standard "assess and refer"

Safety Planning Intervention (SPI)

The SPI should be developed ***after*** a comprehensive suicide risk assessment

The risk assessment should discuss what happened before/during/after any recent attempts or crises

This can help identify warning signs for crisis

The safety plan should be ***helpful*** and not a source of stress/burden

No part of the plan is mandatory

If the patient feels acutely unsafe, and **not safe even for a brief time**, they should go to an emergency setting

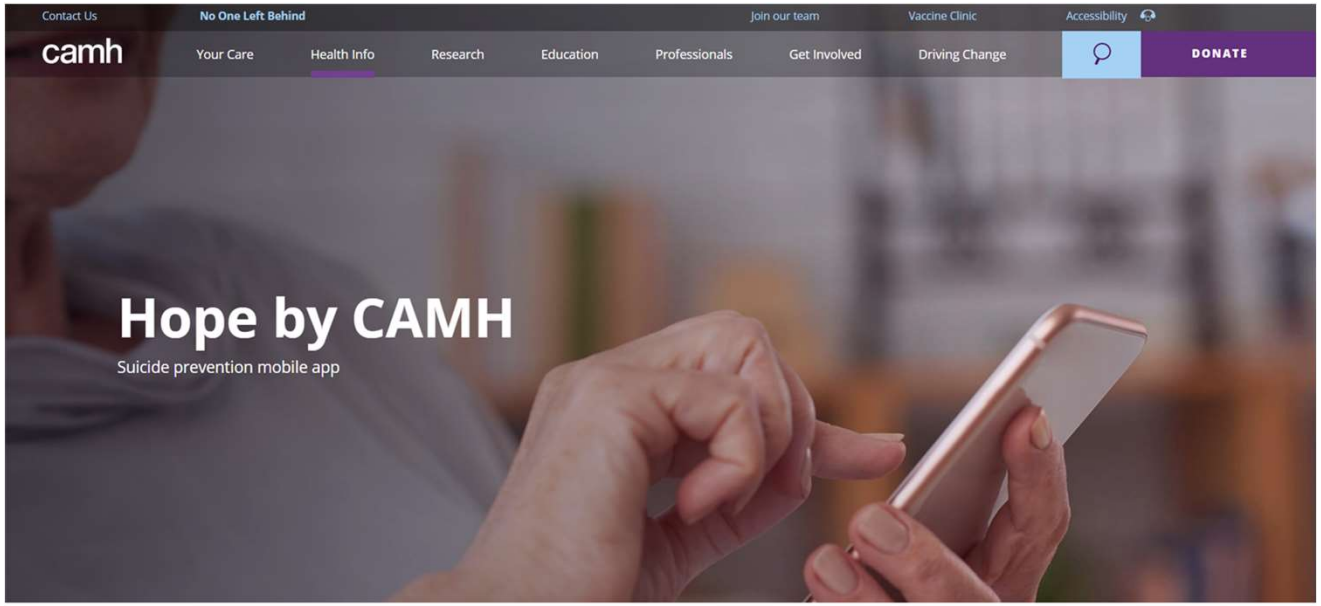
SPI Stepwise Approach

1. Recognizing warning signs of a suicidal crisis
2. Using internal coping strategies (*e.g. 5 senses from DBT)
3. Using social supports and contacts as a way of distracting (**socializing**)
4. Contacting friends or family who can resolve the crisis (**asking for help for the suicidal crisis**)
5. Contacting supports and professional supports/agencies – **including contact information, e.g. help lines**
6. Restriction of lethal means (sharps, ligatures, weapons, medication)

Hope by CAMH

Suicide prevention mobile app

Personalized safety planning



Your Feedback!

Please fill out the feedback survey.

Any comments at this time?

Acknowledgments

The Brantford RAAM & team
- Stephanie Rochon
- Kelly Kokus NP
- Dr. Preeti Popuri, Dr. Parminder Bahra, Dr. Alyson Holland

Dr. Peter Selby

Dr. Jonathan Bertram

Dr. Tim Guimond

Dr. Wiplove Lamba

Dr. Daniela Lobo

Dr. Leslie Buckley

Dr. Jan Malat

Dr. David Rodie

Dr. Faye Doell

Dr. Paul Kurdyak

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