Collaboration Mental Health Care in Canada: Lessons Learnt and Future Directions

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Plan

- Why do mental health and primary care need to collaborate
- The in gredients of successful collaboration
- The Canadian Collaborative Mental Health Initiative
- The Hamilton HSO Mental Health and Nutrition Program
- Where are we heading
- Chronic disease management

Up to 40% of individuals visiting their family physician have a mental health problem

Edmonton Study (Bland et al 1997)

- 28.1% of individuals with a mental disorder received help in a year. Of these
  - 78% saw a physician (usually family physician)
  - 29% saw a psychiatrist
  - 18% saw a psychologist
  - 10% saw a social worker

Untreated Psychiatric Disorders

72% of individuals with a psychiatric disorder receive no treatment over the course of a year.

81% of these individuals will visit their family physician.

Lesage Ontario Mental Health Supplement 1997

Primary care may be the ideal (only) location for detecting the problems of and initiating appropriate treatment for many of these individuals.

Co-Morbidity

- Increased prevalence of psychiatric disorders (often depression and anxiety) with all chronic illness
- If untreated, these lead to poorer self-management
- If untreated, these lead to poorer outcomes
- If untreated, these lead to increased medical costs

6-Month Mortality Post -MI

- Depressed post-MI patients have a four to five four fold risk of death over the next 6 months when controlling for other risk factors - > twice the risk of smoking
- Impact of depression on mortality is at least as significant as left ventricular dysfunction and history of previous MI

Frasure-Smith et al. *JAMA.* 1993;270:1819.

Traditional mental health care delivery doesn't always make sense

- Intake procedures / access
- Compartmentalisation of care
- Exclusion criteria
- Expectation people come to us
- Responsibility only for individuals seen

Common elements of primary care reform

- Larger groups of providers
- Interdisciplinary teams
- Integrate specialised services
- Comprehensive care
- Consumer-centred
- Health promotion and prevention
- Management of chronic diseases
- Evidence-based
- Electronic health records

Problems between mental health and primary care services

Summary of Recurrent Themes

- Poor communication between Family Medicine and Psychiatry
- Difficulty in accessing timely psychiatric consultation.

Summary of Recurrent Themes

- Psychiatric intake procedures cumbersome and inefficient.
- General lack of support and respect for the FP as a mental health caregiver.

Summary of Recurrent Themes

- Access
- Communication
- Relationships
- Working at cross-purposes

Collaborative Care

- Delivery of service by two or more stakeholders (including consumers)

- Working together in a partnership characterised by
  - Common goals or purpose
  - Recognition and respect for strengths and differences
  - Equitable and effective decision making
  - Clear and regular communication

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- To improve access to a comprehensive range of services delivered by the right person, in the right place at the right time.

Collaborative Care : Principles

- Primary care and mental health services are both part of a single network of community mental health services
- Consumers are partners too
- Collaboration is a means to an end, not an end
- Care is shared, according to needs , skills, resource availability
- The changes are real, not just cosmetic

Collaborative Care : Principles

- Services are complimentary – based upon mutual respect and support
- Based upon an understanding of the demands each other faces / their limitations
- Partners are equal, partnerships need to evolve

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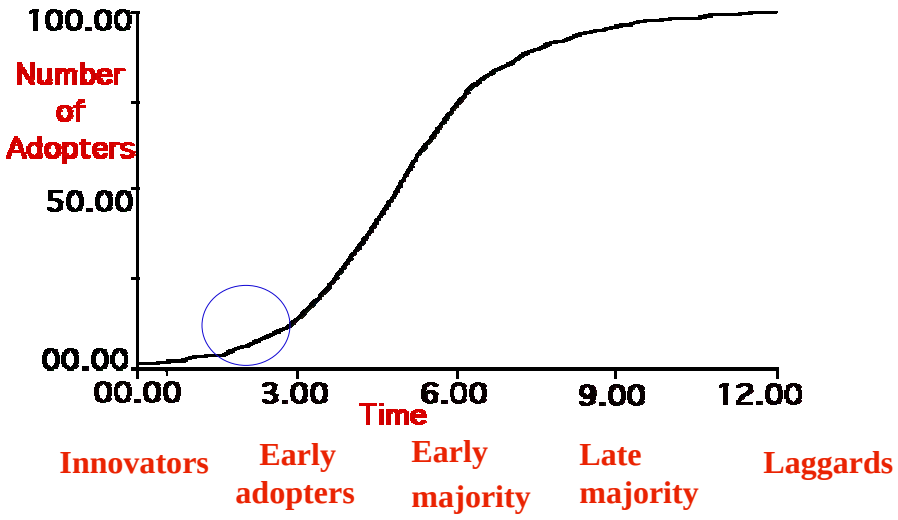
- Partners are equal, partnerships need to evolve
- Personal contacts are the key

Last 10 Year: The National Level

- Family physicians and mental health services working in isolation
- Shared Care : Family Physicians and Psychiatrists
- The partnership broadens – more mental health providers involved
- Consumers involved as equal partners
- Canadian Collaborative Mental Health Initiative

The clinical level

Rogers diffusion of innovation theory



CCMHI - Partner Organizations

- Canadian Psychiatric Association
- College of Family Physicians of Canada
- Canadian Psychological Association
- Canadian Nurses Association
- Dietitians of Canada
- Canadian Association of Occupational Therapists
- Canadian Pharmacists Association
- Canadian Mental Health Association
- Canadian Alliance on Mental Illness and Mental Health
- Canadian Association of Social Workers
- Canadian Federation of Mental Health Nurses
- Registered Psychiatric Nurses of Canada

THE CCMHI

- Funded through the primary health care transition fund
- National strategy envelope
- To develop a national strategy for improved collaboration between mental health providers, primary care providers, consumers, families and other community partners
- Primary (health) care is defined broadly
- Ends on March 31st 2006 (189 days!)
- Major challenge is to look at sustainability

GOALS OF CCMHI

- To review current state of and knowledge regarding collaborative mental health care
- To develop a charter committing partner organizations to working collaboratively
- To develop strategies for the implementation of collaborative care and to address specific problems
- To communicate widely the findings of the survey and to work with to Provincial, Federal, Territorial and Regional Partners towards their implementation

REVIEWS COMPLETED

- Current status
- Current literature
- Bibliography
- Best practices
- Barriers
- International initiatives
- Current primary care reform documents
- Aboriginal mental care
- Funding issues
- Human resources
- Policy issues

TOOLKIT PROJECT

- Practical guide for planners and clinicians
- Easy to use
- Web-based
- 1 general (overall) toolkit
- 8 guides aimed at specific populations

TOOLKIT PROJECT

- Children and adolescents
- Seniors
- Aboriginals
- Ethno-cultural groups
- Individuals living in rural or isolated communities
- Urban disadvantaged populations
- Individuals with an addiction problem
- Individuals with a severe mental illness

CONSUMER TOOLKIT

- Guide for consumers
- Explains the system(s)
- Explains how care may be delivered
- Explains the benefits of collaboration
- Outlines roles and responsibilities of all involved
- Outlines how to get the most out of a collaborative relationship

CHARTER

- Key part of the legacy of the CCMHI
- Declaration by the 12 partners
  - Supporting the values (principles) of collaboration
  - Committing to work together to implement these principles
- Broad-based consultation
  - Consumer focus groups
  - Organisation responses
  - Online survey
  - Further focus groups
  - National forum of leaders

CHARTER (very abridged!)

All residents of Canada have a right to:

- A society that promotes health (prevention)
- Timely access to services and supports
- Collaborative care
- Be full partners in their own care
- Services and supports that respect their diverse needs
- Be informed about available resources
- Quality services that are adequately resourced

SUSTAINABILITY

- Ongoing national framework
- Work with governments and funders as well as providers
- Inform consumers
- Build networks of interested colleagues
- Disseminate broadly our work / findings / recommendations (ie toolkits)
- Commitment by organisations to work together (Charter)

2 OTHER NATIONAL PROJECTS

Common indicators / outcome measures in primary mental health care

Collaborative management of addictions in primary care

MANY PROVINCIAL PROJECTS

Ontario funded 11 Mental Health projects

Will provide a wealth of relevant information

Hamilton HSO
Mental Health & Nutrition Program

Nick Kates
Anne Marie Crustolo
Michele Mach
Lindsey George
Judy Corras

Cathy Shorer
Shelley Brown
Wanda Kelly
Aimee Collings
Sari Ackerman
Elka Persin

HSO Mental Health and Nutrition Program

- 38 practices
- 51 sites
- 80 family physicians
- 170,000 patients (38%)

HSO Mental Health and Nutrition Program

- 80 practices
- 105 sites
- 145 family physicians
- 340,000 patients (68%)

Integrating Specialised Health Services within Primary Care

»	Ratio	FTEs	Clinicians
• Counsellors	1:7,500	22.9	41
• Psychiatrists	1:80,000	2.0	12
• Registered Dietitians	1:23,000	7.0	8

Programs

Central Program

How the Program Works

- See any case / any age (3-98)
- Only criterion is request for help from PCP
- Emphasis on short-term care
- Specialists integrated within primary care
- Indirect as well as direct service
- Emphasis on education
- Charting integrated

How the Program Works

- Continuing care
- Intermittent care
- Advice to family physicians
- Case discussions
- Crisis assessments
- Groups

- Sessional (professional) fee funding
- Central co-ordinating body

Referrals 2003 : Counsellors

- Total 4014
- Counsellors 3460 (87%)

  161 per Full Time Equivalent

- Psychiatrists 1270 (31%)

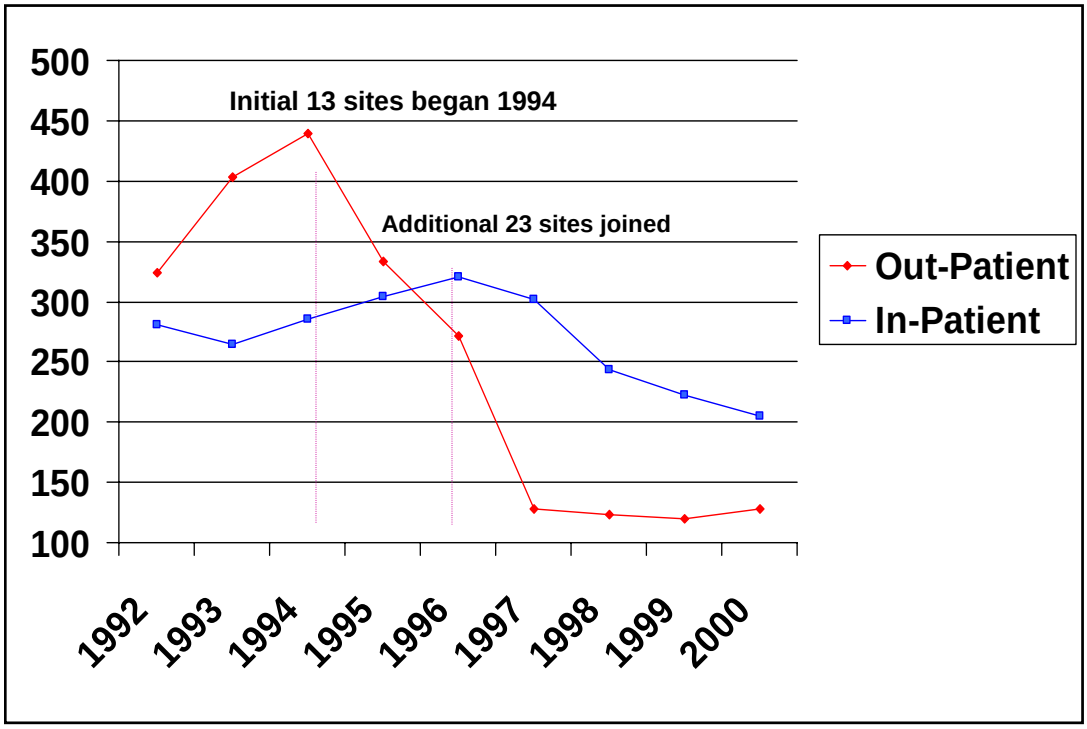
  594 per Full Time Equivalent

Referrals to mental health services (first 13 practises - 45 physicians)

Service	92-93	94-95	2000	2003
Out-patient clinics	203	75	72	82
HSO Mental health team	-	2532	2180	2255
Total Referrals	203	2607	2252	2337
Referrals / Phys / year	5	54	53	55

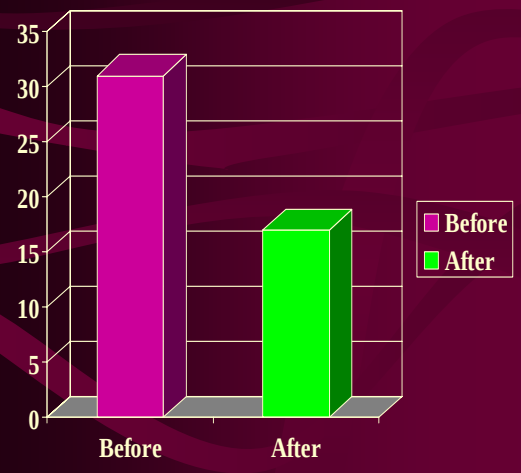
Implications of program data

- Increases capacity of mental health system
- Increases capacity of primary care to handle mental health problems
- Improves access to mental health care
- Improves access for underserved populations
- Changes patterns of utilisation of mental health services


500
450
400
350
300
250
200
150
100
Initial 13 sites began 1994
Additional 23 sites joined
1992
1993
1994
1995
1996
1997
1998
1999
2000
Out-Patient
In-Patient

Outcomes

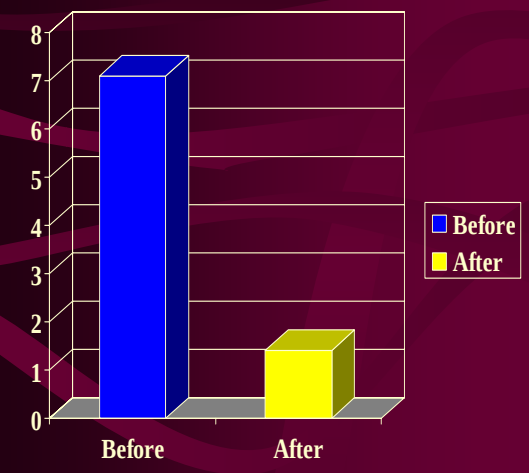
Outcome measures CES-D



- **Mean change 14**
- **Improved > 1 SD 58%**
- **Score reduced > 50% 74%**

All changes significant p<.05

Outcome measures 12 Item GHQ



- **Mean change 5.7**
- **Improved > 1 SD 84%**
- **Score reduced > 50% 81%**

All changes significant p<.05

Benefits of collaborative care

- High level of satisfaction – consumers
- High level of satisfaction – providers

“ I think that knowing we have great back-up makes us less resistant to explore social issues during a busy clinic.”

Family Physician in the Program

“Over the 3 years of the program, I am convinced that my own knowledge and comfort with mental illness has increased to a highly significant degree. It is no longer an area of uncertainty and doubt, but a discipline which has begun to fall into place and gives great satisfaction and reward.”

Family Physician in the Program

Benefits of collaborative care

- Improves quality of care
- Improves co-ordination of care
- Improves continuity of care
- Improves communication

Collaboration has changed

- **Access**
- **Communication**
- **Relationships**
- **Common goals / purpose**

Some lessons learnt

- Change behaviour by changing practices rather than just through education (change the system, rather than the individual)
- Change behaviour through an informed “empowered” consumer
- We must move beyond current thinking / models
- This requires a willingness to do things differently

Physical care for the SMI

- Higher likelihood of physical health problems
- Physical health care often neglected
- May not have a family physicians
- Need to integrate physical health care with mental health care

- Windsor CMHA
  - Nurse practitioner
  - Backed up by Family Physician
  - Addresses first contact health problems

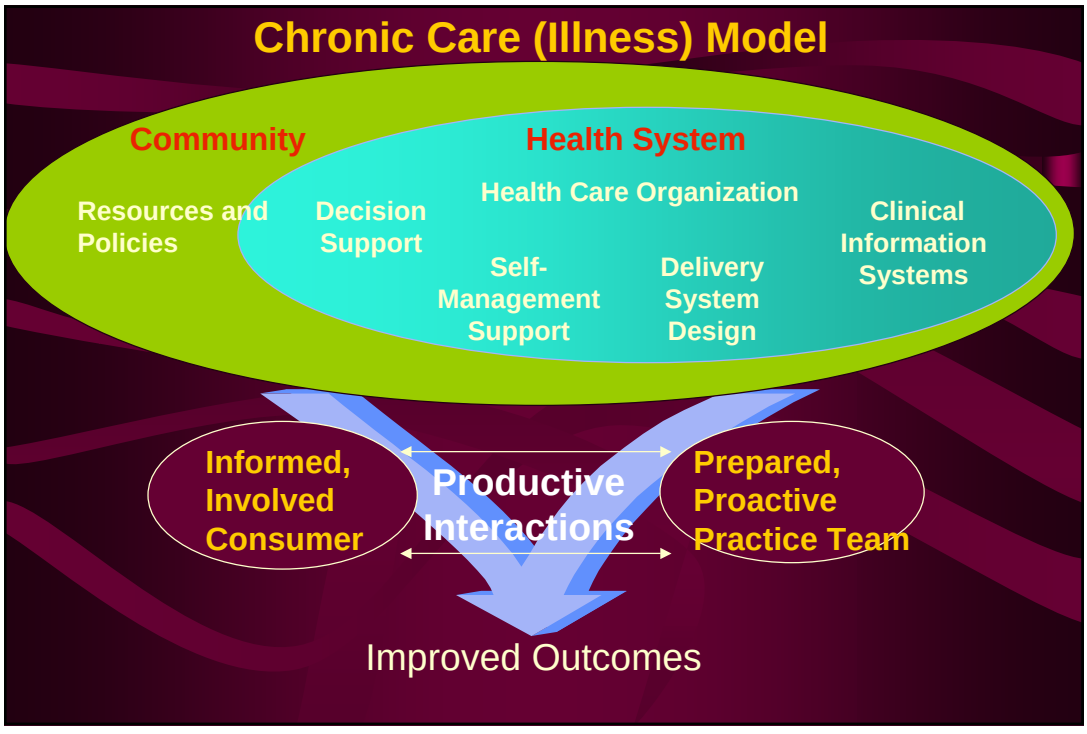
What's wrong with current approaches

- **Focus on care of acute episodes**
- **Problems not always identified**
- **Individuals not followed after acute episode**

- **Services not comprehensive**
- **Need more providers involved**
- **Not consumer-centred**
- **Not based on what works**

Chronic Disease Management or Chronic Care Model

Great Concept - Lousy Name



Chronic Care Models

- Can be applied to specific health problems
- Can be applied to programs
- Can be applied to health systems

6 Priorities for the Health Care System

1. Emphasis Self-Management

Self-Management

- New partnership between providers and consumers
- Consumer fully informed / aware of all aspects of their care
- Consumer receives copies of letters / summaries / medications
- Consumer more responsible for their own care
- Consumer need to hold providers to account
- New models of consumer education

Consumer education

- Missed opportunities
- How much is heard
- Why doesn't it work
  - Different agendas (medical / cultural)
  - Anxiety
  - Language
  - (Mis)perceptions
  - Readiness for change

2. Develop a comprehensive Spectrum of Care

Prevention

- Early detection
- Early intervention
- Consumer education
- Tracking individuals after an acute episode

Early Detection

- Screening
- Specific questions
- Tracking individuals at risk
- Reminders

3. Find new ways to monitor care / individuals at risk

Use of the EHR / Registers

- Electronic health record
- Able to track individuals post-treatment or at risk
- Builds in alerts / reminders
- Can incorporate treatment algorithms

4. Integrate specialists in primary care

5. Organisational (System) support and leadership is essential

6. Continue to build broader partnerships

Summary

- Primary care is a key part of the mental health system
- Much of what we do isn't working
- Need to change processes of care
- Need new approaches to collaboration
- These approaches need to be based on personal contacts
- Consumers and families must be partners in system design and personal care planning
- Tremendous opportunities with primary care reform and concepts of CDM
- We have a chance to do things differently