Presentation to

Global Perspectives on CDM

The Calgary Conference 2005

Scott Dudgeon

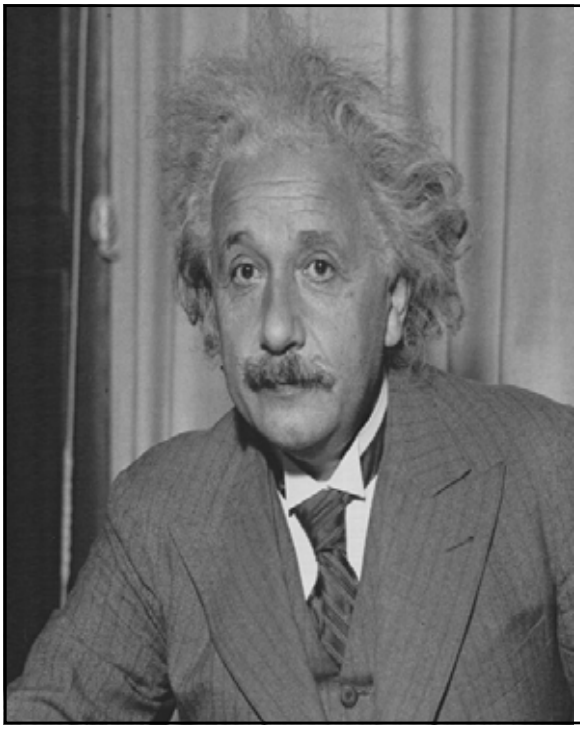
Did you know?

- Researchers estimate that one in five Canadian adults will personally experience a mental illness during a one-year period (Health Canada, 2002).
- In a study of Ontarians with depression, it was found that more than half did not receive any form of treatment or intervention (Parikh et al., 1999).

Where do people get help?

- In a study of Ontarians, over 60% of people who reported a psychiatric disorder said they had received their mental health care from their family physician, often with no involvement from other mental health care providers. (Parikh, et al., 1997)
- Other data indicate that up to 70% of all visits to primary health care providers involve mental health problems. (Craven et al, 1997)
- primary care providers may not have adequate knowledge, skills or time to provide mental health care.
- primary care providers have difficulty accessing mental health specialist assistance.

Canadian Collaborative Mental Health Initiative



“Insanity is doing things the way we’ve always done them, and expecting different results”

Primary Health Care Transition Fund

PHCTF Goals

- More PHC Organizations providing comprehensive services to populations
- Emphasize health promotion, disease prevention
- Emphasize chronic disease management
- 24/7 access to care
- Multidisciplinary teams
- Facilitate co-ordination and integration with other health services
- Emphasis on collaboration

What is the Goal of the Canadian Collaborative Mental Health Initiative?

To improve the mental health and well-being of Canadians by **strengthening the relationships and improving collaboration** among health care providers, consumers, families and communities.

Canadian Collaborative Mental Health Initiative 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

How is Canadian Collaborative Mental Health Initiative going to meet its goal?

Promote and enhance collaborative mental health care (CMHC) through three project deliverables:

1. Analysis of the Current State of Collaborative Care
2. Strategies to Address Barriers
3. Charter

Analysis of the Current State of Collaborative Care

Research Papers

Collaborative Mental Health Care Framework
Key components of collaborative mental health care initiatives and the contexts influencing their implementation.

Advancing the Agenda
Key barriers to collaborative mental health care and potential strategies to address these barriers.

Policy Review
Primary health and mental health care reform in Canada in relation to the promotion of collaborative mental health care.

Review of Selected International Initiatives
Mental health policy in relation to collaborative mental health care and examples of collaborative initiatives in selected countries.

Review of Canadian Initiatives
Description and analysis of collaborative mental health care initiatives in Canada.

Interprofessional Education
Emphasis on collaborative mental health care approaches and skills in pre- and post-licensure programs and in consumer and family organizations.

Aboriginal Populations
The adaptability of collaborative mental health care to the needs of aboriginal peoples in Canada.

Health Human Resources
Challenges facing health human resources in collaborative mental health care.

Annotated Bibliography
The extensive and growing literature on collaborative mental health care.

Current State of Collaborative Mental Health Care
Overview of the research collected by the Canadian Collaborative Mental Health Initiative.

Identifying Best Practices
Key components of successful collaborative mental health care initiatives based on evidence research.

Review of Mental Health Service Utilization
A review of mental health services utilization, by profession, across Canada, using CCHSI data.

What is Collaborative Mental Health Care?

Range of practice models that:

- ***Involves consumers*** and their ***family/caregivers, health care providers*** from both the mental health and primary health care sectors – each with different experience, training, knowledge and expertise;
- ***Promotes*** mental health and provides more coordinated and effective services for individuals with mental health needs;
- ***Works in a range of settings*** including community health centres, the offices of primary health care providers (e.g., family physicians, nurse-practitioners), an individual's home, schools, or community locations, and
- ***Varies according to the needs and preferences of the individual, and the knowledge, training and skills of the providers***.

The Evidence Base

- Benefits of Collaborative Mental Health Care occur at three levels:
  - **Consumer**
  - **Local provider and community**
  - **Broader health system**

The Evidence Base

- At the local provider and community level, benefits of CMHC include:
  - **Quality of care is improved** as primary care providers focus more on the functional status of consumers vs. symptoms only
  - Family physicians are well-placed to provide **continuous long-term follow-up**
  - General **efficiency of the system is improved** as it reduces difficulties associated with referrals between practitioners
  - Transfer of knowledge between providers is increased
  - Primary care provider confidence and **job satisfaction is increased**

The Evidence Base

- At the broader health system level, benefits of CMHC include:
  - Opportunities for **prevention** (in both primary and mental health care) are increased
  - **Earlier access** to care for both physical and mental health problems is promoted
  - Costs are not increased
  - Scarce health human resources are deployed more efficiently
  - Potential to achieve parity between mental disorders and other health/illness conditions = **reduced stigma**

Analysis of the Current State of Collaborative Care

What have we learned so far?

- all provinces and territories have formal or informal policy related to reforming primary care and mental health care
- these policies don't always address CMHC
- all provinces and territories have/are creating some form of local primary care initiative that includes mental health or recognizes the need for collaboration
- health human resource related legislation is being revised in supportive ways, but more needs to be done including alternatives to physician fee-for-service payment
- the use of information technology to support CMHC is increasing but needs to be expanded

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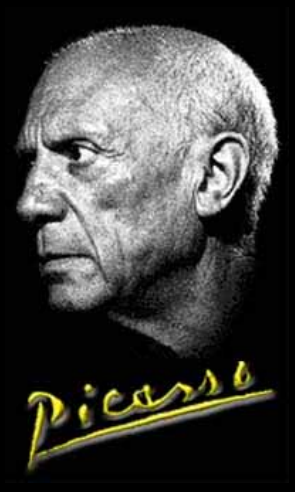
Key Learnings - International

- there is increasing international CMHC using a variety of approaches
- the jurisdictions in which CMHC is most in evidence are those in which there is supportive and explicit government policy – e.g., Australia, New Zealand, the Netherlands and the U.K.
- CMHC in these jurisdictions still face primary and mental health care provider shortages, funding challenges and underdeveloped interprofessional education/training.



Minor artists borrow ideas…
Great artists steal them

Pablo Picasso

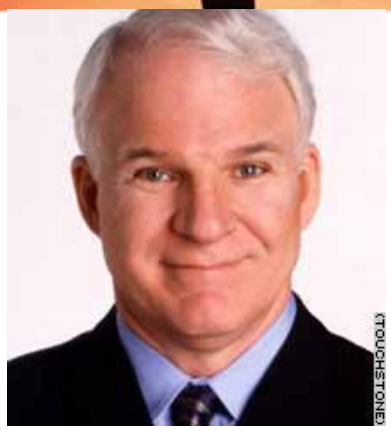
Strategies to Address Barriers

- Toolkits
  - Implementation
  - Consumer
  - Policy
  - Education
  - Research

Framework for Collaborative Mental Health Care

Chronic Disease Management in Collaborative Mental Health Care

- Practical application of concepts of recovery
- Shared care
  - Interdisciplinary collaboration
- Consumer participation
  - Self-management
  - Engagement in program design, evaluation



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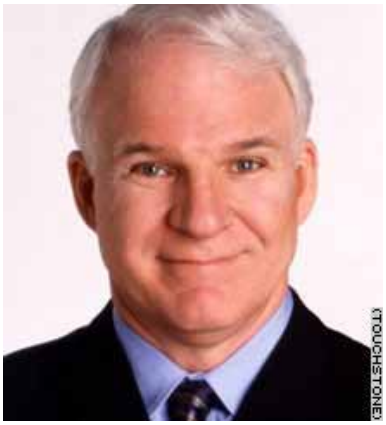
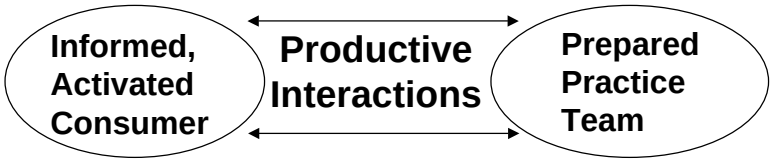
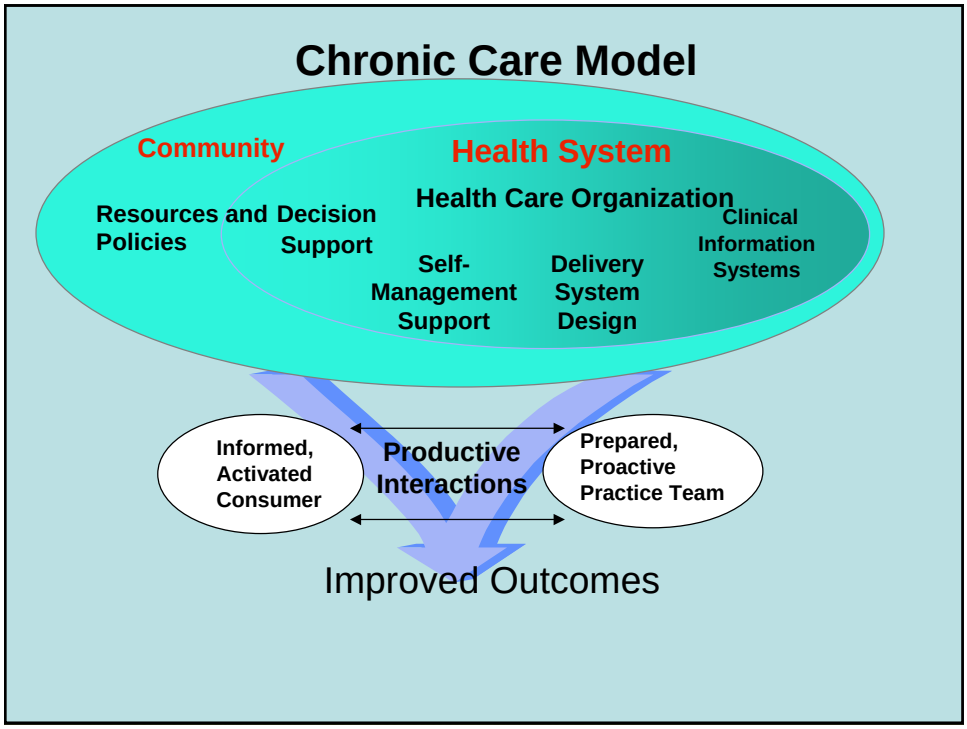


Picasso at the *Lapin Agile*

-Steve Martin

Essential Elements of Good Chronic Illness Care




Chronic Care Model
Community
Health System
Health Care Organization
Resources and Policies
Decision Support
Clinical Information Systems
Self-Management Support
Delivery System Design
Informed, Activated Consumer
Productive Interactions
Prepared, Proactive Practice Team
Improved Outcomes


Self-Management
Reading materials
Manual-based therapy
Peer support
Web sites
Self-monitoring
Exercise programs
Lifestyle changes
Personal goals
Partners in decision making
Responsible for implementing goals
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Features of case management / care navigation

- Regularly assess disease control, adherence, and self-management status
- Either adjust treatment or communicate need to primary care immediately
- Provide self-management support
- Provide more intense follow-up
- Provide navigation through the health care process
- Monitor individuals over time

❖CDM in the UK *Improving Chronic Disease Management*

Key approaches to managing chronic disease

Self-care & self-management
- Involving patients in their own care
- Minimizing unnecessary visits and admissions
- Providing care in the least intensive setting

Disease management
- Multidisciplinary teams
- integrating specialist and generalist expertise
- Evidence-based care (pathways, protocols)

Case management
- Identifying patients with chronic disease
- Stratifying patients by risk
- Co-ordinating care

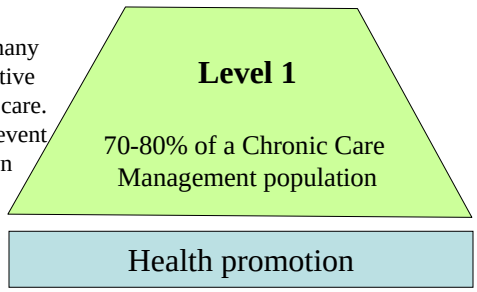
Knowledge management
- Use of information systems to access data on individuals and populations

Supporting people to take an active role in managing their own care

Helping people to manage their specific conditions, and to adopt approaches that prevent these conditions from getting worse.

Population management

With the right support, many people can learn to be active participants in their own care. This can help them to prevent complications, slow down deterioration.



Health promotion

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Population management

Disease/care management – Multidisciplinary teams provide evidence-based care – protocols, pathways, patient registries, care planning, shared electronic health records

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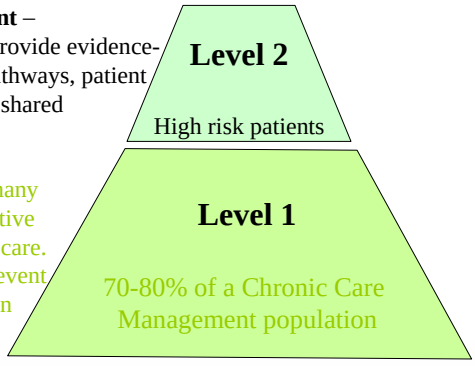

Health promotion

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Population management

Case management
As people develop multiple conditions (co-morbidities), their care becomes disproportionately more complex.

Disease/care management – Multidisciplinary teams provide evidence-based care – protocols, pathways, patient registries, care planning, shared electronic health records

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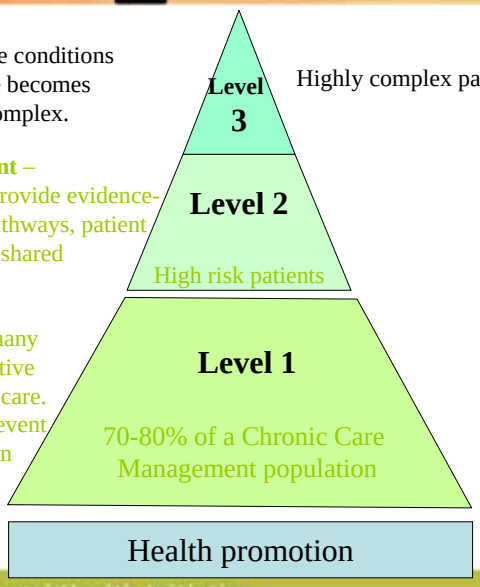

CDM in Mental Health Care

- *MacArthur Initiative on Depression and Primary Care*

Step 1 Recognition & Diagnosis	General impression or patient self-identifies, screening tools, formal assessment, confirm diagnosis.
Step 2 Patient Education	Clinician and staff educate the patient about depression and the care process, engage the patient and determine patient preference for treatment
Step 3 Treatment	Clinician and patient select an approach for treating depression: ❖Watchful waiting with supportive counseling ❖Antidepressant medication ❖Referral for psychological counseling ❖Combination: antidepressant / counseling
Step 4 Monitoring	Clinician and staff monitor compliance with the plan and improvements in symptoms/function; modify treatment as appropriate.

New Perspective for the Management of Chronic Conditions*

1. Well-defined care plan
2. Patient self-management
3. Scheduled follow-up visits
4. Monitoring outcome & adherence
5. Step-by-step treatment protocols

Longitudinal perspective, with an emphasis on prevention
- •Preventing the occurrence of chronic conditions in the first place
- •Preventing predictable complications of chronic conditions

Innovative Care for Chronic Conditions (ICCC) Framework, as described in *Preparing a health care workforce for the 21st century: the Challenge of Chronic Conditions*, World Health Organization 2005

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Reconceptualization of patient care requires a new set of competencies.

- complement existing competences (e.g. evidence-based and ethical care)

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Core competencies for caring for patients with chronic conditions

1. **Patient-centred care**
   - Interviewing and communicating effectively
   - Assisting changes in health-related behaviours
   - Supporting self-management
2. **Partnering**
   - Partnering with patients, other providers, communities
3. **Quality improvement**
   - Measuring care delivery and outcomes
   - Learning and adapting to change
   - Translating evidence into practice
4. **Information and communication technology**
   - Designing and using patient registries
   - Using computer technologies to communicate with partners
5. **Public health perspective**
   - Providing population-based care
   - Systems thinking
   - Working across the care continuum
   - Working in primary health care-led systems

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Chronic Disease Management in Collaborative Mental Health Care

- Chronic Disease Collaborative Initiative,
  Vancouver Island Health Authority, Victoria, BC

  Goal:
  - To enhance the family physicians' ability to treat depression, not only with medications, but also with self-management and patient empowerment strategies

  Description
  - 2 teams of psychiatrists, therapists provide outreach to FPs
  - Staff developed a manual to be used by FPs in designing treatment for their patients – based on CBT, patient self-management & empowerment methods

  Resources
  - Family Physicians, Psychiatric Nurse, Psychiatrist, Therapist, Social Worker

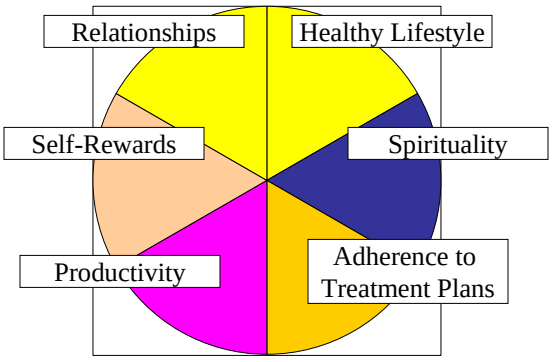
Mental Health Self-Management

Mental Disorders Toolkit: ***Information and Resources for Effective Self-Management of Mental Disorders***

BC Partners for Mental Health & Addictions Information

- an Introduction to Self-Management
- Making Sense of Your Disorder
  - What is psychoeducation?
  - Understanding mental disorders
  - How do I know if I need help?
  - Consumer (and family)-oriented treatment guides
- Becoming an Active Partner
- In Treatment: Shared Decision-Making
- Developing an Early Warning System and Action Plan
- Assessing Your Need for Other Self-Management Resources

Self-Management Goals



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WORKING WITH YOUR MENTAL HEALTH TEAM

Canadian Collaborative Mental Health Initiative's Toolkit for Consumers, Families and Caregivers

- **Diagnosis and Medication**
- **Sources of information** from people who have "been there"
  - such as Learning about Schizophrenia: Rays of Hope (www.schizophrenia.ca); Beyond the Depths of Depression (www.mooddisorderscanada.ca
- **Your team**: description of roles of various health professionals
- **Recovery**: Educating yourself and your professional team about recovery goal setting
- **What you can do to help yourself**: Self management, peer support, alternative therapies. To tell or not to tell? Some coping skills. The role of spirituality.
- **Culturally safe mental health care**:
- **Caregivers** – what helps, what doesn't. How caregivers, themselves need support. Sites and resources for caregivers (www.ontario.cmha.ca/families).
- **Getting involved**: The many ways you can become part of a collaborative care project including governance (defined and described), service planning, participating in evaluation and research etc.

Advantages of a General System Change Model

- Applicable to most preventive and chronic care issues
- Makes it easier to think about the health of populations
- Once system changes in place, accommodating new guideline or innovation much easier
- Fits well with other redesign initiatives
- Approach is being used comprehensively in multiple care settings and countries

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Some General Observations

- Primary Health Care requires strengthening
  - Particularly in the management of chronic conditions
- Mental health is an important element of primary health care
  - Mental illness is largely characterized by chronic conditions
- Collaborative mental health care looks a lot like CDM
  - Consumer engagement
    - Self-management
  - Interdisciplinary collaboration
    - Focus on learning
  - We have a lot to learn from each other.