

Ensuring Primary Health Care in the Mental Health Care Setting: A Multi-Disciplinary Approach

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Overview of Presentation

- Describe the process and outcomes of integrating primary health care strategies within an active mental health care organization.
- Summarize current literature pertaining to primary health care in the mental health care setting.
- Describe clinical examples that illustrate how a collaborative approach provides a solid foundation for tailoring client care for clients with mental illness, and to identify and overcome common challenges that may be experienced.

Background

- Persons with mental illness and/or homeless (or at risk) experience poor physical & mental health outcomes
 - limited health care access
 - often considered “difficult to serve”
- Housing instability, chronic substance use, and cigarette smoking can exacerbate mental and physical health problems

Serious Mental Illness (SMI)

- Life expectancy reduced by 25%
- Higher risk of hypertension, respiratory illnesses, chronic infections
- Obesity 3.5 x higher
- Diabetes >2.5 x higher (25-33% undiagnosed)
- Cardiovascular disease 2 x higher
 - Women with depression are 80% more likely to have heart disease

Tobacco and SMI

- 75% of people with SMI smoke (Lawn, 2008)
- 40-50% of cigarettes smoked by SMI
- People with SMI are half as likely to quit
- 3/4 want to quit – same as general population
- One out of every two mentally ill smokers dies of tobacco-related illnesses (Els et al., 2008)
- Tailored Community-Based Program
 - success rate similar to rates for other smokers
 - no untoward effects on mental illness (Currie et al., 2008)

Diagnostic Overshadowing

- Physical symptoms misattributed to mental illness without sufficient assessment (Jones et al., 2008)
- SMI less likely to receive screening, preventive care, and treatment (Druss et al., 2002)
- Access to PHC is top unmet need for people with SMI (Bédard et al., 2007)

Barriers to Health for SMI

- Limited income, therefore limited food choices and living environments
- Difficulty navigating multiple services
- Stigmatization, marginalization, access
- Clinicians have limited time, and limited experience and training in psychiatry
- Little information sharing among providers

Action is Needed on Multiple Levels:

- Structured system for recording metabolic monitoring and collaboration with family physicians, psychiatrists, and specialists
- Supportive environment addressing determinants of health

Integrated Care Models

- Improved addiction outcomes when integrated with quality PHC (Kim et al., 2007)
- Integration of mental health and diabetes services would result in improved outcomes (Goldberg et al., 2007)
- All providers must have and document clearly defined responsibilities

**“It’s time we put the head
back on the body.”**

Michael Kirby, 2008

Care Delivery Models

1. Primary care embedded in program for people with SMI
 - integrated care, single treatment plan
2. Unified mental/ primary health programs
3. Mental health professionals located in PHC setting (Co-location, eg: Smith, 2007)
4. Collaboration between separate agencies

Bazelon Centre, 2004

CMHA Ottawa: The View from Inside

- **Mission:** To offer opportunity and support for individuals with mental health issues so that they may achieve meaning and success and improve their level of functioning in the environment of their choice
- We deliver recovery-focused, evidenced-based integrated services for people with both a serious mental illness and complex needs

Programs and Services

- Case Management and long term Community Support
- Hospital Outreach
- Court Outreach
- Housing Outreach
- Concurrent Disorders
- Brokerage Services
- Dialectical Behavioural Therapy
- Wellness Recovery Action Planning
- Vocational Support

Population Served

Individuals who:

- Have severe and persistent mental illness
- Experience homelessness or are at risk of homelessness
- Have co-occurring substance use disorders
- Are in conflict with the law
- Have co-occurring developmental disability
- Have complex primary care needs

Population Served

938 clients with SMI

- 123 Bipolar disorder
- 142 Depression
- 342 Schizophrenia
- 84 Schizoaffective disorder
 - 279 smoke
 - 43 use alcohol
 - 92 use cannabis
 - 79 use cocaine
 - 33 opiates and unspecified

Population Served

559 reported an Axis III

- Diabetes I & II
- Heart Disease
- HIV/AIDS
- Hep C
- IBS
- Obesity

CMHA Setting

- 32 Community Support Workers
- 23 Outreach
- 6 Addiction Workers
- 4 Dual Diagnosis Specialists
- 4 Intake Staff
- 3.5 RNs, 1 PHC Nurse Practitioner
- 9 hours/ week Psychiatrist

Integrated Health Services

- **2004** - added multi-disciplinary support (in house): psychiatry, psychology, RN, OT & RT
- **2007** - funding lost for psychology, OT & RT, added Vocational specialist
- **2008** - added a Primary Health Care Nurse Practitioner

Email 3/30/09
From Our Receptionist

Hi Everyone:

I just received a call from a Dr. _____
regarding "taking new patients". He
cannot accommodate us anymore as he is
not able to treat the type of issues our
clients have.

Challenges

- High level of complexity →
– "rejected" from "doctors accepting new patients"
- PTSD → Reluctance to have procedures
- Symptoms that mimic mental illness
- Low level of trust in fragmented services
- Homelessness, no ID, OHIP or address

Challenges

- Clients may need more support to follow-up on doctor's orders
- Health care professionals need more education regarding SMI
- Psychiatrists, dietitians, physical activity programs usually not connected with PHC facility
- Need for assertive case management and system navigation

Shared Care

- Complex clients are often assessed and followed by psychiatrist and all nurses
- Nurse Practitioner does physical assessments, writes prescriptions, orders and interprets diagnostic tests
- Diverse population = Diverse response

New Initiatives

- In-house assessment and health promotion clinics
- Healthy food and cigarette policies
- New community partnerships
 - diabetes educators, CHCs, Public Health, Ottawa Inner City Health

- Diabetes self-management programs tailored to SMI
- Integrate health promotion activities within DBT/ CBT to encourage consumers to take charge of their health (McIntosh, 2008)
- Expand WRAP (Wellness Recovery Action Plan) to address consumer-generated goals for physical well being

Education for CSW's

- “Red flags” to report to the nurse or family doctor, when to call 911
- Health Fair - metabolic syndrome topics
- Smoking cessation - brief interventions
- Bi-Monthly info sessions
 - Eg: Infection topics, respiratory illnesses, CPAP, diabetes

Case Study: Jennifer

- 55 year old with history of depression, diabetes type 2, rheumatoid arthritis
- Government employee x 20 years, let go on disability due to lack of hygiene and absenteeism
- CMHA worker met client in shelter
- Obtained housing December 2008
- One month later, client refusing to answer door, apartment full of garbage, feces and urine in bathroom and on bed

Where do we go from here?

- Develop structured health promotion programs (eg. smoking cessation/ reduction program)
- Link with other organizations in Ottawa for proposal for Family Health Team or NP-Led Clinic
- Champlain LHIN Integrated Health Service Plan 2010 – 2013
 - Targeting: diabetes, mental health, addictions, frail population

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