Interprofessional Progress
Psychiatry

- GP: 1978 – 84
- Psychiatrist 1984 – present
- Environmental characteristics
- Hospital based with emerging (failing) community orientation
- No free standing CMH organizations
- Wide gap between family physicians and psychiatry
- Hierarchical structure/ physician centered/ biomedical model (idealized but impractical biopsychosocial approach [Engel’s])
- Primarily psychotherapeutic approach with imminent explosion of neurobiological/ pharm approach
- Far less pharmaceutical industry influence and funding
- DSM III - in its infancy

Interprofessional Mental Health Care Progress

- Knowledge of mental illness in primary care and development of primary care based research was just beginning (Goldberg/ Shepherd)
- Family physicians were frustrated with their lack of training to deal with the mental illness they saw in their practice
- This was why I left family practice to remain in psychiatry
- My idea of practicing primary care psychiatry in 1984 was minimized to “an interesting hobby” by my colleagues
- It was thought by psychiatry that family physicians did not see “real” mental illness but cared for the “worried well”
- Other professions in mental health were subservient to psychiatry
- Psychiatrists were not seen to be “real Dr’s. ( I was told by my colleagues that I was ‘wasting my skills’ when I left FM to start psychiatry
**Progress in Interprofessional Collaboration**

- I am the “boss”… “top of the heap”….. “expert” (but I learn from and rely heavily on family physicians, nurses, social workers, occupational therapists, psychologists etc….how does that work?)

- All mental health / mental illness knowledge originates from THE GOD OF PSYCHIATRY

- I will see your patient now (and give him/her back when I feel like it….don’t call me, I’ll call you (maybe?)

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**Interprofessional Care Progress**

- **Late 1980’s:**
  - Explosion in biological approach to mental illness with exponentially increasing influence from pharmaceutical industry/drug trials
  - Increased training of family medicine trainees in primary care aspects of mental health/illness
  - Increased complaints from GP’s re gulf between themselves and mental health care for their patients
  - DSM IV; explosion of psychiatric diagnoses and “scientific” approach to diagnoses (not used by GP’s or other MH professionals
  - Strong antipsychiatry movement which intensified tensions between increasingly visible “other” mental health professionals and psychiatry (biomedical model in early decline)

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- I am missing the “person” (is it patient or client or consumer)
- What happened to talking and listening

- What about their life problems, housing, families, supports, work, life stories

- Where did the “art” go…my soul has been misplaced

- What!!?? I only see 20 -30 percent of the mentally ill in the community!??
Interprofessional Progress
Psychiatry

• 1992: first position paper by joint national collaborative mental health care committee (Nick Kates/ Marilyn Craven) identifying major problems in the fragmented approach to mental health care
• Focus on psychiatrists and family physicians with the aims being increased communication, improved access and improved knowledge exchange
• Primary Care Reform gathers steam: family physicians are listened to
• Ditto for other mental health care professionals and organizations
• Increased presence of Shared Care in the mainstream psychiatric literature with numerous pilot projects across Canada/ strong influence from UK where primary care based mental health was ahead of us
• Major shared projects in Ontario (Hamilton), Nova Scotia (Halifax) and Alberta (Calgary)
• Mental illness begins to be recognized as world public health problem

• Is anybody listening to me…I am the Dr. after all
• There is more than one way to deliver mental health care???
• Maybe these family physicians and all those other people can teach me something.
• Hey! Maybe a Team!!!
• You want me to see how many patients????!! You want to watch me work????

Interprofessional Progress
Psychiatry

• Increased presence in community of Community Mental Health Agencies with ++ antipathy between them and psychiatry
• Increased awareness of "recovery" model "demedicalization" of mental health care
• Hospital emptying and bed cutting in mental health in full swing; homelessness explodes
• Addictions and mental health care are "worlds apart"
• Now we have DSM IV; more diagnoses; industry has "moved in" we are increasingly reliant on them for funding/ education/ research
• Psychotherapy in psychiatry is manualized and dying ("can't get a free dinner talking about that stuff")
Progress in Collaboration Psychiatry

- 2000
  - marked increase in collaboration clinically, educationally, in research and care planning
  - Community mental health agencies become a fact of life
  - Collaborative care models explode in numbers, models, sizes
  - Nurse practitioners increase visibility in primary care
  - I am working regularly in family physicians offices
  - Increased awareness and reliance on multidisciplinary teams for community based mental health care
  - Family Health Teams arrive in Ontario (2005)
  - Addictions and mental health finally lay down the hatchet and begin sitting
  - CANMEDS 2000: clinical expert (consultant), communicator, collaborator, manager, health advocate, scholar, professional

CanMEDS 2000: my goodness am I supposed to be all that?!?!
OMG....there aren't enough of us! Help!!
This is fun!!! I have so many more friends at work!
I am beginning to feel really valuable
What the heck does Collaboration and Interprofessional mean??
Am I using all my skills or just becoming a consult machine?
Where does all this fit with the hospitals and emergency rooms and specialties...are we with or against each other

Progress in Interprofessional Collaboration Psychiatry

- Present Day
  - My department has recently moved toward making collaborative IP care the central approach to implementing psychiatric care in the community
  - Collaboration now (potentially) includes all the players in mental health care delivery and we are reaching out to develop working relationships with them
  - collaboration is infiltrating education in medicine and health sciences
  - Shared care psychiatrists are still uncommon the gulf between psychiatry and other professions is still wide but we have begun to swim toward each other
  - Opportunities for knowledge exchange are increasing exponentially
  - I am still puzzled and searching for an understanding of what mental health is for an identity and clear job description
  - Money appears to be drying up just as we are getting rolling
  - I am hopeful!
Progress in Interprofessional Collaboration

Family Physician

- Academic family medicine was in its infancy; I graduated in the second FM residency program in 1973.
- I was in a teaching unit; psychiatrist who "lived" down the hall; a really good addictions worker; we made relationships with them.
- There was not a "model" of mental illness in primary care and very little literature…we just did it; we collaborated but we had to go and find it ourselves.
- I was not aware of DSM I or II.
- We have always been networkers and brokers of community services.
- Far less psychopharmacology; I don’t think that we knew too much about what psychiatrists did in their offices; we thought it was strange.
- I was trained in inpatient psychiatry; not very relevant to what I would do in practice.
- I learned most of my mental health care knowledge in practice.

- I learned from other GP’s; I don’t think that most psychiatrists had much understanding of what I did but our psychiatrist did; he was very rare; he had been a family physician himself.
- The first time I thought about psychiatry in family practice: Michael Balint (The Dr, His Patient and His Illness).
- I didn’t hear about “Shared Care” till late 1990’s; first thought about applying it in about 2000 when the opportunity became a possibility.
- Off and on over time I had relationships with nurses, public health nurses, social workers, etc. who did mental health care.
- I worked in CMHC with nurses doing MH care in the 1970’s; joint house calls/psychosocial assessments.
- I felt constantly out of my depth; much more so than now with the presence of other professionals within my “team.”

- I moved to rural family practice in 1997.
- Part of a Primary Care Reform Pilot Project with 5 other rural practices.
- I remember hearing one of my young colleagues fighting to get a patient with psychosis seen.
- Accessing psychiatry was next to impossible; it made my heart sink when I had to do it.
- I felt almost completely on my own with a wide variety of really hard problems… I really missed the academic medicine and access to psychiatry (for which we paid by seeing some of their very complex patients).
- When I worked with CPSO I worked with GP Psychotherapy groups teaching them boundaries, etc. No interface with psychiatry.
**Progress in Interprofessional Collaboration**

**Family Physician**

• We began a collaborative relationship with a psychiatrist in 2002
• With the collaborative model I can get help when I need it
• I feel better about starting the process with my mentally ill patients
• I have more confidence in my own skills; I don’t feel out on a limb; less likely to feel out of my depth.
• I feel I have a conduit to the generic mental health service
• I have seen the growth of CMH services; they now come to my office; mental health workers, psychogeriatric clinician
• We have formalized our relationship with mental health and other professionals; we feel like we are weaving a net work.
• It is what we have always done but we have more willing partners now. The learning goes in both directions and the mutual respect is more evident.

**Social Worker**

**Beyond Multidisciplinary Referral Toward Interdisciplinary Care**

• The change has been toward strong and persistent advocacy for consumers and their families
• Decrease in “culture of the expert” and increased recognition of the importance of lived experience of mental illness and the process of recovery
• Increased awareness of social determinants of mental illness and their influence in the recovery process
• FHT’s further emphasize that mental illness is a chronic disease and that management, self care, support are more likely than “cure”
• Increased recognition of the importance of “Networks and Linkages” among formal providers and inclusion of community supports outside the formal “mental health care system”

**Implications for Consumers**

• Joint responsibility of tertiary and primary care providers in collaboration and improved access to MH care
• Improved communication (and understanding) amongst various mental health professions based on personal relationships around patient care
• More equal contribution of more professionals in the recovery process
• Increased inclusion of consumer, families and community supports in the collaborative recovery process
• Serving people where they live

**Implications for Providers**

• Reduced isolation and improved mutuality and support
• Attitudinal shift toward mutual trust for all colleagues’ contributions to improved outcomes for individuals, families and supporters
• More face to face contact amongst professionals potential for closer relationships
Progress in Interprofessional Collaboration

Social Worker

- Silos and Solitudes 1970's and early 1980's
- Traditional, hierarchical multidisciplinary relationships
- Culture of "the expert"
- Prescriptive referral process
- Primacy of psychopharmacology in treatment of mental illness
- Huge communication and understanding gulf between psychiatrists, family physicians and community service providers
- Implications for Consumers:
  - Barriers to accessing service and care/ lack of systemic community service/ falling through the cracks
  - People lost social roles, meaningful occupation, income support, housing, family and social relationships
- Implications for Providers:
  - Isolation/ shouldering burden of care alone/ often out of our depth

My Present Job: Specialized Mental Health Rural Outreach Worker

- Provide direct specialty services
  - Intake and triage
  - Assessment
  - Time limited treatment
  - Shared care/ direct collaborative relationships with other community based professionals
  - Linkage and access to specialty services
- Community Development and Education
- Collaborative Program Development

Nursing Evolution: Diploma to Baccalaureate to NP

- RN: Hospital based 2 Years
  - Provide physical care
  - Focus on the environment
  - Dependent
  - Follow orders
- BScN: University 4 years
  - Assessment
  - Critical thinking
  - Evidence based
  - Patient advocate
Progress in Interprofessional Collaboration
Nurse Practitioner

• NP- PHC: Master’s 2 years
• Improve patient’s access to care
• Manage care
• Collaborate
• Independent, interdependent
• Diagnose, prescribe, order diagnostic tests