10th Annual Collaborative Mental Health Care Conference

Hamilton 2009

Inteprofessional Collaboration in Mental Health Care

A Historical Prospective

Joseph Burley
Susan Ablack
Laurel Dempsey
Brenda Bonner
Lisa Smith
Alan Mathany

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
  - - heirarchical structure/ physician centered/ biomedical model (idealized [but impractical] biopsychosocial approach (Engels)
  - - primarily psychotherapeutic approach with imminent explosion of neurobiological/ pharm approach
  - - far less pharmacuetical 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 retrain 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
- Psychiatrist 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)

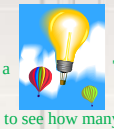
Interprofessional Care Progress

- **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)

- 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

- **1997:** 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 MH 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 multidisicplinary 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 talking.
- 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 subspecialties….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 careknowledge in practice

Progress in Interprofessional Collaboration
Family Physician

- 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 MHC 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"

Progress in Interprofessional Collaboration
Family Physician

- 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 vey 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

Progress in Interprofessional Collaboration
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 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"

Progress in Interprofessional Collaboration
Social Worker

- **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, heirarchical multidisciplinary relationships
- Culture of "the expert"
- Prescriptive referral process
- Primacy of psychopharmacology in treatment of mental illness
- Huge communication and understanding gulfs between psychiatrists, family physicians and community services 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

Progress in Interprofessional Collaboration Social Worker

- **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

Progress in Interprofessional Collaboration

- 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**