

# **The Evolution of Collaborative Mental Health on P.E.I.**

**Experience, Good Practice, and Design**

**National Collaborative Mental Health Conference June 2013**



# Sharing our experience

- Learning objectives:
  - Describe the evolving continuum of mental health services as an example of an integrated system of mental health care
  - Overview of the planning approach and mechanisms for building a collaborative service approach
  - How clinical tools were applied in this planning process: blending art and science



# Disclosures

- **Relationships with commercial interests:**
  - **Bell Let's Talk Fund- grant for training to provide Cognitive Behavioural Interpersonal Skills Manual**



# Context for change: driving the need for integrated and collaborative care

## ■ A little bit about PEI

- Population of 146, 000
- Fastest projected population growth is in those aged 65+ (22,223 in 2010 < 40,226 in 2030)
- Working age population peaked in 2011 and will continue to drop substantially- where prevalence rates for mental health conditions are highest
- In 2011, PEI had Canada's third highest rate of current smokers at 19.1%
- Between 2000 and 2006 there were 842 new cases of diabetes diagnosed
- In 2009/2010 30% of the Island population reported a chronic condition (national average is 28%)
- 5 million opioid pills were prescribed in 2012/13
- High utilization of existing MH & A services proportional to population
- Mental health and addiction conditions accounted for 8.9 % of admissions and 15.1% of all acute care bed days (2010-2011)

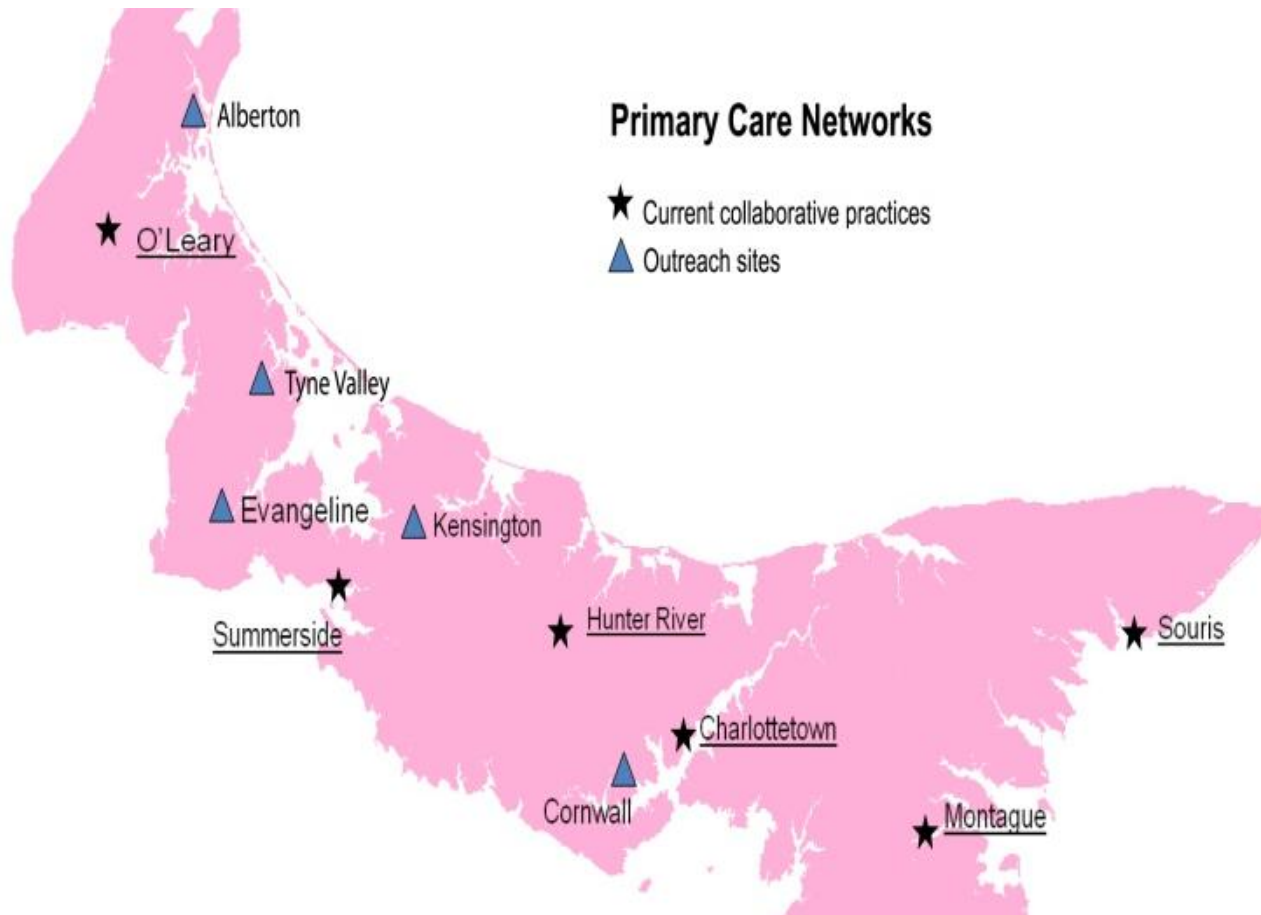


# Primary Care Network Development

- Formally established in 2011, previous iterations dating back to 2000
- Creating service hubs in five geographical catchment regions, organized under one health authority (Health PEI)
- Service hubs are intended to establish improved access to primary health care services and improved linkage to ambulatory care
  - In addition to MH, strategic improvement focused on COPD, Hypertension, INR, Minimal Intervention, and soon work will begin on Obesity



# Primary Care Networks

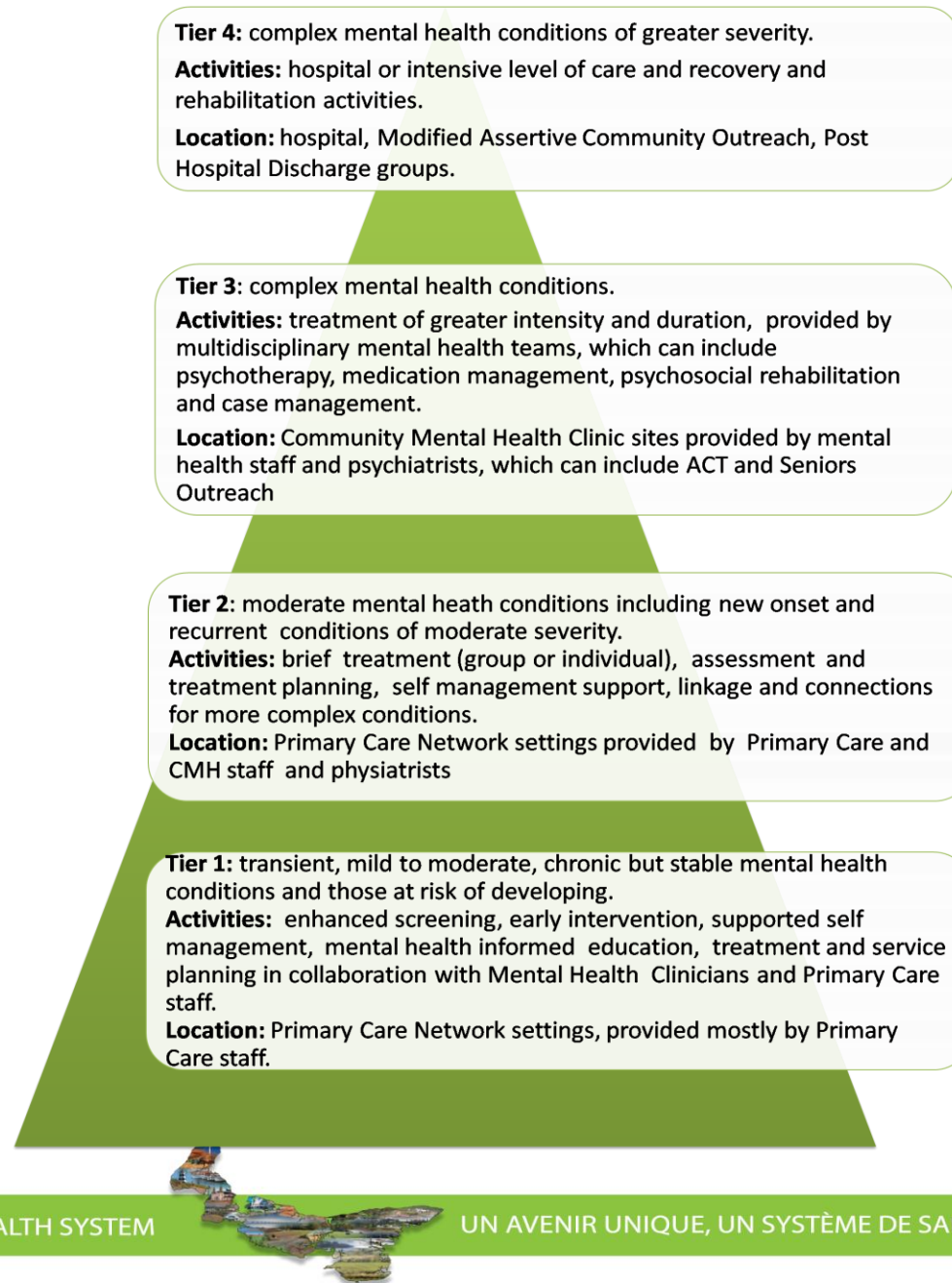


# Mental Health and Addiction Services

- Before 2011, CMH&A operated with one provincial manager, but addictions and mental health planning and operations largely separate
- February 2011, hospital based and community based mental health services, joined with Addiction Services, and medical leadership to form one integrated continuum of MH&A services
- An evaluation completed in 2013 (data gathered in 2012) identifies areas for continued improvement including improved integration and equitable distribution of resources
- The mandate to formally expand mental health services into primary care given in 2011



# Framework for the Expanded Mental Health Services Continuum





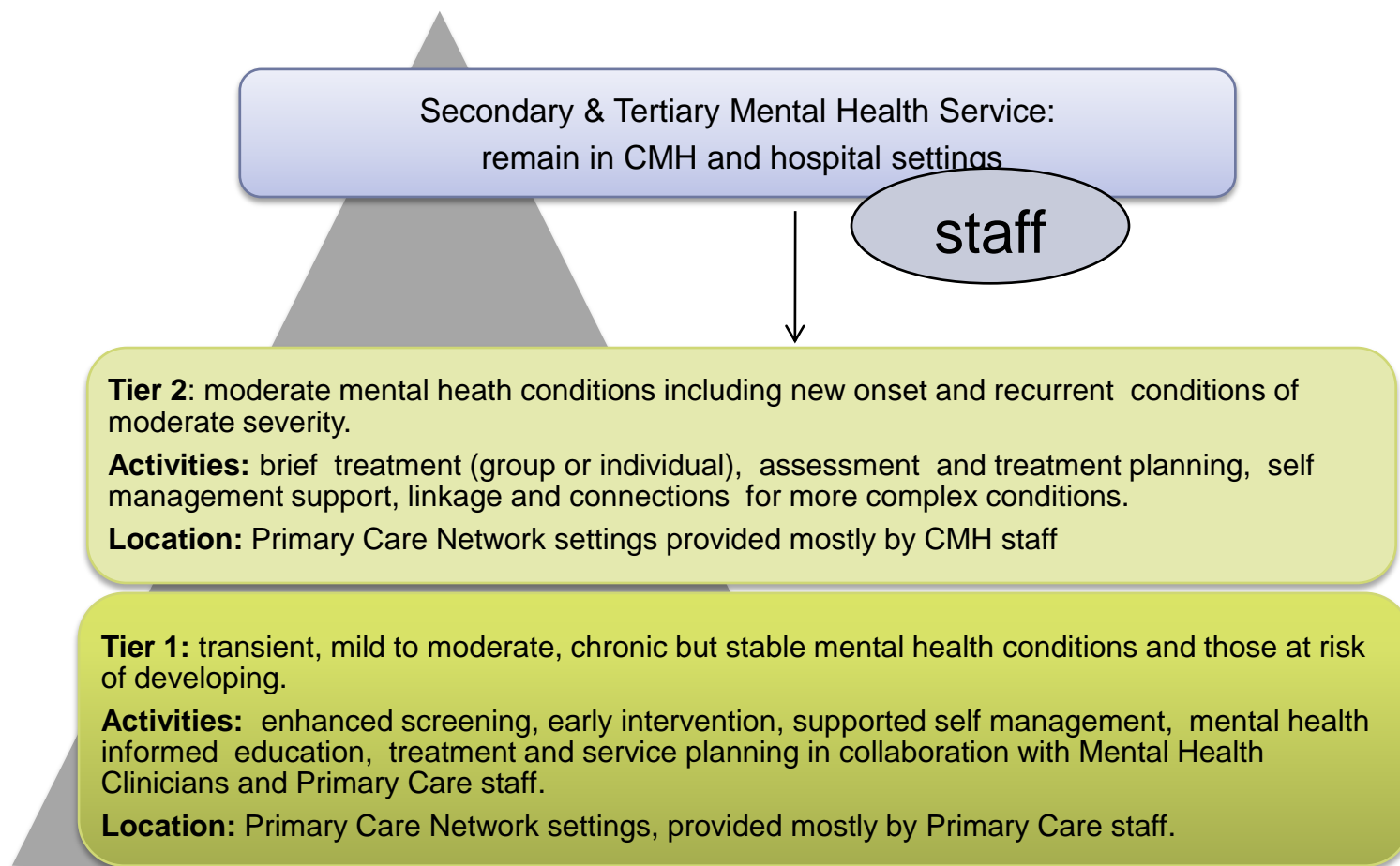
# History of Collaborative MH:

Learning from our past experiences:

- Direct physician access: family physician/ pediatrician refers to psychiatry- increased points of access
- Visiting clinician provided to (Family) Health Centers: Four Neighborhoods, Hunter River/ Rustico, and Cornwall with limited capacity building focus
- O'Leary Health Center: co-location of mental health staff with no clear plan



# Building a Primary Health, Collaborative Mental Health Service



# Collaborative MH in Primary Care

- Building on our past experiences:
  - Build the expectation and ownership to provide and support lower threshold care by non-mental health clinician: build in screening in CD management, provide learning events, support integration into practice, embed preventative mental health care in to health practices including
  - Clarify roles: Build relationship
  - Space, staff , and roles need to be defined
  - Principles need to be clear



# Collaborative MH in Primary Care

- Building on our past experiences:
  - Create predictable access
  - Provide common tools and guidelines to support common language, role and activity differentiation, to create a structure
  - Good infrastructure needs to be in place before delivery of service
  - The perils of co-location: clinician 'walk down the hall' rather than 'walking the client down the hall'; referral versus consultation



# Using the 'Evolution of Collaborative Mental Health Care in Canada' (2011) as a guide:

- Build on personal contacts- within a supportive structure
- Base on respect, trust, recognition of potential roles and contributions
- Base on effective practices, evidenced and experienced based
- Be responsive to changing needs
- Shaped by local context and culture
- Relevant and responsive to local resource availability



# **We needed a planning approach: the Framework development**

- Formation of the Collaborative MH working group
- Involves Primary Care and MH Program Development Leads, PC & MH Managers, Clinical Practice Leaders, Physician
- Clinical and consultative activities defined
- Clarifying roles, expectations, capacity, aligning with best practice and experiential knowledge
- Expected outcomes: set of steps and resources to plan for priority activities, generic care pathway to assist with decision making, clear mechanism for easy access, shared access to group programming, and psycho-educational tools, learning opportunities with supports built into structure/ processes, opportunities to share clinical wisdom



# Sample of Roles

- LPN - Assisting team; administer screening tools, initiate assessment tools with patients, gather relevant health information as reported to share with physician
- RN - Explains planned treatment options and provides education, engages in goal setting, implements treatment plan, assess ability and readiness to self-manage, counsel or referral, encourage compliance with medication, support through care and case management and coordination for low threshold conditions.
- Physician/NP - Diagnosis, medication initiation, treatment, and management, refer for education about depression & care process, shared care, or referral for counseling and relevant programming, establishes treatment goal/ plan.
- MH Clinician - Takes referrals from health centre, contributes to case management of client goals, shares treatment strategies, supports learning through formal and informal methods, provides time limited therapy, assessment, case management or other forms of intervention.
- Psychiatry - Direct and indirect consultation to assist with assessment, treatment planning, and initiation of medication. Provides time limited direct care, advice in a collaborative primary care setting (which includes CMH and Primary Care). May offer formal and informal learning opportunities.



# Shared Learning Opportunities

- MHFA: focusing training on administrative, LPN, and clinical leads
- Cognitive Behavioral Interpersonal Skills Manual, an organized approach to depression and anxiety, to support self management and treatments in primary care settings: wide scale and targeted training
- Introduction of the Nice Guidelines for Common Mental Health Disorders: guidance for appropriate types of interventions and competency needs
- 'Evolution' Position Paper: framework of what activities are best position in primary versus secondary care, shifting some work to another setting (brief counseling), and creating some new activities (screening and education)
- MH learning component at each Spring Into Action (e.g.)
- Informal case based learning
- Lunch and learns and shared psycho-education sessions planned





# NICE Guidance for Common Mental Health Disorders

CommonMHDIsordersPathway.pdf - Adobe Reader

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## The stepped-care model

A stepped-care model is used to organise the provision of services and to help people with common mental health disorders, their families, carers and healthcare professionals to choose the most effective interventions. The model presents the key interventions from this guideline. For recommendations focused solely on specialist mental health services see related NICE guidance (page 22).

Focus of the Intervention	Nature of the Intervention
<b>Step 3:</b> Persistent subthreshold depressive symptoms or mild to moderate depression that has not responded to a low-intensity intervention, initial presentation of moderate or severe depression; GAD with marked functional impairment or that has not responded to a low-intensity intervention; moderate to severe panic disorder; OCD with moderate or severe functional impairment; PTSD.	<b>Depression:</b> CBT, IPT, behavioural activation, behavioural couples therapy, counselling <sup>2</sup> , short-term psychodynamic psychotherapy <sup>2</sup> , antidepressants, combined interventions, collaborative care <sup>3</sup> , self-help groups. <b>GAD:</b> CBT, applied relaxation, drug treatment, combined interventions, self-help groups. <b>Panic disorder:</b> CBT, antidepressants, self-help groups. <b>OCD:</b> CBT (including ERP), antidepressants, combined interventions and case management, self-help groups. <b>PTSD:</b> Trauma-focused CBT, EMDR, drug treatment. <b>All disorders:</b> Support groups, befriending, rehabilitation programmes, educational and employment support services; referral for further assessment and interventions.
<b>Step 2:</b> Persistent subthreshold depressive symptoms or mild to moderate depression; GAD; mild to moderate panic disorder; mild to moderate OCD; PTSD (including people with mild to moderate PTSD).	<b>Depression:</b> Individual facilitated self-help, computerised CBT, structured physical activity, group-based peer support (self-help) programmes <sup>3</sup> , non-directive counselling delivered at home <sup>4</sup> , antidepressants, self-help groups. <b>GAD and panic disorder:</b> Individual non-facilitated and facilitated self-help, psychoeducational groups, self-help groups. <b>OCD:</b> Individual or group CBT (including ERP), self-help groups. <b>PTSD:</b> Trauma-focused CBT or EMDR. <b>All disorders:</b> Support groups, educational and employment support services; referral for further assessment and interventions.
<b>Step 1:</b> All known and suspected presentations of common mental health disorders.	<b>All disorders:</b> Identification, assessment, psychoeducation, active monitoring; referral for further assessment and interventions.

<sup>2</sup> Discuss with the person the uncertainty of the effectiveness of counselling and psychodynamic psychotherapy in treating depression.  
<sup>3</sup> For people with depression and a chronic physical health problem.  
<sup>4</sup> For women during pregnancy or the postnatal period.

6 NICE clinical guideline 123

Quick reference guide

Common mental health disorders

The stepped-care model

start

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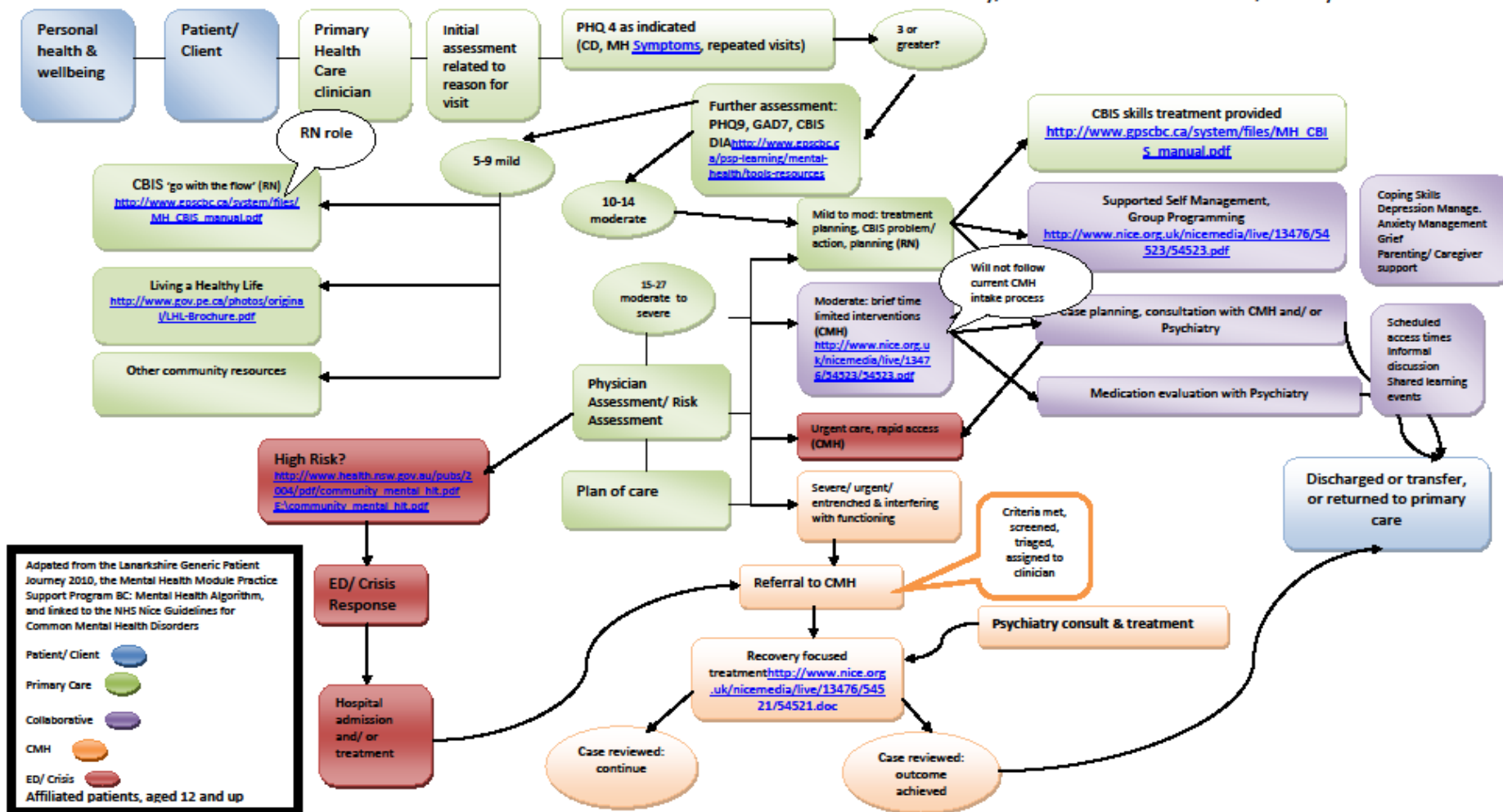
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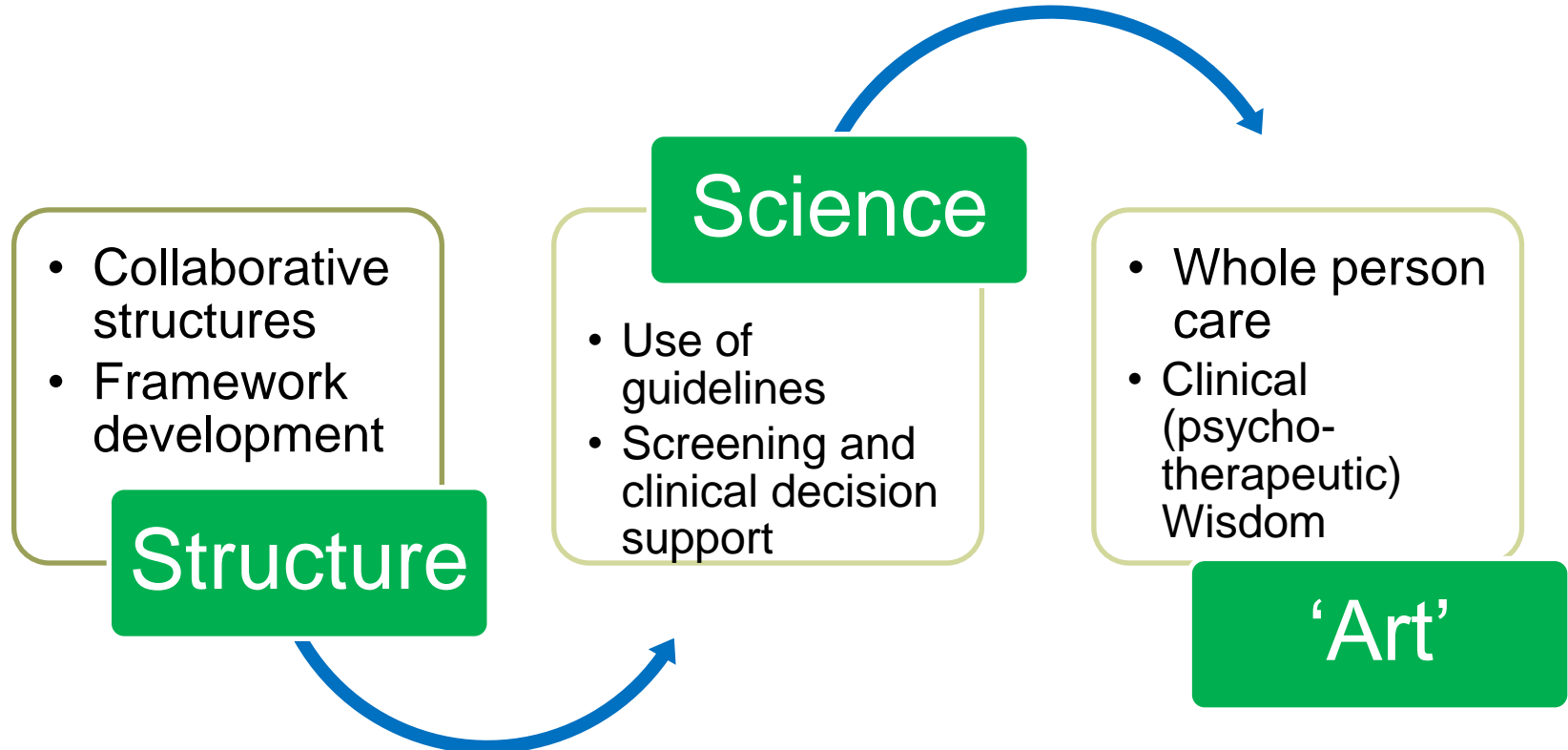
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# Generic Care Pathway: Pulling it all together

Draft Generic Care Pathway, Collaborative Mental Health, January 2013



# Complementary nature of evidenced based medicine and clinical wisdom



# Narratives of Clinical Wisdom

- Creative technique and pushing treatment limits
- Wise listening
- Humility, kindness and humor
- Pearls of wisdom
- Appeal to paradigm cases
- Mentors and mentoring



# Clinical Wisdom is...

- Pragmatic
- Balanced
- Paradoxical
- A manner of being



# What is happening now:

- Implementation expected in October 2013 for Kings Collaborative MH
- Currently expanding West Prince Collaborative MH
- Re-profiling position in East Prince Network to plan for implementation
- Continue learning and support to Primary Care Clinicians through use of CBIS and shared learning
- Continued negotiation with psychiatry to provide services



# References:

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