



**CANADIAN MENTAL
HEALTH ASSOCIATION, ONTARIO**

**ASSOCIATION CANADIENNE
POUR LA SANTÉ MENTALE, ONTARIO**

Mental Health, Mental Illness & Chronic Disease Prevention & Management in Ontario

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Overview of Presentation

1. CDPM in Ontario
2. What is the Fit with Mental Health/Illness
 1. Mental health in CD prevention
 2. SMI as a chronic disease
 3. Risk of MI in people with chronic conditions
 4. Risk of chronic conditions in people with SMI

(What is happening in the health system in each area)
3. Diabetes & Serious Mental Illness
4. Recommendations from a primary care/ mental health/ diabetes cross-sectoral think tank.

Chronic Disease – why is it a concern now?

Chronic Disease - the Issue

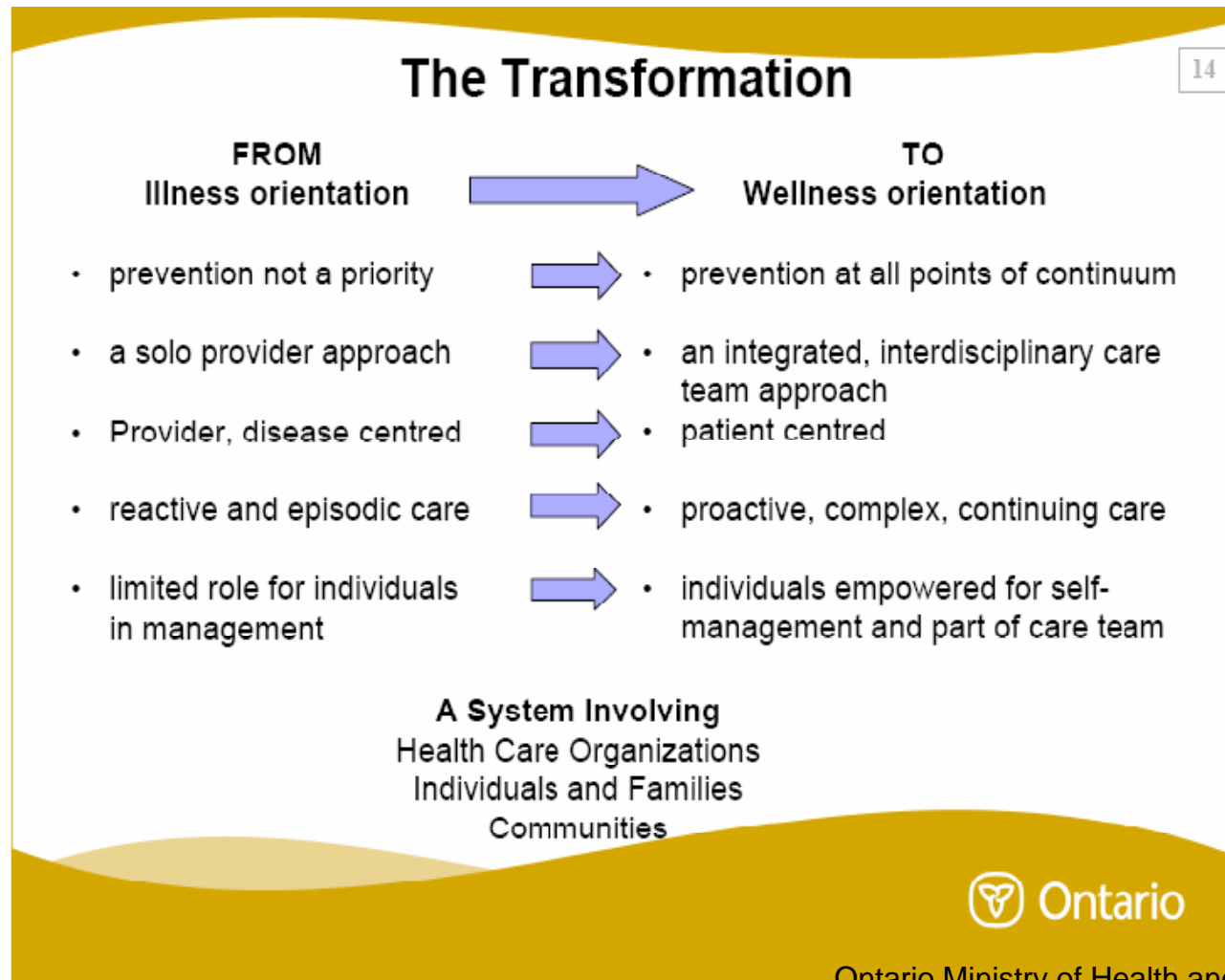
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- Ontario - economic burden of chronic disease estimated at 55% of total direct and indirect health costs (EBIC 2002)
- Almost 80% of Ontarians over the age of 45 have a chronic condition, and of those, about 70% suffer from two or more chronic conditions (CCHS 2003)
- Left untreated, chronic diseases like diabetes and depression are causally related to other diseases
- Yet...the current system is designed to treat and cure acute illness, not prevent nor manage chronic illness



Ontario Ministry of Health and Long-Term Care

Health system shift: from acute to chronic illness



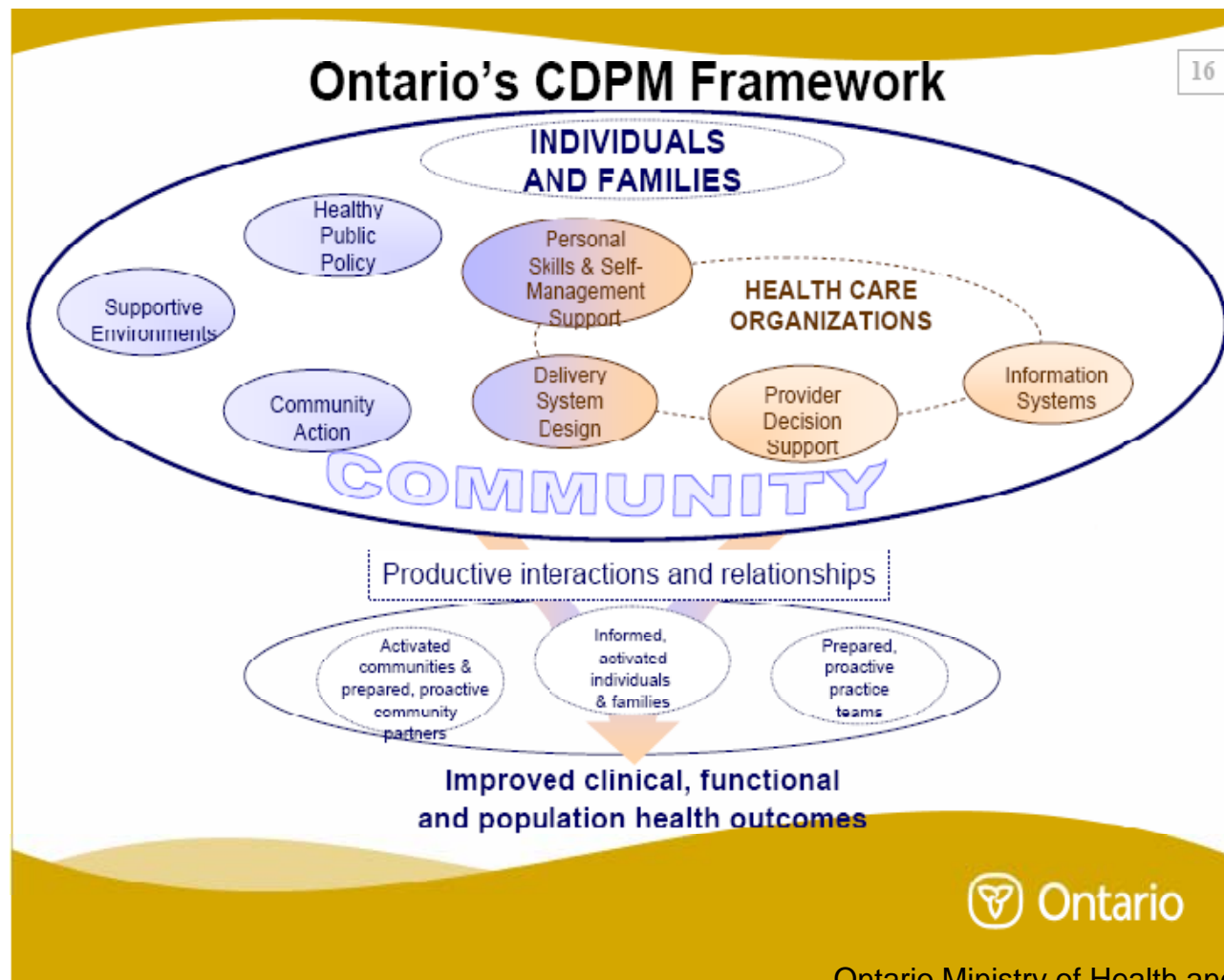
Ontario Ministry of Health and Long-Term Care

Why Chronic Disease Needs a Different Approach

	Acute Condition	Chronic Condition
BEGINNING	Rapid	Gradual
CAUSE	Usually One	Many
DURATION	Short	Indefinite
DIAGNOSIS	Identify Cause (one)	Multiple, Interacting Influences
DIAGNOSTIC TESTS	Often decisive	May Not Be Useful, Imprecise
TREATMENT	Cure; treat cause	Manage symptoms, prevent, cope
ROLE OF PROFESSIONAL	Select & Conduct Therapy	Teacher & Partner
ROLE OF PATIENT	Follow orders	Partner with health professionals, responsible for daily management

(Slide courtesy of Joan Canavan, Ministry of Health and Long-Term Care)

Chronic Disease Prevention & Management



Ontario Ministry of Health and Long-Term Care

Four aspects to the relationship between MH, MI and CD

- 1. Poor mental health is a risk factor for chronic physical conditions.**
2. Mental illnesses can be perceived as chronic illnesses
3. People with chronic physical conditions are at risk of developing mental health problems
4. People with serious mental illness frequently have co-existing chronic physical conditions.

Preventing Chronic Disease – how does mental health fit?

- A healthy state of well-being includes the whole person – body and mind.
- Many initiatives to promote physical well-being also promote mental health.
- To be effective, however, chronic disease prevention must recognize the interaction between physical and mental wellness and find ways to consciously address it.

Common Sense reasons to address MH in CDP

Action on both physical and mental health is:

- **Effective:** What's the point of improving people's physical health if they are miserable? Well-being includes both mind and body.
- **Efficient:** What 's the point of reducing health care costs on the physical side, while costs escalate on the mental side?
 - Depression will rank second only to heart disease as the leading cause of disability worldwide by the year 2020 (WHO)
 - Mental health claims (especially depression) have overtaken cardiovascular disease as the fastest growing category of disability costs in Canada

Relationship between poor mental health & CDs

- High comorbidity and inter-relatedness
- Biochemical relationship
 - anxiety and depression impact immune system
 - impact brain chemistry that may be related to CDs
- Self-care
 - Impacts your ability to do the things that keep you healthy:
 - Sleep
 - Exercise
 - Eating
 - Social engagement and involvement in life
- Communication
 - Impacts ability to communicate physical needs and health problems

What can be done about mental health as a risk factor for CD?

1. Address the socioeconomic conditions that promote mental health
2. Improve people's understanding of mental health, mental illness and how to get support.
3. Improve access to depression screening and early intervention.
4. Reduce stigma.

1. Address the socioeconomic conditions that promote mental health

- In particular,
 - Social inclusion,
 - freedom from discrimination/violence, and
 - access to economic resources
- evidence that action in these 3 areas improves mental health

(*Mental Health Promotion: A Call to Action*, November 2008

http://www.ontario.cmha.ca/policy_positions.asp?cID=25899)

2. Improve people's understanding of mental health, mental illness and how to get support.

- If people can't recognize the signs and symptoms of mental illness, they won't seek help
- Three key aspects to mental health literacy:
 - **Education** about mental health, mental illnesses, maintaining mental health, preventing problems
 - **Information** about how to get support
 - **Support for skill development and empowerment** so that people can take action with this knowledge

(See *National Integrated Framework for Enhancing Mental Health Literacy in Canada Final Report*, July 2008

<http://www.camimh.ca/files/literacy/CAMIMH%20MHL%20National%20Integrated%20Framework%20July%202008.pdf>)

3. Improve access to depression screening and early intervention.

- Guidelines and tools exist for screening and managing depression in primary care
 - Not always linked to CDPM
 - Not always implemented
- Evidence-based protocols and tools must be developed and integrated into prevention and management of CDs at all levels of health care
- Screening is inappropriate and unethical if follow-up and treatment are not available

4. Reduce the stigma of mental illness.

- Self-stigma => resist seeking help
- The judgements, attitudes, behaviours of health care providers are also a barrier
- Stigma of health care providers a major issue identified by people with mental illness & a priority for Mental Health Commission of Canada

(See MHCC's operational plan for reducing stigma, Sept. 2008 at <http://www.mentalhealthcommission.ca/SiteCollectionDocuments/Anti-Stigma/Operational%20Plan%20SD%202008%20sept2908.pdf>)

How can stigma be reduced?

- Three aspects: **knowledge, attitude and behaviour**, a.k.a. ***ignorance, prejudice and discrimination***
- Requires both **education** (to dispel commonly held myths about mental illness) and **contact with people with mental illness**
- **Education + positive contact => attitudes and behaviour change for the long-term**

(Mental Health Commission of Canada, 2008)

2. What is happening in Ontario re: incorporating MH into CDP?

- Ontario Chronic Disease Prevention Alliance (OCDPA)
 - Disease and HP orgs “thinking like a system”
 - Common messages on healthy eating, active living, tobacco, alcohol and mental health as risk factors.
 - Common messages for mental health are:
 - Address socioeconomic conditions that promote mental health
 - Improve people’s understanding of mental health, mental illness and how to get support.
 - Improve access to depression screening and early intervention.
 - Reduce stigma.
 - Education and strategizing on integration of mental health into CDP – think tank and follow up action

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Are mental illnesses chronic diseases?

- Chronic disease literature includes mental illnesses as chronic diseases
- However, in mental health field, serious mental illnesses are not framed in terms of chronicity or management but in terms of recovery
- So is a CDPM approach appropriate for people with serious mental illnesses?
- CMHA Ontario has some concerns but also sees some opportunities

Risks of a CDPM orientation for serious mental illness

- SMI used to be seen as a chronic condition
 - People defined by their illness
 - Perceived as chronically disabled
 - “Treatment” and “management” of illness/symptoms was the focus
 - Consumers fought hard to move from “chronicity” to “recovery”

How are serious mental illnesses different from chronic physical conditions?

- Early onset and episodic nature of illness
 - ⇒ Disrupts education, employment, relationships
 - ⇒ Disempowerment, poverty, isolation
- Recovery involves restoring all these losses,
 - + Inclusion in community life
 - + Self-determination
 - + Improved mental health

Recovery & CDPM

“If mental illnesses are linked to a chronic disease framework, it will be important that the meaning and value of recovery remains clear, and the broader foundations for support that promote recovery remain in place. Thus, the label “chronic” is, at best, nuanced and must not subsume hope of a way forward for people living with serious mental illnesses.”

(What is the Fit Between Mental Health, Mental Illness and Ontario’s Approach to Chronic Disease Prevention and Management, August 2008
http://www.ontario.cmha.ca/admin_ver2/maps/cmha_chronic_disease_discussion_paper.pdf)

Congruence between CDPM and MH

- Although there are dangers in seeing mental illnesses as “chronic”, as “diseases”, as something to be “managed” rather than as long-term episodic illnesses that one can recover from, the CDPM model has been used successfully in primary care to improve depression.
- There are also features of the CDPM model that are part of the way mental health services are already organized.

CDPM as a tool for depression treatment

Tools of CDPM have improved treatment in PHC settings.

- Structured diagnostic assessment
- Care plan
- Evidence-based treatment protocols
- Multidisciplinary team
- Psychiatric consults/visits
- Relapse prevention planning
- Education and support for people experiencing depression to manage their own mental health
- Proactive follow-up and monitoring
- Client information systems
- Ongoing training for providers

Congruence between CDPM and MH system

- Mental health services incorporate many of the features of the CDPM model
 - Multidisciplinary team-based care
 - Informed and activated individuals & families
 - Strong partnerships in the broader community involvement
 - Action on public policy, creating supportive environments to improve quality of life beyond health care system
 - Self- management support
 - Decision support and client information systems

Personal Skills & Self-Management Support

- Individual Takes Active Role:
 - Client-centred care – people set their own goals
 - Involve people in their care planning and delivery
 - Strengths-based approach
 - Support effective self care strategies that include assessment, goal-setting, action planning, problem solving and follow-up
 - Organize internal and community resources to support to people to meet their goals
 - Emphasize person's central role in managing their health and improving quality of life

Community Action, Supportive Environments, Healthy Public Policy

- Mobilize community resources to meet needs of people
 - Encourage people to participate in community programs
 - Partnerships with community organizations to support and develop interventions that fill gaps in services
 - Advocate for policies to improve care

Community Action, Supportive Environments, Healthy Public Policy

- Promote mental health in the community
 - Mental health education and awareness initiatives
 - In schools, workplaces, community settings
 - Sometimes targeted to vulnerable populations, sometimes for general community
 - Note: MH organizations not usually government-funded to do this, but raise funds to do this work

Community Action, Supportive Environments, Healthy Public Policy

- Action on factors outside the health care system that influence individual and community health
 - Support individuals to access housing, employment, income and social support
 - Strong advocacy role in local community and provincial: working partnerships with other stakeholders to deal with social and economic issues affecting quality of life and health status
 - Participation in health and social system planning, policy development

Individuals & Families as part of the system

- Volunteers, board members and peer workers in mental health organizations.
- Involved in system planning, design and delivery
- Consumer- Survivor Initiatives
- Family organizations

- Still a very small part of the system, but the role of consumers and families as more than recipients of services in individual care and in the system has been established

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People with chronic conditions often develop mental health problems

- 3X more likely to have a mental health problem
- Lower perception of overall mental health
- Often not recognized by health care providers
- Reduces motivation for self-care
- CD + MH problem = poorer physical health outcomes

CDPM and Depression in People with Chronic Conditions

Opportunities:

- Integrate depression prevention in care
- Involve regular screening as part of care
- Create self-help and support groups for people with the same chronic condition
- Provide depression education and self-management support

BC program to address mental health problems in people with CDs

- BC government funds a self-management support program for people with chronic diseases experiencing mild to moderate anxiety or depression
- The Bounce Back program offers two levels of a low-intensity, cognitive-behavioural intervention:
 - (1) psychoeducation provided through a DVD
 - (2) a guided, structured short-term self-help program available in manual and web-based formats.
Working in cooperation with primary health care providers and mental health specialists, community coaches provide motivational support, program instruction, and follow-up.

<http://www.cmha.bc.ca/services/bounceback>

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CDPM Disparities for Individuals with Serious and Persistent Mental illness (SPMI) ...

- Higher rates of COPD, breast, colon & lung cancer, stroke and heart disease.
- 2X greater cardio-vascular mortality rate (Dixon Et al , Schizoph. Bul, 26:903-912, 2000).
- 10 yr risk of coronary artery disease in individuals dx with schizophrenia is 50% higher for women and 34% higher in men compared to the general population. (Brown et al , J. Psychiatry, 171:502-508, 1999)
- **a 25 yr less life expectancy** (CDC, 2006).

(Slide courtesy of: Primary Care Diabetes Support Program)

Why the Disparity?

Under Diagnosis
&
Under Treatment

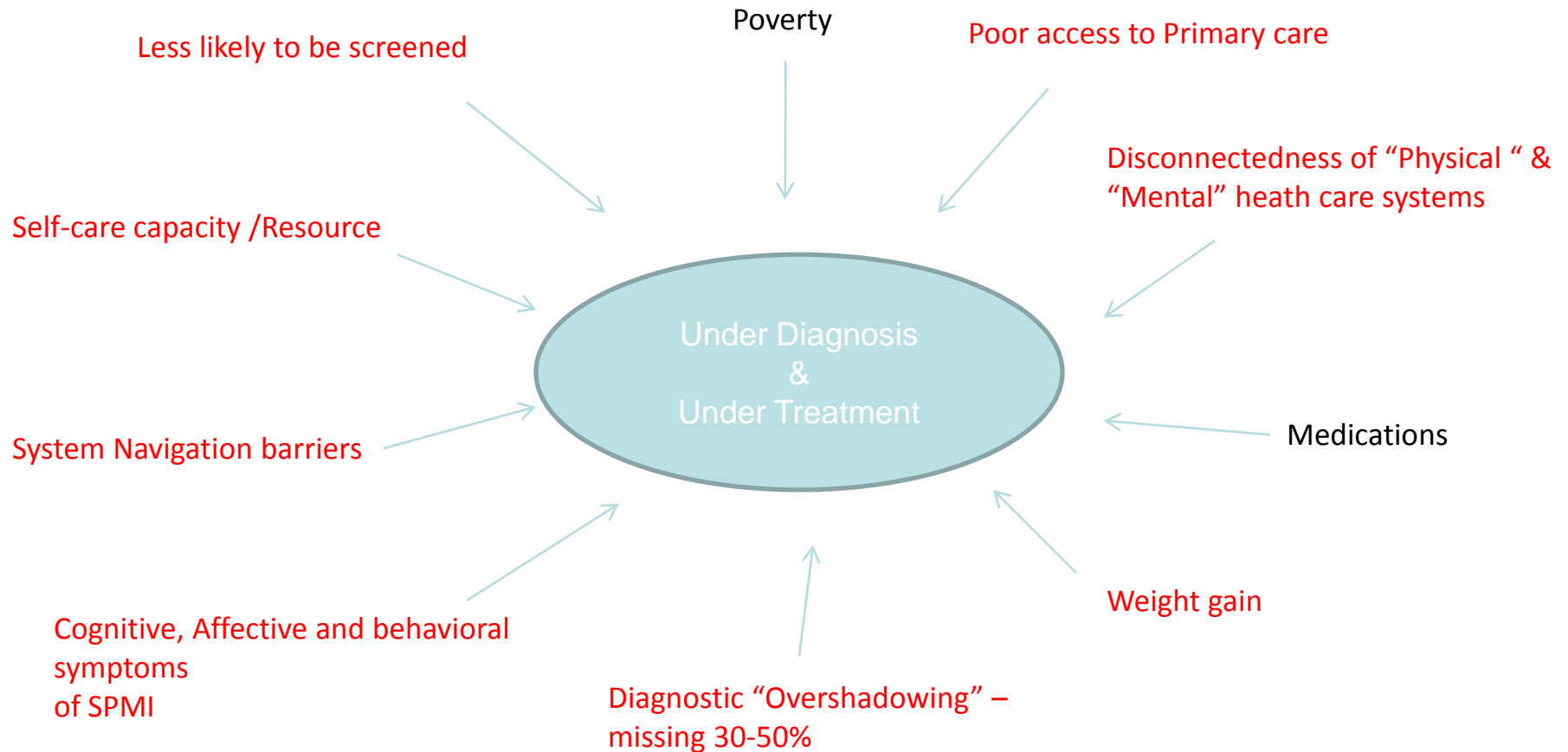
(Slide courtesy of: Primary Care Diabetes Support Program)

Disparity in Diabetes Burden for Individuals with SPMI...

- **Under diagnosed** - 25-33% incidence of previously undiagnosed pre-diabetes and diabetes in community based cohorts. (Schiz. Bul, 80:19-32, 2005).
- **Higher prevalence** - 2-4 times greater prevalence compared to the general population.(Schiz. Bul, 80:19-32, 2005).
- **Undertreated** - resulting in higher rates of diabetes- related complications on setting **sooner** (Brown Et al Br J Psychiatry, 177:2112-217, 2000; Osby et al , Schizophrenia Res, 45:21-25, 2000)

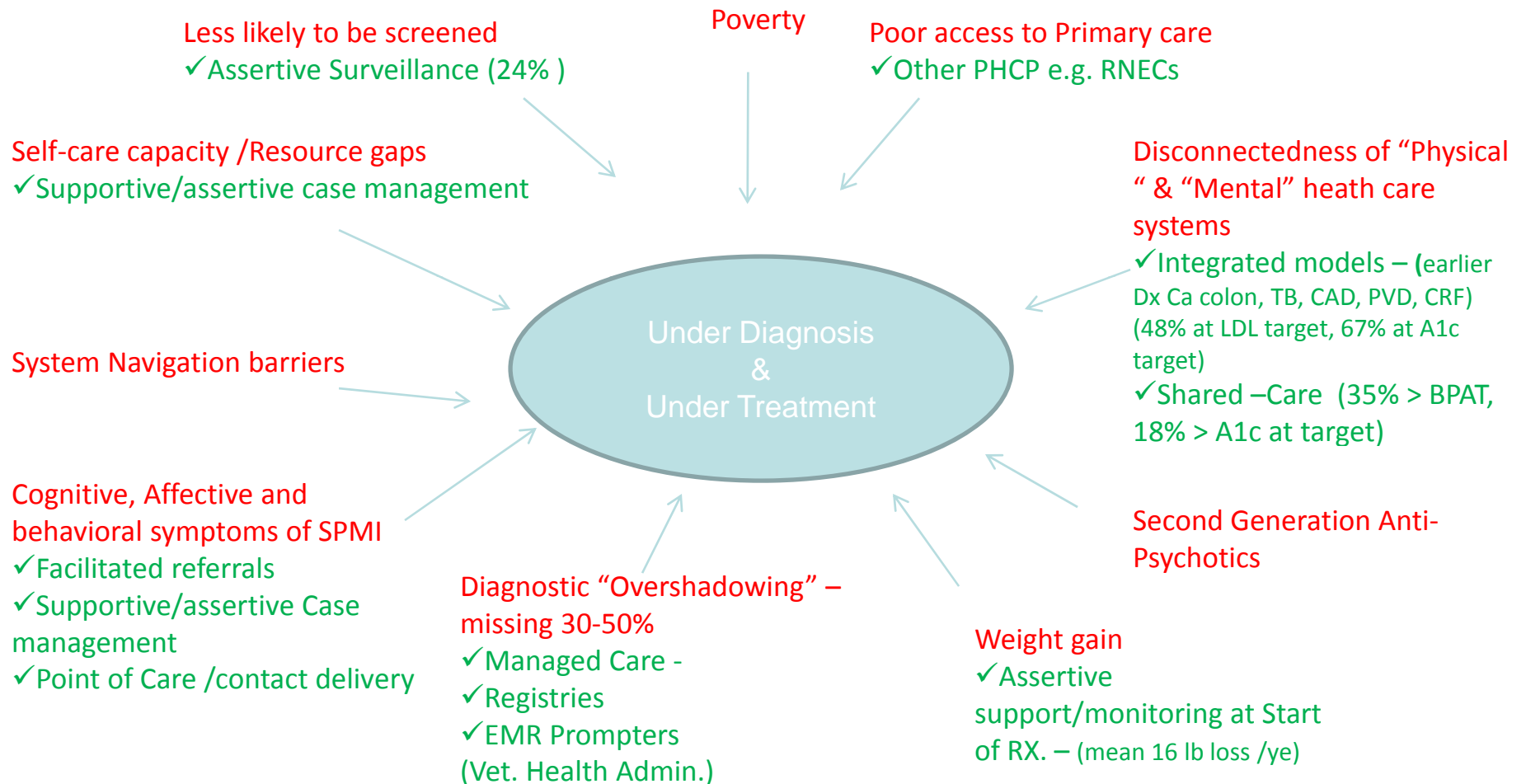
(Slide courtesy of: Primary Care Diabetes Support Program)

Why the Disparity?



(Slide courtesy of: Primary Care Diabetes Support Program)

Reducing the Diabetes Disparity?



(Slide courtesy of: Primary Care Diabetes Support Program)

What's happening in Ontario to address high rates of CD in people with SMI?

- MOHLTC rolling out CDPM framework starting with a provincial diabetes strategy
- CMHA Ontario think tank on diabetes and SMI with leaders in PHC, diabetes and mental health at provincial and local levels March 30, 2009
 - Think tank included organizations involved in innovative strategies
 - Report based on think tank with recommendations for future action

Strategies for improving diabetes prevention & management in people with SMI

1. Support knowledge transfer between the three sectors.
2. Assess risk for diabetes in everyone with SMI in mental health and PHC settings.
3. Support system navigation & incentives for collaboration
4. Make effective lifestyle/behaviour change/self-management support available
 - Long-term support for change
 - Integrate with peer support and social recreation programs
 - Recognize and address role of poverty

Training and Education Recommendations

- Identify core competencies
- Educate MH, Diabetes & PHC providers in core competencies appropriate to profession, setting and level of care
- Educate all three systems in each other's frameworks (CDPM, psychosocial rehab, recovery)
- Fund knowledge transfer between sectors and provide structures for supporting change e.g. QIIP, lead organizations in each LHIN, etc.

Supporting Collaborative Care

- Funding models and incentives to enhance collaboration across the three sectors
- Support more multi-disciplinary team-based primary care
- Increase efficiency of primary health care services (appropriate use of disciplines and specialists)
- Reduce disincentives for PHC to work with this population

Recommendations at system level

- Identify people with SMI as high-risk population for diabetes strategy
- Allocate specific funding at LHIN level
- Develop standards & benchmarks for DM & SMI
- Diabetes registry - Include data on this population for tracking and planning both provincially and locally
- Risk assessment & screening tools developed, standardized and integrated into PHC & MH
- Evaluate promising programs
- Inventory available programs, promising practices and health information and make info available through existing channels

For more info on the think tank and its recommendations

“Diabetes & Serious Mental Illness: Future Directions for Ontario” (Report from March 30, 2009 think tank on diabetes and serious mental illness)

http://www.ontario.cmha.ca/includes/collection/collection_page.asp?cID=135189

Promising collaborative initiatives

- WOTCH Community Mental Health Services, London
- Trillium Health Centre's diabetes program partnership with community mental health organizations, Etobicoke
- St. Joseph's Family Health Team, London
- Diabetes Education Community Network of East Toronto
- CMHA Sarnia
- Others?

Links and Contact Info

- CMHA Ontario's work on chronic disease, mental health and mental illness:
http://www.ontario.cmha.ca/policy_and_research.asp?cID=53904
- Barbara Neuwelt: bneuwelt@ontario.cmha.ca