SUPPORTING COLLABORATIVE CARE THROUGH MENTAL HEALTH GROUPS IN PRIMARY CARE

Hamilton Family Health Team

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About Family Health Teams

- Family Health Teams are a key piece of the Ontario provincial government's plan to build a health care system that promotes good health, reduces wait times and improves access to care. In Family Health Teams, family doctors work with other health care professionals such as nurses, nurse practitioners, mental health counsellors, dietitians and pharmacists to see more patients and to keep them healthy.

The Hamilton Family Health Team includes:

- 145 Physicians serving approximately 280,000 patients
- 135 Nurses and Nurse Practitioners
- 21 Registered Dietitians
- 73 Mental Health Counsellors
- 22 Psychiatrists
- 10 Pharmacists

Mental Health Program

- Many people will experience a mental health-related problem or mental illness at some point in their lives. The HFHT Mental Health Program brings mental health services into the offices of participating family doctors in Hamilton, Ontario. Family doctors, nurses, practice administrators, mental health counsellors and psychiatrists work together to help individuals, couples, and families with mental health-related problems.

The Goals of our MH Program

1. To improve access to mental health services in primary care
2. To expand the range of mental health issues seen in primary care
3. To increase collaboration between family doctors and mental health care providers
4. To increase family doctors' knowledge and comfort managing mental health issues
5. To strengthen links between all levels of the health care system
6. To support illness prevention and mental health promotion through education and advocacy

Improve access to mental health services in primary care

- As more services are offered in primary care, case findings are increasing
- As case findings increase, it is more difficult to meet the growing demand in primary care
- FPs are struggling to manage the large demand for mental health services in primary care

1. ISSUE----NOT ENOUGH MENTAL HEALTH SERVICES

Expand the range of MH issues seen in primary care

- As FPs begin to ask the questions, it becomes evident that it is necessary to provide a service response.
- Health care teams are better informed about mental health issues and how to use assessment tools.

2. ISSUE----SERVICE RESPONSE IS INADEQUATE

Increase collaboration between family doctors and MH care providers

- FPs generally are very appreciative of MH services provided by the HFHT
- When mental health issues arise, the team can refer to the MH counsellor or ask for a psychiatric consultation (HFHT services)
- Hamilton has many great community programs to refer to as well:
  - Community Psychiatric Services
  - Anxiety Treatment and Research Centre
  - Mood Disorders Program

3. ISSUE----MANY PATIENTS DO NOT MEET THE CRITERIA FOR COMMUNITY PROGRAMS

Increase FP's knowledge and comfort managing MH issues

- FPs supported by the HFHT are given opportunity to learn more about Mental Health and how to manage it in primary care, as well as when and how to refer to specialty programs.

4. ISSUE----FP DOES NOT HAVE THE TIME TO MANAGE ALL MENTAL HEALTH ISSUES ON HIS/HER OWN. WAITLISTS FOR MH COUNSELLORS, PSYCHIATRISTS AND COMMUNITY PROGRAMS ARE TOO LONG.

Strengthen links between all levels of the health care system

- Some patients need to go to specialty community services
  - They also will need to come back to primary care
- Some patients are accepted into specialty community programs but spend over a year on a waitlist
  - They need to be seen in primary care while waiting
- Some patients will not be accepted by specialty community programs
  - They need to be seen in primary care

5. ISSUE----NEED TO WORK COLLABORATIVELY WITH COMMUNITY PROGRAMS/HELP PATIENTS TRANSITION FROM PROGRAM TO PROGRAM

Support illness prevention and MH promotion through education and advocacy

- Need to offer services sooner and better

- Not good enough to begin work after years of undetected and untreated mental illness

6. ISSUE----PATIENTS WHO ARE NOT DIAGNOSED AND TREATED FOR MENTAL ILLNESS ARE HIGH USERS OF HEALTH CARE SERVICES

Can MH Groups Address Issues

1. ISSUE----NOT ENOUGH MENTAL HEALTH SERVICES

   Mental Health Counsellors' hours are based on rostered patients in the practice. Groups are a way to offer additional services.

2. ISSUE----SERVICE RESPONSE IS INADEQUATE

   This is not just an additional service; it is a different service that can meet other needs.

3. ISSUE----MANY PATIENTS DO NOT MEET THE CRITERIA FOR COMMUNITY PROGRAMS

   Our groups have more inclusive criteria, allowing for more individuals to participate.

4. ISSUE----FP DOES NOT HAVE THE TIME TO MANAGE ALL MENTAL HEALTH ISSUES ON HIS/HER OWN. WAITLISTS FOR MH COUNSELLORS, PSYCHIATRISTS AND COMMUNITY PROGRAMS ARE TOO LONG.

Groups afford us the opportunity to involve the whole practice team in delivering the mental health services. We educate the team on what our groups offer, how to refer individuals to group and we stay connected with the practice after the referral is made to let them know when or if the referral attends group. We send a follow-up form to the practice when group has been completed, enabling the practice team to support the work done in group.

5. ISSUE----NEED TO WORK COLLABORATIVELY WITH COMMUNITY PROGRAMS, HELP PATIENTS TRANSITION FROM PROGRAM TO PROGRAM

Our groups can be used to start treatment while waiting for a community program. It is also valuable as a follow-up to outpatient care or discharge from hospital or community programing. This is helping us to build bridges with specialty services, thereby enhancing collaborative patient care.

6. ISSUE----PATIENTS WHO ARE NOT DIAGNOSED AND TREATED FOR MENTAL ILLNESS ARE HIGH USERS OF HEALTH CARE SERVICES

Supported by the research. Group is a wonderful opportunity to provide education and resources to patients.

So what about Groups?

Hamilton Family Health Team
Better care, together.

True or False:

- Cost Effective?
- Better than individual?
- It is what people want?
- Practices are asking for it?
- No one else is offering group?
- Group is easy?
- One size fits all?

So Why Bother?

- Group itself may not always be cheaper to run, but having enough CBT-trained therapists to do the work individually would be hard to accomplish and costly
- For some, group is equal to or better than individual
- Often, individuals and practices do not ask for group because they don't understand it and it is scary
- Community and hospital groups have long waitlists and strict criteria
- Group can be hard work and challenging, but it does pay off
- Group is not the right fit for everyone; it does offer things individual therapy does not
- Research does support group as evidence-based treatment

Group offers the individual…

- Education
- Skill development
- Early Intervention
- Prevention
- Relapse prevention
- Peer Support
- Accountability
- Encouragement
- Challenge

- Promotes self management
- Normalize experience
- Feel less alone
- Empowerment
- Opportunity to laugh
- Give and take

Group offers the team…

- Common language
- Treatment options
- Ways to stay connected
- Ways to support each other
- Opportunity for input
- New ways to understand and talk about MH

Present MH Groups

- Two depression groups
  - Rise Up, 4 sessions
  - Shifting Gears, 7 sessions
- Three anxiety groups
  - GAD, 7 sessions
  - Panic, 4 sessions
  - Social Anxiety (in development, pilot to begin in September)

Present MH Groups

- Women's Self Esteem and Stress Management
  - 7 sessions, under review
- Substance Groups
  - DrinkWise, 5 sessions
  - Family Support Group, 1-day workshop
- Community Groups, in our locations
  - Run in collaboration with McMaster Children's Hospital
  - Their program in our space

Groups that have not worked

- Wellness Workshops
  - series of 8 workshops
- Insomnia Group
  - 7 sessions, 3 of which are telephone coaching
- Youth Focused
  - Girls Talk, 8 sessions (CAMH, Vitality project)

Group Program is growing

- 2009
  - 280 referrals, 130 assigned to group (46%)
- 2010
  - 440 referrals, 185 assigned to group (42%)
- 2011
  - 1060 referrals, 555 assigned to group (52%)

General Information

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- Groups use CBT – Cognitive Behavioral Therapy
- Meant for adults, 19+
- Ability to read and write
- Some motivation to work towards change
- Stable enough to do the work
- Not suicidal, no personality disorder
- Ability to understand English
- Administer Questionnaires, Scales and Surveys
- Groups generally facilitated by MHCs
- Offer handout of resources
- Follow-up forms are sent to doctor’s office when group is finished

Changes in process

- Groups offered regularly
- Post schedule ahead of time
- Promote groups to MHC, FP and practice teams (involve whole team)
- Respond quickly to referrals
- Send letter as well as phone, try at least three times to connect with referrals

Changes to our program

- Shorter groups (Rise Up, Panic)
- Less reading/handouts (Shifting Gears)
  - Health literacy
  - Language and cultural barriers
- Ask for participant input
  - Questionnaires
  - Feedback at end of group
- Offer at different locations
- Offer at different times

What have we learned?

- Simple is better
- Identify barriers and help people overcome
- People need more then one chance
- Mail and phone are not reliable
  - Moving towards electronic referrals
- Include the team
- Support facilitators – make it easy
- Evaluations
- Be enthusiastic and energetic

What Works?

- Promote groups, sell it to the practice
- Take the time to make referrals comfortable
- Use a structured CBT model
- “Push” homework, without saying it
- Two facilitators
- Passion
- Participant-driven
- Follow-up form to practice

What Isn't Working?

- Booster sessions
- Support group
- Practice based groups
- Attendance, ongoing challenges
- Telephone sessions, yes/no/maybe
- Group does not always meet the need, hard to determine what the best service response is
  - Code Red area
  - One group does not meet the needs for different populations within one community
  - Need to involve consumers

Future plans

- Social Anxiety, will begin pilot in September 2012
- DBT, training in community program, will begin DBT Coping Skills group for emotional dysregulation in January 2013
- Some changes to GAD and WSESM
- Create video to teach practice teams how to talk about group
  - Use Motivational Interviewing
- Improve evaluation
- Analyze data

Recent example of Group Development Process: Panic Group

- Mental Health program has focused on a variety of initiatives and pilot projects over the years
- These come out of both the population we are working with, and the literature
- In 2010 we began to look more closely at how we are doing in primary care at detecting and treating anxiety disorders
- We began a collaboration with a new psychiatric consultant, Dr. Catherine Mancini; her specialty is in Anxiety

Use of Health Services by Panic Disorder Patients

- High utilization of heath care services by patients with panic disorder (vs. other psychiatric disorders)
- 28% (vs. 5%) reported emergency room use
- 35% (vs. 8%) required hospitalization for emotional problems
- 12 office visits/yr
- High utilization may precede diagnosis by 10 years

Katon W., J Clin Psych 1996

Brief Treatment of Emergency Room Patients with Panic Attacks

Swinson et al 1992

40 patients seen in ER with panic attacks

- **physical illness ruled out**
- **seen within 48 hrs by research assistant (60 min interview)**

SCID for DSM-3-R
Fear Questionnaire (fear and avoidance subscale)
Mobility Inventory
Beck Depression Scale
Panic Diaries

Reassurance
n = 16

Exposure
n = 17

Follow-up at 3 and 6 months

Brief Treatment of Emergency Room Patients with Panic Attacks

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Reassurance Group

- Reassured that what patient had experienced was a panic attack and that there was no physical or psychiatric disorder

Exposure Group

- Told that the most effective way to reduce fear was to confront the situation in which the attack had occurred
- Advised to return to the anxiety-provoking situation as soon as possible and to wait there until the anxiety decreased

Brief Treatment of Emergency Room Patients with Panic Attacks

RESULTS

- Exposure group significantly improved on all measures over time compared with the reassurance group
- Frequency of panic attacks decreased in the exposure group but increased in the reassurance group
- Agoraphobic avoidance increased in reassurance group

Brief Treatment of Emergency Room Patients with Panic Attacks

Early intervention with exposure instructions in a setting that is often the first contact point for health care delivery may reduce the long-term consequences of panic attacks

Benefits of Panic Group

- Early detection and treatment of Panic would be beneficial to the client and the health care system
- Treatment, especially without agoraphobia, can be done in a relatively short period of time
- Rather than training all 73 mental health counsellors to do CBT for Panic, we could train a few people to run a CBT Panic Group

Group Development

- Groups Coordinator worked with consultant to create the group, developed our own material
- 4 mental health counsellors from the HFHT were trained and mentored
- Training provided by experienced clinician (worked may years in community anxiety clinic)
- Referral to the group was open to the entire HFHT; the majority of referrals came from the mental health counsellors

Panic Group Initial Format

- Evidence-based CBT treatment; focus on the three components of panic (sensations, thoughts and behaviours)
- 4 weekly sessions, 1.5 hours each
- Each week was composed of an educational component, in-session practice, and between-session assignment on a particular theme
- After facilitating two groups, we reviewed the group content and made adjustments accordingly
- Feedback was received from the group facilitators and the group members (formal and informal)

New Panic Group :

- Changes made
  - Expanded to 2 hours
  - Rewrote some of the handouts for clarity
  - Reduction in the educational component
    - In the 1st session, initially provided information on all the anxiety disorders; reduced this to primarily focus on panic disorder
- Added some new material such as thought records
- Increased access for consumers, offered at various times and locations
- Additional mental health counsellors being trained after group modified

Benefits

- Increased service access for consumers; wait time for community services can be anywhere from 8 months to a year
- Groups offered 4-5 times a year, between September and June, evening and afternoon groups
- Participants report:
  - increased competency
  - reduction in panic attacks
  - decreased severity of attacks
  - increased confidence in dealing with their panic sensations
  - decreased use of clonazepam or lorazepam

Scoring for the PDSS-SR

- The PDSS-SR generates a total score ranging from 0 to 28, with a higher score indicating more severe panic symptoms.
- A cut-off score of eight may discriminate between the presence or absence of current DSM-IV panic disorder, and may be useful as a tool to screen patients in settings such as primary care, for diagnosis-level symptoms.
- A cut-off score of thirteen may be used to discriminate between mild and severe panic disorder.

http://www.chammp.org/LinkClick.aspx?fileticket=X5jANTx3KfE%3D&tabid=207

PDSS-SR Pre and Post

Pre

- 10.33
- 10.90
- 12.50
- 7

Post

- 8.33
- 7.6
- 6.75
- 3

Groups started with participants' average score in the mild/moderate range and completing the group in a range that is said to be no longer Panic Disorder.

Email from Participant

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Areas to Consider

- Referrals primarily come from mental health counsellors, working on more collaboration
- Goal is to increase referrals from the family doctor, nurse and/or nurse practitioners
  - This would aid in early detection and prevention; we are not yet adequately serving those patients with recent onset of panic (need team referrals)
- Suspect there has been reduction in visits to family doctors and ER for those who attended group; however, this would need to be studied

Collaborative Care

- Feedback provided to the family doctor and referral source on those who attended
  - attendance, participation, comments, and when necessary recommendations are made
- Receive feedback from participants, verbal and written