Collaborative Care for Inner City Populations
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Characteristics of south-east Toronto
- Very socio-economically disadvantaged area of over 350,000 people
- Includes St. Jamestown (highest density population area in the country), Regent Park, and Moss Park
- Significant percentage of recent immigrants/refugees
- High rates of homelessness, substance abuse, and chronic psychotic disorders

St. Michael’s Hospital Context
- Large inner-city University of Toronto teaching hospital
- One of the major Toronto sites for residency training in both psychiatry (15 residents) and family medicine (28 residents)
- Both services are part of the very active SMH Inner City Health Program
Collaborative Mental Health Care at St. Mike’s

- Since 2002 direct partnership with the four St. Mike’s family practice units plus primary care providers at Regent Park Community Health Centre, Sherbourne Health Centre, and Ryerson University
- Psychiatrist and resident connected to each of the primary care centres

Model of Collaborative Care Used

- Primarily use the Case Discussion Consultation-Liaison Model (CDCLM, Kates et al 1992)
- Involves regular on site indirect consultation/case discussions plus ongoing availability/support by phone
- Goal: provide the support/education necessary for the primary care team to manage most of the mental health issues of their pts

Our Experience with Collaborative Care

- Regular on site case discussions considerably decrease the need for direct psychiatric assessments
- Even when direct assessments are necessary, family md often able to provide the ongoing care
- >50% of direct assessment involve assessment/recommendations only
Primary Care Demographics at SMH

- Total of 33 FTE family docs across the 4 smh sites
- About 10,000 total patient visits per month
- At all of the sites mental health issues ranked either 1st or second in terms of most frequent diagnoses encountered

Current Study

- 2006: CIHR grant to do a RCT looking at the effectiveness of different collaborative care models
- SPMI pts without family mds are randomized to either our existing model (CDCLM) or to a more intensive model (CLIP), developed by Meadows et al 1998 and widely used in Australia

Study Targets

- 64 pts to be randomized to each model and followed for 12 months
- Assessments at baseline, 6, and 12 months
- Outcome measures: pt functioning, symptoms, pt satisfaction, pt service use, cost, and family md satisfaction
Proportion with a 1° care visit

With a 1° care visit & Without a 1° care visit

\[ \begin{array}{lcc}
\text{With a 1° care visit} & \text{Without a 1° care visit} \\
\hline
\text{Male} & 64.3 & 70 \\
\text{Age (in yrs)} & 39.1 (sd = 14.8) & 35.3 (sd = 11.0) \\
\text{Married} & 7.1 & 26.3 \\
\text{Did not complete high school} & 38.5 & 43.8 \\
\text{Household income <$20k} & 85.7 & 55.6 \\
\text{Homeless} & 35.7 & 31.6 \\
\end{array} \]

With a 1° care visit & Without a 1° care visit

\[ \begin{array}{lcc}
\text{With a 1° care visit} & \text{Without a 1° care visit} \\
\hline
\text{Prescription drug use} & 78.6 & 89.5 \\
\text{Chronic physical disorder} & 41.7 & 50 \\
\end{array} \]
Summary of Results

- More than half of clients did not see their 1st care physician.
- There were no significant differences between the two groups with respect to demographic characteristics.
- The trend in the data suggests, those who did not see their 1st care physician were:
  - lower functioning
  - had higher severity with alcohol use
- Clients with a primary diagnosis of psychotic disorder are significantly less likely to see their 1st care physician.
Discussion

- Recruitment Challenges
- Barriers to SPMI getting to first appointment with primary care
- ? Need for transitional case management to help make the connection