Ensuring Primary Health Care in the Mental Health Care Setting:
A Multi-Disciplinary Approach

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Overview of Presentation

- Describe the process and outcomes of integrating primary health care strategies within an active mental health care organization.
- Summarize current literature pertaining to primary health care in the mental health care setting.
- Describe clinical examples that illustrate how a collaborative approach provides a solid foundation for tailoring client care for clients with mental illness, and to identify and overcome common challenges that may be experienced.

Background

- Persons with mental illness and/or homeless (or at risk) experience poor physical & mental health outcomes
  - limited health care access
  - often considered “difficult to serve”
- Housing instability, chronic substance use, and cigarette smoking can exacerbate mental and physical health problems

Serious Mental Illness (SMI)

- Life expectancy reduced by 25%
- Higher risk of hypertension, respiratory illnesses, chronic infections
- Obesity 3.5 x higher
- Diabetes >2.5 x higher (25-33% undiagnosed)
- Cardiovascular disease 2 x higher
  - Women with depression are 80% more likely to have heart disease

Tobacco and SMI

- 75% of people with SMI smoke (Lawn, 2008)
- 40-50% of cigarettes smoked by SMI
- People with SMI are half as likely to quit
- ¾ want to quit – same as general population
- One out of every two mentally ill smokers dies of tobacco-related illnesses (Els et al., 2008)
- Tailored Community-Based Program
  - success rate similar to rates for other smokers
  - no untoward effects on mental illness (Currie et al., 2008)

Diagnostic Overshadowing

- Physical symptoms misattributed to mental illness without sufficient assessment (Jones et al., 2008)
- SMI less likely to receive screening, preventive care, and treatment (Druss et al., 2002)
- Access to PHC is top unmet need for people with SMI (Bédard et al., 2007)

Barriers to Health for SMI

- Limited income, therefore limited food choices and living environments
- Difficulty navigating multiple services
- Stigmatization, marginalization, access
- Clinicians have limited time, and limited experience and training in psychiatry
- Little information sharing among providers

Action is Needed on Multiple Levels:

- Structured system for recording metabolic monitoring and collaboration with family physicians, psychiatrists, and specialists
- Supportive environment addressing determinants of health

Integrated Care Models

- Improved addiction outcomes when integrated with quality PHC (Kim et al., 2007)
- Integration of mental health and diabetes services would result in improved outcomes (Goldberg et al., 2007)
- All providers must have and document clearly defined responsibilities

“It’s time we put the head back on the body.”

Michael Kirby, 2008

Care Delivery Models

1. Primary care embedded in program for people with SMI
   - integrated care, single treatment plan
2. Unified mental/ primary health programs
3. Mental health professionals located in PHC setting (Co-location, eg: Smith, 2007)
4. Collaboration between separate agencies

Bazelon Centre, 2004

CMHA Ottawa: The View from Inside

- ***Mission*:** To offer opportunity and support for individuals with mental health issues so that they may achieve meaning and success and improve their level of functioning in the environment of their choice
- We deliver recovery-focused, evidenced-based integrated services for people with both a serious mental illness and complex needs

Programs and Services

- Case Management and long term Community Support
- Hospital Outreach
- Court Outreach
- Housing Outreach
- Concurrent Disorders
- Brokerage Services
- Dialectal Behavioural Therapy
- Wellness Recovery Action Planning
- Vocational Support

Population Served

Individuals who:

- Have severe and persistent mental illness
- Experience homelessness or are at risk of homelessness
- Have co-occurring substance use disorders
- Are in conflict with the law
- Have co-occurring developmental disability
- Have complex primary care needs

Population Served

938 clients with SMI

- 123 Bipolar disorder
- 142 Depression
- 342 Schizophrenia
- 84 Schizoaffective disorder
  - 279 smoke
  - 43 use alcohol
  - 92 use cannabis
  - 79 use cocaine
  - 33 opiates and unspecified

Population Served

559 reported an Axis III

- Diabetes I & II
- Heart Disease
- HIV/AIDS
- Hep C
- IBS
- Obesity

CMHA Setting

- 32 Community Support Workers
- 23 Outreach
- 6 Addiction Workers
- 4 Dual Diagnosis Specialists
- 4 Intake Staff
- 3.5 RNs, 1 PHC Nurse Practitioner
- 9 hours/ week Psychiatrist

Integrated Health Services

- **2004** - added multi-disciplinary support (in house): psychiatry, psychology, RN, OT & RT
- **2007** - funding lost for psychology, OT & RT, added Vocational specialist
- **2008** - added a Primary Health Care Nurse Practitioner

Email 3/30/09
From Our Receptionist

Hi Everyone:

I just received a call from a Dr. _____ regarding "taking new patients". He cannot accommodate us anymore as he is not able to treat the type of issues our clients have.

Challenges

- High level of complexity →
  - "rejected" from "doctors accepting new patients"
- PTSD → Reluctance to have procedures
- Symptoms that mimic mental illness
- Low level of trust in fragmented services
- Homelessness, no ID, OHIP or address

Challenges

- Clients may need more support to follow-up on doctor's orders
- Health care professionals need more education regarding SMI
- Psychiatrists, dietitians, physical activity programs usually not connected with PHC facility
- Need for assertive case management and system navigation

Shared Care

- Complex clients are often assessed and followed by psychiatrist and all nurses
- Nurse Practitioner does physical assessments, writes prescriptions, orders and interprets diagnostic tests
- Diverse population = Diverse response

New Initiatives

- In-house assessment and health promotion clinics
- Healthy food and cigarette policies
- New community partnerships
  - diabetes educators, CHCs, Public Health, Ottawa Inner City Health

- Diabetes self-management programs tailored to SMI
- Integrate health promotion activities within DBT/ CBT to encourage consumers to take charge of their health (McIntosh, 2008)
- Expand WRAP (Wellness Recovery Action Plan) to address consumer-generated goals for physical well being

Education for CSW's

- "Red flags" to report to the nurse or family doctor, when to call 911
- Health Fair - metabolic syndrome topics
- Smoking cessation - brief interventions
- Bi-Monthly info sessions
  - Eg: Infection topics, respiratory illnesses, CPAP, diabetes

Case Study: Jennifer

- 55 year old with history of depression, diabetes type 2, rheumatoid arthritis
- Government employee x 20 years, let go on disability due to lack of hygiene and absenteeism
- CMHA worker met client in shelter
- Obtained housing December 2008
- One month later, client refusing to answer door, apartment full of garbage, feces and urine in bathroom and on bed

Where do we go from here?

- Develop structured health promotion programs (eg: smoking cessation/ reduction program)
- Link with other organizations in Ottawa for proposal for Family Health Team or NP-Led Clinic
- Champlain LHIN Integrated Health Service Plan 2010 – 2013
  - Targeting: diabetes, mental health, addictions, frail population

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