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

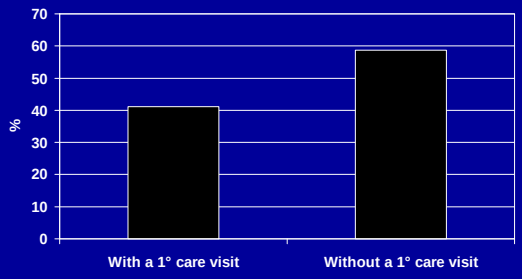
Current Study

- 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

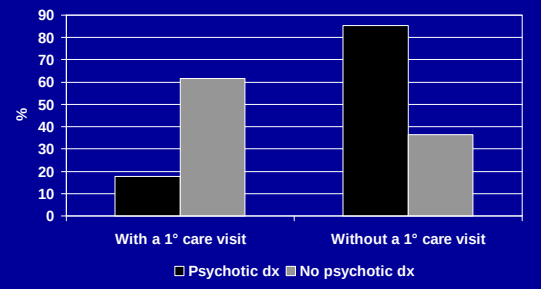
- 64 pts to be randomized to each model and followed for 12 months
- Assessments at baseline, 6 , and 12 months
- Outcome measures: pt functioning, symptoms, pt satisfaction, pt service use, cost, and family md satisfaction

Proportion with a 1° care visit



	With a 1° care visit	Without a 1° care visit
	n = 14	n = 20
Male	64.3	70
Age (in yrs)	39.1 (sd = 14.8)	35.3 (sd = 11.0)
Married	7.1	26.3
Did not complete high school	38.5	43.8
Household income <$20k	85.7	55.6
Homeless	35.7	31.6

	With a 1° care visit	Without a 1° care visit
	n = 14	n = 20
Prescription drug use	78.6	89.5
Chronic physical disorder	41.7	50



Significant difference: Fisher's Exact p = 0.016

	With a 1° care visit n = 14	Without a 1° care visit n = 20
Community Fxning	56.2 (sd = 8.0)	55.1 (sd = 6.8)
Severity of alcohol use	5.6 (sd = 5.3)	9.8 (sd = 9.2)

Summary of Results

- More than half of clients did not see their 1° 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 1° 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 1° 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