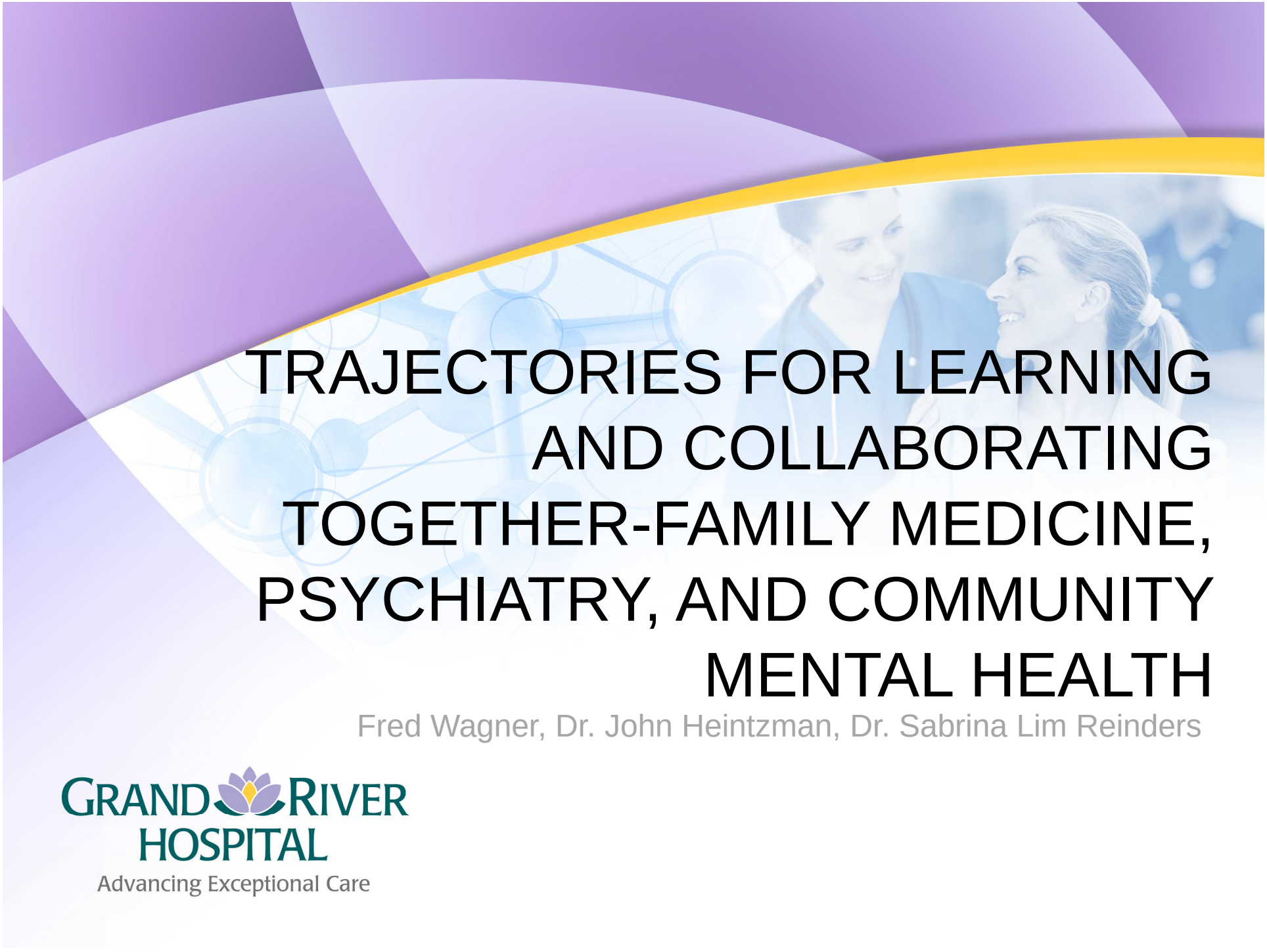

TRAJECTORIES FOR LEARNING AND COLLABORATING TOGETHER-FAMILY MEDICINE, PSYCHIATRY, AND COMMUNITY MENTAL HEALTH

Fred Wagner, Dr. John Heintzman, Dr. Sabrina Lim Reinders

GRAND RIVER HOSPITAL
Advancing Exceptional Care

Trajectories for Learning and Collaborating Together-Family Medicine, Psychiatry, and Community Mental Health

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Executive Director
CMHA-Waterloo Wellington Dufferin

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Primary Care Physician Lead WWLHIN

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Chief of Psychiatry
Grand River Hospital
Physician Lead, Waterloo-Wellington CMHA

A Day in Psychiatry- 2017
Wednesday November 8th, 2017
Bingeman's Conference Centre
Kitchener, Ontario

Trajectories for Learning and Collaborating Together-Family Medicine, Psychiatry, and Community Mental Health

Fred Wagner, Dr. John Heintzman, Dr. Sabrina Lim Reinders

Day in Psychiatry 2017

Declaration of Conflict of Interest:

I DO NOT have any affiliation with any pharmaceutical, medical device or communication organization.

I DO NOT INTEND to make therapeutic recommendations for medications that have not received regulatory approval (e.g “off-label”use).

Trajectories for Learning and Collaborating Together-Family Medicine, Psychiatry, and Community Mental Health
Fred Wagner, Dr. John Heintzman, Dr. Sabrina Lim Reinders
Day in Psychiatry 2017

This 2017 Day in Psychiatry educational event has received unrestricted educational grants from the following organizations:

- Lundbeck
- Otsuka
- Pfizer
- Janssen
- Purdue
- Shire
- Sunovion
- KW Guardian Pharmacy
- HLS Therapeutics
- Allergan

Trajectories for Learning and Collaborating Together-Family Medicine, Psychiatry, and Community Mental Health

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Day in Psychiatry 2017

Mitigating Potential Conflicts of Interest:

Not applicable

Trajectories for Learning and Collaborating Together

Fred Wagner, Dr. J. Heintzman, Dr. S. Lim Reinders

Day in Psychiatry 2017

Learning Goals

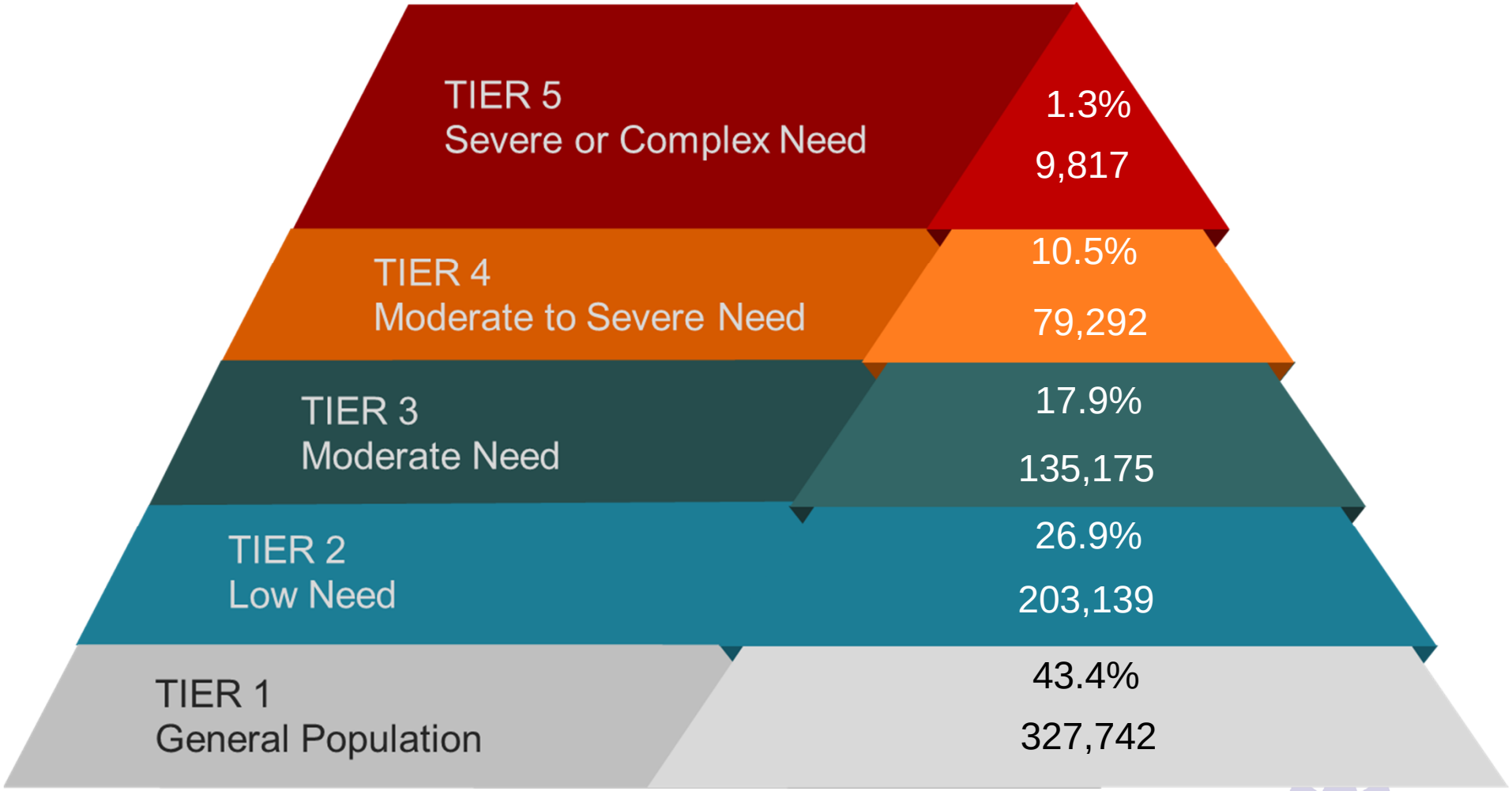
1. Understanding CMHA programs available in the Waterloo-Wellington LHIN
2. Overview of shared care-collaborative care
3. Review of learning formats (OFCP mentoring program, PBSG, didactic teaching sessions, small learning groups-Hamilton model)
4. Case discussion to highlight collaborative care

OVERVIEW OF SERVICES & SHARED CARE

Fred Wagner

GRAND RIVER HOSPITAL
Advancing Exceptional Care

TIERED FRAMEWORK



Population of Waterloo-Wellington 2016 Census: 755,165

1 844 437 3247

(HERE247)

Call anytime to access Addictions, Mental Health & Crisis Services

Waterloo-Wellington-Dufferin

HERE 247 PARTNERS

STONEHENGE Therapeutic Community

Waterloo Regional Homes for Mental Health Inc.

Canadian Mental Health Association Waterloo Wellington Dufferin | Association canadienne pour la santé mentale Waterloo Wellington Dufferin

CAMBRIDGE MEMORIAL HOSPITAL

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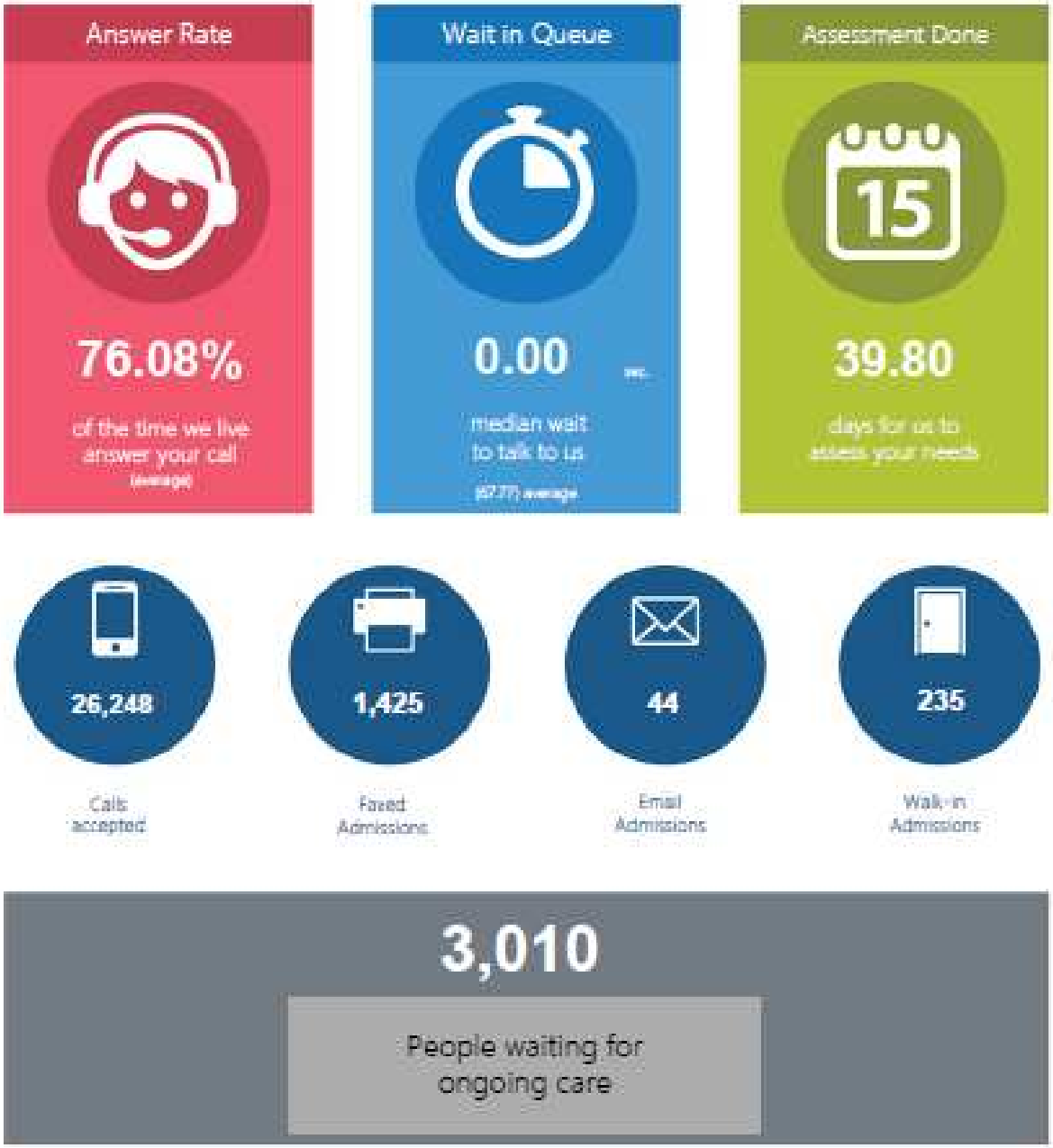
PORTAGE

GRAND RIVER HOSPITAL

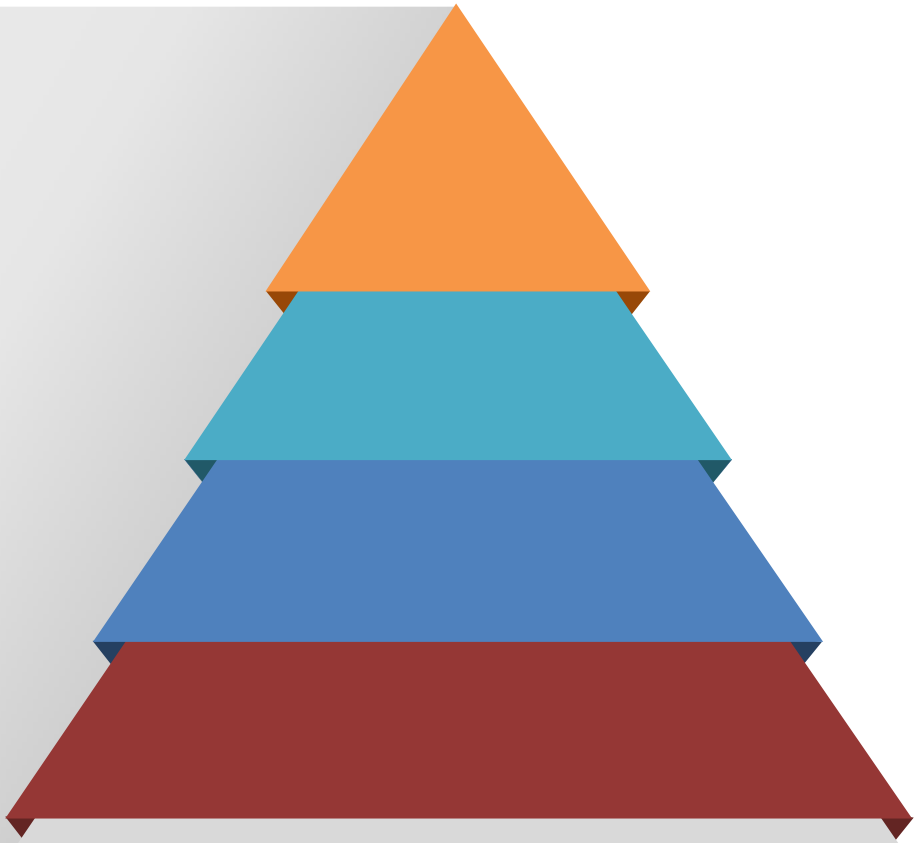
Homewood Improving Life | Health Centre de Santé

Ray of Hope

Ontario Waterloo Wellington Local Health Integration Network


Answer Rate
76.08%
of the time we live answer your call
Wait in Queue
0.00
median wait to talk to us
Assessment Done
15
39.80
26,248
Calls accepted
1,425
Faxed Admissions
44
Email Admissions
235
Walk-in Admissions
3,010
People waiting for ongoing care

SERVICES BY TIER

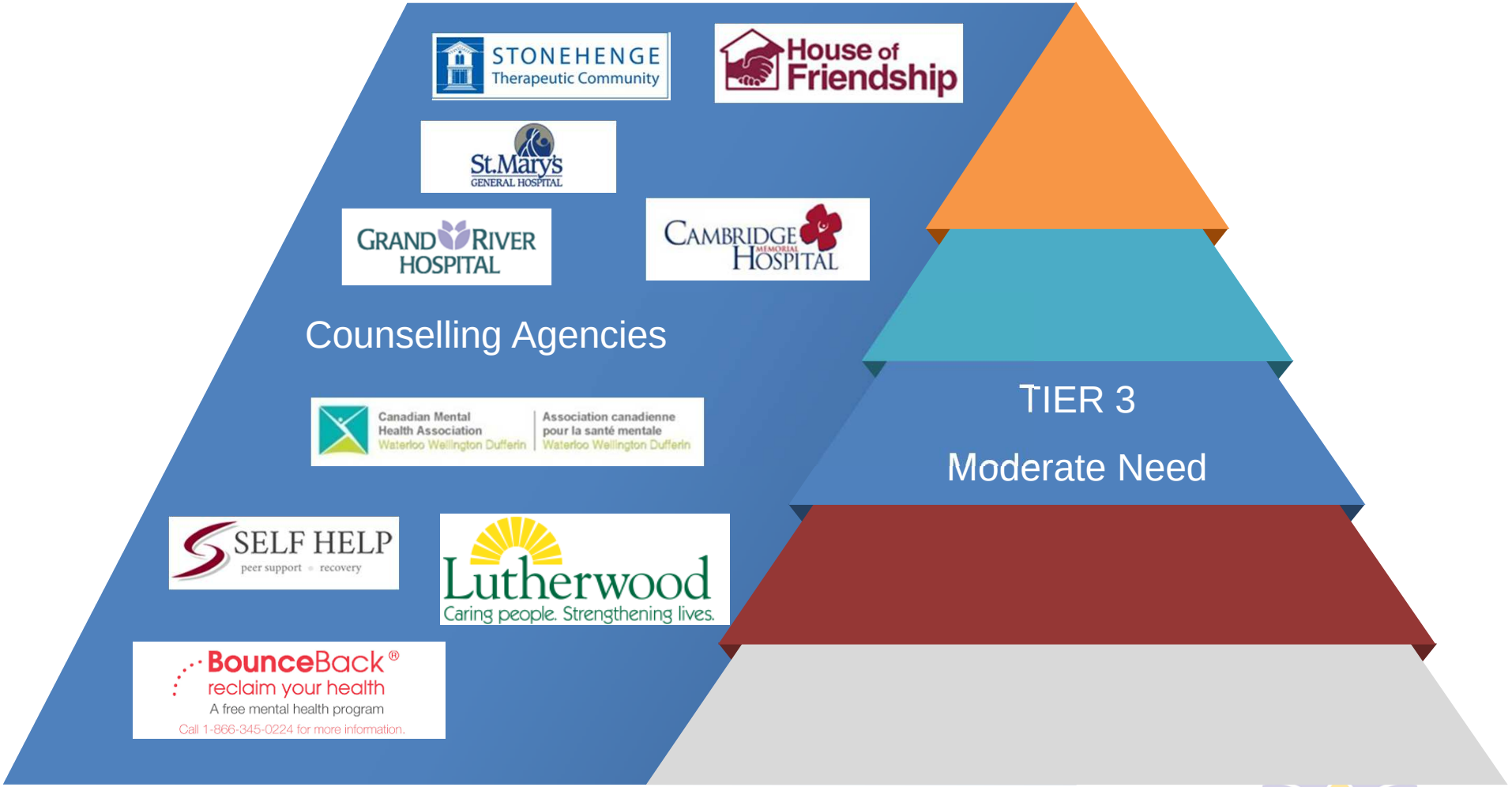


Canadian Mental Health Association
Waterloo Wellington Dufferin
Association canadienne pour la santé mentale
Waterloo Wellington Dufferin

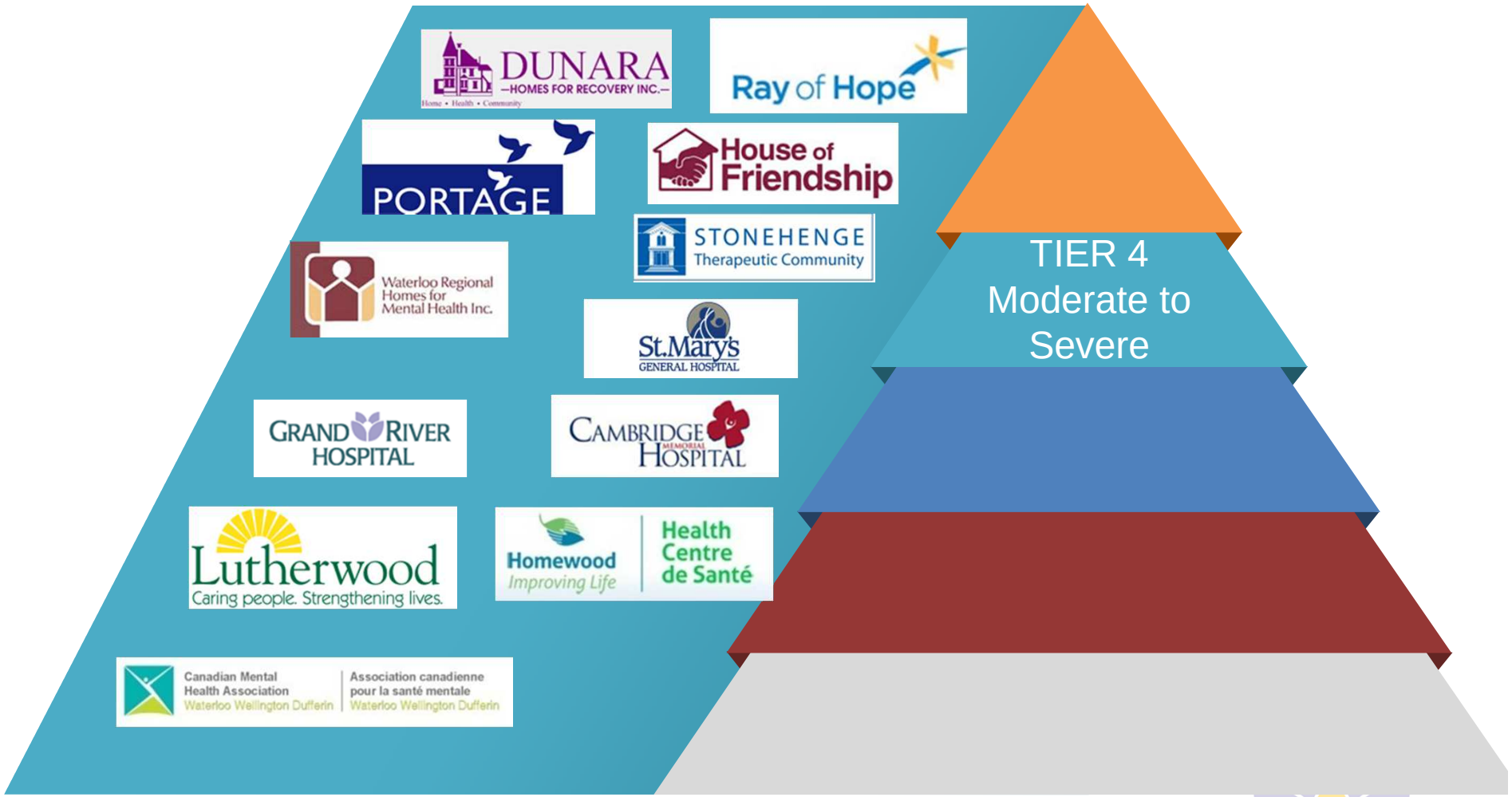
TIER 1
General Population

SERVICES BY TIER - continued

SERVICES BY TIER - continued



SERVICES BY TIER - continued



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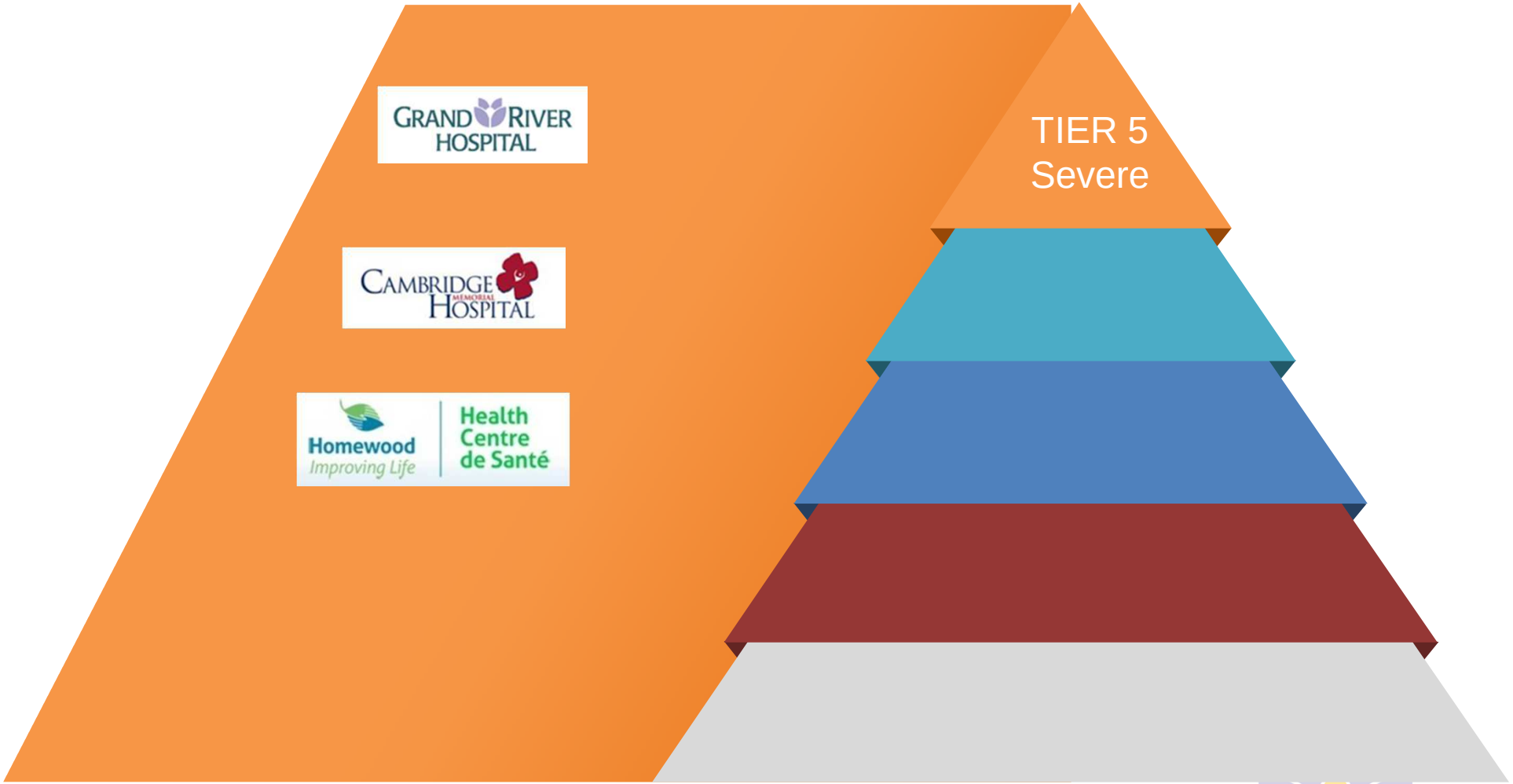

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A free mental health program
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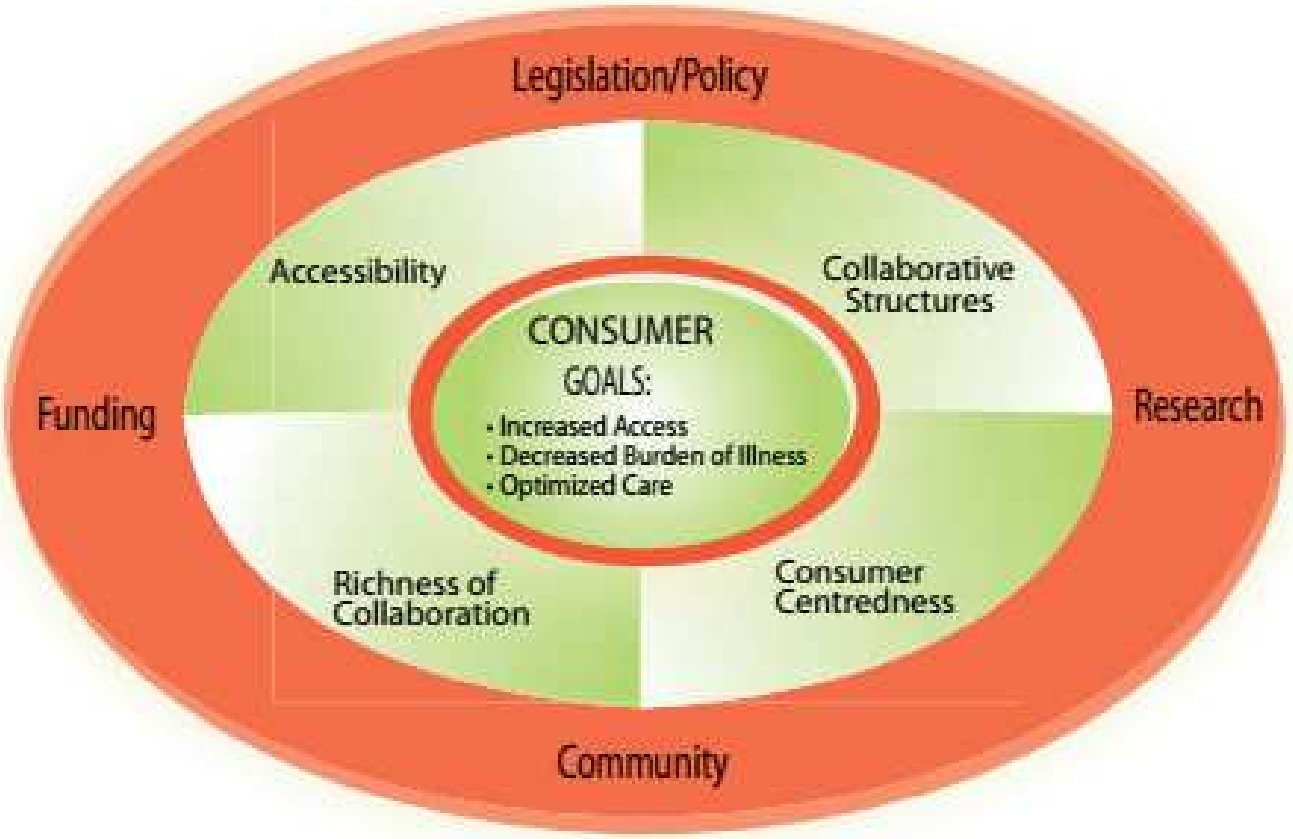
SHARED CARE

Shared Care

Stepped Care Mental Health

Who is responsible for care?		What is the focus?	What do they do?
Step 5	In patient care, crisis teams	Risk to life, severe self-neglect	Medication, combined treatments, ECT
Step 4	Mental Health Specialist, including crisis teams	Recurrent, a-typical, and significant risk	Medication, complex psychological interventions, combined treatments
Step 3	PC Team Primary Mental Health Worker	Moderate severe mental health problems	Medication; psychological interventions; social support
Step 2	PC Team Primary Mental Health Worker	Mild mental health problems	Watchful waiting; guided self- help; computerized CBT, exercise, brief psychological interventions
Step 1	G.P. Practice Nurse	Recognition	Assessment

SHARED CARE CONCEPTUAL FRAMEWORK



LOCAL & PROVINCIAL EXAMPLES OF SHARED CARE

Canadian Mental Health Association
Lambton Kent

Association canadienne pour la santé mentale
Filiale de Lambton Kent

Guelph Family Health Team

Rapid Assessment Intervention Team

Langs
Community. Health. Wellness.

Kitchener Downtown
COMMUNITY HEALTH CENTRE

Hamilton Family Health Team
Better care, together.

Review of Learning styles in adults

VARK Learning styles: visual, aural, read/write, kinestetic

•multimodal learning styles with auditory ➔kinestic learning based on self-learning apprentice models

Learning Methods

•didactic teacher & subject centric

•Interactive problem based, online learning

•Group learning – PBSG, mentorship groups

•Shared care new interactions for FP and Specialist

•Evidence for colocation ➔Co management

CASE 1 – COLLABORATIVE CARE – MENTAL HEALTH TEAM BASED – “JJ”

JJ is a 32 year old male new to your practice. He was referred by his parole officer. He has been in and out of the correctional system for mostly non violent crimes and occasional physical assaults. He has a diagnosis of Paranoid Schizophrenia and takes Risperdal Consta 25mg q 2 weeks im, Wellbutrin 300mg and Sentraline 150mg. He also has active IBD and takes Mesalamine and Metamucil for his Crohn’s Disease. He has a history of several past hospitalizations both for Crohn’s flare ups and escalated paranoid/violent thoughts to others, often triggered by substance use or medication non-adherence.

JJ lives in a group home but does not feel safe there. He worries his housemates will break into his room, wanting to steal his medications. Sometimes they ask him to share his Wellbutrin so they can snort it together. He lives on ODSP and often runs out of money by the end of the month. He has no family support. He attends the hospital outpatient clinic every 2 weeks to see the nurse and receive his injection, and sees a psychiatrist there about every 2-3 months. He smokes regularly, uses marijuana occasionally, and has used alcohol & cocaine in the past.

JJ has not generally seen a family doctor regularly. He usually goes to the ER if he doesn't feel well or if he stops his medications. A quick review shows four visits in the last 6 months, and you note he missed his last GI follow up. You set up regular appointments at your office, get some baseline blood work and get his GI appointment rescheduled. You wonder how to reach his psychiatrist and what type of mental health support the patient is receiving.

The next time you see JJ he seems agitated. He asks for your help to find a new place to live as he thinks people are getting into his room. He is using marijuana daily now, and missed his last injection of Risperdal. Your nurse is able to contact the clinic and get him there later that day to get caught up. The next scheduled appointment he does not show for and your nurse cannot reach him by phone. Your secretary reaches his parole officer who thinks he was taken to the hospital a few days ago. You are concerned about your ability to treat JJ and are frustrated with the amount of time it takes and the way care feels very fragmented.

What types of care providers should be involved in JJ's case?

- Family doctor
- Psychiatrist
- Nurse
- Social worker
- Addictions counsellor
- Housing coordinator
- Recreation therapist
- Peer support worker
- Parole officer

In the past has a care system existed to readily access these providers and help them easily work together?

What new model of care did you hear about today that would better respond to JJ's needs?

- Recruiting more psychiatrists?
- Opening more long term psychiatric beds at Freeport?
- Psychiatrist – family doctor mentoring program?
- FACT team?

What does FACT stand for?

- Family doctors Accept Complete Treatment responsibility
- Fred and CMHA Try Harder
- Flexible Assertive Community Treatment

What services can FACT provide to help improve this patients care?

- Multidisciplinary team planning/coordination
- Regular updates/info to family doctor and follow up on family doctor concerns
- Health teaching and modelling of healthy lifestyle choices
- Housing support and advocacy
- Recreational/vocational supports
- Optimization of pharmacotherapy
- Linkage/integration with hospital if ER visits or admissions
- Urgent/crisis supports
- Addictions counselling/supports
- Peer/social interactions

What does Flexible mean in this model?

- Service intensity is geared to the needs of the patient?
- The patient, mental health team and family doctor adjust treatment plans as new concerns arise or previous issues resolve or resurface?
- The services are conditional upon the patient complying with medication and not using substances?
- The patient continues to receive services for as long as they need to?

CASE 2 – COLLABORATIVE CARE – FAMILY PHYSICIAN OFFICE BASED - GARY

Gary is a 50 year old male who you see regularly for annual exams. He has a wife and 3 children. He recently lost his job as a construction foreman through the company downsizing. He is having trouble finding a similar position else where and has lost his employee health benefits. He is unable to take a manual labour position due to his back pain, likely secondary to Degenerative Disc Disease. He asks you if taking daily marijuana is safe and legal.

You ask more about his pain and learn that it feels worse since he lost his job. He developed trouble sleeping and a friend offered him a joint. The marijuana helped his pain so he kept using it, but admits feeling “like a junkie” when he smokes it. He was hesitant to discuss with you sooner as he remembers you saying you would not prescribe narcotics, although he recalls them being helpful for an acute flare up when he had a herniated disc. He is also consuming 3-4 alcoholic drinks a night to get to sleep. He is worrying about paying his mortgage on a reduced income. He denies being depressed but in addition to poor sleep you note a month history of decreased appetite, lower energy, feeling like he is letting his family down and he seems much less talkative than usual. Today he asks for something for his pain and sleep.

You are interested in helping Gary and generally feel comfortable prescribing antidepressants, however the substance use and pain issues concern you in this case. You would like psychiatric input but are not sure if Gary would agree to “go and see a psychiatrist”. Although you know the GRH psychiatric consultation clinic will usually see a non urgent referral in 4-6 weeks, sometimes you find limited value in a one visit only consultation with little opportunity for collaboration or further input as concerns arise. And you need to make some decisions now.

What immediate next steps are indicated before Gary leaves your office today?

- Ask about suicidal thoughts?
- Review how to access crisis services?
- Inquire about withdrawal symptoms?
- Perform focused PX exam – vitals, back, MSK, neuro (lower extremity)?
- Explore Gary's willingness to decrease/stop substance use and discuss concerns with continued use?

Upon further review with Gary he occasionally feels hopeless but has no suicidal thoughts. He is ashamed of his marijuana use and would much rather follow a medically approved treatment plan for his back pain. His wife is greatly concerned about his drinking and he would agree to stop or reduce this if he had “something else” to help him sleep. Your PX exam shows mild increased BP 140/85 and no acute MSK/neuro findings.

Based on this you would now:

- Send him to the ER?
- Consider starting a short term sleep aid (ie Imovane, Librium, Clonazepam or Trazodone) in a limited supply?
- If no indications start on regular Tylenol or Ibuprofen for this back pain?
- Arrange a nursing phone check in over the next 2-3 days?
- Schedule a follow up appointment for next week?

At your next F/U appointment you wish to learn more about possible depressive SX – you should:

- Screen using SIG E CAPS?
- Administer a short questionnaire re depressive SX (i.e. PHQ-9) and ask Gary about his answers?
- Ask about previous mood episodes, past/current suicidal thoughts and family psych HX?

Gary reports numerous neurovegetative symptoms but continues to deny that he is feeling depressed. You remain concerned recognizing that in addition to his PX concerns there are numerous psychosocial stressors possibly impacting on Gary's mood including:

- Current and upcoming financial needs (i.e. children's education)
- Guilty feelings re his substance use
- Frustration secondary to ongoing pain and work limitations
- Feelings of boredom, and unsure how to occupy his time during the day when not working
- Impaired view of himself as an able provider for his family

You are considering starting Gary on an antidepressant, but when you suggest this he is hesitant. You explain that there is a new “shared care” program in KW in which family doctors and psychiatrists work together to treat patients with physical and emotional concerns. You tell Gary that you would appreciate a specialist opinion on treatment recommendations. Fortunately the shared care psychiatrist for your family health team happens to be at your office site that day, and you are able to briefly introduce Gary to her. She seems approachable so Gary agrees to the referral.

After the consultation, the psychiatrist's treatment plan includes:

- A schedule for regular exercise for mood and physical health benefits
- Antidepressant trial (mirtazapine) chosen to help with appetite and sleep issues
- Referral to Family Health Team social worker for some introductory CBT for depressive SX and some joint marital sessions to better manage increased stressors at home.
- A joint meeting with the patient, his wife, the psychiatrist, family doctor, and nurse around developing/monitoring a pain management plan including use of non opioid analgesics, physical therapy tracking, and sleep hygiene strategies
- Recommendations around regular monitors for substance use and guidelines around safe limits re alcohol consumption and plans for next steps if maladaptive use returns
- A phone number/email contact for the family doctor to quickly connect with the psychiatrist if questions/concerns or new problems occur.

Gary and his family doctor appreciate the collaboration and practical support. He does well for 6 months but then experiences acute increased anxiety and decreased sleep in the context of several unexpected home repair bills. He reports feeling a desire to start drinking again. His family doctor contacts the shared care psychiatrist who suggests requesting a short term benzodiazeoine trial and asks for Gary to return for a check in visit the next week.

CASE 3 – COLLABORATIVE CARE – INTEGRATED CLINIC BASED – MARY

Mary is a 19 year old, second year university student in biomechanical engineering. She comes to the student health clinic on campus where you work two days a week. She has complaints of fatigue, joint pain and low mood. She has no significant post medical history and is on an oral contraceptive.

Mary did well in first year, but is now having trouble keeping up with her studies. She is having trouble focusing in class and feels overwhelmed by the competitive nature of her program. Her PX exam shows small lymph nodes in her neck, but no other abnormalities to explain her fatigue and joint pain. She asks for a note to miss her midterm tomorrow, which you provide. You order some blood work and arrange to see her back in follow up when you are next in the clinic.

Mary returns as planned. Her blood work is normal. When you tell her this she bursts in to tears stating that she is using marijuana most everyday to cope with how stressed she feels, and is frequently not getting to class. She is worried that she will fail and be “flunked out of school” which will “ruin her life”. As you listen you notice some faint scars on her forearms that you had not appreciated previously. She reports a history of cutting in grade 7 and 8, but does not do that anymore. You ask about mood symptoms and are further concerned to hear that she feels down much of the day, hopeless about her situation and often feels like giving up.

What help can you get for Mary today that is best suited to her needs?

a) Send her to the ER for an evaluation

b) Ask the psychiatric clinic nurse to see her

The nurse meets with Mary, and notices the presence of occasional suicidal thoughts but no active plan or intent. Mary agrees to return for outpatient follow up in 2 days with the nurse. The possibility of hospitalization is discussed but she does not want to be “locked up” and worries that she would get further behind academically.

You should now:

a) Complete a Form 1 because of the suicidal thoughts

b) Ask the nurse to help Mary prepare a safety plan for the next two days and check in by phone tomorrow

Mary returns to see the nurse as planned. Suicidal intention thoughts have not increased. She is open to continued outpatient care at the student health clinic, and can see you next week. At your next visit you take a more detailed psychiatric HX and identify features suggestive of a first time presentation of a major depressive episode, and a family HX of an uncle with bipolar disorder, currently on Lithium Mary thinks.

You should:

a) Start an SSRI

b) Refer for urgent psychiatric consultation with the student health psychiatrist

The student health psychiatrist sees Mary. He agrees that an SSRI could be indicated, identifies no current or past manic or hypomanic symptoms in Mary, but is worried about the family HX of bipolar disorder, especially when Mary suggests that her father and older brother have a history of “extreme mood swings”.

The evidence based intervention least likely to cause harm to Mary is:

a) Nursing counselling around healthy coping, safety check ins and referral to the clinic CBT treatment for depression group (starting next week)

b) Starting an SSRI

Mary continues to see the psychiatric nurse and applies what she is learning in the CBT group to better cope with stressors, engage in healthy behaviours and challenge her negative depressive thinking. She greatly reduces her marijuana use, attends class more regularly, and brings her roommate in to meet her nurse as a part of safety planning. With the nurses encouragement and assistance she also updates her parents on some of her struggles so they can assist when she goes home for Christmas.

She returns home for the holidays but experiences increased suicidal thoughts and engages in some superficial cutting after finding out her first semester marks. Her parents take her to her regular family doctor who insists she should be on an antidepressant and starts Mary on Cipralex.

Mary returns to the student health clinic two weeks later. She is talking louder and quickly, and has stayed up two nights in a row writing a paper. She feels “great” and likes the extra energy. She says she needs to work a lot harder this term to raise her average so is unconcerned by her lack of sleep. An urgent follow up appointment is arranged with the psychiatrist.

An urgent follow up appointment is arranged with her psychiatrist who is worried about:

a) SSRI induced hypomania
b) Evolution of a first presentation of bipolar disorder

The psychiatrist should:

a) Discontinue the Cipralex

b) Consider starting an atypical antipsychotic such as quietapine or olanzapine to help settle acute mood symptoms

Mary is monitored closely by the psychiatric nurse and starts seeing the psychiatrist weekly. She is tolerating olanzapine 5mg well, is sleeping better, and is no longer pressured in her speech, off the cipralex. The psychiatrist asks if he could talk to her parents by phone to learn more about the family psychiatric HX with respect to future medication planning for Mary. He also copies his note to the local family doctor advising her of the concern with the SSRI trial. He will update the Student Health family doctor and continue to see Mary regularly until the diagnostic picture is clear, and she is on a stable treatment plan.