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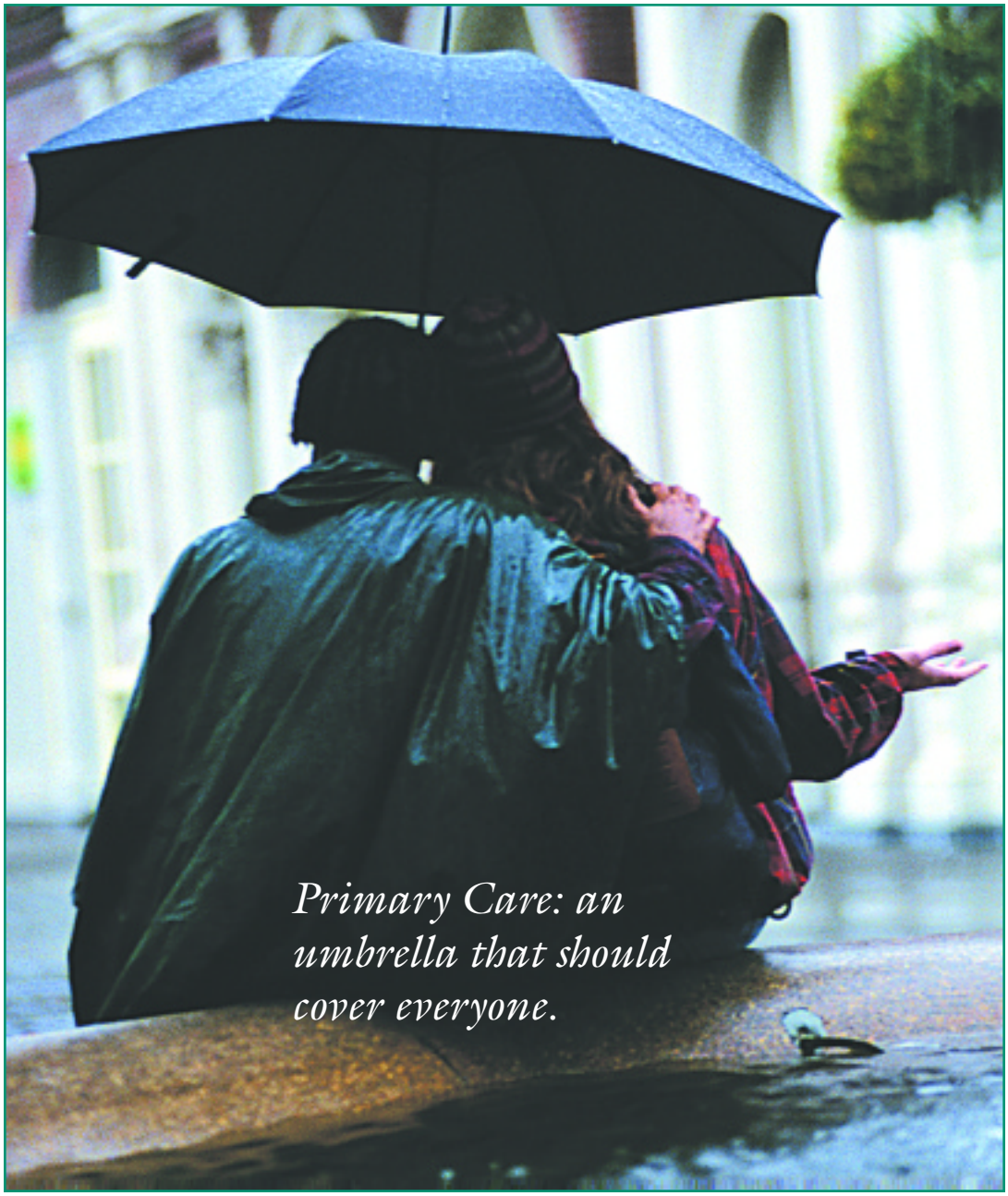

CANADIAN MENTAL
HEALTH ASSOCIATION
L'ASSOCIATION CANADIENNE
POUR LA SANTÉ MENTALE
Ontario Division/Division de l'Ontario

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OUR MISSION:
To provide leadership in advocacy and service delivery for people with mental disorders, and to enhance, maintain and promote the mental health of all individuals and communities in Ontario.

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Telephone 416-977-5580
Fax 416-977-2264
E-mail: division@ontario.cmha.ca
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A symbol of resilience and recovery for people who care about mental illness and health.

Primary Care Reform

BARBARA EVERETT, PH.D.
Chief Executive Officer

Primary care is the term health professionals, policy makers and others use to describe, in the main, the services people receive from their family physician.

Finding a family physician these days can be difficult. For people living in rural and remote areas of the province, it can be extraordinarily difficult. For people with mental illness, the search may be never-ending. Yet people with mental illness not only need high quality physical care, many, if not most, could have their mental illness managed by a family physician with support and proper links to psychiatric and community services. As a result, there is a lot of hope that plans to reform primary care in Ontario will take the needs of people with mental illness into account.

In Ontario, primary care reform refers to the government's policy to offer family physicians an opportunity, on a voluntary basis, to join a Family Health Network. While it could be assumed that this means that physicians will come together to form a larger and more accessible clinic staffed with other health professionals who will help with patient care, the actual intent is to electronically link physicians via the internet and special secure software. Mostly, they will continue to have their own offices dispersed throughout the community, but communicate with one another through secure email and shared electronic patient records. Service is to be offered on a seven-day per week, 24 hour basis augmented by the government's Telephone Health Service. While there has been some funding available to hire nurse practitioners, it is unclear if there is money to hire other health professionals such as social workers and mental health specialists. The government's commitment is to have 80% of physicians in Ontario practicing in Family Health Networks by the end of 2004. To date, very few Networks have been established and only 302 physicians have asked to explore the idea further after attending an information session. To put this number in perspective, there are 6,300 physicians who are members of the Ontario College of Family Physicians.

The reality is that there will never be enough physicians or psychiatrists to meet patient demand in Ontario or across the nation, as Lynne Raskin states in our first article in this issue of *Network*. Primary care solutions must focus not only on physicians but also on truly creative ideas that utilize to their full potential other health care specialists (nurse practitioners being only one example) who would have access to medical expertise on an as-needed basis. Community Health Centres, located conveniently and visibly in many communities across Ontario, have physicians on staff available for medical consultation while allowing the bulk of service to be delivered by a myriad of health care professionals. In a recent strategic review, these Centres were found to be highly effective in delivering primary care.

Shared care, meaning linking family physicians with psychiatrists, is described in our second article. This approach allows family physicians to help people with mental illness most of the time in their own offices, with the confidence that a psychiatrist is available in times of crisis, or when expert advice is needed. The Collaborative Mental Health Network is another version of shared care. Finally, the Canadian Mental Health Association Branch in Windsor-Essex has employed a nurse practitioner to provide primary care services for the people with mental illness and their families that this organization serves. One nurse practitioner in one community mental health agency has demonstrated that she can reduce visits to emergency rooms by 84% for clients with mental illness. A remarkably effective and cost-efficient way to deliver primary care.

The innovative primary care ideas described in this issue not only suit the needs of people with mental illness and their families, but have demonstrated success. Change comes slowly, it's true. But the time has come for an all-encompassing multi-disciplinary approach to primary care reform in Ontario.

PRIMARY CARE:

Building a Better Umbrella

Primary healthcare reform is on the minds of many these days. The recently released Romanow report placed heavy emphasis on this aspect of our healthcare system as well as calling for improvement in the quality of care and support available to people with mental illness. The term primary healthcare is one that has different meanings depending on the frame of reference of the person using it. A newly published document *Primary healthcare: Delivering the best to Canadians*, produced by the Canadian Health Services Research Foundation, examines research into different models of primary healthcare with respect to their adequacy in fulfilling the values inherent in our healthcare system. Researchers asked whether any one model can achieve the multiple objectives of providing equal access, continuity, quality, responsiveness and productivity. In the review process, they differentiate between what they call the professional approach, mainly physicians, and a community-based approach which uses interdisciplinary teams and, in addition, provides non-health services. Each model has two variations. The professional approach breaks down into the first-contact professional, consisting mainly of physician networks, and the coordinated approach where there is a stronger emphasis on integration and nurses work with physicians in the delivery of care. The community-based approach is divided into integrated community care, providing services around the clock with linkages to other teams/networks, and non-integrated, with restricted hours and no formal network. The synthesis document concludes that no one model is likely to produce all the desired results. Instead, it recommends that policy developers and health planners adopt a combination of the integrated community-based and professional contact model as research demonstates that they work well together.

People with mental illness not only need high quality physical care, many, if not most, could have their mental illness managed by a family physician with support and proper links to psychiatric and community services.

DR. BARBARA EVERETT, CEO
CMHA, Ontario Division

Building a Better Umbrella examines innovations occurring in Ontario in primary care for people with mental health problems. The reader will encounter different models on different points of the spectrum. It is most encouraging to see the interest and commitment of so many mental health providers to grapple with the complex issues of how best to improve services to people with mental health problems at the primary care level. With the promise of significant Federal funding to be made available for effective innovations in primary care, it is important that we continue to develop our experiential knowledge base so we can truly build a better umbrella.

"Primary care is an umbrella that is supposed to embrace everyone...but those people who most desperately need the medical system, those who have complex mental health problems, are frequently the most marginalized and most shut out from access."

Lynne Raskin, Executive Director
South Riverdale Community Health Centre

PRIMARY CARE:

Defining the Needs

***Lynne Raskin** is the Executive Director of the South Riverdale Community Health Centre in South East Toronto. She spent over 15 years in mental health prior to moving into the community health centre (CHC) sector, was the founding Executive Director of Alternatives, a community-based mental health program in East Toronto, and was also a senior policy analyst for the Mental Health and Rehabilitation Reform Branch in the Ministry of Health. She has served as President of the Ontario Federation of Community Mental Health and Addictions Programs, has been a keynote speaker, given workshops, taught at a community college, led and participated in many initiatives promoting community partnership and collaboration. Lynne has a background in nursing and psychology, has been a committed community volunteer and engages in initiatives with passion and a commitment to equity and social justice.*

South Riverdale Community Health Centre is a multi-disciplinary provider of primary health care. Health promotion, prevention, treatment and care are incorporated into the services and programs through community-based programming and clinical services. Services are provided to the broad Riverdale community, and focus on both general and population specific health needs. South Riverdale CHC is funded primarily by the Ministry of Health and Long Term Care and operates with an independent community Board of Directors, who are accountable to the membership, comprised of residents within the catchment area. There are 65 CHCs within the province, developed primarily to serve those who have barriers to accessing the health care system. South Riverdale, and other CHCs, operate from a Health Determinants perspective and embrace the World Health Organization definition of health as being more than an absence of illness.

Are we falling short as far as primary care for mental health patients is concerned?

Lynne Raskin: Definitely. From a primary care perspective we are talking about the first point of contact for someone who is struggling with mental health issues, and that could be their family physician, it could be a nurse practitioner, it could be a community health centre. The question then is, what is it that we should be doing as a primary care service? In the case of a family physician, for instance, can he or she help people directly or do they need to refer people with mental health issues to a psychiatrist? From a community health centre perspective, people often show up who are not part of the formal mental health system for a number of reasons. Either they aren't eligible, so for instance assertive community treatment teams (ACTT) won't pick them up, or they've been in the mental health system and it hasn't been helpful, or they want to be in a place where they are anonymous. They know they need help but their mental health needs are only one piece of who they are and they want to be in a setting that serves the general population. So those are some of the reasons that people with mental health issues show up at our door. Ironically a lot of the people we deal with are probably the most difficult to serve because they do not fit neatly into any of the major mental health categories – depression, manic depression, schizophrenia – or any of the other primary diagnoses that the mental health system has historically been built around. Another group that is typically very difficult to connect with at the primary care level are homeless people who have serious mental health problems. We see quite a lot of these individuals at South Riverdale.

The challenge for us in primary care becomes how do we manage these issues, because there are certain things in the current mental health system that we can't access. For instance, we are not a transfer payment agency for mental health so we can't directly

apply for mental health services funding through the mental health branch and we desperately need case coordinators or case managers in-house. What we can arrange are partnerships with mental health services. We also try to bring the shared care model into the community health centre sector to help the clinicians that are here to better manage people with mental health challenges.

You mentioned nurse practitioners. Do you see them as an important part of an inter-disciplinary team?

LYNNE RASKIN: I think they are the key. We have nurse practitioners here in teams working with the physician and a social worker. Because they can do some diagnosing and prescribing they also carry their own case load and have medical backup if they need it, so they can operate quite independently. They are critical in terms of patient care and people love them. If you are trained to do something and you do it well you should be doing it. How does it serve the public? I think it's clear that nurse practitioners do a pretty good job and the system needs them, leaving physicians free to do what physicians do best. This is also, in my opinion, the beginning of a 'client-centered approach' to primary health care.

Do you run into the problem that is common to many family physicians where someone comes in with a physical illness but also has a mental health problem that doesn't always get addressed?

LYNNE RASKIN: It's certainly true that this is a problem in terms of a family physician's ability to diagnose a mental illness with any kind of confidence, depending upon their experience. In terms of the shared care model, what happens here at South Riverdale is that we have a psychiatrist who comes weekly and meets with the clinical staff and social work staff, and they troubleshoot. The idea is to help the clinician acquire the skills to deal with the clientele directly. I've also worked in places where the shared care model works a little bit differently and the psychiatrist will actually operate as a member of the team and see clients and have their own case load. From a primary care point of view, one of the things that needs to happen is this entrenchment of inter-disciplinary teams which includes non-professionals. We need to look at health promotion and prevention as well as treatment, and community health centres already do that. I think it's really incumbent upon us not to duplicate services though. So do we need a case management service within our own Centre? Not if that person can be linked to existing case management programs in the community. However, it is becoming apparent that we do need case coordination within the Centre to make that link to mental health programs. My thinking around mental health reform and primary care reform is that they need to be happening and informing each other as they are rolled out. One of the reasons that primary care, as it exists, needs to be re-examined, is that there aren't enough physicians to infuse the system. We know that not everybody has access to a family physician. Add to that the fact that people with mental health problems take up more time and you can understand the reluctance of family physicians to add patients with mental health issues to an already full practice load. In the community health centre model, where physicians are paid a salary, we have the time and we are set up to deal with people who have complex and multiple problems. The other thing is that the Ministry of Health and Long-Term Care is trying to organize family practitioners within modules, not unlike community health centres, but different in the sense that they are physician-centered practices. So there is a recognition that working in teams is going to ultimately be better for people with complex mental health problems. Family physicians aren't psychiatrists, nor should they be, but people with complex mental health problems can burn physicians out to the point where they do not want to see these individuals, or will not take them back when they fall off their client case load

"One of the reasons that primary care, as it exists, needs to be re-examined, is that there aren't enough physicians to infuse the system. We know that not everybody has access to a family physician. Add to that the fact that people with mental health problems take up more time and you can understand the reluctance of family physicians to add patients with mental health issues to an already full practice load."

LYNNE RASKIN
Executive Director, South Riverdale Community Health Centre

Primary Care: Defining the Needs

after being in a shelter, or losing their housing or going to jail or something, and we struggle with trying to get them back with their original family physician or psychiatrist.

We know we don't have enough family physicians, do we have enough psychiatrists? Do we have enough people to build these inter-disciplinary teams?

LYNNE RASKIN: There probably aren't enough people, but I don't think there ever will be. The numbers are only part of the problem, it's the way we are organized that I think is of greater concern. The other issue is that we all feel we are entitled to have a family physician who will be our physician for life unless we decide to make a change. But that's not necessarily true of other parts of the health system. Many of the clinical experts that could be part of the team aren't necessarily going to be needed on an ongoing basis – they are there for consultation, to help with different situations like housing needs and so on. So multi-disciplinary teams do not have to be there for life.

What about the move towards trying to enroll people in a geographic area with a primary care service provider? What are the implications of this for individuals with mental health illnesses?

LYNNE RASKIN: Our instinct is to fight this move to rostering, especially in an urban environment. Much of the clientele that a lot of CHCs are serving are not easily enrollable. For instance, how do you get street people on a roster?

So the very people who most need primary care might not be able to access it at all?

LYNNE RASKIN: Precisely, and that should be a red flag for those who are rolling out mental health reform in terms of acknowledging what has happened in primary care reform. Rostering is certainly on the table and we need a safety net in place for people with mental health issues. I think those CHCs who have the infrastructure to accommodate more programming and more services should have a direct connection to mental health programs. Across the province there are a couple of CHCs who house ACT teams, and there are probably variations on a theme in other places. For instance we have a mental health program that rents space from us and they allow us to access their services, but we don't have a formal agreement with them. We need to formalize more of these kinds of relationships with community mental health programs. It's really important, but, as I said, we also need some 'bridging' personnel on our staff to do the connecting. I don't think there is any other way of doing it. Infusing more services into community-based care is one thing. Infusing more resources into primary health care and the medical side of mental health is another. We can all use more. But it's what happens in the relationships that will make the services really effective. Community health centres are really a microcosm of what's out there, the perceived dichotomy between the medical model and all the other non-medical models. You have two world views, and we have to bridge those two world views and make it work.

What other segments of society do you consider to be marginalized as far as primary care is concerned?

LYNNE RASKIN: A third leg to the stool of primary care and mental health is the whole substance use issue, because it often gets left out. Having worked in mental health, and now being at a CHC and having a harm reduction program which works with injection drug users, I think people that are the most marginalized are drug users because of the legality issues. How do you bring these people into the medical system? If you look at primary care it's an umbrella that is supposed to embrace everyone.The medical system, the way it is currently set up, best helps the most compliant patient, and yet espouses to help the most marginalized. When you think in terms of systems you think in terms of common denominators. You can't build a whole system around individual needs when they are so disparate. And yet those people who most desperately need help negotiating the medical system, those who have complex mental health problems, are frequently the most marginalized and most shut out from access. System responsiveness to the most marginalized groups is extremely important, and that is where CHCs play a vital role.

PRIMARY CARE:

Innovations in Shared Care

Dr. Ty Turner, M.D., C.C.F.P., F.R.C.P.(C), is currently Chief of Psychiatry and Medical Program Director at St. Joseph's Health Centre, Toronto. Prior to that he was Chief of Psychiatry at Toronto Doctors' Hospital. Since 2000, he has been the President of the Association of General Hospital Psychiatric Services (Ontario). Prior to completing psychiatry training at the University of Toronto in 1990, he was the first Provincial Coordinator of the Psychiatric Patient Advocate Office, and prior to that was a family physician in inner city Toronto. Dr. Turner has been a member of the Toronto Peel Mental Health Implementation Task Force. He is interested in general psychiatry, primary care liaison, and health care system planning. Dr. Turner also organized the first national conference on Shared Mental Health Care, presented by St. Joseph's Health Centre in conjunction with the University of Toronto and McMaster University, in Toronto in June 2000. This has now become an annual event, with the third conference planned to take place in Halifax, Nova Scotia, later this year.

Where does shared care for mental health disorders fit into primary health care?

TY TURNER: Primary care reform and shared mental health care go hand in glove. Shared mental health care is a means of providing psychiatric expertise for primary care patients, whether they be in a fee-for-service practice, capitated or salaried fee-for-care practice. It's a way of organizing the psychiatric support for those patients. Basically the way it tends to work is that the primary care personnel – the family physician, the nurse practitioner – refer the patient to the shared care program which then has a thorough look at the patient. As often as possible we like the person who made the referral to also be there. Advice and support for a treatment plan is then developed, and this support is ongoing. The key to the shared care program is that this is not a one-off thing. The shared mental health care team, which is really a multi-disciplinary team involving psychiatrists and other allied mental health professionals, remains in contact with the patient, the family and the primary care physician, and will provide whatever backup is needed when it is needed. Often these shared mental health care programs are part of a hospital spectrum of services.

So there is a continuity of care for the patient and support for the primary care giver?

TY TURNER: Exactly. It is about the traditionally understood continuum of mental health care linking up in an organized way with primary care physicians and nurse practitioners in the community.

This sounds like a win-win proposition for both family physicians and patients. Why is this not more widely implemented?

TY TURNER: There are a number of reasons. A lot of family physicians aren't aware of it. A lot of patients don't know about it, and the advantages of this type of approach are not widely understood. But there are huge advantages as to why a lot of patients prefer this over traditional direct service. First of all there is much less stigma. You are not going to see a psychiatrist every week or every month. You are not going to a mental health clinic. You are going to your own family physician. There is also the whole thing about ethno-cultural sensitivity. Your family physician is much more likely to speak your language. Your family physician also knows more about you and your family. They've built a relationship with you, delivered your children, helped you with your smoking addiction, eating disorder, back pain, etc. And that relationship tends to better integrate both physical and mental health. In fact research shows that people with mental illness are much more likely to also have physical health problems, and these are much better brought together through a person who has clinical responsibility for both types of problems – and that's your primary care physician. It also means fewer potential

Primary Care: Innovations in Shared Care

problems with medication. When medications are prescribed by different specialists, using different pharmacies, conflicts can emerge. As people become aware of the advantages of the shared care model, many are opting to go that route. People in large urban centres like Toronto, however, are much more likely to think about not just having a consultation from a specialist but actually having their care delivered directly through a specialist. Some of the time that is the best and only approach, but not always. Once you get out into medium and smaller sized communities they don't ask for those sorts of things. Some of the best models of shared care that you will see are in more remote communities where the family physician really has to get involved with the mental health problems. We're not just talking about prescribing medication, we're talking about counselling, psycho-educational support and the interaction with various agencies.

When you talk about shared care you are not necessarily talking about a team in the same physical location are you?

TY TURNER: No. Of course it's nice if the shared care can reach right into the physician's office and meet the patient on-site, but a fair amount of shared care involves the patient coming to see the specialty team but then going right back to the family physician and continuing to receive care, in an ongoing way, through the family physician. The other good thing about shared care is that it is often easier to get the patient in quickly, whereas waiting to get merely a direct consult, let alone having a psychiatrist take over the care of the patient, can take several months. Now sometimes we do find that some patients are so unstable, so ill, that they really need to have the direct, regular involvement of the psychiatrist and that can always be organized through shared care. Increasingly we are looking at shared care as being the first way to go, and then if special needs are identified, such as the need for regular direct contact with a psychiatrist or other mental health professionals, that can be organized secondarily. Shared care has now become the dominant model in child psychiatry and geriatric psychiatry partly because there is such a shortage, even in large urban centres, of those specialists.

You talk about a shortage of psychiatrists, but we also have a shortage of family physicians. If family physicians are the gatekeepers to the rest of these specialists and to the shared care model, what happens if we don't have access to that gatekeeper?

TY TURNER: That's a good question. I'll tell you what we do here. When you work closely with family physicians you get to know them pretty well and find out which ones are accepting new patients. What we can sometimes do is provide the initial mental health care for the depressed 'orphan' patient, and then link them up with a family physician. People also access shared care through walk-in clinics. Research shows that increasingly some walk-in clinics are providing more comprehensive care that is beginning to look more and more like the care you would receive from a family physician. Shared care can also be accessed through nurse practitioners. Nurse practitioners are not widely enough distributed, but I think they will become an important pathway in the future. The other problem with nurse practitioners is that the legislation that has established them does not really address their participation in the mental health field. There is a restricted list of medications that they can prescribe and currently there aren't any psychiatric medications on that list.

What innovative approaches to primary mental health care, either here in Canada or around the world, are you aware of?

TY TURNER: The Collaborative Mental Health Network program *(see page 12)* should be province-wide and available for all family physicians. It's a remarkable program and is a wonderful way for a psychiatrist to get his expertise out, because in a relatively limited period of time you can really contribute in a meaningful way to a person getting better. It amazes me how sick the patients are that the family physicians are working with. A lot of them have patients who refuse to see a psychiatrist, for a variety of reasons, and now we

have a way of getting to these patients and caring for them.

As far as any other innovative approaches to primary care, Dr. Nick Kates in Hamilton-Wentworth is directing what is generally acknowledged as one of the leading shared care programs in Canada. It won an American Psychiatric Association Significant Achievement Award. Basically what they are doing is actually sending psychiatrists into the family physician's office and seeing patients there. So the program puts the counsellors into the physician's office and pays for them. The physicians participating in that program are under the Health Services Organization (HSO) program. There is also the underserviced area program which I am involved with where the university sends specialists to work in underserviced areas with primary care physicians. I mentioned psycho-geriatrics and child and adolescent care, those are big areas in shared care which are really happening out of necessity. There are shared care programs in North Bay, Thunder Bay, and there is also one at North York General and the University Health Network in Toronto. They are definitely becoming increasingly prevalent, but still there are not enough.

"At the primary care level for people with mental health issues we have three main problems: funding, the lack of physicians and psychiatrists, and the way the health care system is organized and the dominant thing is to do with the way in which we are organized."

DR.TY TURNER
Chief of Psychiatry and Medical Program Director
St. Joseph's Health Centre

What do you see happening next in the area of shared care?

The next innovation we are expecting with shared care will involve shared care for people who have addictions problems – alcohol and drugs – and people who have addictions and mental health problems, which we call concurrent disorders. We expect to see innovations in those areas in the next couple of years. We've searched around the world and haven't found a program that does that yet and we'd like to be the first here at St. Joseph's. I'm pretty certain that in time we are also going to develop an innovation involving getting mental health care out to incarcerated prisoners through a shared care model. It's already happening informally within detention centres and jails. The needs are so enormous and there are not enough psychiatrists to go around.

Another innovative program is a shared care mental health program for homeless people in Toronto which now works out of the Centre for Addiction and Mental Health. In this program, clinicians go into hostels, and work with the staff to identify patients who are then provided with the services of a family physician, backed up by a psychiatrist. This is a group of people that typically is not going to fit into traditional primary care practice. And certainly a group that if we go the route of rostering could be left out of the loop. We regularly run into people who are mentally ill and homeless who have no OHIP card. They've had it maybe 15 times in the last few years but just keep losing it. They don't have an address, they lose their documents, and each time it takes them a month or so to get new OHIP coverage. I can see that any system that depends on a person of fixed address, who has the same name all the time, with the expectation that they will carry certain documents and numbers and IDs, is going to be a real challenge for people who have a less stable lifestyle. For as long as we have a system that is based on those kinds of things with respect to providing the financial basis for care, it's always going to be difficult for mentally ill people. The mental health implementation task forces are calling for expansion and enhancement of shared care, but I have yet to see in this province a vision of how the family health network scheme is going to help people with mental illnesses.

Building the Lines of Communication

The Collaborative Mental Health Network program, run by the Ontario College of Family Physicians, is a mentoring program which links family physicians with psychiatrist and GP psychotherapist mentors in a collaborative relationship to enhance mental health care. This program provides telephone and e-mail back-up and support for family physicians on a case-by-case basis. It also offers an educational component. The program was launched in February 2001.

DR. MICHAEL CORD, (MENTOR), A GENERAL PRACTITIONER, PSYCHOTHERAPIST, AND DR. BRETT JAMIESON, (MENTEE), A FAMILY PHYSICIAN PRACTICING IN EASTERN ONTARIO, DISCUSS HOW THE COLLABORATIVE MENTAL HEALTH NETWORK PROGRAM WORKS.

What do you think the main problems are with our primary care system as it relates to people with mental health problems?

MICHAEL CORD: I guess there are a number of factors. A principal one is the closure of a large number of the available in-patient beds in the general hospitals over the last three years. I think it's a process that is ongoing, so that tends to mean the primary care practice load for people who have severe mental illness is continuing to increase. That's one serious problem. The other is that the availability of psychiatric consultation is always problematic, not just in the sense of access, but in the sense that the communication channels tend to be discontinuous. There doesn't tend to be a lot of time, or interest, between a psychiatrist and a family physician to carry on a conversation about a patient with a mental health problem. I think it's a different situation if you have a patient with a rash and you send them to a dermatologist and get a diagnosis. Then you know what the treatment is. That's a very bare bones consultative process which doesn't necessarily require interactive communication. But when you have a patient with a complicated psychiatric history and you are trying to understand how to support them in an ongoing way from the primary care point of view, that is a very complex problem. You don't get a lot of help from a written consultation note that has a diagnosis and a recommendation for medication at the end of it. You really need more, so that's what the Collaborative Mental Health Network program attempts to answer.

BRETT JAMIESON: I moved to Eastern Ontario about eight years ago. Before that I was in the Niagara peninsula for 12 years. The picture of mental health here in Eastern Ontario, to my mind, is far worse than it was in Niagara. I have tried on several occasions to access psychiatrists since I have been here and I have basically given up. I have had very sick people who needed to be admitted to hospital and have not been able to get them in. I have tried to get sick people, who didn't need to be admitted right away, in to see a psychiatrist, and put up with incredibly long waiting lists and basically ended up dealing with them myself. The few times that I have managed to get patients into a hospital and seen by a psychiatrist, the psychiatrists were very disinterested in communicating with me beyond a discharge summary. The Collaborative Mental Health

Network program has been absolutely wonderful because it has resolved some of those problems. To be fair to the psychiatrists, let me add here that I think a lot of family physicians have a disinterest, or lack of knowledge or skills, in terms of psychiatric problems, and psychiatrists probably feel family physicians are not really on side in terms of implementing some of their strategies.

I understand that the Collaborative Mental Health Network program has both mentoring and continuing education components. How helpful have both of these elements been to you in your practice?

BRETT JAMIESON: From the educational point of view there is a lot of opportunity to make suggestions to Patricia [Dr. Patricia Rockman, Chair, Collaborative Mental Health Network program] in terms of feedback for needs that the mentees have. A lot of times when you go to a meeting with a few hundred people the agenda has already been set, there's not a lot of interaction, and you may or may not get something out of it. Being a small group we can have some input into what is talked about at the educational level. Because we are divided into small groups it's also comfortable in terms of being able to ask direct questions to our mentors about actual cases we have. The education component is very flexible, very geared to our needs, so I find it extremely helpful for my practice. In terms of the mentoring relationship, I know that some mentees do not utilize their mentors as much as they could or should for various reasons, but from my point of view it has worked, and continues to work, extremely well. I have practiced as a family physician for 20 years so I do have some experience with straight-forward mental health issues like depression, some anxiety disorders and a few other things, but for patients with comorbidity, or twists to their management that I can't sort out when it comes to medication, having a mentor that I can e-mail and get a response from within 24 hours makes a huge difference. My mentor will usually put me on track straight away, or just confirm that what I think and plan is correct and an appropriate approach to the problem. So guidance for drugs, resources in terms of literature to read about different problems, and direction in terms of ancillary resources that I might use for patient management are mostly what I get out of the mentoring program.

MICHAEL CORD: I recently had a patient where, with some urgency, I needed to have a question answered about medication. I called my psychiatric mentor counterpart, Jon Hunter, and almost immediately got an answer which resolved my mini-crisis in the office with my patient. So that's another example of how the program works in a very positive way where there is horizontal consultation available. It's not just a question of mentees having access to mentors, but mentors and mentees having access to each other as well. This means that supportive relationships can be built either because they have a shared clinical interest or geographic location. In either case, what the program is providing is something quite different from the usual consultative vertical relationship where the family physician looks to an expert opinion from a consultant. What the collaborative program offers is a kind of network of relationships, and anyone in the network can access anyone else.

One thing I found surprising is that the mentors have been used less frequently than was originally anticipated.

MICHAEL CORD: I think there are two aspects to this. One is that there hasn't been a program like this in the province before so there really isn't a good comparison. The other factor is that a lot of participants feel supported just by being part of the program, and that's a separate thing from the actual number of times that they utilize the mentoring. We also have the continuing medical education component and participants know that they will be part of both the conferences and small group gatherings two or three times a year, and that's actually very supportive. That's been borne out by the evaluation reports we have received from the mentees. Now to make it more particular, what's happened in my group for instance is that one physician who had seemed very reticent to ask questions of me or my co-mentor in the first year and a half of the program has, in the last few months, started to become active. I think that physician just needed time to become more

"What the program is providing is something quite different from the usual consultative vertical relationship where the family physician looks to an expert opinion from a consultant. [Instead] it offers a kind of network of relationships, and anyone in the network can access anyone else."
DR. MICHAEL CORD

Primary Care: Building the Lines of Communication

confident and to feel safer in asking questions without appearing foolish.

Dr. Jamieson, do you think the program has given you a greater confidence level in taking on mental health issues that you might not have wanted to have dealt with before?

BRETT JAMIESON: I think in all honesty it has given me both a greater confidence and greater competence. You don't want to have false confidence but when you've had a bit of experience and been given feedback that yes, you are on the right track, you certainly become more confident and you become more competent as well.

What do you think the overall benefits of this type of program are to the patient?

MICHAEL CORD: I think that the more communication that anyone's physicians have amongst themselves when they are providing care is going to be a boon to the patient. That's the ideal provision of medical care, not just when it comes to mental health but any aspect. You want your family physician and your specialist to have as much communication as possible so that they know what each other is thinking and understand how to apply their treatment programs. The other benefit that is somewhat more subtle, is that if you have a serious mental health problem and you go to your family physician your physician is more likely to be able to help you if they are part of a program in which they feel supported. If not, then the chances are that they will say 'go and see a psychiatrist', because they will not want to deal with a complex problem without some kind of support. So the improvement in the confidence level, which Brett referred to, in handling mental health problems is a major boon to the patient.

What about the fact that dealing with a patient who has mental health problems typically takes up more time than someone who has a physical disorder? Has the program helped you to manage mental health care problems more efficiently timewise?

BRETT JAMIESON: The short answer is yes. It has made me feel that these are manageable problems within a finite period of time. The long answer is that I think part of the collaborative mental health process that needs to be explored a bit more is making family physicians aware of the different models of psychotherapy and coming up with some sort of teaching model to learn the different models and how to apply them.

MICHAEL CORD: I think there is a kind of filtering that happens whereby the physicians who have signed up for this program already have a curiosity and a willingness to deal with the kinds of complex problems that mental health patients have. Physicians who don't have that interest or curiosity won't take the time and will manage their practice accordingly. I don't think there is an easy way to be more efficient with mental health problems – they do tend to take more time. I think if you deal with these problems appropriately you have to devote that time from your practice. There isn't a shortcut.

Lynne Raskin, Executive Director at Riverdale, says that although lack of physicians is a concern that is only part of the problem. The other part is the way the health system is organized, we need more inter-disciplinary teams. How would you respond?

BRETT JAMIESON: That's exactly what we are doing with the program of course, and that point is very well made because my basic job, as I was taught it, is to diagnose, treat and manage organic diseases. Even in that regard if you are managing someone with diabetes for instance you need dieticians involved, you need optometrists, you need podiatrists, so there should be a team approach to the management of all illnesses as well as mental health issues, whether it's access to social workers, to help schizophrenic patients or psychotic patients to manage finances or work their way through the various government systems, or trained therapists. That is the other huge problem that we have in Eastern Ontario, funded psychotherapists or funded counsellors are basically non-existent, and if they do exist it takes months to get in to see them. I think a lot of family physicians take this kind of work on out of necessity, when in fact it might be better bang for the health care dollar to have someone else doing it. I think trained therapists are much better than

most family physicians at doing it, and probably provide better care for the patient.

So shared care or inter-disciplinary teams are the most beneficial for the patient and the physician?

BRETT JAMIESON: Yes, and it's interesting that very few people outside of say the College of Family Physicians or the Canadian Medical Association really seem to be concerned about what matters to the physicians. We talk about 24 hour coverage and sure it makes sense, but I don't want it because I have a wife and children and feel I have as much right as anyone else to have some time to spend with my family. So there are a lot of things to get my brain around with regard to primary care reform.

The issue of liability when working as part of a team has been raised by some physicians. For instance, the fact that it can be risky to be part of a health care team when some are going to be held more accountable, take more risks, than others. How do you feel about this?

BRETT JAMIESON: You know it's not a concern for me. Part of being on a team is knowing who the members are, what their capabilities are and assuming that they know their limitations. The big issues in mental health are that of patients being suicidal or homicidal, or having adverse reactions to medication. As a family physician, every time I see a depressed patient I specifically ask, 'Are you suicidal? Are you homicidal? Have you had any side-effects with medication?' I make sure that I feel comfortable that they have been adequately informed about adverse effects. Because I take care of the things that I need to, and trust the people on the team I am involved with to take care of the things they are responsible for, it isn't an issue for me. It certainly wouldn't prevent me from being part of a team.

Could you give me a few examples of how you have used the collaborative program?

BRETT JAMIESON: One of my patients is an elderly gentleman. He's an alcoholic, probably drinks 26 ounces of alcohol a day. It's difficult for his wife to manage. He was incarcerated for a drunk driving charge, but once he got out he slipped back into his old ways again. When I was at the Collaborative Mental Health Network weekend conference in January, we talked about Brian's Law and changes to the Mental Health Act. I was not aware that I could certify this man and have him admitted against his consent to a treatment facility. Of course he could choose to leave after a week, but at least we could get him started. So I talked to my mentor about some of the aspects in that regard and it's been very helpful. I wouldn't have known about that had I not been involved in the program.

A young female patient I deal with has some congenital problems, as well as substance abuse problems. She had been labelled as attention deficit disorder and put on medication. I started seeing her about 18 months ago when she was not doing well, she was skipping school and having trouble with relationships. I e-mailed her case to my mentor and gave him a thumbnail sketch of what I saw. It turned out that she had been misdiagnosed and has in fact a bi-polar disorder. She is now on the correct medication and dramatically better.

MICHAEL CORD: One thing I would like to add is that I think that one of the reasons that the program is as viable and energetic as it is is a function of the management. In the case of this program the management consists of Jan Kasperski who is the Executive Director for the Ontario College of Family Physicians, Pat Rockman, Chair, and Lena Salich who is the Continuing Medical Coordination coordinator. They have a great working relationship and it's their management and personalities that have really been crucial to the success of this program.

BRETT JAMIESON: I am a big fan of the program. It's so nice to be able to pick up the telephone and get a friendly voice, or an e-mail from someone telling me I am on the right track. If this can be a part of primary care reform I am all for it.

"There should be a team approach to the management of all illnesses as well as mental health issues, whether it's access to social workers, to help schizophrenic patients or psychotic patients to manage finances or work their way through the various government systems, or trained therapists."
DR. BRETT JAMIESON

PRIMARY CARE:

The Role of the Nurse Practitioner

In October 2000, CMHA, Windsor-Essex Branch received funding to hire a nurse practitioner (NP) to provide primary care to consumers/survivors in the Windsor area. The NP, Bonnie Myslik, recently received a national award from the Canadian Mental Health Association for her dedication, compassion and skill. Ms. Myslik provides primary care services, in consultation with a physician, and collaborates with staff to provide the best overall care for more than 800 clients in the primary care clinic.

THE NURSE PRACTITIONER PROGRAM IN WINDSOR HAS HAD A POSITIVE IMPACT ON THE REGION'S OVERWHELMED EMERGENCY WARDS. FOR THOSE CLIENTS WHO HAD MADE HOSPITAL EMERGENCY ROOM VISITS PRIOR TO USING THE CLINIC, 84% REPORTED A DECREASE IN THEIR EMERGENCY ROOM VISITS AFTER BEGINNING TO USE THE CMHA CLINIC FOR PRIMARY CARE. SEVENTY-FIVE PERCENT REPORTED A DECREASED USE OF CRISIS CENTRES.

How did the primary care clinic in Windsor get started?

BONNIE MYSLIK: After the CMHA, Windsor-Essex Branch received funding from the Ministry of Health and Long Term Care for their proposal to hire a nurse practitioner, Pam Hines, the CEO, interviewed me and I began work in October 2000. We really started from the ground up with an empty room with no medical equipment. Today we have two rooms completely outfitted where we provide medical care for more than 800 clients who have no other primary care provider.

What kind of cases are you treating and at what point do you liaise with a psychiatrist or general practitioner?

BONNIE MYSLIK: I'm mainly dealing with medical care – bronchitis, skin rashes, urinary tract infections – you name it, if it's medical I will deal with it. Case workers also book people into the clinic for me to check on their psychiatric stability. One woman with mental health problems came to the clinic who was quite a challenge. She had bounced from one clinic to another because she was so difficult to deal with, very hostile. I did a complete physical, which I do with all new patients who come to the clinic, and discovered a walnut-sized tumour in her right breast. Within a week she had had a mammogram, a biopsy and surgery. I like to think that I had a really positive impact on that woman's life; that she's alive today because she did have access to medical care at a clinic that understood how difficult it can be for people with mental health problems to access health care. Mental health patients need more than a 10 minute appointment. They don't react well to sitting in a waiting room for an hour. We understand that and

the clinic is designed around their needs, both physical and mental. As far as liaising with other medical staff, I have a case conference at the end of each week with a psychiatrist and general practitioner. Under their directive, medications for mentally ill patients are increased or changed.

Did the woman with the tumour come to the clinic with a mental health issue?

BONNIE MYSLIK: Yes, and because she was such a challenging patient nobody had ever conducted a complete physical on her. The attention had always been given to the mental health problems she presented with. We have to look at the whole picture when we treat someone.

How do you see the role of the nurse practitioner as part of an inter-disciplinary care team at the primary care level, and does that role in any way change the role of the family physician?

BONNIE MYSLIK: Primary care reform at this point has some limitations. Because of the way the funding currently is laid out it self-selects against mental health patients because of their complexity. Physicians who work in primary care would tend to bring people into their practice who do not require the amount of follow-up and time that mental health clients require. I think nurse practitioners have a huge role to play in primary care reform. If we had one nurse practitioner to work with every family physician in Ontario much of our problem with access to medical care for clients would be solved. Nurse practitioners can do approximately 80% of what a general practitioner can do and we've proved that here at the clinic. I work five days a week and consult with a physician for half-an-hour to one-hour a week total for all the clients I see. Nurse practitioners can prescribe medications for physical health problems, we can order ultra-sounds, x-rays and diagnostics tests and then when we need to consult or refer to a specialist we can do that under the directive of a physician. We can also renew medications for clients who have chronic stable illnesses. I like to think that in some cases I extend the arms of a physician. I fill out Ontario disability forms, CPP forms, housing forms, and if the physician is the only person who can authorize those things, and in many cases that is the only signature that is accepted, I am able to advocate for patients in a timely way by completing these forms and then after a quick review the physician can sign them and they're in the mail. As far as how this would change the role of a family physician, in many ways it would free a physician up to do what he or she is uniquely qualified for.

"I'm more and more confident that there has to be a link between primary care and mental health services. I'm a believer in the shared care model. If physical health is not managed, how can we manage mental health in the community?"

PAM HINES, CEO
CMHA, Windsor-Essex Branch

What do you think should be done differently at the primary care level especially as it relates to patients with mental health problems? What would improve the system from their point of view?

BONNIE MYSLIK: Access is number one. And you are going to have to have people who are committed to providing that access. Many people are inexperienced in the area of mental health and they don't realize how gratifying it can be. Giving that extra bit of time, not rushing them, is something patients are so grateful for. In most places we line them up in an emergency waiting room. We see them at their worst because they've been left for three hours with the voices in their head getting more insistent, or becoming more delusional, thinking that people around them are talking about them. No wonder they seem hostile by the time they get to see a physician. So we need to find a way for people to come in for a timely appointment with people who truly care about them and have the time to talk to them. I think the current system of remuneration is one of the biggest barriers for physicians in dealing with this population. If you are a family physician who has 40 people to see each day and five of those patients have complex mental health issues that require a

Primary Care: The Role of the Nurse Practitioner

half-an-hour appointment each you're just not going to be able to find the time. We also need proper remuneration for physicians who work with nurse practitioners in clinics so that if the physician is being consulted, or their name is being used to renew medication or to order a CT scan, they will be remunerated for their time, and for their consultation with the nurse practitioner.

I understand that since the clinic has been operating there has been a major reduction in the number of hospital stays for this population?

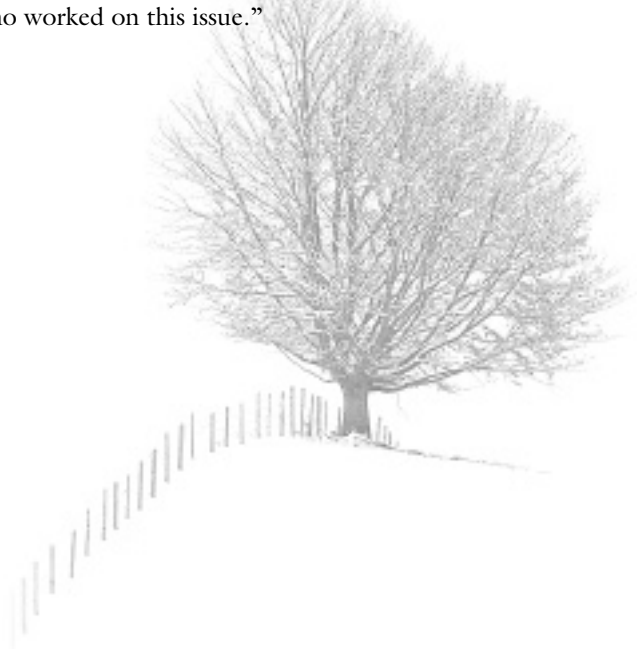
BONNIE MYSLIK: The data shows that among those using the clinic there has been a significant decrease in hospitalization. I think that alone supports the need for this kind of care. If we are only treating someone for their mental health problems, physical ailments can sometimes go unnoticed, just as when a family physician is treating physical ailments the mental health issues can go undetected. Let me give you an example of that. One of our clients has chronic schizophrenia and was brought here when she suddenly became more delusional. I did a physical check up on her, including a urine test, and she turned out to have a bladder infection. I prescribed an antibiotic, the infection cleared up and the delusional behaviour went back to baseline. We didn't need to change her psychiatric medication or have any psychiatric intervention at all. Instead of going to a hospital emergency room this woman was able to get a timely appointment, have a complete check up and have the issue quickly resolved. The kind of primary health care that we are delivering at the clinic is an absolute necessity if we are to meet the needs of patients with mental, and physical health issues.

Responding to the topic of Recovery

(*Network, Winter 2003*)

The Winter 2003 issue of *Network*, which dealt with the topic of *Recovery: the emergence of new life from the depths of winter*, inspired one reader to share her creative response. "I wanted to write and thank everyone who worked together to produce this issue of *Network*. The visual presentation is excellent and so relevant, and the content is thought-provoking and hopeful. In itself it is a therapy session. I am enclosing a copy of the poem I was inspired to write by your cover photograph and the contents of your magazine; it is my personal thank-you to everyone who worked on this issue."

When Winter frosts clamp hard upon the land
And snow obliterates all trace of life,
Then earth solidifies beneath the hand
Of bitter winds, as sharp as any knife.
Crystallised in ice, tree branches groan,
Birds are silent, shivering in the hedge;
Fields lie barren frozen to the bone,
Life hangs in balance, teetering on the edge.
Yet, undeterred, the sunlight falls much stronger,
Drifts around the tree trunks melt away;
Sap stirs, reluctant to be still much longer,
Encouraged by the lengthening of each day.
Though Winter howls, it is the final fling;
Recovery is well in hand for Spring.



HILARY MOSS, FEBRUARY 2003

MAY 5-11, 2003

National Mental Health Week. The goal this year is to reduce the shame and social isolation associated with mental illness so that people can comfortably seek help and not fear losing their friends, family, work opportunities and other areas of support. Watch for a public campaign during this week with the tagline: *"Respect, Don't Reject! If you have a brain, you can have mental illness"*. Call your local Branch of the Canadian Mental Health Association for activities and events in your area.

MAY 6-7, 2003

Mental Health Tune Up 2003
This free Public Education Forum and Community Resource Fair, taking place during National Mental Health Week, will feature exhibits, lectures/speakers and representatives from over 50 community service organizations in the GTA. Featured experts will address such issues as emotional intelligence in the workplace, balancing work and family responsibilities, children's mental health, depression and anxiety, productivity, mental health tips and numerous other subjects affecting mental health. Printed materials, videos, on-site experts and practitioners ("Talk with a Doc") will provide a broad range of mental health expertise for people of all ages. Mental Health Tune Up 2003 is a partnership between the Ontario Psychological Association and the Canadian Mental Health Association, Ontario Division. For more information, visit www.mentalhealthtuneup.ca or call 416-813-2282 ext. 2001.

JUNE 6 -7, 2003

People in Motion. Canada's premier event for persons with disabilities, seniors with special needs and professionals working in related areas. Queen Elizabeth Building, Exhibition Place, Toronto, Ontario. For more information: Tel: 905-702-1121, Fax: 905-702-1244, e-mail: sales@people-in-motion.com or visit the website: www.people-in-motion.com.

JUNE 13, 2003

Canadian Mental Health Association, Ontario Division's Achievement Awards Banquet. CMHA Ontario Division's annual awards program to recognize individuals and organizations who contribute to the important work of enhancing mental health for the people of Ontario. Holiday Inn Select, Toronto Airport, 970 Dixon Road, Toronto, Ontario. For more information: Tel: 416-977-5580, Fax: 416-977-2264 or e-mail: division@ontario.cmha.ca.

JUNE 14, 2003

Canadian Mental Health Association, Ontario Division's Annual General Meeting. Holiday Inn Select, Toronto Airport, 970 Dixon Road, Toronto, Ontario. For more information: Tel: 416-977-5580, Fax: 416-977-2264 or e-mail: division@ontario.cmha.ca.

JULY 7-9, 2003

FedEx Indy Bike Challenge. Canadian Mental Health Association, Ontario Division is proud to be participating for the 8th consecutive year in this fun, friendly and competitive event. Teams obtain pledges and sponsorships to race and raise money to support the CMHA and other Toronto charities. Great incentives for participants. Exhibition Place, Toronto. To get involved or for more information contact Aileen Mitchell: Tel: 416-977-5580 ext. 4140, e-mail: amitchell@ontario.cmha.ca or visit the website: www.ontario.cmha.ca.

JULY 18-21, 2003

Building Community Supports - Canadian Mental Health Association, National Conference 2003. The conference will consist of 12 workshops over a two day period with a key note address on Friday morning by Stephen Lewis. Yellowknife Inn & Capital Theatre, Yellowknife, Northwest Territories. For more information contact Mike Mann, CMHA Northwest Territories, Tel: 867-873-3190, Fax: 867-873-4930, e-mail: cmha@yk.com or visit the website: www.cmha.ca.

AUGUST 24-27, 2003

The Balancing Act: Governance, Innovation and the Public Good. The 2003 National Institute of Public Administration of Canada Annual Conference. The Conference theme will explore the dynamic balance among three important realities for public administrators: governance, innovation and the public good. For more information contact IPAC: Tel: 416-924-8787, Fax: 416-924-4992, e-mail: ntl@ipaciapc.ca or visit the website: www.ipaciapc.ca.

Mental Health Works Launches Web Site

Want to know how to tell your manager that you have a mental health problem? Wondering what your rights and responsibilities are if you have an employee with a mental health problem? Take a browse through our new web site. You'll find the latest information about mental health in the workplace for employers and employees, answers to frequently asked questions, links, breaking news stories, and much more. ***www.mentalhealthworks.ca*** *– your first stop for information about mental health and the workplace.*

Making Gains

Research, Recovery & Renewal in Mental Health & Addictions.

in Mental Health & Addictions

THE CANADIAN MENTAL HEALTH ASSOCIATION, ONTARIO DIVISION (CMHA), THE CENTRE FOR ADDICTION AND MENTAL HEALTH (CAMH), THE ONTARIO FEDERATION OF COMMUNITY MENTAL HEALTH AND ADDICTION PROGRAMS (OFCMHAP), AND THE ALCOHOL AND DRUG RECOVERY ASSOCIATION OF ONTARIO (ADRAO), FOUR OF THE LEADING ORGANIZATIONS IN MENTAL HEALTH, ADDICTIONS AND SUBSTANCE ABUSE IN ONTARIO WILL BE HOSTING A MAJOR CONFERENCE TO BE HELD AT THE HILTON NIAGARA FALLS HOTEL (ONTARIO).

SEPTEMBER 28 – OCTOBER 1, 2003

For more information contact:
Rachel Gillooly, Conference Coordinator
Tel: 705-454-8107 or Toll-free: 1-877-372-2435
Fax: 705-454-9792, e-mail: rachel@haliburtonhighlands.com
or visit the website: www.ontario.cmha.ca.

The latest research results from the Community Mental Health Evaluation Initiative will be the focus of the opening plenary at the Making Gains conference, setting the stage for two and one-half days of sessions in six key areas: recovery, dual diagnosis, organizational strategies in times of change, evidence-based practices in mental health and addictions, concurrent disorders, and addictions. This event will be of interest to mental health and addictions professionals, volunteers, public educators, policy makers, community organizations, and consumer groups. Presentations will focus on innovative policies and initiatives, demonstration projects, and research results. Participants will explore new perspectives on mental health and addictions across all six streams, share strategies for surviving and thriving in a changing environment, and learn how to translate knowledge into practice.

Network

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CANADIAN MENTAL HEALTH ASSOCIATION
L'ASSOCIATION CANADIENNE POUR LA SANTÉ MENTALE
Ontario Division/Division de l'Ontario

180 Dundas Street West, Suite 2301
Toronto, Ontario
M5G 1Z8