

**Shared Collaborative
Mental Health Care:
The Good, The
Bad & The Ugly**

**Best Brains Exchange, CIHR, St. John's, Newfoundland
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Thomas E. Ungar, MD, M. Ed, CCFP, FCFP, FRCPC, DABPN
Psychiatrist-in-Chief, St. Michael's Hospital
Associate Professor, University of Toronto
ungart@smh.ca

Objectives

- Enhanced knowledge of the service delivery model **Shared Collaborative Mental Health in Canada** and where it might fit in tiered care
- Attitudes, Skills and role clarification processes to enhance shared collaborative integrated mental health care.
- Attitudinal and structural barriers and challenges

Today's Presentation Based Upon

- Some evidence
- Some informed expert opinion
- Personal experience
- Personal opinion
- To stimulate group discussion

Recurrent Themes Prior Shared Care

- Poor communication between Family Medicine and Psychiatry as specialties
- Difficulty in accessing timely psychiatric consultations.
- Psychiatric intake procedures cumbersome and inefficient.
- General lack of support and respect for the FP as a mental health caregiver.

Kates,N

Health Law in Canada

Editor-in-Chief: Gilbert S. Sharpe, B.A., LL.B., LL.M.

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• TWO SOLITUDES: PSYCHIATRY AND PRIMARY CARE FAMILY MEDICINE — A GROWING RELATIONSHIP •

Dr. Thomas E. Ungar and Dr. Brian F. Hoffman

Psychiatry and primary care/family medicine have traditionally been practised in relative isolation from each other in both the clinical service delivery and the educational experience, despite a natural affinity between the professions in terms of patient care. For example, over 50 per cent of primary care office visits are due to mental health related concerns,¹ and over 50 per cent of people with mental health disorders who receive care do so from their family physician.² This paper will attempt to explain why this current lack of relationship exists. It will then describe and explain many of the current forces of change on this relationship. Finally, a new, emerging, more collaborative relationship will be described with examples.

TWO SOLITUDES

Primary care physicians generally report a need for improved access to psychiatric services for their

patients.³ They report waiting lists for mental health care services for their patients in general, and a specific lack of timely psychiatric services. They describe a frustrating lack of communication between themselves and psychiatrists, and an inability to speak directly to a psychiatrist, or failure to have telephone calls returned. Psychiatrists, on the other hand, report frustration with the skills of the primary care providers in mental health-related problems and an inability to move patients out of mental health care services back into their primary care physician's offices. The lack of communication between family physicians and psychiatrists can result in poor patient care. Coroners' inquests have often recommended improved communication between psychiatrist and family physician.⁴ There are several reasons why this distant non-responsive inter-professional relationship exists.

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The Premise of Shared Care

Do you think we can provide better care and quality working together?

What is Shared Mental Health Care?

A service delivery model

The Traditional Model

- Psychiatrist half-day/week in family practice offices
- Evolved to broader collaborative care team
- In the US evolved to Integrated Care, with stepped care pathways/rules by HMO's

The Good

ORIGINAL ARTICLE

Collaborative Care for Patients with Depression and Chronic Illnesses

Wayne J. Katon, M.D., Elizabeth H.B. Lin, M.D., M.P.H., Michael Von Korff, Sc.D., Paul Ciechanowski, M.D., M.P.H., Evette J. Ludman, Ph.D., Bessie Young, M.D., M.P.H., Do Peterson, M.S., Carolyn M. Rutter, Ph.D., Mary McGregor, M.S.N., and David McCulloch, M.D.

ABSTRACT

BACKGROUND

Patients with depression and poorly controlled diabetes, coronary heart disease, or both have an increased risk of adverse outcomes and high health care costs. We conducted a study to determine whether coordinated care management of multiple conditions improves disease control in these patients.

METHODS

We conducted a single-blind, randomized, controlled trial in 14 primary care clinics in an integrated health care system in Washington State, involving 214 participants with poorly controlled diabetes, coronary heart disease, or both and coexisting depression. Patients were randomly assigned to the usual-care group or to the intervention group, in which a medically supervised nurse, working with each patient's primary care physician, provided guideline-based, collaborative care management, with the goal of controlling risk factors associated with multiple diseases. The primary outcome was based on simultaneous modeling of glycated hemoglobin, low-density lipoprotein (LDL) cholesterol, and systolic blood-pressure levels and Symptom Checklist-20 (SCL-20) depression outcomes at 12 months; this modeling allowed estimation of a single overall treatment effect.

RESULTS

As compared with controls, patients in the intervention group had greater overall 12-month improvement across glycated hemoglobin levels (difference, 0.58%), LDL cholesterol levels (difference, 6.9 mg per deciliter [0.2 mmol per liter]), systolic blood pressure (difference, 5.1 mm Hg), and SCL-20 depression scores (difference, 0.40 points) ($P < 0.001$). Patients in the intervention group also were more likely to have one or more adjustments of insulin ($P = 0.006$), antihypertensive medications ($P < 0.001$), and antidepressant medications ($P < 0.001$), and they had better quality of life ($P < 0.001$) and greater satisfaction with care for diabetes, coronary heart disease, or both ($P < 0.001$) and with care for depression ($P < 0.001$).

CONCLUSIONS

As compared with usual care, an intervention involving nurses who provided guideline-based, patient-centered management of depression and chronic disease significantly improved control of medical disease and depression. (Funded by the National Institute of Mental Health; ClinicalTrials.gov number, NCT00468676.)

From the Departments of Psychiatry and Behavioral Sciences (W.J.K., P.C.) and Medicine (B.Y.), University of Washington School of Medicine; Group Health Research Institute (E.H.B.L., M.Y.K., E.J.L., D.P., C.M.R., M.M., D.M.); and the Department of Biostatistics, University of Washington School of Public Health (C.M.R.) — all in Seattle. Address reprint requests to Dr. Katon at the Department of Psychiatry and Behavioral Sciences, Box 356160, University of Washington School of Medicine, 1959 N.E. Pacific St., Seattle, WA 98195-6160, or at wkaton@u.washington.edu.

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Cost, effectiveness, and cost-effectiveness of a collaborative mental health care program for people receiving short-term disability benefits for psychiatric disorders.

Dewa CS, Hoch JS, [Carmen G](#), Guscott R, Anderson C.

Source

Centre for Addiction and Mental Health, Health Systems Research and Consulting Unit, Toronto, Ontario. carolyn_dewa@camh.net

Erratum in

Can J Psychiatry. 2009 Jul;54(7):428. Gusscott, Richard [corrected to Guscott, Richard].

Abstract

OBJECTIVE:

To examine the cost, effectiveness, and cost-effectiveness of a collaborative mental health care (CMHC) pilot program for people on short-term disability leave for psychiatric disorders.

METHOD:

Using a quasi-experimental design, the analyses were conducted using 2 groups of subjects who received short-term disability benefits for psychiatric disorders. One group (n = 75) was treated in a CMHC program during their disability episode. The comparison group (n = 51) received short-term disability benefits related to psychiatric disorders in the prior year but did not receive CMHC during their disability episode. People in both groups met screening criteria for the CMHC program. Differences in cost and days absent from work were tested using Student t tests and confirmed using nonparametric Wilcoxon rank sum tests. Differences in return to work and transition to long-term disability leave were tested using chi-square tests. The cost-effectiveness analysis used the net benefit regression framework.

RESULTS:

The results suggest that with CMHC, for every 100 people on short-term disability leave for psychiatric disorders, there could be \$50 000 in savings related to disability benefits along with more people returning to work (n = 23), less people transitioning to long-term disability leave (n = 24), and 1600 more workdays.

CONCLUSIONS:

CMHC models of disability management based on our Canadian data may be a worthwhile investment in helping people who are receiving short-term disability benefits for psychiatric disorders to receive adequate treatment.

Shared Care



- Shared Care originally defined as:
 - “A process of collaboration between the family physician and the psychiatrist that enables the responsibilities of care to be apportioned according to the treatment needs of the patient at different points in time in the course of a mental illness and the respective skills of the family physician and psychiatrist” (Kates, et al., 1997)



Collaborative & Shared Care

- Within Canada the movement towards Shared Care began in 1996 (Craven, & Bland, 2002; Kates, et al., 1997)
- Included the development of a number of initiatives:
 - Collaborative Working Group between the College of Family Physicians and the Canadian Psychiatric Association (Craven, & Kates, 2000)
 - Canadian Collaborative Mental Health Initiative (CCMHI, 2006)
- The term Shared Care evolved to Collaborative Mental Health Care to include all members of the health care team including the person with mental illness and their families



- “Over the last 10 years [since the movement began in 1996], shared or collaborative mental health care has moved from being a “fringe” area of practice for a handful of providers across the country to one that is increasingly seen by provinces and health authorities as an integral part of their mental health care delivery systems”

Kates, Gagne, & Whyte, 2008

Keys to Success of Shared Care

- Improved communication
- Increased accessibility
- Personal contacts
- Mutual support
- Mutual respect
- Issues resolved as they arise

Kates, N

Key to Success of Shared Care


- Supported at every level
 - Clinicians
 - Local Planners
 - Academic Departments
 - Funders
 - Provincial planners

Shared Mental Health Care in Canada (CFPC & CPA) (1997)

**Canadian Collaborative Mental Health
Initiative (2006)**



**Enhance: Enhancing Collaboration in
Primary and Mental Health Care &
Addictions Through Inter-Professional
Care and Education (2010)**



**CPA/CFPC Position Statement Evolution of
Collaborative Mental Health Care (2011)**





Canadian Psychiatric Association
Dedicated to quality care
Association des psychiatres du Canada
Dedicated aux soins de qualité

THE COLLEGE OF
FAMILY PHYSICIANS
OF CANADA



LE COLLÈGE DES
MÉDECINS DE FAMILLE
DU CANADA

POSITION PAPER

The Evolution of Collaborative Mental Health Care in Canada: A Shared Vision for the Future

N Kates, MBBS, FRCPC, MCFP¹; G Mazowita, MD, CCFP, FCFP²; F Lemire, MD, CCFP, FCFP³;
A Jayabarathan, MD, FCFP⁴; R Bland, MB, ChB, FRCPC, FRCPsych⁵; P Selby, MBBS, CCFP, MHSoc;
T Ioumra, MD, FRCPC⁶; M Craven, MD, PhD, CCFP⁷; M Gervais, MD, FRCPC, MBA⁸;
D Audet, MD, MCFP⁹

A position paper developed by the Canadian Psychiatric Association and the College of Family Physicians of Canada Collaborative Working Group on Shared Mental Health Care and approved by their respective Boards in August 2010.

Executive Summary

The last 10 years has seen a burgeoning interest in building collaborative partnerships between primary care and mental health care providers, including the integration of mental health services within primary care settings. Collaborative models have improved access to mental health care and increased the capacity of primary care to manage mental health and addiction (MH&A) problems. Successful projects in Canada and other countries have demonstrated better clinical outcomes,

a more efficient use of resources, and an enhanced experience of seeking and receiving care.

There are many steps that can be taken by any primary care practice or MH&A program to promote collaboration and improve access to mental health care, often without requiring additional resources. To support these initiatives, regional and provincial planners need to look for opportunities to introduce collaborative projects into their service provision strategies, fund targeted projects that will broaden the scope and knowledge base of collaborative care, and implement specific policies that

¹ Professor, Department of Psychiatry and Behavioral Neurosciences and Associate Member, Department of Family Medicine, McMaster University, Hamilton, Ontario.

² Head, Department of Family and Community Medicine, Providence Health Care; Clinical Professor, Faculty of Medicine, University of British Columbia, Vancouver, British Columbia; Chair, Mental Health Program Committee, College of Family Physicians of Canada.

³ Associate Executive Director, Professional Affairs, College of Family Physicians of Canada, Mississauga, Ontario.

⁴ Member, Community Council of Family Physicians and Quality Mental Health Council, Capital District Health Authority, Nova Scotia; Member, Membership Committee, Collaborative Family Health Care Association, Rochester, New York; Member, National Institutes of Health Informatics, Waterloo, Ontario.

⁵ Professor Emerita, Department of Psychiatry, University of Alberta, Edmonton, Alberta.

⁶ Clinical Director, Addictions Program, Centre for Addiction and Mental Health, Toronto, Ontario; Associate Professor, Departments of Family and Community Medicine, Psychiatry and Dalla Lana School of Public Health Sciences, University of Toronto, Toronto, Ontario.

⁷ Program Medical Director and Regional Department Head, Mental Health and Addictions, Fraser Health Authority, Surrey, British Columbia; Clinical Instructor, University of British Columbia, Faculty of Medicine, Vancouver, British Columbia.

⁸ Associate Clinical Professor, Department of Psychiatry and Behavioral Neurosciences, McMaster University, Hamilton, Ontario.

⁹ Medical Counsellor, Department of Mental Health, Ministry of Health and Social Services of Québec, Québec, Québec; Member, Department of Psychiatry, Centre de santé et de services sociaux de l'Énergie, Shawinigan, Québec.

¹⁰ Clinical Professor, Department of Family and Emergency Medicine, Université Laval, Laval, Québec; Family medicine unit of Saint-François d'Assise, Québec, Québec.

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Note: It is the policy of the Canadian Psychiatric Association to review each position paper, policy statement, and clinical practice guideline every five years after publication or last review. Any such document that has been published more than five years ago and does not explicitly state it has been reviewed and retained as an official document of the CPA, either with revisions or as originally published, should be considered as a historical reference document only.

The Collaborative Mental Health Care Project-OCFP

- Ontario College of family Physicians – Feb. 2001
- Partnered – 1 Psychiatrist as mentor & 10 family physicians

Another Good Model-Capacity Building

- Build capacity and develop skills in primary care (Dr. Rivian Weinerman Victoria BC)
- CME – Paid for FP/GP's to attend 3 separate 1 day training course in mental health skills.
- In 2011 over 1/3 of all BC FP/GP's have completed program
- www.gpsbc.ca

Reversed Shared Care in Mental Health: Bringing Primary Physical Health Care to Psychiatric Patients

Thomas Ungar

North York General Hospital and University of Toronto

Stuart Goldman

North York General Hospital

Madalyn Marcus

York University

ABSTRACT

Because of the significant comorbidity between mental and physical health conditions, it is imperative that access to high-quality primary physical health care be available for those with severe mental illnesses. Recognizing a gap in care, North York General Hospital (NYGH) developed and piloted a new service that built on the benefits of collaborative and shared care and the importance of co-location and service integration. In this reversed shared care clinic, access to primary physical health care was provided to patients of NYGH's mental health department. Descriptive findings demonstrate the implementation of the service and patient demographics.

Keywords: mental health, health care access, Reversed Shared Care, physical health care, comorbidity

“Reversed Shared Care”

- Proposed to implement a form of Collaborative Care the author’s of this paper have conceptualized as “Reversed Shared Care”
- Captures the less often thought of need for primary physical health care practitioners to provide service in psychiatric and mental health care practice settings

NYGH's Reversed Shared Care Program

- Provides **assessment** and **treatment** for all patients of the NYGH Mental Health Department who do not have a Primary Care physician
- Provides **co-location** of both primary medical care and psychiatric care within one clinic



Goals of Reversed Shared Care Pilot Project

- Interdisciplinary team: Physicians more available to each other and patients
- May lead to improved service delivery and improved patient outcomes
- Best practices in Interprofessional Care suggest co-location of services as an indicator and facilitator of increased collaboration (Appleby, Dunt, Southern, & Young, 1999; Koyanagi, 2004; Craven & Brand, 2002)



Goals of Reversed Shared Care Pilot Project

- Provided opportunities for hallway interaction and relationship development between health care providers
- Multi-disciplinary team (mental health staff)
- Interdisciplinary team (mental health & primary care clinicians)



The Bad

Yet to be developed Opportunity – Tom's Opinion

- Clarify roles and responsibilities of primary care and specialty consultation
- What can/should FP manage (? CTAS levels)
- What can/should psychiatry manage
- When do you transfer back once stable?
- How often should psychiatry see patient?
- What are the accountabilities in the shared service?
- What is the role and expectations of non-hospital affiliated psychiatrists?
- What is the role and expectations of FP to psych?

Professional Development Activity

Responsibility Checklist:

Consultant Worksheet

		Consultee has major responsibility, I have little	I have major responsibility, consultee has little
		50/50	
1.	Contacting each other		
2.	Defining the initial clinical problem.		
3.	Gathering the relevant information		
4.	Analyzing and formulating the information		
5.	Making the diagnosis		
6.	Giving feedback about the case		

Medical Expertise of Shared Care Psychiatrist-draft? Ungar, T 2011

- Level 1- General Psychiatry medical expertise
- Level 2- Focus on somatization process & presentations
- Level 3- Cultural knowledge of and experience in primary care practice settings
- Level 4- Content field of knowledge of Consulting skills, collaborative care, IPE/IPC
- Level 5- Hi- Level academic scholarship and knowledge translation (KT/KE) to primary care skills + (QI, systems, design, population health, policy development)

Skill Sets of a Consultant

1. Technical skills
2. Interpersonal skills
3. Consulting skills

Peter Block, 1999

Qualifications:

The consultant may be described as one who is:

- ❖ **Wanted** (one who is sought after for help)
- ❖ Helpful (one who helps others to help themselves)
- ❖ Informed (one who has a broad knowledge of the problem area)

R.J. Lee and A.M. Freedman, 1983



Ideas at Work

Shared Mental Healthcare: A Collaborative Consultation Relationship

The North York General Hospital Experience

THOMAS E. UNGAR AND SARAH JARMAIN

Shared mental healthcare, defined as a process of collaboration between psychiatrist and primary care physician, has recently been pushed into the forefront through a position statement by the College of Family Physicians of Canada and the Canadian Psychiatric Association. However, the question of how to foster and implement such a process has not been addressed. We set out to answer this question.

In an examination of an innovative service delivery program at North York General Hospital (NYGH), in North York Ontario, between psychiatry and primary care, we compared and contrasted our experiences with traditional consultation models. We also performed a review of the literature, broadening our scope to include the areas of anthropology/sociology, relational theory, education and business management.

We found that the critical factor in shared mental healthcare is the establishment of a collaborative relationship, which can be enabled by the following factors: stance – assuming an open, nonjudgmental stance, while simultaneously protecting “self”; cultural competence – striving to understand the

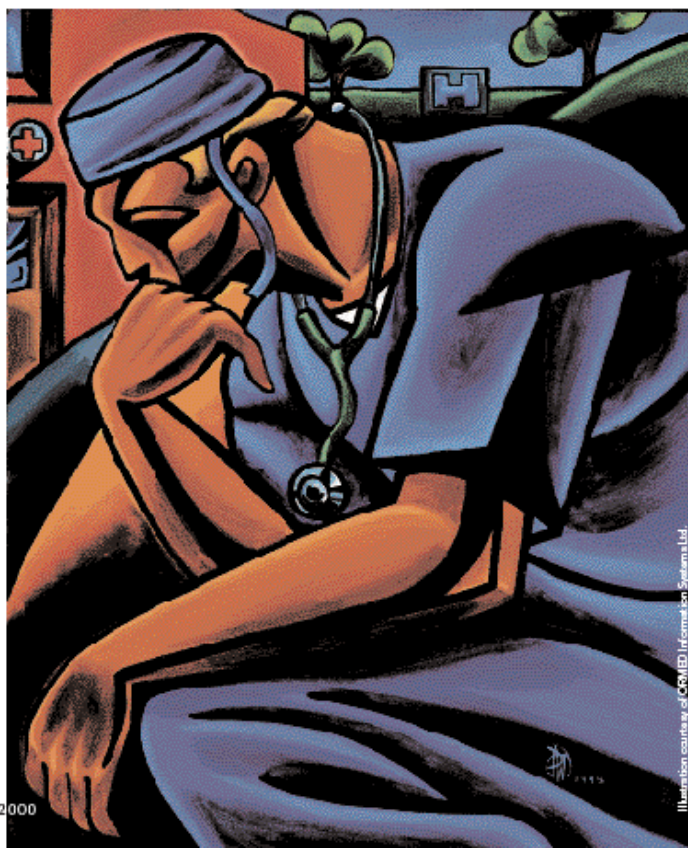


Illustration courtesy of ORCID Information Systems Ltd.

Stance

Stance is a position of receptive open-mindedness that considers other ways of understanding without being personally threatened (Trussler and Marchand 1997). It involves looking after one's self, while simultaneously attempting to meet the needs of the other. It is the ability to maintain an empathic position, to be a participant and an observer simultaneously, and to allow for variability rather than demanding uniformity.

Cultural Competence

Cultural competence is actively striving to understand the culture and context of the primary care physician. This requires participation in the primary care physician's world, and awareness of their unique language, customs, beliefs, and ways of interacting.

Integrative Systemic View

An integrative systemic view is the ability to hold different representations and viewpoints all at once. This requires acknowledging the limitations of one's paradigm, and the curiosity to search for alternative ways of thought. This requires tolerance for complexity, uncertainty, as well as flexibility and fluidity. It is also the ability to synthesize these views and apply them in a practical manner.

Consulting Role Grid

Consultant responsibility for Consultee growth ↑	Counselor 9.1	Coach 5.9	Partner 9.9
	Facilitator 5.1	Teacher 5.5	Modeler 9.5
	Reflective observer 1.1	Technical Adviser 5.1	Hands-on expert 9.1
Consultant Responsibility for patient's clinical (project) results →			

CANMEDS Role of Collaborator for training MD

- The Royal College of Physicians and Surgeons has identified the role of 'Collaborator' as a learning objective for trainees in psychiatry (CANMEDS)
- This has created a demand for curriculum to support this, but as of yet, there remain limited options available



Canadian Collaborative Mental Health Initiative

<http://www.ccmhi.ca>



Canadian
Collaborative
Mental Health
Initiative

Initiative
canadienne de
collaboration en
santé mentale

Strengthening collaboration through interprofessional education:

A resource for collaborative mental health care
educators

EDUCATORS

Shared Care informed By Inter-professional Education for Collaborative Patient-Centred Practice (IECPCP)

A key part of Canada's Health Human Resource Strategy

The specific objectives of the IECPCP initiative are as follows:

- Promote and demonstrate the benefits of IPE for collaborative patient-centred practice;
- increase the number of educators prepared to teach from an interprofessional collaborative patient-centred perspective;
- increase the number of health professionals trained for collaborative patient-centred practice before, and after,
- entry-to-practice;
- stimulate networking and sharing of best educational approaches for collaborative patient-centred practice; and
- facilitate interprofessional collaborative care in both the education and practice settings.

Collaborative Competencies for Interprofessional Education

1. Describe one's **role** and responsibilities clearly to other professions.
2. Recognize and observe the constraints of one's role, responsibilities and competence, yet perceive needs in a wider framework.
3. Recognize and respect the **roles, responsibilities** and competence of other professions in relation to one's own.
4. Work with other professions to effect change and resolve conflict in the provision of care and treatment.
5. Work with others to assess, plan, provide and review care for individual patients.
6. Tolerate differences, misunderstandings and shortcomings in other professions.
7. **Facilitate** interprofessional case conferences, team meetings, etc.
8. Enter into **interdependent** relationships with other professions.

Barr, 1998 as cited in Oandasan & Reeves 2005a

Table 3: Levels of collaboration

Levels of Collaboration	High	Moderate	Moderate	Low	Low	Low
Co-location of services	XX	X	X	X		
Consultation with formal feedback to the primary care provider	XX	X	X	X		
On-going relationship	XX				X	
Opportunities for case discussion and review	XXX	X				
Shared assessment, decision-making or treatment planning	XXX					
Delegated clinical activities involving feedback of patient information to the primary care provider			X			
Designated clinical activities which do not involve feedback to the primary care provider						X

Note: adapted from Craven and Bland (2006).

What is EnHANCE? Organizational Collaboration

- *“EnHANCE Ontario was a multi-partner project with a vision of leading the development of inter-organizational partnerships and enhancing capacity for the delivery of collaborative and interprofessional care for people seeking access to services across primary care, mental health and addictions organizations in Ontario.”*
- Funded by HealthForceOntario
Interprofessional Care/Education Fund
- 2010 www.enhanceontario.ca

IPC from the Provider Perspective

Sharing

- Responsibilities
- Decision making
- Healthcare philosophy
- Values
- Data
- Planning and intervention
- Professional perspectives

Teaming

- Authentic and constructive relationships
- Open honest communication
- Mutual trust and respect
- Valuing contributions of others
- Common goals

Inter-dependency

- Mutual dependence
- Common desire to address client needs
- Emergent synergy
- Whole greater than sum of parts
- Leads to collective action

Power

- Empowerment of each participant
- Respective power recognized by all
- Based on knowledge and experience rather than titles/functions

The Ugly

Social Stigma- some don't want to participate or share care-often MH&A patients or providers are not wanted

Structural discrimination and stigma refers to institutional accumulated practices that work to the disadvantage of mental health patients even in the absence of individual prejudices or discrimination. This “disabling environment” is created by the barriers to participation of receiving care that reside in the architecture or structures we have constructed.

Mental health provider Stigma/Inequity-Psychiatrist Payment for Shared Care half day session

\$ 85% – Psychiatry (approx)

\$ 100% - Internal Medicine

Other relativity inequities for mental health
resources at many levels

Other Ugly Observations

- Psychodynamic – Latent Disguised Aggression/envy
- Political – Confused Power Grab
- Payer/Insurer – Hidden Cost Cutting
- Role & Demotion – De-professionalization Self-employed professional to employee
- Health providers as offenders of stigma
- Specialists mistake this as low status work

Applying a Bauhaus Design Approach to Conceptualize an Integrated System of Mental Health Care: Lessons from a Large Urban Hospital

Dr. Thomas Ungar, MD, M.Ed, CCFP, FRCPC, FCFP,
DABPN

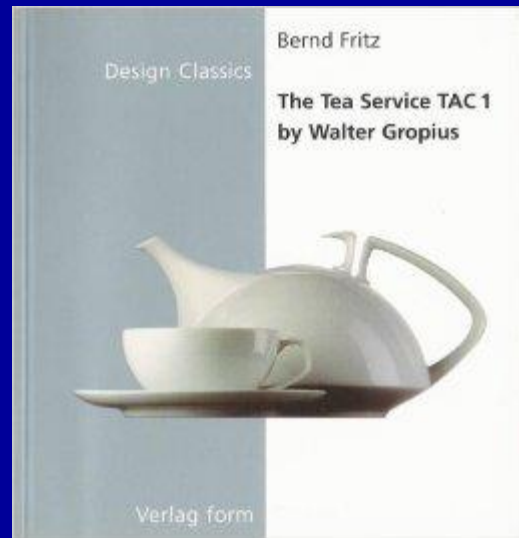
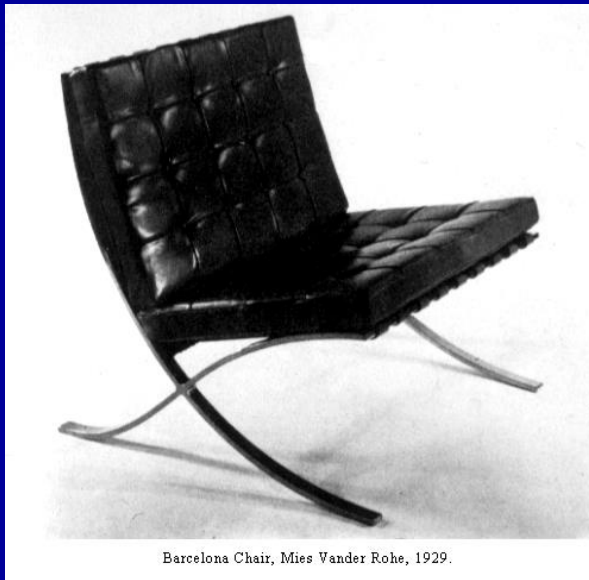
Dr. Marlene Taube-Schiff, PhD., C. Psych.

Dr. Vicky Stergiopoulos, MD, FRCPC

Harvey Stancer Research Day June 16 2016

Bauhaus Design: Form Follows Function

- Walter Gropius (1919) founded the Bauhaus school of design in Germany
- His philosophy was that “form follows function”
- Designs embraced this idea: “simplified forms” and “unadorned functionalism”



Bauhaus Design and Healthcare

- Grumbach (2009) described principles of a Bauhaus-inspired healthcare system:
 1. Healthcare workers function at top of skill set and in collaboration with others
 2. Care delivered matches patient population
 3. Physical design of system allows for improved flow and care
 4. Resources follow need
 5. Patients involved in designing healthcare system



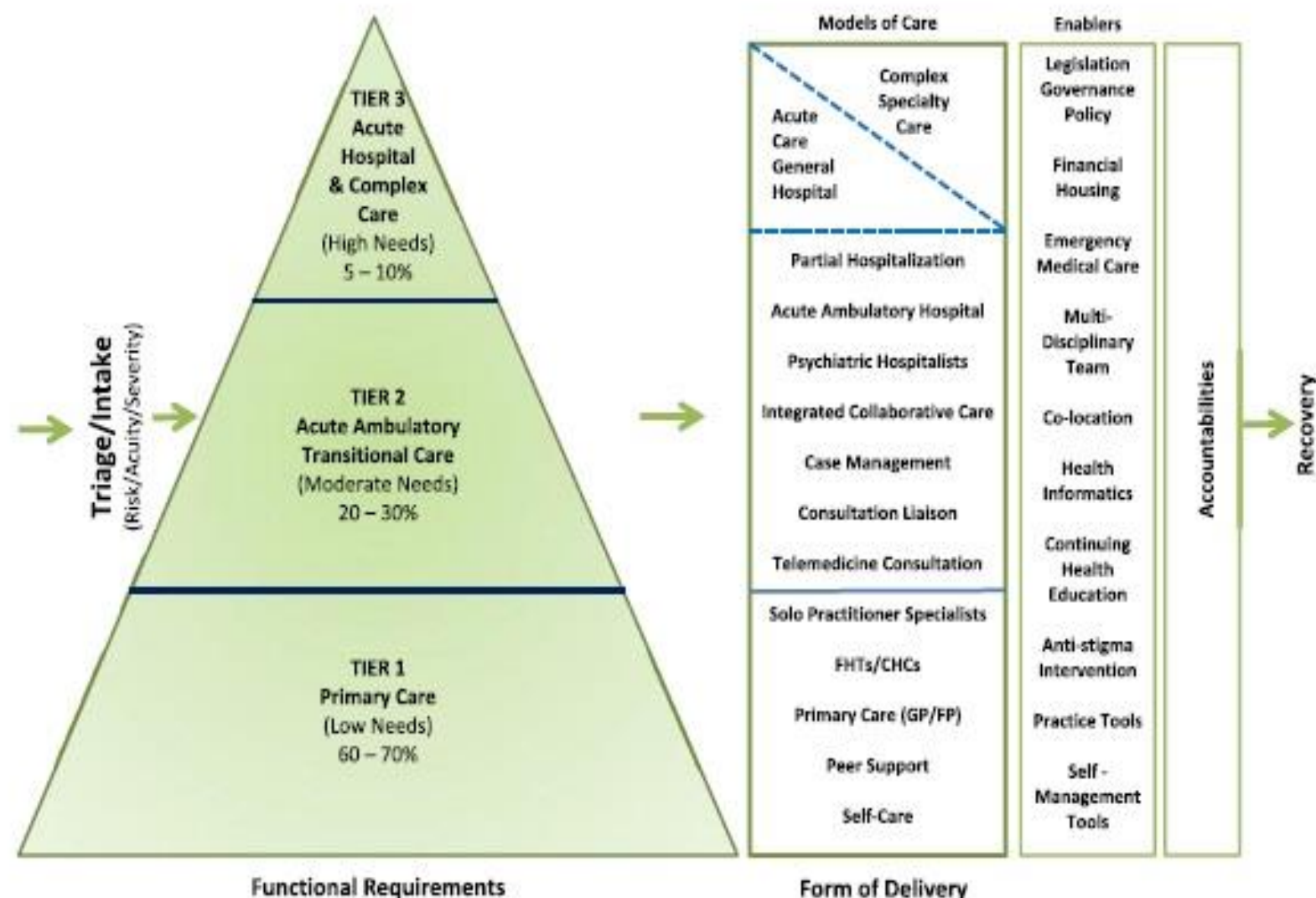
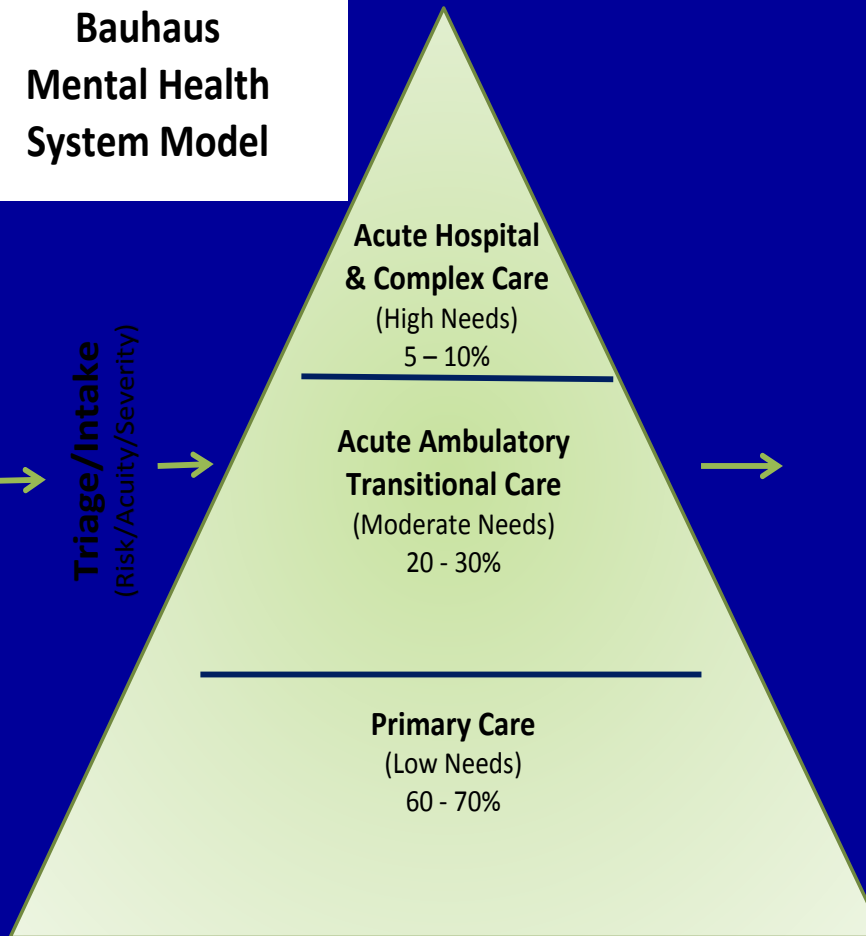


Fig. 1. Bauhaus mental health system model (concept and figure created by Dr. Thomas Ungar prior to the drafting of this manuscript). This figure illustrates how the form of services within the mental health care system follows patient needs. Patient care pathways begin at intake/triage and flow through to three patient-centred tiers of care: (1) primary care (low needs), (2) acute ambulatory transitional care (moderate needs), and (3) acute hospital and complex care (high needs). Within each tier, various models of care are organized from low to high service intensity. All models of care require enablers to function optimally and

Bauhaus Mental Health System Model

→ **Triage/Intake**
(Risk/Acuity/Severity) →



Functional Requirements

Models of Care



Form of Delivery

Enablers

Legislation
Governance
Policy

Financial
Housing

Emergency
Medical Care

Multi-
Disciplinary
Team

Co-location

Health
Informatics

Continuing
Health
Education

Anti-stigma
Intervention

Practice
Tools

Accountabilities

→ **Recovery**

Enablers

High complex needs models:
acute general hospital ER care with proper patient care areas; acute care psychiatric inpatient beds; medically supported substance detox; longer term inpatient beds and care teams, housing, vocational rehab, high intensity

Moderate transitional need models of care:
multidisciplinary allied health teams, co-location, resources for PHPs, credentialing

Low need models of care: self-management tools, continuing education

All Tiers: Skilled Professionals; Supporting Legislation and Policy; Adequate Funding Models; Electronic Charting

Accountabilities

High complex needs models:
overcoming stigma for chronic
mental health patients; outcome and
recovery; triage of needs (medical
and mental health complexities)

Moderate transitional need models of care:
timely access to consultation; extensive wait
lists; back up and support availability

Low need models of care: treatment trials
before referring to mid-tier; resume ongoing
care following specialized care

**All Tiers: Equitable Care; Stigma; Quality of Care
Metrics**

Thank-you

ANY QUESTIONS?

Thomas Ungar MD, MEd, CCFP, FCFP, FRCPC,
DABPN
Associate Professor, University of Toronto
Psychiatrist-in-Chief
St. Michael's Hospital
30 Bond Street, 17th floor
Toronto, Ontario
Canada
M5B 1W8
Phone: 416-864-3080
Fax: 416-864-5445
ungart@smh.ca

Personal Experience

- 1987 – 1989 - CCFP, Family Medicine residency U of T, UHN (St. George Health Centre)
- 1989 – 1991 - Community Family Physician Office, Walk-In Clinic and Staff Donwood (ACLS, ATLS)
- 1991 – 1994 - Psychiatry Residency – U of T – Chief resident UHN
- 1994 – 1996 - Fellow Psychosomatic Medicine UHN , and Medical Education
M. Ed – OISE
 - Master's thesis on Contextual Features of Mental Health Care In Primary Care

Why IPE?

What is it?

- **Interprofessional Education is....**
- "occasions when two or more professions learn **with, from and about each other** to improve collaboration and the quality of care"

Why is it important?

- **Collaborative Patient-Centred Practice**
- "is designed to promote the active participation of each discipline in patient care. It enhances patient- and family-centred goals and values, provides mechanisms for continuous communication among caregivers, optimizes staff participation in clinical decision making within and across disciplines and fosters respect for disciplinary contributions of all professionals"

Program Objectives

The overall objectives of the EnHANCE Education Program include:

- Examining ways providers can work together to enhance services for clients with complex mental health and addiction needs seeking access to services across MH&A and primary care settings
- Exploring ways organizations can collaborate to enhance services for clients with complex mental health and addiction needs seeking access to services across MH&A and primary care settings
- Reviewing elements of interprofessional collaboration and inter-organizational partnerships

Principles Forming the Foundations of Success

- Core values are necessary to help people with day-to-day decision-making....People need “guiding stars” to navigate and make decisions day to day. But core values are only helpful if they can be translated into concrete behaviours
- Operating principles of a partnership need to be articulated and understood by all members of the healthcare team – including the client.

Principles

- **Equity** – an equal right to be at the table and a validation of those contributions that are not measurable
- **Transparency** – openness and honesty build trust – a key ingredient of successful partnerships
- **Mutual benefit** – reaping the rewards of the partnership fosters continued commitment to it and sustainability

Provider-Level Principles

EICP principles:

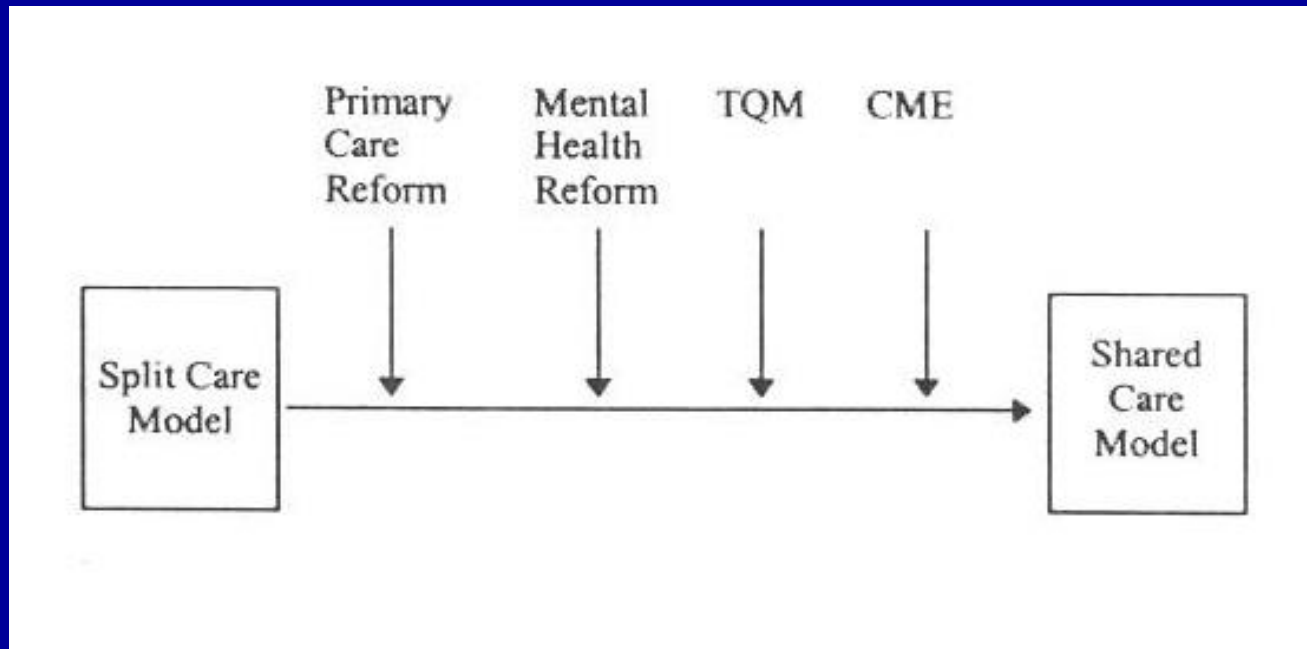
1. Client centredness
2. Population health approach
3. Best possible care and services
4. Access
5. Trust and respect
6. Effective communication

Competencies for Inter-Organizational IPC

- Two identified competencies that must be present for success:
 - **Responsiveness** – the perception that team members are willing and able to follow up on requests and needs of other team members
 - **Facilitation** – the ability of team members to direct work, problems and concerns through proper channels to ensure appropriate completion or resolution

The Split Care Model-1998

Ungar/Hoffman



Consulting Role Grid

Typical Statements

Champion, Kiel, McLendon 1990

Counselor “You do it; I will be your sounding board”	Coach “You did well; you can add this next time”	Partner “We will do it together and learn from each other”
Facilitator “You do it; I will watch and tell you what I see and hear”	Teacher “Here are some principles you can use to solve problems of this type”	Modeler “I will do it; you watch so you can learn from me:
Reflective observer “You do it; I will watch and tell you what I see and hear”	Technical Adviser “I will answer your questions as you go along”	Hands-on expert “I will do it for you; I will tell you what to do”

APA Textbook of Psychosomatic Medicine

Psychosomatic Medicine practitioners work as hospital-based consultation-liaison psychiatrist (Kornfeld 1996), on medical-psychiatric inpatient units (Kathol and Stoudemire 2002), and in settings in which mental health services are integrated into primary care (Unutzer et al. 2002).

Consulting - Definition

- You are consulting any time you are trying to change or improve a situation, BUT have no direct control over implementation
- If you have direct control over a situation then you are managing, not consulting

“The consultant’s lack of direct control is what makes our task difficult and at times drives us crazy”.

Peter Block

Consulting Skills:

1. Entry and Contracting
2. Discovery and Dialogue
3. Feedback and the decision to act
4. Engagement and Implementation
5. Extension, Recycle and Implementation

Peter Block, 1999

Participant Observation: A Methodology for Human Studies

- The insider's viewpoint
- The world of everyday life
- The socio-cultural context of research
- Gaining entrée to a setting
- From outsider to insider roles
- Developing and sustaining field relationships
- Trust and cooperation
- Leaving the everyday life setting

Why ? in 2006

- The CCMHI commissioned a study to examine the current state of Canadian IPE programs, related to collaborative mental health care
- The study (McVicar et al., 2005) indicated a paucity of programs in this area (both pre- and post-licensure), prompting the development of the CCMHI education toolkit

Rationale

- The training and education techniques of health care professionals is a key determinant of their willingness to collaborate
- Key benefits of interprofessional education (IPE) include:
 - Increased understanding of roles and responsibilities
 - Enhanced mutual respect and trust – improved relationships and communication strategies
 - Stereotypes are dispelled
 - Significant improvement in attitudes towards other professional groups

The Toolkit

- **Purpose:** The toolkit serves as an educational resource to assist in the implementation of educational initiatives and programs that promote collaborative mental health care in primary health care settings.
- **Target Audience:** education program developers, professional associations, regional health authorities, family health teams, governmental departments, and educators within academic and care delivery settings.

Key Features of the Toolkit

- The toolkit is comprised of 2 sections.
- **Section A: Background**
 - Provides the rationale for, and benefits and principles of IPE; and
 - very brief examples of existing IPE programs
- **Section B: Implementation**
 - Facilitator and participant instructions
 - Sample lesson plan (full and ½ day workshop)
 - 2 interactive exercises
 - 4 case studies
 - Evaluation materials

Interprofessional Education in the Context of Collaborative Mental Health Care

- Collaborative mental health care is one approach to improving the delivery of mental health services in primary health care settings.
- Interprofessional education is a key method of ensuring that various collaborators improve team functioning, for the benefit of the consumer.
- Interprofessional education develops knowledge and understanding of other professionals and promotes the respect needed for effective collaboration.

What is Interprofessional Collaboration (IPC)?

IPC occurs when members of two or more health disciplines come together around the client – to work together to address issues and concerns.

It is characterized by shared decision-making and mutual accountability within appropriate scope of practice roles.

Client is the focus.

Our goals for today:

1. Describe Bauhaus design and what it can offer the healthcare system
2. Present and describe a model to enable a conceptualization of a more integrated healthcare system
3. Briefly review enablers and accountabilities that should exist within our system

Introduction

- Mental health care system is fragmented
- Patients do not always move through it in a rational, direct or beneficial manner
- Acute care general hospitals provide diverse range of services
 - Increasing demands and volumes along with decreasing resources = increased wait times, less timely service and follow up
- What might be the answer?

Consultants Expertise

- Content info
- Process
- Planning
- Design
- Evaluation
- Idea Generation
- Facilitation
- Objectivity
- Sounding Board
- Extra pair of hands
- Blame basket

Diane Abby Livingston OISE, 1995

Activity

List your ideal qualities / expertise of a consultant

Rank the order of the following job descriptions from 1 to 3, where 1 is “requires the most skilled consultant” to 3 “requires the less skilled consultant”.

MH professional who _____
consults to other mental health
team members

MH professional who _____
consults to FP/GP's.

MH professional who _____
consults to community
settings.

Collaboration IPE/IPC

- Inter-Disciplinary
- Inter-Departmental
- Inter-Professional
- Inter-Agency
- Inter-Organizational

REVERSED SHARED CARE IN MENTAL HEALTH: BRINGING PRIMARY PHYSICAL HEALTH CARE TO PSYCHIATRIC PATIENTS

Thomas Ungar, Stuart Goldman,
Madalyn Marcus, Antoinette
Wertman

First presented National Shared Care Conference,
Halifax, June 2011

In press, Canadian Journal of Community Mental
Health

Disclosure

No conflicts related to this presentation

Speaker/Advisory Board/Education Consultant:

Allergan, Lundbeck, Otsuka

Grant: Movember Foundation

Director: Mental Health Minute Inc

From your experience as a consultant or consultee identify one example when things

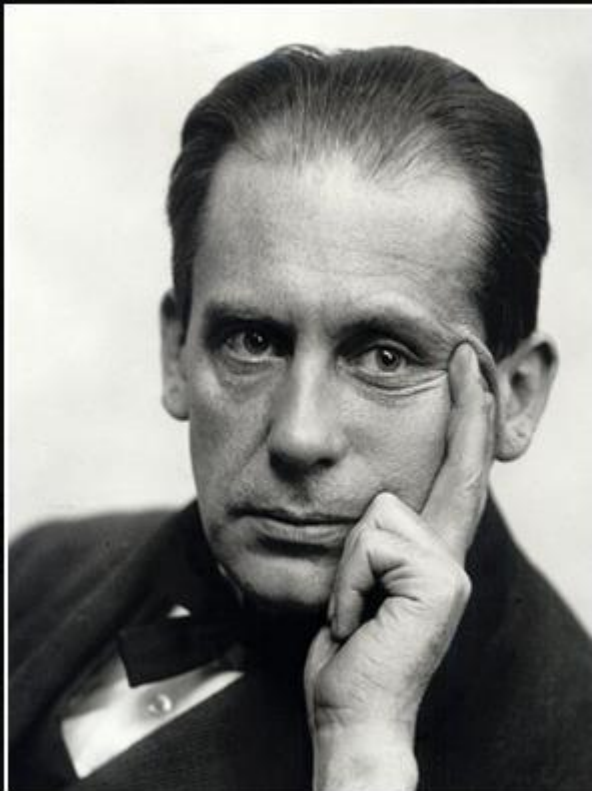
- Went well
- Went poorly
- List one place / group you hope to consult to in the future

Best Practices for Interprofessional Education

Successful interprofessional education requires:

- Collaborative planning from all key stakeholders involved;
- Commitment from all key stakeholders;
- A focus on enhancing the knowledge, skills and attitudes of learners to become collaborative practitioners and team members; and,
- The involvement of consumers, families and caregivers, and other key stakeholders in the planning, implementation, and evaluation phases.

As Walter Gropius has said:

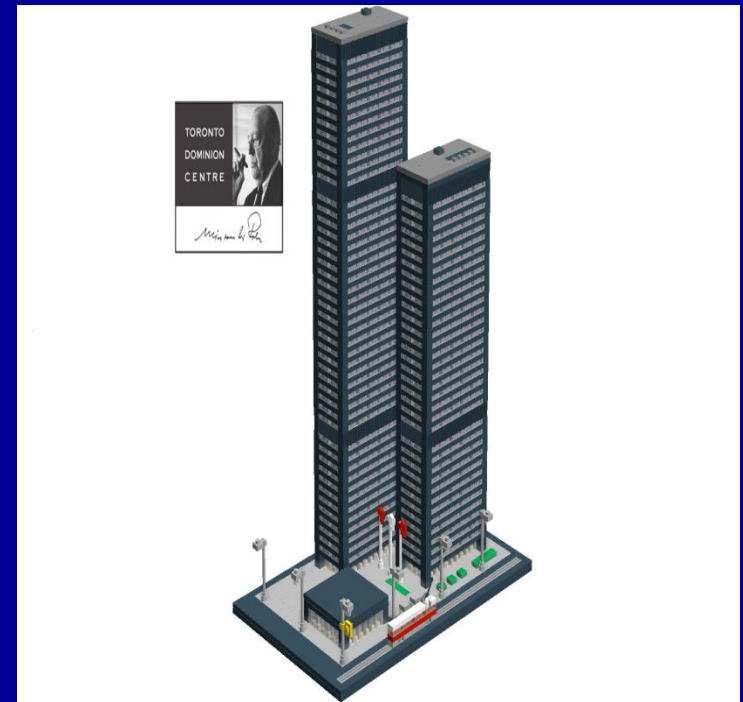


If your contribution has been vital
there will always be somebody to
pick up where you left off, and that
will be your claim to immortality.

— *Walter Gropius* —

AZ QUOTES

Bauhaus Design: TD Centre, Toronto, Ontario





“Strengthening Collaboration Through Interprofessional Education:

A Resource for Collaborative Mental Health Care Educators”

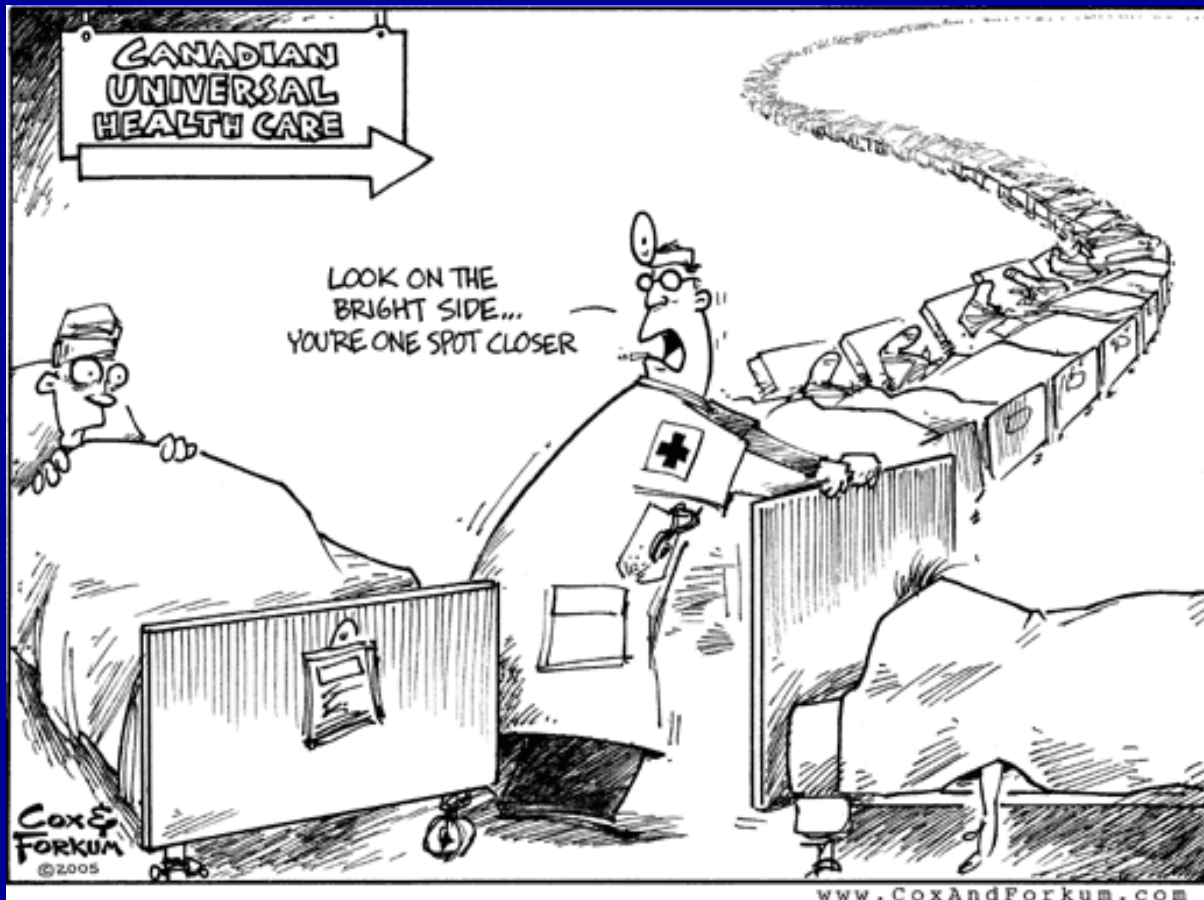
Thomas Ungar, MD, M.Ed, CCFP, FRCPC, DABPN

Vernon Curran, PhD

Enette Pauzé, MSc, CK

2006

Difficulties accessing services...



Conclusions: No One Model is The Answer

Strengths of this model:

1. Highlights role of primary care providers in mental health
2. Role of acute ambulatory transitional care vs solo practitioners
3. Ambulatory transitional services – part of higher acuity care
4. Highest tier includes acute general hospitals and tertiary centres
5. Similar providers can function at different levels regardless of skill set
6. Enablers needed at all levels
7. Accountabilities at all levels

*Continuum of services and models of care
needed to meet continuum of patient needs*



Disclaimer

This will be an unsatisfying presentation as it is an unsatisfying topic.

Collaborative Mental Health Care Teams

- An interprofessional team approach allows providers to contribute from their individual areas of expertise and creates an environment for innovative care.
- There are unique benefits of interprofessional team care for consumers, providers, educators, and students, and for the health delivery system.
- The individuals involved on the collaborative team will depend on the needs and wishes of the consumer.
- Care plan development requires a holistic approach (considering the spectrum of health promotion, illness prevention, treatment, recovery, etc.)

Challenges: Reversed Shared Care Program

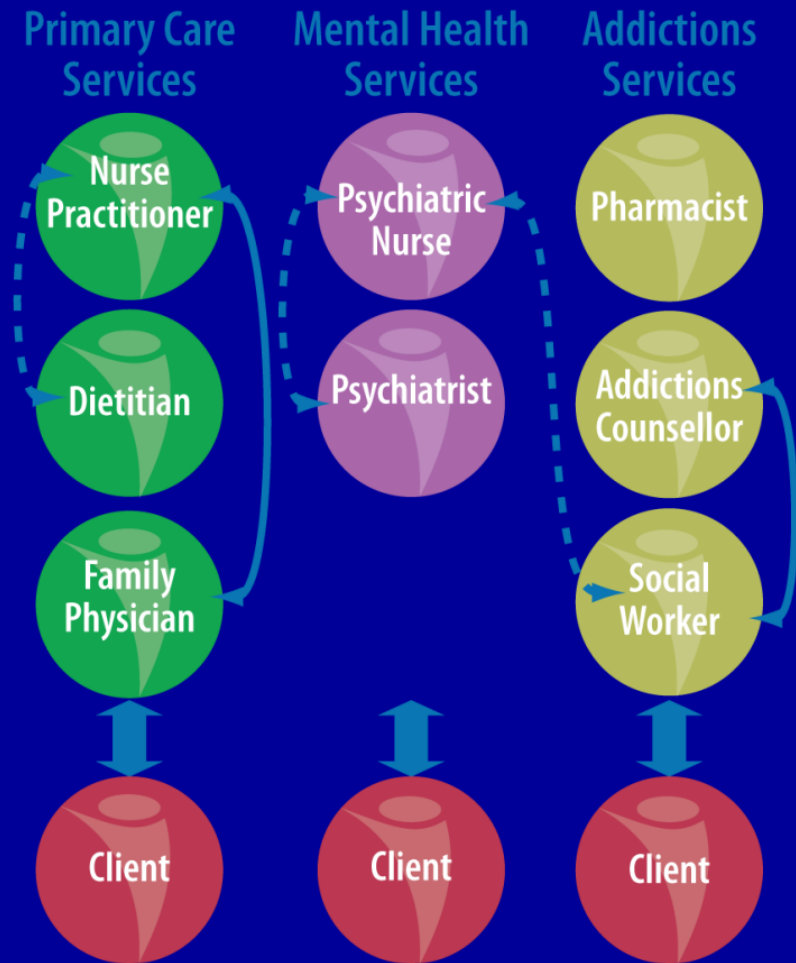
- Initial challenges in securing administrative and institutional support
- Developing adequate financial, time, and resource remuneration
- Need for a system-wide and integrated vision of service delivery and resource allocation from decision makers

Summary

- Consulting skills and expertise is additional to a physician's technical skills-medical expert
- Articulating consulting skills as well as recognition of this expertise can help individuals and organizations with future development
- Skillful consulting assists in developing truly collaborative relationships of particular importance with interdisciplinary work-collaborator role

Inter-Organizational IPC

- Currently 3 systems spanning physical health, mental health and addictions
- Gaps and duplications



The Goal

- All providers work together on behalf of the client
- The client is in the centre

