

# **Integrating Mental Health Care into a continuous Primary Care Framework**

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# Health care for people



Holistic vs. Fragmented Care

- Why we can't afford to think about mental health and physical health separately
- Some of the challenges to providing integrated care
- One man's story
- Explore some of the solutions

# Why Do We Need to Integrate Care?

- Sense of wellbeing consists of both physical and mental health
- 1:5 Australians has a mental health disorder/disease

# Why Do We Need to Integrate Care?

- Mental health disorders are a risk factor for physical disease
- Those with chronic physical disease - higher incidence of mental health disorder /illness
- Those with mental health disorders/illness - higher risk of physical disease

- Mental health status is an independent risk factor for:
  - Development of physical health problems
  - Service utilisation

# Depression and Heart Disease

- Strong and consistent evidence of an independent and causal association between **depression, social isolation and lack of quality support** and the causes and prognosis of CHD
- The increased risk.... Is of similar order to the more conventional CHD risk factors such as **smoking, dyslipidaemia and hypertension**

*Expert working group National Heart Foundation*

*MJA March 2003*

- In a population based sample - depressive symptoms predicted greater medical care utilisation
- Independent of a number of medical severity measures

*Rowan PJ et al Psychological medicine Jul 2002*

- Those with chronic medical conditions are more likely to have a comorbid mental health disorder or illness

# Depression in people with coexisting medical illness

- Prevalence in
  - general population ~ 5 %
  - 10 – 15% of any general medical population has clinically significant depression
  - 20 – 50 % in selected chronic illness

*Nesse RE et al Mayo Clinic Am Fam Physician 1996*

# Psychosocial aspects of Diabetes

- Depression in diabetics may be 3 times that of the non diabetic population

*Harris MD Curr Diab Rep Feb 2003 – Cedars Sinai*

# Psychosocial aspects of diabetes

- Depressed patients with diabetes have:
  - Poorer glycaemic control
  - Higher incidence of microvascular and macrovascular complications
- Treatment of depression assoc with diabetes:
  - Improved glycaemic control
  - Improved quality of life

*Harris MD Curr Diab Rep Feb 2003 – Cedars Sinai*

# Prevalence and costs of major depression among elderly claimants with diabetes

- Those with both depression and diabetes:
  - more services
  - more time in hospital
  - incur higher medical costs
- This holds even after costs for services related to mental health treatment is excluded

*Finkelstein EA et al Diabetes Care Feb 2003*

- Many with Mental Illness have poorer physical health status, and outcomes

- PTSD alone / with depression:
  - Direct negative relationship with physical health
  - More frequent use of primary health care services
  - No suggestion of inappropriate utilisation of services

*Deykin EY et al Psychosom Med Sept 2001*

# Comorbidity in patients with schizophrenia

- 50% patients with schizophrenia have at least one comorbid psychiatric or medical condition
  - Depression is associated with suicide
  - OCD may worsen prognosis
  - Alcohol and substance use disorders associated with poor outcome

# Comorbidity in patients with schizophrenia

- Comorbid medical conditions:
  - Cardiac disease
  - Pulmonary disease
  - Infectious disease
  - Diabetes
  - Hyperlipidaemia
  - Hypogonadism
  - Osteoporosis

# Effect of physical ill health on course of psychiatric disorder in GP

- Psychological outcome after 1yr:
  - No medically explained symptoms – ~50% recovered
  - 1-4 medically explained symptoms – 41% recovered
  - 5 or more - 21% recovered

*Kisely SR, Goldberg DP: British Journal of Psychiatry 1997*

# Treating both improves outcomes

- Effectively addressing the mental health aspects of care results in:
  - Improved
    - Health outcomes
    - Quality of life
  - Reduced
    - Hospitalisation / medical service utilisation
    - Overall health costs

# Challenges

- Current health system structures / funding models present significant barriers
- General practice is experiencing rapid change
  - Increased expectations
  - Increasing pressures - workforce shortages
  - Avalanche of changes:
    - Clinical
    - Administrative

# Recent Changes

- General practice systems reform
  - Accreditation of general practice
  - Computerisation

# **New Initiatives**

- **Enhanced primary care**
  - Health assessments/Care plans/Case conferences
- **BOiMHI**
- **Asthma 3 + plan**
- **Diabetes initiative**
- **Cervical cancer screening initiative**
- **DMMR**

- A.20.15 In addition, the assessment will usually cover additional matters of particular relevance to the patient. The medical literature and consensus medical opinion support the following additional components: multi-system review; fitness to drive; hearing; vision; oral health; diet and nutritional status; smoking; foot care; sleep; need for community services; home safety; cardiovascular risk factors, including blood pressure; and alcohol use. **A.21 EPC Multidisciplinary Care Planning (Items 720 to 730)** A.21.1

EPC multidisciplinary team care planning is a specific, defined approach to care planning. An EPC

multidisciplinary team care plan is a written, comprehensive, longitudinal plan for the care of patients with one or more chronic conditions and complex care needs, developed and managed by a multidisciplinary team comprising the patient's GP and other health and care providers. EPC multidisciplinary care planning involves team-based management of the patient's complex care needs. A.21.2 The development or review of an EPC multidisciplinary team care plan involves collaboration by the members of the team. Each of the members of the team must contribute to the development or review of the plan and not simply provide a service specified in the plan to the patient. **Chronic conditions and complex care needs**

A.21.3

To be eligible for a Medicare rebate EPC multidisciplinary team care plans and case conferences may only be provided for patients with one or more chronic conditions and complex care needs requiring multidisciplinary care from a team of health and care providers, including the patient's GP. A.21.4 A chronic medical condition is a medical condition that has been, or is likely to be, present for at least 6 months, or that is terminal. EPC multidisciplinary team care plans and case conferences have been found to be most useful for patient's with complex care needs, *for example*, where routine management of the condition is compounded by the presence of one or more of the

following: unstable or deteriorating condition; increasing frailty and/or dependence; development of complications, including falls or incontinence; co-morbidities; significant change in social circumstances (eg death, illness or 'burnout' of carer); or two or more hospital admissions in the past six months. **Items 720 - 730: Application** A.21.5

Items 720, 724 and 726

apply only to a service in relation to a patient who suffers from at least one medical condition that

# Challenges

- Expanding medical knowledge
  - New drugs
  - New therapies
  - Changing guidelines
  - New diseases
  - New technologies

# How does one cope?????

- Is it a matter of guidelines / tools?
- Is it a matter of general practice system change?
- Can general practice continue to cope with this without policy and system change that facilitates integrated care?
- How can we strengthen GP and Primary Care?

# Jack's experience

- Resistant Hypertension
- Heart Disease
  - Coronary Artery Bypass Grafting 1990
  - Graft Stenosis ~ 5 yrs later
  - Myocardial infarction 2002
  - EF 50%-55%, Aortic sclerosis
  - Acute pulmonary oedema secondary to acute coronary syndrome 2002

# Jack's experience

- Diffuse atherosclerosis
  - Abdominal Aortic Aneurysm - Aortic Graft
  - Peripheral Vascular Disease
  - Iliac Artery Angioplasty
  - Renal artery bilateral stenosis
  - Diffuse extracranial carotid disease duplex
- Impairment of glucose tolerance
- Elevated homocysteine levels
- Old left fronto- parietal cerebral infarct CT 2001

# Jack's experience

- Chronic obstructive airways disease
- Bilateral macular degeneration
- Renal Disease
  - Chronic renal impairment
  - Acute renal failure Nov 2003
- Ureteric stricture – recurrent
- Severe degenerative disease spine
  - Cervical degenerative change esp. C6/7
  - Thoracic spine - crush fracture 2003
  - Advanced lower lumbar disc and facet joint degenerative disease, crush fracture L1
- Osteopaenia

# Jack's experience

- Cholecystectomy 2000 - exploration of CBD/removal of stone
- Ulcer
- Appendectomy
- Tonsillectomy/Adenoidectomy
- Multiple excisions skin malignancies
- Depression in 30's

# Medications

1. Imdur
2. Frusemide
3. Hydralazine
4. Aspirin
5. Ikorel
6. Diltiazem
7. Nitrolingual spray
8. Ventolin
9. Seretide
10. Atrovent forte
11. Folic acid
12. Pyridoxine
13. Paracetamol
14. SSRI

# Medications

- Information systems – helpful but .....

**35 interaction warnings!!!!**

# Jack's experience

- Depression in late 2001
- Initially improved on SSRI
- Condition and quality of life deteriorated
- Multiple admissions
- Expert opinion – not able to increase dosage further

# Jack's experience

- Unable to see
- Constant shortness of breath
- Difficulty walking across the room
- Depressed, dejected

# Jack's experience

With in 2 months

- Back to playing bowls
- Happy
- Wife - different man with a whole new outlook
- Brought a treadmill and rowing machine
- No further admissions



# Jack's experience

- Respiratory Rehabilitation Program-multidisciplinary
  - Nursing
  - Physiotherapy
  - Psychologists
  - Pharmacists
  - Physicians

# Jack's experience

- No change in respiratory function tests
- Increased walking distance
- Marked reduction in symptom level from 60.7 to 24.8
- Improvement across all SF36 parameters esp. social, vitality and mental health factors

# Solutions

*"The significant problems we face cannot be solved at the same level of thinking we were at when we created them."*

*Albert Einstein (1879-1955)*

# Solutions

- Policy framework
- Education and Training
- Access to:
  - Multidisciplinary services
  - Rehabilitation services
  - Carer supports
- Funding models that support access to streamlined integrated care

# Solutions

- Tools:
  - Information management tools
  - Evidence Base
  - Guidelines
- Systems implementation and refinement
- Support infrastructure
- Simplification of “red tape”

*"In theory, there is no difference between theory and practice.*

*But, in practice, there is."*

*- Jan L.A. van de Snepscheut*

# Strengthening our Knowledge Base

- Knowledge alone is necessary but not sufficient – **practice environments** and **incentives for change** are **critical** (*Dr Caroline Clancy M.D. Director Center for Outcomes and Effectiveness Research*)
- Real world is “messy” – **flexible** / tailored to the environment and the **individual**
- Needs to influence **policy**

# Treat the whole person

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