Embracing Complexity:
or How To Get the Most Out of Psychiatry

Disclosure of Commercial Support

Potential for conflict(s) of interest:

- *Dr. Tanya Hauck* has received Fellowship Funding from Bellwood Health Services.

Faculty/Presenter Disclosure

- Faculty: Dr. Tanya Hauck
- Relationships with commercial interests:
  - *None*

Mitigating Potential Bias

- No concerns have been identified, and Bellwood Health Services was not involved in the preparation of this presentation.

By the end of this presentation, attendees should be able to:

- 1. Describe an example of a community which is building capacity in addictions and mental health treatment
- 2. Outline service needs related to psychiatry and addictions psychiatry in Ontario and Canada
- 3. Examine other models of addressing gaps in services, both through direct and indirect care, such as telepsychiatry interventions

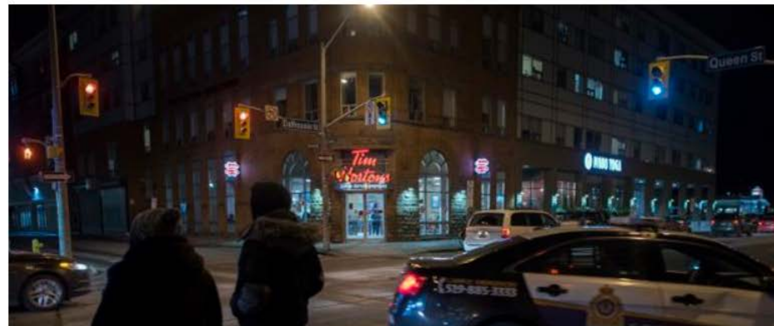
THE GLOBE AND MAIL | CANADA | MEMBER BENEFITS

[1]

In a Brantford Tim Hortons, the toll of the opioid crisis is in full view

A 24-hour Tim Hortons in the Southwestern Ontario municipality has become an informal clubhouse: a place to get out of the cold, chat with friends and buy and use drugs

MARCUS GEE
PUBLISHED FEBRUARY 3, 2019
UPDATED FEBRUARY 4, 2019
56 COMMENTS



[2]

In Brantford's opioid nightmare, a community sees more hopeful days ahead

A year of surging opioid deaths spurred this Ontario town to action. Now, signs of progress are appearing, though officials warn the crisis may be far from over

MARCUS GEE >
INCLUDES CORRECTION
PUBLISHED FEBRUARY 24, 2019
UPDATED FEBRUARY 25, 2019
13 COMMENTS

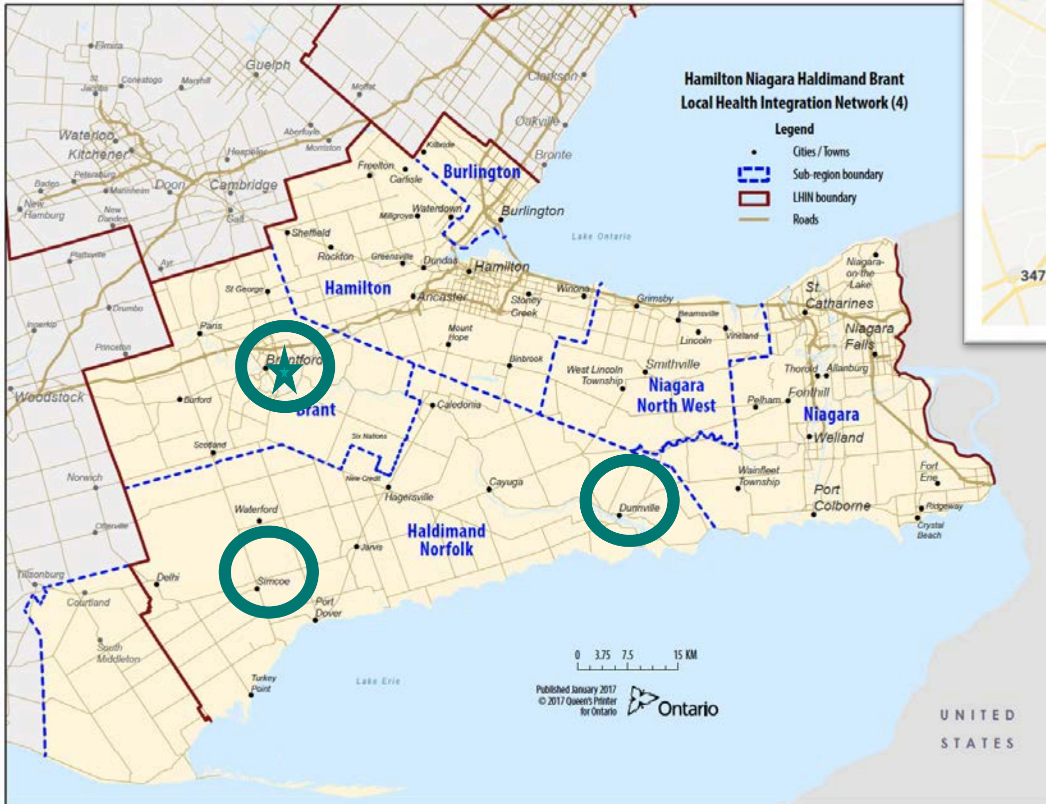
The Request:

From META:PHI Jan 23 2019

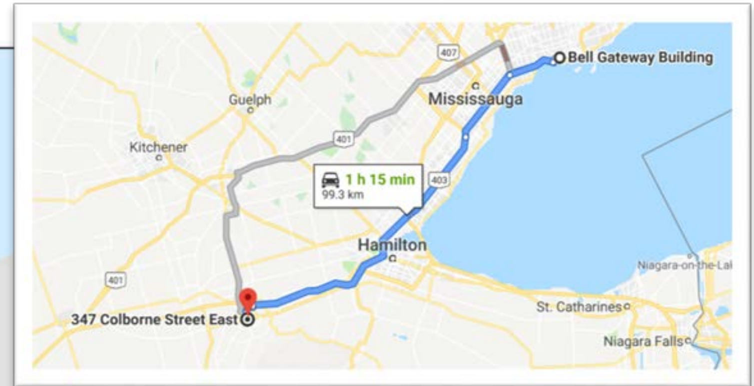
"Good Morning,

I wanted to inquire if any psychiatrists in the province are doing OTN consults. We are in short supply of psychiatrists in Brantford, and some of our doctors and nurse practitioners are just looking for consults and can follow the patient post consult. Thank you for any assistance.

Stephanie Rochon"



(Hamilton Niagara Haldimand Brant LHIN, 2014)



The Brantford Haldimand Norfolk RAAM

[3]

The BHN RAAM

"in 2017, Brantford's opioid poisoning hospitalization rate was more than 3.5 times the Ontario average" (CIHI)

Community Background

- Increasing opioid and methamphetamine use
- Overdoses
- Hospitalizations for alcohol intoxication
- Clients with a history of criminal justice involvement
- Connections with First Nations communities
- Homelessness
- Underserviced area for psychiatry

[4, 5]

The BNH RAAM

Opened September 28, 2018

- 5 days/week in 3 communities
- 3 Physicians, NPs
- Concurrent Disorders Counsellors
- Mental Health Social Worker
- Case Managers, Peer Support Workers
- Affiliations
  - *St. Leonard's Community Services*
  - *Canadian Mental Health Association - BHN*
  - *Brantford General Hospital*
  - *Brant County Public Health Unit*
  - *De dwa da dehs nye s Aboriginal Health Centre*

The BHN RAAM

Common Psychiatric Comorbidities

- Substance use disorders
  - Opioid, alcohol, stimulant, cannabis
- Substance-induced disorders
  - Psychosis, bipolar, mood, anxiety
- Comorbid disorders
  - PTSD, depression, anxiety, social anxiety
  - Schizophrenia, bipolar disorder

The BHN RAAM

Ongoing Development

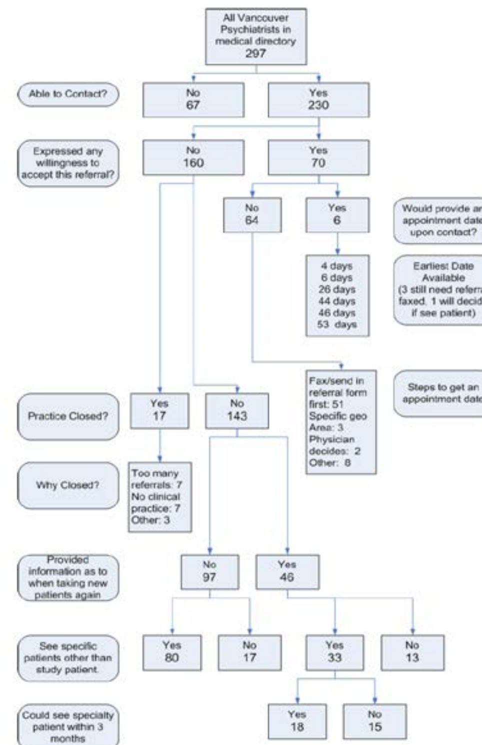
- Withdrawal Management – open!
- Residential treatment – open!
- BDOT Outreach Team – open!
- COAST: crisis service – open!
- MCERT: EMS/police – open!
- Expansion into Haldimand and Norfolk – ongoing, Dunnville is open

Access to Psychiatry Across Canada

Access to and waiting time for psychiatrist services in a Canadian urban area: a study in real time.

Goldner EM, Jones W, Fang ML. Can J Psychiatry. 2011 Aug;56(8):474-80. [9]

35.1% of all family physicians identify access to psychiatry as "poor" [8]



Access to Psychiatry Across Canada

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This was a referral for:

“provisional diagnosis of MDD”

Not a referral for:

“psychosis, methamphetamine use disorder, opioid use disorder, trauma history”

50
45
40
35
30
25
20
15
10
5
0

Percent

2003 2004 2005 2006 2007 2008 2009 2010 2011 2012 2013

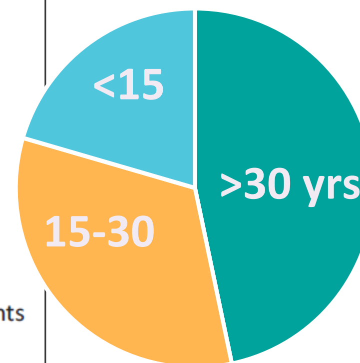
≤15
16 to 30
>31

<100 Outpatients Per Year

<40 Outpatients Per Year

Figure 1. Proportion of psychiatrists who see fewer than 40 and 100 outpatients total annually by years since medical school graduation, 2003-2013.

2070 Psychiatrists in Ontario in 2013 Years Since Graduation



[10] Kurdyak et al, CJP 2017, Vol. 62(1) 40-47

"Controlling for sociodemographic characteristics, comorbidities and past-year service use, those with 1–4 ED visits for SUD and those with 5+ ED visits for SUD had reduced odds of being hospitalised or visiting a psychiatrist in the 30 days following their index ED visit, relative to those with no ED visits for SUD"

Urbanoski K, et al. Emerg Med J 2018;35:220–225 [11]

Table 4 Logistic regressions predicting the receipt of follow-up care* and 2-year mortality among frequent ED users for mental disorders†

	No of ED visits for substance use disorder			
	1–4 visits (vs 0) n=1319		5+ visits (vs 0) n=1573	
Outcome	OR (95% CI)	P	OR (95% CI)	P
Hospitalisation	0.555 (0.474 to 0.650)	<0.001	0.283 (0.237 to 0.339)	<0.001
Primary care	1.025 (0.883 to 1.189)	0.746	0.678 (0.580 to 0.792)	<0.001
Psychiatrist visits	0.692 (0.589 to 0.812)	<0.001	0.250 (0.206 to 0.304)	<0.001
2-year mortality	1.044 (0.635 to 1.715)	0.866	2.633 (1.813 to 3.825)	<0.001

Concurrent disorders are common in RAAM patients

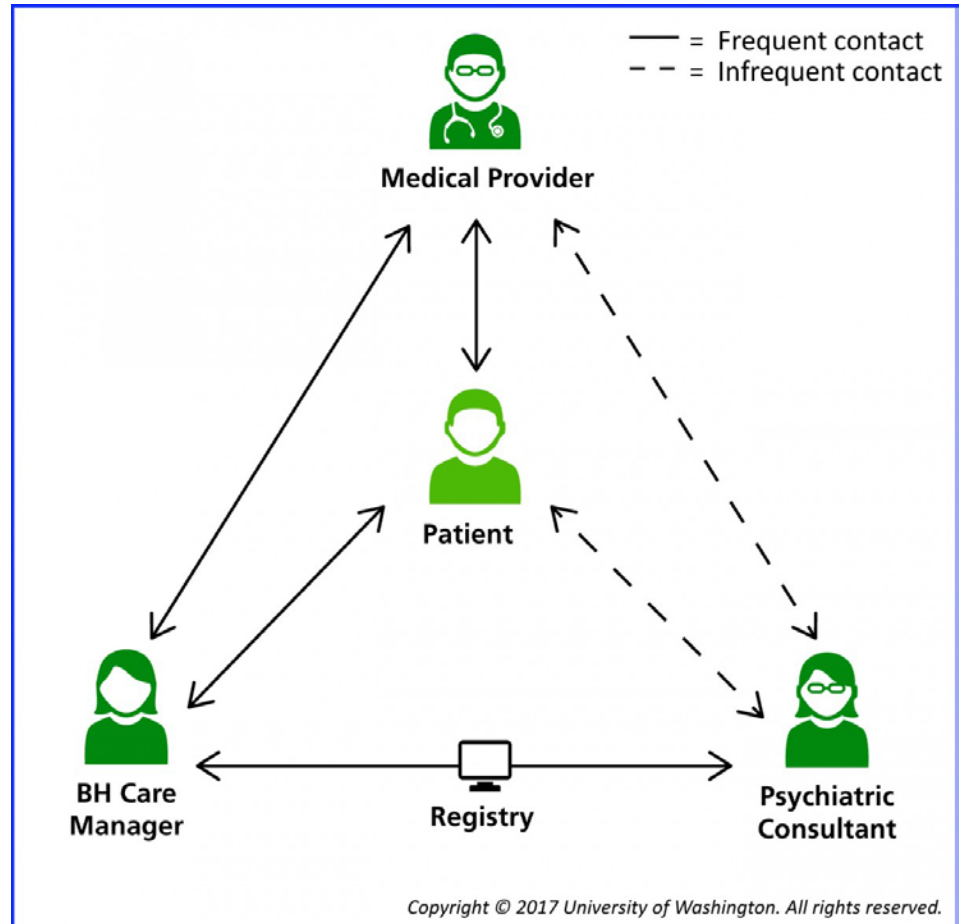
Across Canada, access to psychiatry services is a challenge

Access to psychiatry for people who use substances is even more of a challenge

Where do we go from here?

An example of evidence for collaborative care: The AIMS Center

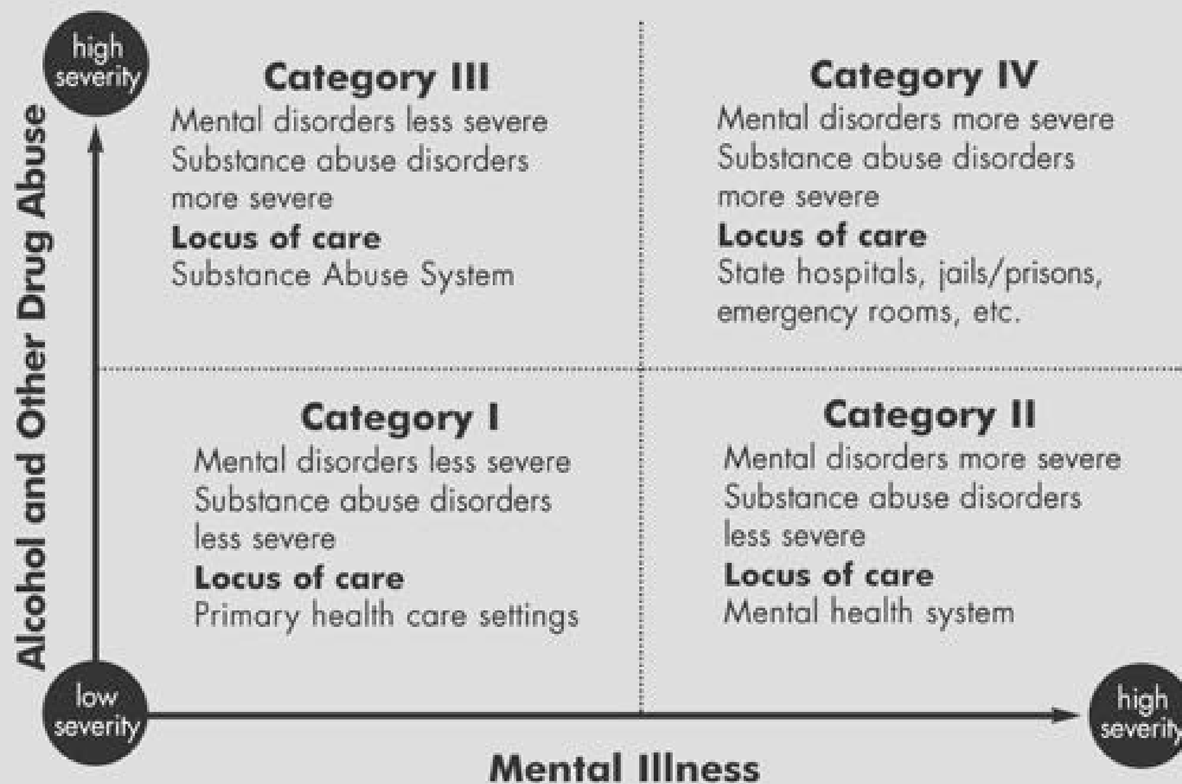
DR. JÜRGEN UNÜTZER
UNIVERSITY OF WASHINGTON
[11]



Principles of Effective Integrated Health Care: "co-location will not produce the same results"

Patient-Centered Team Care / Collaborative Care.	Population-Based Care	Measurement-Based Treatment to Target	Evidence-Based Care	Accountable Care

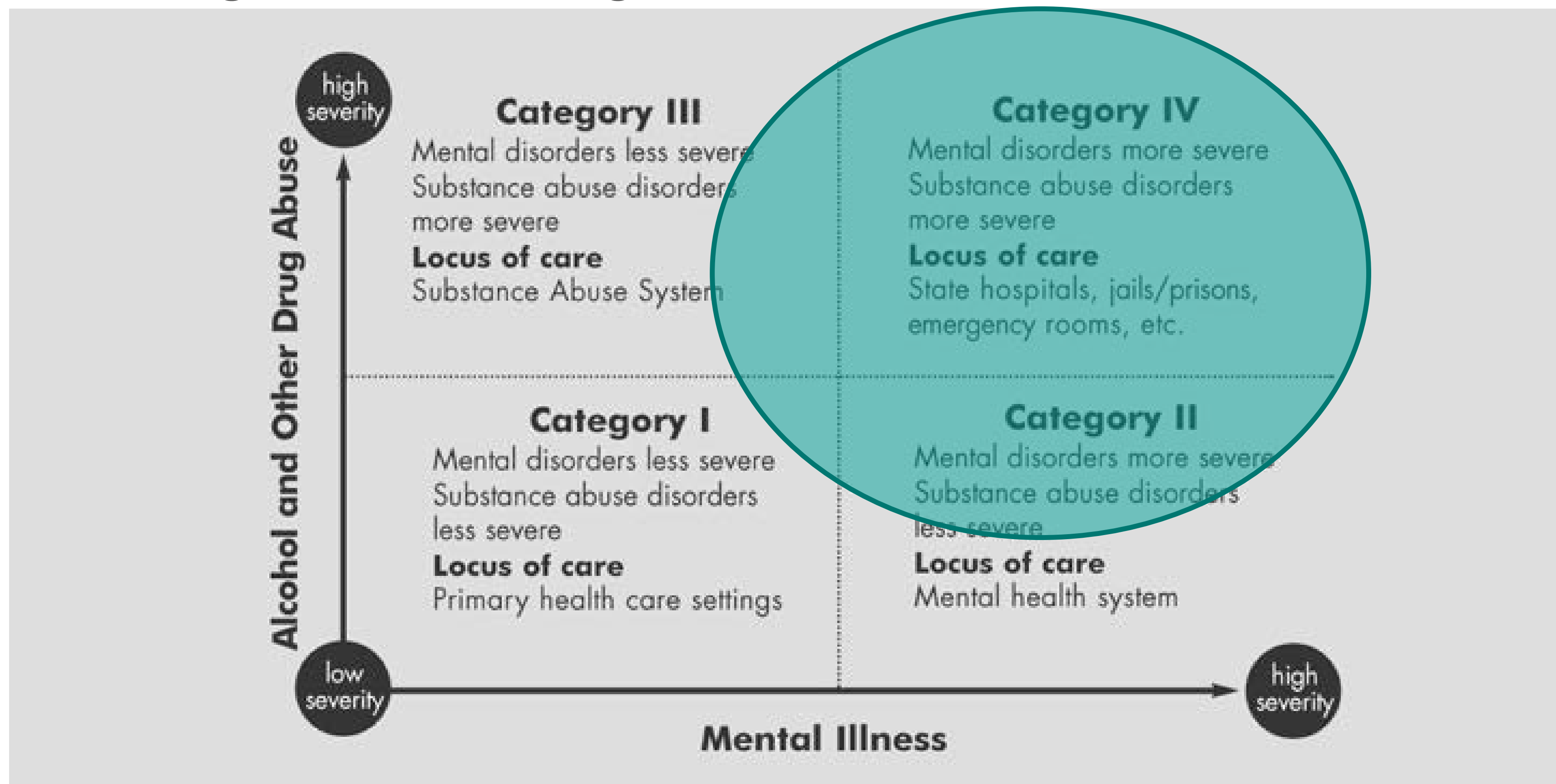
"Collaborative care is associated with significant improvement in depression and anxiety outcomes compared with usual care, and represents a useful addition to clinical pathways for adult patients with **depression and anxiety**." [13, 14]


high severity
Category III
Mental disorders less severe
Substance abuse disorders more severe
Locus of care
Substance Abuse System
Category IV
Mental disorders more severe
Substance abuse disorders more severe
Locus of care
State hospitals, jails/prisons, emergency rooms, etc.
Alcohol and Other Drug Abuse
Category I
Mental disorders less severe
Substance abuse disorders less severe
Locus of care
Primary health care settings
Category II
Mental disorders more severe
Substance abuse disorders less severe
Locus of care
Mental health system
low severity
high severity
Mental Illness

Substance Abuse Treatment for Persons With Co-Occurring Disorders (SAMHSA)

Quadrant IV: Quadrant IV is divided into two subgroups. One subgroup includes individuals with serious and persistent mental illness (SPMI) who also have severe and unstable substance use disorders. The other subgroup includes individuals with severe and unstable substance use disorders and severe and unstable behavioral health problems (e.g., violence, suicidality) who do not (yet) meet criteria for SPMI. **These individuals require intensive, comprehensive, and integrated services for both their substance use and mental disorders.** The locus of treatment can be specialized residential substance abuse treatment programs such as modified therapeutic communities in State hospitals, jails, or even in settings that provide acute care such as emergency rooms (see chapter 7 for an example in an emergency room setting).

Avoiding Silos and Creating Silos



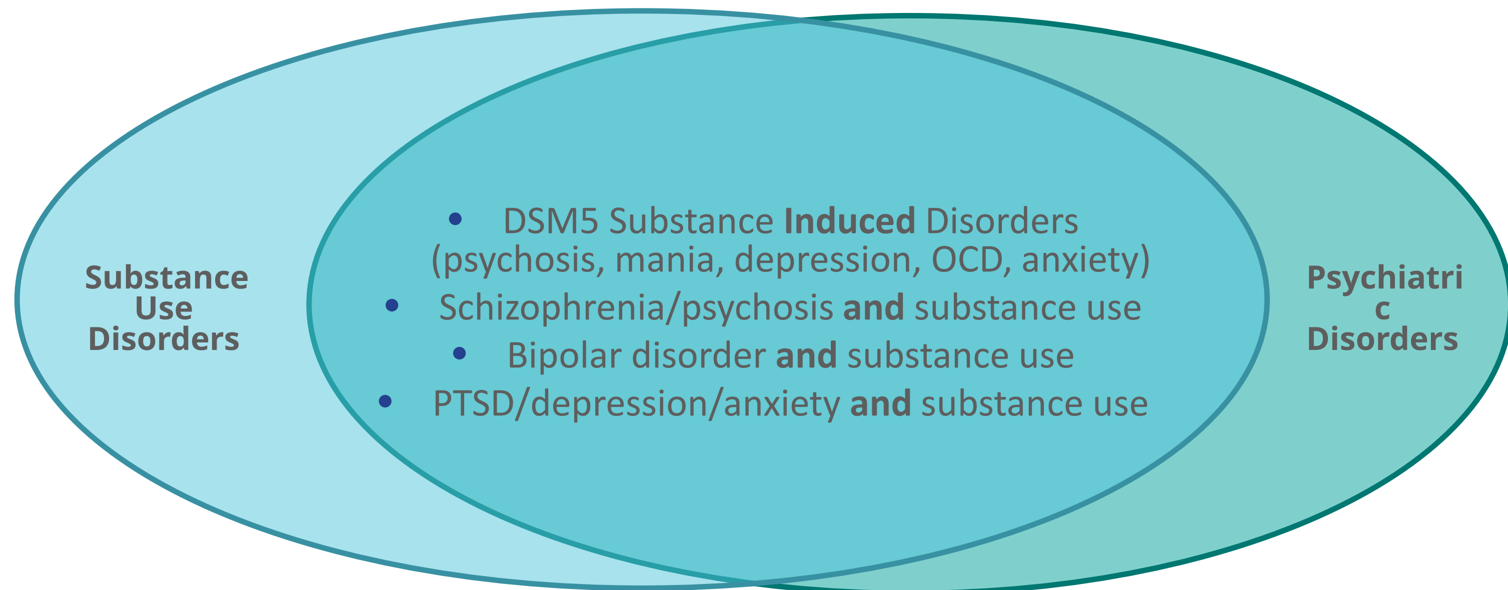
Concurrent disorders need different models of care

The need for rapid access and treatment:

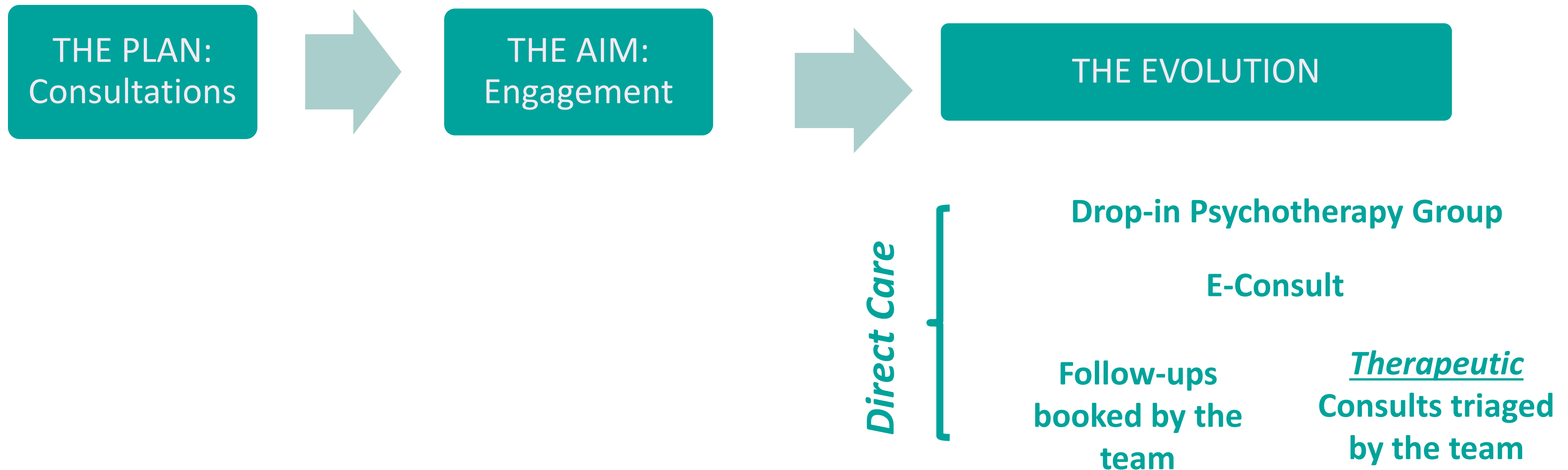
“The substance use service gap in rural communities results in clients having **extensive delays** for such care, which is a barrier for treatment success. As 1 client summarized: “A lot of people that are here for help today and then are put on a wait-list for a call next week, their mind has totally changed, ‘I don’t want the help or I don’t need the help.’” “ Browne et al 2016

[18]

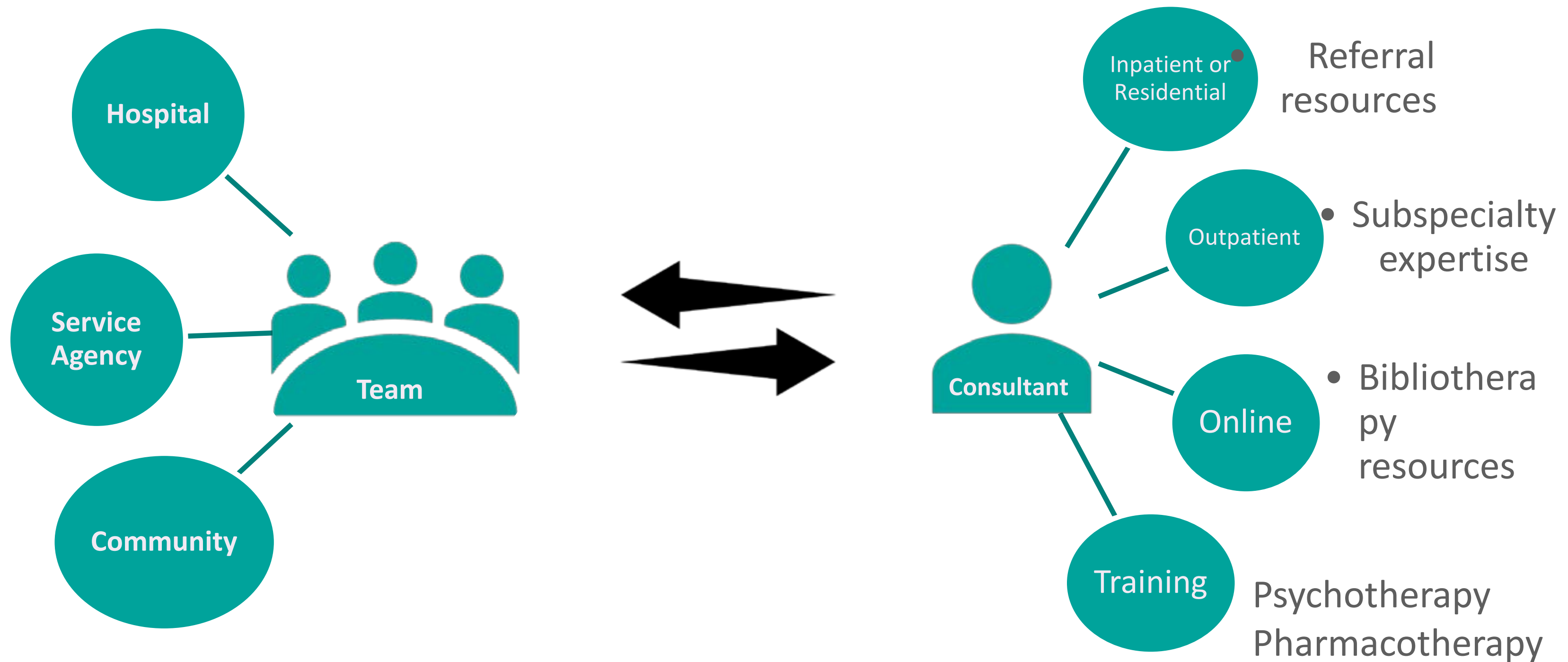
The BHN RAAM: Embracing Complexity



The BHN RAAM: Evolving Telepsychiatry Care



Case consultation and capacity building



Principles of Effective Integrated Health Care: How is this working at the BHN RAAM?

Patient-Centered Team Care / Collaborative Care

Population-Based Care

Measurement-Based Treatment to Target

Evidence-Based Care

Accountable Care

How to make the most of your psychiatrist

- **While you wait for a consult…**
  - consider medication trials, such as prazosin for PTSD symptoms
  - guideline-based trials of antidepressants or antipsychotics

- **Use community resources**
  - Seeking Safety groups
  - DBT skills groups

- **Encourage integrated care through billing instruments**
  - if you have unused sessional funds, propose their use to available consultants
  - use other available billing instruments such as telephone consults (K730/K731)
  - encourage your consultant to sign up for OTN e-consults – it's easy!
    - …but make sure you ask **a clear and specific question**
  - if you have team, you can bill the team code for OAT (K684)

How to make the most of your psychiatrist

- **Consider giving up a consult slot (for other activities)**
  - is this time be better spent on a consult?
  - would teaching and capacity building be more helpful?
  - consults versus follow ups?
  - control your own waitlist/follow ups

- **For your consults… ask the most specific question you can**
  - “please evaluate this patient for PTSD and medication treatment options”

Feedback from the BHN RAAM Team

“Telepsychiatry consults are a valued addition to the services provided at RAAM. However, the addition of e-consults, telephone consults, monthly lectures and the MI community of practice are the components of this model that I find most valuable. They’ve really helped me to increase my knowledge, confidence and skills when treating concurrent disorders, resulting in optimized and improved care for RAAM patients”
– Nurse Practitioner

Client feedback that the wait time for psychiatry is improved (from two years previously)

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Questions and Reflections

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