Continuum of Care for the Mentally Ill

A new model of care: two psychiatrists, one half day per week, six months = 210 new patients assessed and treated.

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RATIONALE

Access to psychiatric care in Canada remains problematic. Those individuals with non life threatening/non psychotic psychiatric disorders (e.g. predominantly mood and anxiety disorders) have difficulty accessing (due to lengthy wait times that can average six months from time of referral) psychiatric assessment let alone treatment. Psychological treatment is increasingly provided by non medical health care professionals (e.g. psychologists) which are not covered by Canadian medical insurance, making it financially prohibitive for many.

The morbidity and mortality associated with untreated mood and anxiety disorders is staggering. Depression is the second leading cause of medical long term disability in North America. Depression is now the leading cause of global burden of disease while bipolar illness is the 6th [1].

Our group has long believed that even brief limited access to a psychiatric evaluation where a diagnosis and treatment plan is offered could make a significant impact on patient morbidity and mortality. Further, we have found in our lengthy clinical careers as well as with our long term association with advocacy organizations (MDABC, OBAD) that in lieu of direct individual one on one patient contact for follow-up visits that patient and family psycho education, encouraging and expecting patient input into their treatment, coupled with the generous use of phone and email support and direction could result in greater numbers of patients assessed and offered treatment.

We have attempted to put these concepts into place in our current Clinic.

METHODOLOGY

In March, 2009, we initiated a collaborative project with the Mood Disorders Association (MDA) of BC to offer in-house psychiatric assessment for MDA members. MDA membership is $15 per annum and the fee is waived if this charge is cost prohibitive for the member.

Our Clinic is currently not funded by any health authority or government agency so psychiatric reimbursement is through the patient's medical health insurance. Accordingly, patients require a referral from their family physician/GP before assessment. If they do not have a GP, they are directed to one of the several local walk in clinics where those doctors have previously agreed to assess potential referrals, anto refer if appropriate, and to provide any required ongoing care post assessment. Office space and administrative assistance (e.g. coordinating and booking referrals) is provided by the MDA staff.

Referred patients are greeted at the MDA office reception, registered as an MDA member(if not a prior member) and encouraged to use MDA resources (regular weekly support groups, free available brochures, encouraged to review our website/read our newsletter, etc.). They are also given a sheet (see Patient Handout – available on request) prior to the psychiatric assessment outlining the mechanics of our assessment procedure. We outline in the Patient Handout:

a. Our emphasis is on empowering informed consumers who must take increasing responsibility for their own mental health care to insure they receive adequate care and treatment.

b. A thirty minute psychiatric assessment is conducted focusing on specific symptoms in order to generate a psychiatric diagnosis and treatment plan.

c. A dictated psychiatric report is completed and is sent directly to the patient as well as the referring source within one week.

d. Patients are encouraged to review this report carefully and if comfortable with the findings to begin implementation of these recommendations either with their GP and/or with our assistance.

e. We make it clear that we will not reassess them individually again but they can dialogue with us via email and/or attend at any time our weekly medical monitoring group. This is based on a model currently used for other chronic illnesses (i.e. diabetes, hypertension).

f. In our medical monitoring group patients openly discuss their current treatment, ask questions and/or request further direction with the treatment plan that has been outlined in the dictated report. Both psychiatrists attend the group and respond (e.g. common questions include –"I am on 100mg of drug X for one week and do not feel better", "How do we know if I have ADHD or mania?", "Should I try cognitive therapy/how does it work?", etc.) by directly answering the individual but also 'generalizing" the response to educate other group members about psychiatric disorders and their treatment. There is regular interchange and support offered among the attending group members and the psychiatrists.

We are compiling basic psychometric data on all referrals which include a DSM IV Diagnostic Checklist, Clinical Global Impressions Rating Scale (CGI), and the Global Assessment of Functioning (GAF).

RESULTS

1. Two psychiatrists, working one half day each, have assessed 210 new referrals from March 4, 2009 – August 26, 2009 (n.b. As of October 1, 2009 we have each expanded our time to one full day for each psychiatrist).
2. The average length of time from receiving a fax referral until psychiatric assessment is 10.9 days.
3. An average of 15-20 patients are consistently attending the weekly group monitoring sessions.
4. The current breakdown of DSM IV psychiatric Axis I diagnoses is noted in Appendix A.

DISCUSSION

Our Clinic is assessing a very large number of psychiatric patients with relatively rapid access who have previously had limited or no access to a psychiatric assessment. In our community a wait of 6 months or more for a referral for psychiatric consultation is not unusual. Our wait is currently 10.9 days.

The vast majority of patients with mood/anxiety disorders in our community have limited access for psychiatric evaluation. In contrast, patients with psychotic disorders, patients who are admitted to hospital and require follow-up treatment, and/or those with serious substance abuse often have easier access to care (e.g. mental health team, ACT program, detox or treatment center, etc) than mood and anxiety patients who make up the bulk of psychiatric diagnoses.

Stepping Out of the Shadows[2] a recent British Colombia Medical Association commissioned study emphasized that for the vast majority of psychiatric patients all that is needed is a diagnostic evaluation, not necessarily long term psychiatric care and follow-up.

In order to increase accessibility we are using group based medical monitoring for follow up visits in lieu of one or more visits with no psychiatrist. Our patients appear to have embraced the concept and have no concerns about confidentiality or expressing themselves in a group setting. Rather, they find the interactions with other group members and frequent access at any time to psychiatric intervention supportive and reassuring.

The use of email as a therapeutic medical technique is underutilized. While the research has cautioned on liability and risks of this intervention[3,4], our experience is that it is efficient, rapid, and very satisfactory for many, and it eliminates the need for more costly and less efficient direct one to one physician-patient contact. We believe this intervention has come of age.

There are clear advantages and potential future risks or problems associated with our method. We have outlined some of these in Appendix B.

We are currently collaborating with a research team to more formerly evaluate the efficacy and efficiency of our model compared to standard psychiatric outpatient care. If research bears out our clinical impression, this model of care may be one that health agencies, advocacy/support groups for other medical disorders, and clinicians may wish to consider in the future.

APPENDIX A

DSMIV Diagnosis – MDA Clinic

DSM IV Diagnosis	N(%)
Major Depressive Disorder	65 (30.4)
Depressive Disorder, NOS	15 (7.1)
Bipolar I	15 (7.1)
Bipolar II	18 (8.9)
Bipolar Disorder, NOS	8 (3.6)
Generalized Anxiety Disorder	15 (7.1)
Panic Disorder	15 (7.1)
Other Anxiety Disorder (e.g. OCD, PTSD)	18 (8.9)
Other (ADHD, Sleep Disorder, Int. Explosive, etc)	8 (3.6)
No Axis I (e.g. marital strain, situational problem)	15 (7.1)
Substance Abuse	18 (8.9)
TOTAL	**210 (100)**
Concurrent mood or anxiety disorder with substance abuse	53
Concurrent mood and anxiety disorder	41

APPENDIX B

MDA Clinic – Advantages and Future Problems with this model of care.

Advantages

1. **Quick access** to a psychiatric diagnosis and treatment plan
2. Encourages and expects **increasing responsibility from patient** for his /her care and treatment
3. **Less traditional techniques** (patient copied on dictated consult report; use of email; group follow-up treatment) are more efficient, freeing up psychiatric availability for additional new assessments
4. **Alliance with advocacy/support agencies** and their resources for patients and families

Future Problems

1. Risk that the accessibility of this model will overwhelm the psychiatrists currently available
2. 'Mantra' of potential legal consequences/liability of email interchange between physician/patient will 'turn off' psychiatric usage with resultant return to more time consumptive/less efficient model
3. Funding/financial issues:
   A. no 'bridge' funding for psychiatrists who are not compensated for 'no shows' which are more likely to occur with this model
   B. with no compensation for email interchange, it is less likely to become a widespread practice

MDA
MOOD DISORDERS ASSOCIATION OF BRITISH COLUMBIA

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3. Seeman MV, Seeman B: E-psychiatry: the patient-psychiatrist relationship in the electronic age. CMAJ 1999; 161: 1147-1149.
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