Using a Stepped Model of Care in the Management of Depression in a Complex Medically Ill Population

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The Poul Hansen Family Centre for Depression presents:

Clinical Advances in Depression Care

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Declaration of Conflict of Interest

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FACULTY/ PRESENTER DISCLOSURE

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- Employee of Fraser Health Authority (BC)
- Independent Contractor CloudMD

MITIGATING POTENTIAL BIAS

- Source of research funding and other employment is unrelated to current clinical work and is unrelated to today's presentation

Land Acknowledgement

We acknowledge the land we are meeting on is the traditional territory of many nations including the Mississaugas of the Credit, the Anishnabeg, the Chippewa, the Haudenosaunee and the Wendat peoples and is now home to many diverse First Nations, Inuit and Métis. We also acknowledge that Toronto is covered by Treaty 13 with the Mississaugas of the Credit.

Learning Objectives

At the end of this session participants will be able to:

1. Describe the complexity in managing mental health care for individuals living with co-occurring physical and mental health needs.
2. Identify how each member of the interprofessional team meets patient needs across the care continuum.
3. Consider how a stepped-care model improves patient outcomes in medical psychiatry.

Depression and Medical Psychiatry

- Depression is a common and chronic mental disorder with rates nearly doubling during the pandemic
- When depression co-occurs with a chronic physical health condition it has a significant impact on disability and health outcomes
- Co-occurring chronic physical health conditions can be a barrier to depression care
- Medical Psychiatry specializes in the provision of mental health care in a complex, medically ill population.

The Mental Health in Medicine Clinic

- Provision of mental health/psychiatric consultation, care, and connection to UHN patients with complex medical illness through an interprofessional, low barrier, time limited, and stepped care model.
- Patient Population: Those who require follow up after receiving mental health care from UHN's inpatient medical psychiatry consult service during an inpatient medical or surgical admission. Those who require mental health care to optimize their physical health outcomes as they receive outpatient care from UHN's physicians and surgeons for medical and surgical disorders.

What is stepped care?

The UHN Stepped Care Model was informed by the National Institute for Health and Care Excellence (NICE) and Kings College London's IMPARTS Protocols.

Stepped care provides a framework that uses limited resources to their greatest effect on a population.

Stepped care provides treatments of differing intensity. To ensure the most effective care is being delivered; intensity can be 'stepped up' based on the patient need and level of distress.

For some individuals, lower levels of care would never be appropriate for the patient. Thus, stepped interventions offer a variety of treatment options to match the intensity of the patient's presenting problem.

PROMS Score	Focus of the intervention[1]	UHN Stepped Model	Example Interventions
PHQ-9: If a patient responds "several days" or more frequent to item 9 of the PHQ-9 ("Have you been bothered by thoughts that you would be better off dead or of hurting yourself in some way")	**STEP 4:** High Risk • Severe and complex depression; risk to life; severe self-neglect	Medical Psychiatry Patients with high level of complexity and/or risk	• Medication • High-intensity psychological interventions • Electroconvulsive therapy • Crisis service • Combined treatments • Multi-professional and inpatient care
PHQ-9: 20-27 GAD-7:15-21	**STEP 3: High Complexity** • Persistent moderate anxiety or depression symptoms with inadequate response to initial interventions • Initial presentation of severe anxiety or depression • Moderate to severe panic disorder • OCD with moderate or severe impairment • PTSD	***Medical Psychiatry*** *Comorbid mental health problems needing additional expertise (due to mental or physical health needs)*	• Medication • High-intensity psychological interventions • Combined treatments • Collaborative care • Referral for further assessment and interventions
PHQ-9: 15-19 GAD-7: 11-14 AUDIT-C: • Male: 5-12 • Female: 4-12	**STEP 2: Mild to Moderate** • Depression; anxiety; panic disorder; OCD; PTSD	**Healthcare Professionals (NP, SW)** Patients with comorbid anxiety and/or depression with low complexity or severity	• Low-intensity psychosocial interventions • Psychological interventions • Medication • Referral for further assessment and interventions (e.g. RAAM)
PHQ-9: 0-14 GAD-7: 0-10 AUDIT-C: • Male: 0-4 • Female: 0-3	**STEP 1: Low Complexity** • All known and suspected presentations of common mental health disorders.	**Self-Management & Resources** Patients with low complexity and symptom severity	• Identification and assessment • Psycho-education • Active monitoring • Referral for further assessment and interventions

UHN Toronto General Toronto Western Princess Margaret Toronto Rehab Michener Institute

1. National Institute for Health and Care Excellence (NICE). Stepped Care Model. Available at: https://www.nice.org.uk/guidance/cg123/chapter/1-guidance#stepped-care.
2. Kings College London. IMPARTS Standard Operating Procedure. 2021.

Nurse Practitioner Role at MHiM

- In the UHN stepped model of care, the NP becomes involved in the patient's episode of care during triage
- The NP will assess, treat, and continue to provide clinical management of low acuity, moderate acuity and moderately high acuity patients
- If a patient's clinical status changes to high acuity, the NP can step up care to the psychiatrist; conversely, if the patient's clinical status improves, the psychiatrist can step down care to the NP
- In a stepped care model, the NP role includes clinical management, counselling, health promotion and education, leadership, research, collaboration, and advocacy

TRIAGE

Triage patient according to degree of acuity and send to the relevant clinician(s) based on this assessment:

1. Low acuity patients—> NP provides system navigation on community mental health resources and supported self-help
2. Moderate acuity patients—> mental health assessment by NP with referral to SW as needed
3. Moderately high acuity—> mental health assessment by NP or MD with referral to SW as needed
4. High acuity patients—> psychiatric consultation by MD with referral to SW as needed

STEPPING UP/DOWN CARE

Clinic patients under care of NP and/or SW:

1. SW identifies a change in patient acuity, refers to NP/MD
2. NP identifies a change in patient acuity/complexity/lack of response to treatment, refers to MD

Acute safety concerns and/or incidents:

1. NP/SW risk assessment indicative of active SI/VI, with plan, intent, and means, requiring emergency intervention
2. NP/SW risk assessment indicates acute SI and requires an urgent assessment by psychiatrist for consideration of certifiability

Clinic patients under care of psychiatrist:

1. Psychiatrist stabilizes patient and acuity decreases, refers to NP and/or SW for ongoing management

SOCIAL WORK SERVICES AT MHiM CLINIC

- Referrals to Social Work often include issues relating to **Safety/Risk, Distress, System Navigation, and Practical Concerns** for patients.
  - **Safety/Risk:** child maltreatment, vulnerable adults due to cognitive or physical deficits, unsafe environments, violence in relationships
  - **Distress**: Crisis Interventions/Traumatic event, Grief and Loss, family system challenges, caregiver challenges, adjustment & transitions (new diagnosis)
  - **System Navigation**: complex situations requiring enhanced collaborative care planning, barriers to accessing resources, coordinating legal issues (immigration, legal, health, financial etc)
  - **Practical Concerns**: eligibility for various services/Benefits (Ontario Works, Employment Insurance), Housing Resources, Financial concerns, Drug Coverage, Transportation, linking/referring to other community resources(immigration, parenting, seniors etc.)

SOCIAL WORK SERVICES AT MHiM CLINIC

- In the UHN stepped care model, Social Work can be referred at all levels of acuity due to various roles of the MHiM social worker, to support an individual's multiple and complex psychosocial needs.
- A patient with mild to moderate depression may benefit from counselling/psychotherapy support from a Social Worker, where the intervention is to provide brief cognitive behavrioual therapy (CBT) during their 6 month episode of care.
- A high-complexity patient may be referred to social work as they require case management, to refer and coordinate access to various services, related to income, housing, substance use, and complex illness management.
- In a stepped-care model, Social Work roles include being an advocate, broker, case manager, counsellor, educator, supporter, and facilitator.

Stepped Care Model in Action: Case Study

ID	Mackenzie is a 32-year-old female who is recently separated and is temporarily living with a friend. She has no children. She currently works part-time.
RFR	Alcohol abuse and difficulty coping. Please assess.
HPI	Mackenzie was referred to the MHiM clinic by the general internal medicine clinic following an inpatient admission for sickle cell crisis. During this admission, Mackenzie disclosed that she has been consuming alcohol on a regular basis to manage her pain and stress. The GIM team suspects that her alcohol use is what precipitated her sickle cell crisis. Mackenzie is followed by UHN's Red Blood Cell Disorders Clinic.
Referral Screening	The administrative team reviews the referral and notes that the referral meets all the inclusion criteria and sends the referral to the NP for triage.
Triage	The NP reviews the referral, patient chart, and regional health record. The NP contacts Mackenzie by telephone and Mackenzie states she was unaware of the referral to the MHiM clinic. The NP provides education on the clinic and their role. Mackenzie expresses an interest in talking to "someone who might actually listen to me." Following a brief review of symptoms and a risk assessment, the NP learns that Mackenzie is consuming alcohol regularly which she states helps with her physical and emotional pain. Mackenzie endorses hopelessness, anhedonia, and chronic, passive suicidal ideation. Mackenzie engages in non-suicidal self-injury (cutting) 3-5 times/week, the last episode occurring 2 days prior. Mackenzie consents to a mental health assessment with the NP.
NP Triage Assessment:	Moderately high acuity

Case Study: NP Perspective

The NP schedules a mental health assessment with Mackenzie which occurs two days later. Following the assessment, the NP identifies the following problem list:

- Complex PTSD
- AUD, Mild
- Anorexia Nervosa, restricting type, in full remission
- History of suicidal behaviour
- Current non-suicidal self-injury
- Low income
- Housing problem

NP Recommendations:

1. Initiation of antidepressant
2. Education on low-risk drinking guidelines. Information on RAAM clinic. Information on AA groups.
3. Referral to publicly funded DBT program
4. CBT/DBT skills with NP while waiting for DBT program
5. Referral to SW for support with housing and finances.

Case Study: NP Perspective

At their third session, Mackenzie tells the NP that she can't live with her friend any longer because they have had a big fight. Mackenzie has no other friends or family to stay with, so she has been staying in a shelter. She states that she is really struggling to manage her alcohol use as it is the only thing, she can count on that gives her comfort. Mackenzie discloses that she has been cutting more frequently (approximately 8 times in the last week) and is experiencing more frequent and intense thoughts of suicide. Mackenzie tells the NP that this typically occurs while she is under the influence. Mackenzie tells the NP that she can be safe for now but isn't sure about when she is drinking. Mackenzie tells the NP that she will try to cut back on her drinking. After a lengthy discussion, Mackenzie consents to a referral to see the psychiatrist.

NP Recommendations:

1. Titration of antidepressant.
2. Safety planning.
3. Psychoeducation on anti-craving medications.
4. Referral to psychiatry for review of symptoms and recommendations for management.
5. Continue with weekly follow up.

Case Study: MD Perspective

Mackenzie is assessed by the psychiatrist the following week.

MD Recommendations:

1. Titration of antidepressant.
2. Initiation of gabapentin for support with minimizing alcohol cravings and treating anxiety. Guidelines for titration of this.
3. Continue to follow up bi-weekly with NP, will review as needed with NP.

Case Study: SW Perspective

Mackenzie is referred to Social Work for support with housing and finances.

SW Recommendations:

1. Complete SW psychosocial assessment to assess patient's strengths, formal and informal supports and important cultural & spiritual factors
2. Support NP and MD with referrals, and/or any barriers to accessing services that could require case management, collaboration with community partners and advocacy
3. Stabilize financial stressors by assisting with navigating provincial (Ontario Works, Ontario Disability Support Program) vs. federal income replacement programs (Employment Insurance, Canadian Pension Plan Disability)
4. Refer patient to community resources for shelter and housing resources.
5. Refer to culturally relevant resources (for example: Women, LGBTQ2S+, Indigenous, Newcomer/Refugee, BIPOC resources) to build support network.
6. Provide education and information regarding healthy relationships due to conflict with friends

Discussion Questions

1. What are the benefits of using a stepped care model in depression care?
2. Could a stepped care model work in your practice setting?
3. What are the barriers/facilitators to the implementation of a stepped care model in your practice setting?

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