Primary Care Psychology Newsletter

YOUR SOURCE FOR EXCELLENCE IN MENTAL HEALTH

HEALTHY TALK

PSYCHOLOGY IN FHTS

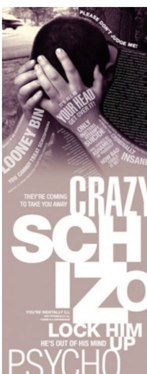
NEED TO SLEEP

FRONTLINE PSYCHOLOGY

BROUGHT TO YOU BY YOUR FAMILY HEALTH TEAM PSYCHOLOGISTS

It's So Mental.

Dr. Mirisse Foroughe, C. Psych. ***Summerville FHT***



Mental health has been receiving a lot of attention lately, thanks to campaign's such as Bell's Let's Talk, as well as the Changing Minds campaigns of the Canadian Mental Health Association. But changing the stigma associated with mental health is a process that each of us can play a role in. This process begins with the language that we use, how we talk to each other and to our patients. We know that mental health stigma exists, but how do people learn and unlearn it?

Consider for a moment the very worst insults that people are used to hearing: "You're insane", "She's completely lost her mind"', "What an idiot", "He's such a retard!", "You're crazy" and of course the most damning: "You need serious professional help!" These comments are heard everyday.

How we talk about mental health will shape how our patients understand it.

"Idiot", "moron", "imbecile", "retard" and others, were originally terms used by physicians and psychologists to describe specific categories of low intellectual functioning. These terms have a dark history, and were used to justify forced sterilization among the intellectually disabled, as well as anti-

immigration policies to keep Jewish people and other groups out of North America when they were fleeing persecution. Being labelled "crazy" or "hysterical" was amongst a woman's worst fears, as a husband's claims that his wife was emotionally unstable was enough to have her institutionalized against her will. As we know through classic studies such as the Rosenhan experiment, once people believe you are "insane", it is really hard to convince them otherwise.

While not everyone is familiar with the history behind these terms, we all know that they have a negative connotation and are related to deficiencies or disorders of the mind/brain.

At Summerville FHT, the third most common reason for a patient visit is disordered mood symptomatology, such as depression or anxiety. Although we often still refer to annual check-ups as "physicals", more and more patients are reporting mental health concerns. Many others with mental health difficulties— including mood disorders but also learning and behaviour difficulties in children, trauma, and relationship problems going on in their families— are suffering in secrecy. These problems impact not only their own well-being but also serve as risk factors for smoking, alcoholism, and heart disease. One of the most potent risk factors for hypertension as well as early onset of myocardial infarction is an *emotional* factor: "free-floating hostility." This refers to people who are ready to fight, impatient, and quickly become aggressive. Often, these traits are highly associated with social isolation and unhealthy lifestyle choices, which are further risk factors for chronic disease. Mind and body factors are much more intertwined, interrelated, and reciprocal than patients may realize.

So how can we encourage patients to share all of their health concerns, without so much shame? It starts with how we talk about mental health: 1) Removing some of the highly-stigmatized terms and phrases from our language; 2) Asking about depression, anxiety, and learning difficulties as easily as we would ask about how well someone is sleeping or eating; 3) Responding to what we see in the patient's presentation (Are they keyed up and tense? Is their child very shy and nervous in the office?), and by asking direct questions about anything from parenting stress to emotional eating.

If we ask "How have you been feeling" and the patient responds only with physical concerns, we can add "And how have you been feeling *emotionally*?", then listen and watch as they respond. The first ten times a patient is asked this, they may become very

MENTAL HEALTH FACTS

WHO considers the lack of integration of mental health into primary care as one of the key barriers to service. In our FHT settings, we have a unique opportunity to change this.

Only 49% of Canadians said they would socialize with a friend who has a serious mental illness.

Two-thirds of homeless people using urban shelters suffer from some form of mental illness.

Only 23 per cent of Canadians surveyed said they would feel comfortable talking to an employer about their mental illness.

In any given year, one in five people in Canada experiences a mental health problem or illness, with a cost to the economy of well in excess of $50 billion.

Rates of mental illness for adults between the ages of 70 and 89, including but not limited to dementia, are projected to be higher than for any other age group by 2041.

Every day, 500,000 Canadians miss work due to a form of mental illness

. CANADIAN MEDICAL ASSOCIATION .

uncomfortable or seem surprised. This is just because they are not used to talking about emotions as part of health. Let's keep at it, showing them over time and across providers that their mental health matters to us. It is likely that the patients most "tight-lipped" about mental health are the ones who could benefit the most from having permission to talk about it.

It may help to remind ourselves that, as health care practitioners, our professions were historically amongst the perpetuators of stigma around mental health. It follows that we have the power to help free our patients from this stigma.

Primary Care Psychology in a FHT Setting

Dr. Adrienne Eastwood, C. Psych. ***Wise Elephant FHT***

As a psychologist, I have historically worked in specialized mental health settings, such as a hospital-based psychology department, or a children's mental health centre. In these settings, clients are formally discharged at the end of service. Despite working almost ten years in the same setting, I did not often experience longer-term relationships with clients.

Since beginning to work at Wise Elephant FHT in 2010, I have noticed that my relationship with patients is different than what I had experienced in previous settings. Wise Elephant is a relatively small FHT, with nearly 9000 patients, so our mental health team consists of myself, just a day a week, and our full-time mental health nurse, Kathy Kruger. Together we collaborate to meet the mental health needs of our patients, either through providing service directly ourselves, or by connecting patients to other locally available services and supports.

Patients at a FHT are often patients for life, and their family physician's office is a place many patients visit on a regular basis. Patients generally see me as a partner with their family physician in caring for their well-being over the long term. Patients are accustomed to coming to their doctor's offices for help with immediate and urgent concerns, as well as for well-being check-ups and preventative care. In a sense, my relationship with patients has revolved around similar goals. Patients are referred to me whenever they, or their physician, would like my input regarding their emotional health or development. For example, some parents would like to know if their child's behaviour is "normal", and appreciate being able to consult with the relevant professional 'in-house'. Whether or not I end up providing a specific treatment to these children myself, I look forward to seeing them again, whether in 6 or 12 months or more, in order to monitor their progress.

Many of the services that I provide in the FHT setting are similar to those that I provided in mental health settings, including diagnostic consultation and psychological treatments. Working just one day a week means that offering comprehensive psychological assessments is not realistic, but I have been able to provide some meaningful briefer consultations including brief reports. I have also found that I am more likely to see parents who are looking for an opinion about their child's adjustment from a psychological perspective, without necessarily wanting any treatment or help at that time. I communicate my impressions simultaneously to the patient and their physician, through the EMR.

While I do not provide crisis services, I have come to realize that physicians highly value being able to refer their patients to the right professional in a timely manner. Primary care physicians want to know that their patients' needs are being met, and they are acutely aware

of the lack of readily available mental health services. I have been impressed by their dedication to helping patients in distress, and I have found that most are well equipped to pick up on signs of mental health problems. Together, the mental health nurse and I brainstorm ways to continue to keep our response time as short as possible. Bringing on psychology and counselling residents has definitely contributed to our success.
My wait time for child and youth referrals is currently around two months, which I am reasonably comfortable with. As I look ahead, I look forward to thinking about the role that I might play in 'chronic care management', such as in developing and implementing a system to monitor patients with chronic mental health conditions, such as ADHD. Wouldn't it be great to have a hand in ensuring that the emotional and behavioural health of children with ADHD is being systematically following over the long term?

My professional life has been enriched by the opportunity to develop long-term relationships with patients, as well as to partner with their physicians, nurses, and other IHPs in promoting and protecting their well-being throughout their lives.

Brain Matters: The Value of Neuropsychology in Primary Care

Dr. Sylvain Roy, C. Psych., *Inner City FHT*

Neuropsychological factors directly impact a person's ability to function independently in the community, and are linked to loss of productivity, family breakdown, and even homelessness. Neuropsychologists are working to address these problems by incorporating aspects of community rehabilitation into FHTs that disproportionately serve the 1 to 5% of patients deemed "high users" of healthcare, accounting for 29 to 58% of health care costs across the Toronto Central LHIN.

Cognitive impairment may be caused by acquired brain injuries such as stroke or head injury, neurodevelopmental disorders such as schizophrenia, degenerative illnesses such as Alzheimer's disease, infectious diseases such as Hepatitis C or HIV/AIDS, vascular problems such as hypertension or heart disease or chronic substance abuse.

Individually, most of these diseases are associated with different neuropsychological profiles. Behavioural disinhibition, for example, may follow traumatic brain injury (TBI), fronto-temporal dementia, or crack abuse due to altered frontal lobe functioning. Learning and memory impairments are frequently observed in schizophrenia, TBI and Alzheimer's disease, though each of these may affect different aspects of memory (e.g. encoding, storage or retrieval). Finally, difficulties with balance, visual-construction, judgment, problem-solving and memory can be observed in chronic alcohol abuse due to poor nutrition (thiamine deficiency) and the toxic effects of alcohol on the brain.

Many high needs patients may present with more than one of the aforementioned conditions, making them particularly challenging to assess and treat. To make matters worse, persons with brain dysfunction are more likely to have future brain injuries. Alcohol

use after a brain injury, for example increases the likelihood of a second injury (Vaaramo et al., 2013). Similarly, chronic crack abuse can lead to erratic and impulsive behaviours, fights and head injuries, or even stroke due the vasoconstrictive effects of the drug. The cumulative effects of multiple brain injuries can have disastrous consequences on a person's ability to think, problem solve and remember, which directly impact an individual's ability to function independently in the community. A simple, but relevant example in primary health settings is that of medication adherence. Patients with poor attention or memory may be unable to fill their prescriptions or remember to take medications as prescribed. Such patients could benefit from cognitive compensation strategies and cueing mechanisms to help them with such difficulties. From a health delivery perspective, addressing poor medication adherence, among other functional difficulties, could translate into less frequent emergency room visits and improved health outcomes.

As a neuropsychologist, my work involves determining the nature of my patients' cognitive impairments and its impact on their functioning. This is accomplished through the use of standardized tests, which are used to complement interview data and behavioural observations. Patients' results on measures of memory, attention, visual perception, language, executive functions (reasoning, planning, and organization), mood and personality are compared with the performances of others of similar age, gender, and education. The obtained pattern or cognitive profile is a crucial component of diagnosis. The neuropsychological report can also useful in recommending court diversion for persons with poor mental health and cognitive impairments who have been charged with a minor offence. It can be useful to support an ODSP application when cognitive impairments result in permanent disability.

At Inner City FHT, a community-based program addresses the needs of homeless individuals with a variety of physical and mental health needs. Preliminary data from our program evaluation suggest that across a widely heterogeneous group of homeless men, impairments are frequently noted in the domains of attention, verbal memory and processing speed. Abstract reasoning abilities were frequently also affected. Such findings will direct future development of cognitive based interventions for homeless men. For example, patients' reduced cognitive processing speed and mental flexibility capacity will likely require clinicians to adjust the rate at which they impart information and to use concrete examples to communicate ideas.

FHTs that include neuropsychologists are well positioned to refine and implement assessment and rehabilitation programming for individuals with cognitive impairment and brain injury, as well as assess and treat children with a range of brain-based impairments. In collaboration with other health care professionals, such as occupational therapists, neuropsychologists can play a leading role in supporting these individuals to become better equipped to access appropriate care and be able to live independently within the community.

Help Someone Sleep: Treating Insomnia in Primary Care

Judith R. Davidson, C. Psych. ***Kingston FHT***

What exactly is Insomnia?

Insomnia is difficulty getting to sleep or staying asleep that persists for weeks, months or years, and interferes with daytime functioning. If you have it, you know it is a frustrating infliction. Along with frustration, people with insomnia often experience: a) unhappiness -- low mood, low energy, and low interest; b) fuzzy thinking -- poor concentration and mental slowness; c) movement impairment – bumping into things and feeling clumsy; and d) social discomfort -- wanting to withdraw and to avoid others.

More than half of primary care patients have sleep complaints in general, and 10-40% have insomnia specifically. Unfortunately, insomnia doesn't resolve by itself, and many people suffer for years. Not only does insomnia lessen quality of life but, if left untreated, insomnia is a risk factor for future mental health problems, especially major depression. In addition, compared to people who don't have sleep problems, people with insomnia visit the doctor more frequently and use disproportionately more health care resources.

Fortunately, there are some excellent treatments. Sleeping pills, especially benzodiazepine receptor agonists, can be useful for acute insomnia, but because of side-effects and tolerance, this approach is generally unhelpful for insomnia that lasts more than one month. The best treatment that we currently have for chronic insomnia is called "cognitive behaviour therapy for insomnia", or "CBT-I." This non-pharmacological treatment uses strategies that reverse insomnia. (It is sometimes confused with "sleep hygiene" education which is good advice but insufficient on its own to reverse chronic insomnia.) CBT-I has plenty of evidence of efficacy and effectiveness, and is the recommended first line treatment for chronic insomnia in practice guidelines from Canada, the United States and the United Kingdom. CBT-I works, not only for patients with "just" insomnia, but for patients with comorbidities such as chronic pain, cancer, heart disease, and depression.

This treatment is beginning to make its way into Family Health Teams. At the Kingston Family Health Team, we offer group CBT-I to patients with chronic insomnia. We call this the "Sleep Therapy" program: six weekly workshop-like sessions, each lasting two hours. Groups have 3-10 patients, and are co-led by the psychologist and a nurse practitioner or a program assistant. Through the sessions, patients learn about insomnia, sleep stages and cycles, sleep and age, effects of sleep loss, and the biological processes that regulate sleep and wakefulness. They log their sleep each morning over the course of the program. The techniques they learn include: associating the bed with sleep ("stimulus control therapy"), reducing time in bed ("sleep restriction therapy"), deep breathing, relaxation, and techniques to calm troubling and racing thoughts.

Patients track their own progress using sleep diaries which are used to estimate average time to fall asleep and average time awake during the night. In addition they complete a validated measure of perceived insomnia severity, called the Insomnia Severity Index. After taking the program, participants' sleep measures show substantial improvement. Based on the first 53

participants in the program and their responses on the Insomnia Severity Index, 89% of participants no longer had clinically significant insomnia by the sixth session. This is a very rewarding program to offer. We see a shift in patients' outlook from scepticism about the techniques before the program, to surprise when the techniques start to work, to optimism and confidence in their ability to sustain good sleep when the program ends.

Want to Learn More?

Davidson JR (2012). Treating insomnia in primary care –Early recognition and management. Insomnia Rounds 1(3):1-10. www.insomniarounds.ca This article was written for primary care practitioners.

Resources for Patients with Insomnia:

http://www.sleepio.com/ This is an effective internet-based CBT-I program developed by Dr. Colin Espie from the UK. There is a cost to the patient.
Carney C & Manber R. Goodnight (2013). Mind: Turn Off Your Noisy Thoughts and Get a Good Night's Sleep. New Harbinger. A book for people with insomnia.
Davidson JR (2013). Sink into Sleep: A Step-by-Step Workbook for Reversing Insomnia. Demos. A CBT-I guide for people with insomnia.
Morin CM. (2013). Vaincre Les Ennemis du Sommeil. HOMME. A CBT-I guide for people with insomnia (French).

This issue of Frontline Psychology is brought to you by your team psychologists:

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