Diabetes and Mental Health Knowledge Exchange Event 2015

March 27, 2015

Summary Report

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Executive Summary

Over 130 mental health workers, diabetes educators and other key stakeholders came together in late March, 2015 to improve the collective understanding of diabetes and mental illness and to discuss ideas for change to best support people living with mental illness and diabetes.

The daylong session offered presentations in the morning from Betty Harvey, a Nurse Practitioner working with clients facing mental health and diabetes issues at a clinic in London Ontario as well as a presentation by Dr. Suzanne Filion, a clinical psychologist and director with the Hawkesbury and District General Hospital.

At the start of the morning and afternoon sessions, two presentations focusing on living with mental illness and diabetes were offered, one from a lived experience perspective and the other from a family/caregiver. The majority of the afternoon was dedicated to small table discussions using case studies and guided questions to assist the conversations towards collaborative asset based strategies.

The end of the session allowed participants to identify opportunities for change and collaboration. The opportunities identified fell into 4 main themes around: Education/Knowledge Exchange; Communication; Case Coordination; and, Research, Evaluation at a System's level.

Overall the session was very well received by the participants and feedback indicates that new information, strategies as well as new connections between the mental health/addictions and diabetes sector would be utilized when participants returned to their work settings.

Participant Feedback

"This has been one of the best training/education days I have been to in quite some time and I am looking forward to putting some of the training (and tools discovered during training) into practice."

"This workshop has made me motivated to increase my knowledge in mental health issues where diabetes care is involved."

1 Overview

On March 27, 2015, over 130 mental health workers, diabetes educators and other key stakeholders came together to improve the collective understanding of diabetes and mental illness and to discuss ideas for change to best support people living with mental illness and diabetes. The objectives for the day were:

- For individuals working with people with severe mental illness to understand the basics of diabetes to support their clients in their self-management;
- For diabetes educators to understand the impact of mental illness on diabetes self-management and how to adapt education and care plans;
- For diabetes educators to have increased awareness of the complexities of mental illness and the prevalence and co-relationship between mental health and addictions;
- To network and improve understanding of existing resources for diabetes and mental illness;
- To identify ideas to best support people living with mental illness and diabetes; and
- To identify potential champions to continue to build capacity amongst and between diabetes educators and mental health workers.

The event was co-hosted and organized by members of the following organizations:

- Champlain LHIN, Diabetes & Vascular Health Team
- Community Diabetes Education Program Ottawa
- Pathways to Better Care (the Royal)
- Canadian Mental Health Association Ottawa
- Pembroke Regional Hospital (Vascular Health)
- Wabano Diabetes Program

This event summary is intended as a working document for event participants and reflects key highlights from the key note speaker presentations, a data capture of the scenario discussions and a summary of the opportunities and suggested next steps identified by the participants.

2 Agenda

The following event agenda guided the day.

AGENDA	
Time	**Activity**
09:00-09:30	Registration
09:30-09:45	Welcome and Introductions
09:45-10:00	Diabetes and Mental Illness – *A Client's Journey…*
10:00-10:30	Diabetes and Mental Illness – Perspectives from Primary Care Presentations by: - Betty Harvey, NP, London Primary Care Diabetes Support Program
10:30-11:00	Diabetes and Mental Illness – Perspectives from Mental Health and Addictions Presentations by: - Dr. Suzanne Filion, Ph.D., C.Psych: Director – Strategic Initiatives, Mental Health & Addictions, Hôpital Général de Hawkesbury & District General Hospital
11:00-11:45	Questions and Answers Key Insights
11:45-12:30	Networking Lunch
12:30-12:45	Diabetes and Mental Health – *A Family's Journey…*
12:45-14:15	Case Scenarios – Enhancing collaboration between Mental Health and Diabetes
14:15-14:30	Health Break
14:30-15:15	Insights and Opportunities for Innovation Dialogue
15:15-15:30	Wrap-Up, Next Steps and Closing Remarks

3 Opening Remarks

The event kicked off with opening remarks from Mrs. Annette Bradfield from the Canadian Mental Health Association and Mrs. Karen Roosen of the Pembroke Regional Hospital who together welcomed participants and framed the event as an exciting opportunity for those who work with clients living with diabetes and mental illness to better understand each other's discipline and consider how they can better support clients with their self-management. They also highlighted the importance of learning from each other and identifying opportunities where we might collaborate in the future.

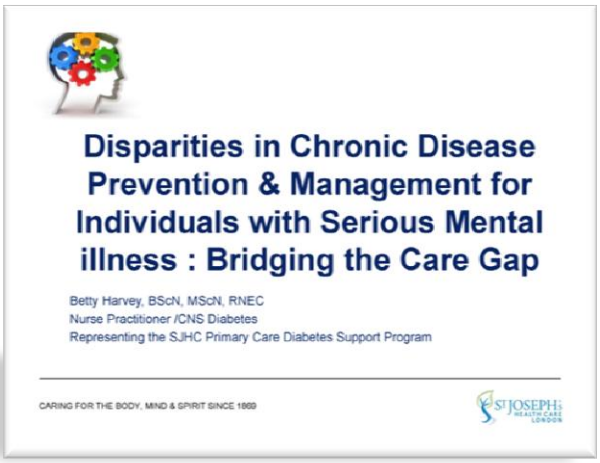
4 Highlights from Client and Family Experiences

To start the morning and afternoon segments of the agenda, we heard two client perspectives, one highlighting an individual's journey, a mother of two, and the other a family's journey supporting their son, both living with mental illness and diabetes. Both spoke of the impact of mental illness on diabetes self-management and the importance of tapping into the support and services available in our community.

5 Key Note Presentations

The key note presentations provided insight from both diabetes and mental health perspectives. Both presentations were intended to enhance the shared understanding of both areas among participants and to serve as a catalyst for discussion on insights and opportunities to collectively improve services to clients.

Betty Harvey, Clinical Nurse Specialist/Nurse Practitioner with the Primary Care Diabetes Support Program at St. Joseph's Health Care, London, Ontario



The first presenter, Mrs. Betty Harvey, shared her insights as a Clinical Nurse Specialist/Nurse Practitioner with the Primary Care Diabetes Support Program at St. Joseph's Health Care, in London, Ontario. Highlights from Betty's presentation titled "Disparities in Chronic Disease Prevention & Management for Individuals with Serious Mental Illness: Bridging the Care Gap" include:

- The double jeopardy of chronic illness, whereas individuals with chronic conditions are disproportionately affected by serious mental illness and individuals with serious mental illness are disproportionally affect by chronic illness

- The story of "Ed" and how we may improve his clinical outcomes through:
    - System redesign: integrated and co-located interdisciplinary care teams; cross training; self-care, remote and EMR support
    - Sensitivity training so that diabetes professionals can inform mental illness professionals on who is at risk and the silent nature of diabetes; and, so that mental health professionals may help diabetes and primary care professionals understand the realities of living with serious mental illness and its implication on self-care and the opportunities in leveraging the Psychosocial Rehab model. The alternative is to hire "hybrids".

- The importance of assertive surveillance and early diagnosis/treatment as an important clinical goal:
    - ensuring that diabetes and primary care are screening for mental illness (e.g. PHQ9, Likert 1-10 stress scale and unpacking it, QOL screening tool, "Promise" functional capacity questionnaire)
    - ensuring that mental health professionals screen for diabetes and other chronic diseases (e.g. CANRISK)

- The reduction of navigational barriers by:
    - Timely communication with the circle of care: identify a care coordinator; follow up on no shows; engaging community pharmacists
    - Offer point of care services: lab, emergency self-care supplies, instrumental support like social worker and community worker and, foot care
    - Innovate: CMHA – LHSC transition program; SJHC LHSC cardiac DM collaboration
    - Shared care at points of existing care delivery (e.g. WOTCH, RMHCL, GPS, Remote Support / ACTT team, facilitated appointments / batched clinics, embedded specialty
    - An opportunity for diabetes educators to go to where these clients are and to not necessarily wait for them to come to us.

- In summary:
    - Chronic diseases are fast becoming the leading causes of death and disability in Canada and has become a driving force behind Health Care Reform;
    - Individuals with serious mental illness are disproportionately affected by Chronic illnesses;
    - There is a gap in under diagnosis and under treatment of diabetes in this population, and
    - Primary and Specialty Care systems need to better integrate services to improve the health outcomes for the "Eds" in our communities.

A copy of Betty's handout are attached in Appendix B.

Dr. Suzanne Filion, Director of Strategic Initiatives in Mental Health and Addictions, Hawkesbury and District General Hospital, Hawkesbury, Ontario

The second presenter, Dr. Suzanne Filion, shared her insights as the Director of Strategic Initiatives in Mental Health and Addictions at the Hawkesbury and District General Hospital and through her private practice in Alexandria, Ontario, serving an adult clientele suffering from anxiety, mood, dissociative attachment and personality disorders, in her presentation titled: Mental Health and Addictions–You Are Not Alone. Key highlights are summarized below:

- Basics:
  - Sources of best practice: research (journals); clinical experience (private practice); administrative challenges (director); five high MHA services (interviews); regional consultations (MOHLTC and Champlain); and, Provincial Frameworks
  - National recognition for the "GPS: Gestion Personelle de ma Santé" which presents and inter-agency partnership framework
  - Hot topics
  - Various approaches and techniques in MHA/CA and global key approach in self-management with a focus on clients who are not "one size fits all". There are a number of different interventions, such as:
    - ACT: Acceptance and Commitment Therapy
    - DBT: Dialectical Behavior Therapy
    - CBT: Cognitive Behavioral Therapy
    - MBSR: Mindfulness-Based Stress Reduction
    - MI: Motivational Interviewing
    - SFT: Schema-Focused Therapy
    - Solution-Focused Intervention
  - A number of practical reference books, including:
    - Depression and Diabetes, 2010
    - Diabetes and The Metabolic Syndrome of Mental Health, 2008
    - Managing Metabolic Abnormalities in the Psychiatrically Ill: a Clinical Guide for Psychiatrists, 2007
    - Get Out of Your Mind & Into Your Life, Steven C. Hayes
    - Grieving Days, Healing Days, J. Davis Mannino

        - Living With ADD, A Workbook for Adults with ADD, M. Susan Roberts, Gerard J. Jansen
        - Managing Social Anxiety, Debra A. Hope, Richard G. Heimberg, Harlan R. Juster, Cynthia L. Turk
        - Mind Over Mood, Christine A. Padesky, Dennis Greenberger
        - Overcoming Generalized Anxiety Disorder, John White
        - Skills Training Manual for Treating Borderline Personality Disorder, Marsha M. Linehan
        - The Anxiety & Phobia Workbook, Edmund J. Bourne
        - Treatment Plans and Interventions for Depression and Anxiety Disorders, Robert L. Leahy, Stephen J. Holland
    - The Research:
        - Depression, social support and nonadherence: less social support and its link to medical non adherence, which leads to more depressive symptoms (Source: The Relationship between depressive symptoms and medication nonadherence in type 2 diabetes, the role of social support., Osborn CY, Egede LE, General Hospital Psychiatry, 2012 May-June, Vol 34 (3), pp 249-53)
        - Schizophrenia: The prevalence of type 2 diabetes among individuals suffering from schizophrenia or schizoaffective disorders is more than double that of the general population
- Simulation:
    - Understanding our client's perspective when communicating the facts about having diabetes
    - Understanding our client's reaction: distress and dissonance as motivators
        - The news of diabetes needs to "get to them", destabilize
        - Need to believe in the better me, and
        - It needs to be their plan
        - Not all clients are able or willing to self-manage their chronic conditions and we must respect that
- What is my job?
    - Create dissonance and motivational distress
    - Psychoeducation: know what you are talking about, use visual aids (e.g. the "doorway" to the cells), build on the client's personal goal(s) (dissonance)
    - Motivational interviewing:
        - Determine readiness for change:
            - Do you view _____ as a problem?
            - Does _____ concern you or cause distress? (Values)
            - Are you interested in changing?
            - Are you ready to change now?
        - Work toward change

        - Why do you want to change?
        - How hard are you willing to work?
        - Are you willing to do the work now even if you don't see the benefits?
    - Set SMART goals
        - Negotiate options, small steps, successes
        - Consider yourself as the client's safety rope, they trust you
    - Helpful hints include compassion and empathy above all!

In closing, Dr. Filion shared the following comprehensive summary:

1. Set SMART Goals and act
2. Self monitor – invite clients to write on charts or forms
3. Cognitive restricting – look to case management and behavioural therapy such as solutions focused therapy and motivational interviewing
4. Stimulus control – identify what are their triggers
5. Social support: family, friends, groups
6. Stress management – coping techniques such as mindfulness
7. Reward system

Dr. Filion's presentation is provided in Appendix C.

6 Scenario Round Tables

To create a shared learning experience, participants were assigned seating to ensure that representatives from both the mental health and diabetes communities were represented and each table was assigned a case scenario with a series of probing questions to stimulate the conversation. Each table was facilitated by a table host who also captured notes from the discussion. The following questions were asked for each scenario, provided in Appendix D.

1. What are your immediate concerns?
2. What would you explore with the client to get a better idea of what support might be helpful?
3. How might the client's psychosocial factors be affecting his/her diabetes self-management?
4. What are the client's strengths, and how can support be provided to build on them?
5. What are the long term goals?
6. How would you and your organization assist the client?
7. How might you as a group collectively provide support to the client?
8. Describe the benefits of working collaboratively in this situation.

Key take aways from the scenario discussions that emerged during the plenary report back included:

- The scenarios provided a great platform for knowledge exchange and to learn more about each other's expertise and how we can best address the needs of our clients
- There is a need for better awareness from both sectors on the services and resources available
- There are many benefits to a holistic team approach
- By working together, we can eliminate the duplication of services
- We need to avoid or stop working in silos
- Look for opportunities to share resources
- Case conferencing and case management – a multidisciplinary approach
- By working together, it allows us to establish several safety nets for our clients
- It is in the client's best interest for us to work more collaboratively

A special thanks to our Volunteer Table Facilitators

Alison Middleboro
Annette Bradfield
Karen Roosen
Kathleen Sowinski
Kevin Barclay
Laura Murray
Leah Bartlett
Marie-Josée Dupuis
Marybeth Colton
Mitsi Cardinal
Nicole Gagnon
Nikki Swenson-Hewitt
Tess Frémont-Côté

7 Opportunities for Future Collaboration and Service Enhancements

To wrap-up the knowledge exchange, each table was invited to identify and share insights, ideas and opportunities for change and greater collaboration in order to best serve clients living with both mental illness and diabetes. The following themes emerged with some suggestions about potential initiatives for next steps to continue to build capacity between the mental health and diabetes sectors. A number of participants identified that they would be interested in hearing more about some of the potential initiatives moving forward. The complete list of ideas can be found in Appendix E.

Education/Knowledge Exchange

- Annual Diabetes and mental health conference
- Different levels of learning seminars/ Platform for continued knowledge exchange
- Access and training to relevant screen tools (evidence-based), what to use and when
- Diabetes and mental health survival skill workshop for clients to better manage in a crisis situation
- Diabetes education for mental health providers
- Sharing assessment tools, interventions, and evaluation between sectors to promote holistic approach (e.g. CANRISK)
- What are the resources/services - a comprehensive list
- Meeting between organizations to be aware of services each provide to be able to refer clients between each (common repository of knowledge).
- Identify cultural resources
- Job Shadowing
- Taking education to the new level: using new skills to work with our clients
- Use of new tools: cognitive pictures; vascular wheel; wands – BG; Algorithms with solutions

Communication

- Broaden the referral process so that RN's/outreach nurses could refer to services (not just physicians) and other regulated health care professionals e.g. pharmacists
- One stop, one # to call "Hub" – info share, coordinated care
- Links between providers: share goals, share concerns
- Balancing responsibilities between group homes/primary care/ diabetes education
- Care meetings for providers between mental health and diabetes
- Cyber support community – after hours, peer support
- Facilitate the creation of networks of practitioners (diabetes & mental health) both ways

Care Coordination

- Strategies for those living in difficult settings, boarding houses, and helping to manage change

- Community diabetes program to come to hospital psychiatry when complex patients need diabetes follow up
- Acknowledge unique needs in rural vs urban areas e.g. rural transportation issues
    - Outreach diabetes/MH support to remote towns?
- Find creative ways to involve families
- Client Chart is where all providers document, client includes on goal and agrees with plan.
    - Family to have access to plan with patient's consent
    - Client/family brings chart to specialists, doctors' appointments etc.
    - Shared care – client/family centred approach
- Transition planning - Collaborative planning breaks down silos and integrates social/medical priorities
    - Coordinated integrated care from all providers, based on client's needs, requirements, goals, to prevent relapse
    - Client ease comfort from knowing that her medical/psychosocial history known by providers in circle of care (and common approach by all providers)
- Chart in the home (until EMR)
    - Include family in care planning
    - Collaborative planning, holistic approach to client goal setting
    - Note: different lenses to same issue
- Case conferences between client, family, CMHA (or similar), Diabetes Education Program, Vascular Team Rep. – clarify goals, what resources are available, one-stop-shopping, develop action plan, identify future needs/expert help.

Research, Evaluation at a System's level

- Follow up with no-shows, why, what are the trends
- Look at data → how better to provide services (esp. those underserved)
- Under Diagnosis: How do we address under diagnosis in a systematic way
- Under Treatment: How do we address under treatment in a systematic way
- Identify emerging care gaps with key stakeholders
- What do we do with the results of new screening tools?

8 Next Steps

A number of participants expressed an interest in being contacted about some of the ideas/initiatives generated during the knowledge exchange day. The most interest was focused on three key themes: Communication, Education/Knowledge Exchange, and Care Coordination.

The Knowledge Exchange organizing committee will connect with those interested in exploring further involvement once the Diabetes and Mental Health Committee meets to review the results of the workshop and identifies priorities for 2015-16.

Appendix A – List of Participating Organizations

- Addictions Treatment Service
- Arnprior Regional Health
- Bruyère Family Health Team
- Canadian Diabetes Association
- Canadian Mental Health Association - Champlain East
- Canadian Mental Health Association - Ottawa
- Carlington Community Health Centre
- Champlain Community Care Access Centre (CCAC)
- Childrens Hospital of Eastern Ontario (CHEO)
- Community Diabetes Education Program of Ottawa (CDEPO)
- Cornwall Community Hospital
- Centre de santé communautaire de l'Estrie
- Greenbelt Family Health Team
- Hawkesbury General Hospital
- Hawkesbury General Hospital, Mental Health & Addictions
- Hôpital Montfort Hospital
- Hôpital Montfort Hospital, Clinique externe santé mentale
- Investors Group
- John Howard Society of Ottawa
- Kemptville Diabetes Program
- Kemptville District Hospital
- Mohawk Council of Akwesanse Home Care & Home Support
- Mohawk Council of Akwesasne
- National Defence
- Options Bytown Non-Profit Housing Corporation
- Ottawa Addictions Access and Referral Services (OAARS)
- Ottawa Salus
- Ottawa Valley Family Health Team
- Pathways Alcohol and Drug Treatment Services
- Pembroke Regional Hospital
- Pinecrest-Queensway Community Health Centre
- Queensway-Carleton Hospital, Mental Health
- Qualicare
- Rideau Family Health Team
- Rideau Valley Health Centre, Ottawa South Diabetes Education
- Sandy Hill Community Health Centre
- Sandy Hill Community Health Centre, Oasis Program
- Seaway Valley Community Health Centre
- Somerset West Community Health Centre
- South East Ottawa Community Health Centre
- Southern Ontario Aboriginal Diabetes Initiative
- The Ottawa Hospital, Division of Endocrinology & Metabolism
- The Royal Ottawa Hospital, Assertive Community Treatment Team (ACTT)
- The Separation and Divorce Resource Centre
- Tungasuvvingat Inuit
- Wabano Centre for Aboriginal Health
- West Champlain Family Health Team
- Winchester District Memorial Hospital

Appendix B – Presentation: Betty Harvey

The presentation is available under separate cover.

Appendix C – Presentation: Dr. Suzanne Filion

The presentation is available under separate cover.

Appendix D – Scenarios

SCENARIO 1 – ROBIN

Part 1

Location: Your mental health agency, diabetes education program, or primary care setting.

Scenario: This 38 year old woman has been diagnosed with bipolar disorder since age 18, and has a history of suicide attempts, and alcohol & pain medication abuse (pain meds more recently, which were prescribed after car accident). Robin has several medical concerns which require attention on a regular basis – fibromyalgia, obesity, tobacco use, high blood pressure, and urinary incontinence.

Robin has been stable for the last few years other than one admission last year, after going off psychiatric medications that were ordered by the psychiatrist. Since the family doctor retired 6 months ago, she has been using walk-ins. Recently Robin was diagnosed with type 2 diabetes.

1. **What are your immediate concerns?**
2. **What would you explore with Robin to get a better idea of what support might be helpful?**

Part 2

Robin has been on ODSP (Ontario Disability Support Program) since 2001, and has been living independently in her own apartment since June 1, 2004. Prior to this, she lived in a supported living environment for two years to develop life skills and coping skills to live alone after a long admission at the psychiatric hospital.

Robin's psychiatrist reports that numerous medications have been tried to stabilize Robin's mood. Robin responded well to Epival and was able to work at a part-time job for more than four years as a personal support worker at a nursing home.

Robin is currently taking Seroquel, Epival, Ativan, Cogentin, Diovan-HCT and nicotine replacement therapy (patches). She would like to hold off on adding meds for diabetes as she is motivated to try to lower her fasting glucose using diet and exercise.

3. **How might Robin's psychosocial factors be affecting his/her diabetes self-management?**
4. **What are Robin's strengths, and how can support be provided to build on them?**
5. **What are the long term goals?**

Part 3

Unfortunately, the Epival caused a large weight gain, making Robin reluctant to take it. She frequently discontinues psych meds on own because they cause weight gain. When Robin stops medications, her mood deteriorates quickly. One year ago Robin lost 40 lbs after going off of medications, and then became ill and had a brief hospitalization for psychiatric reasons.

Recently Robin has become more depressed, isolates, sleeps all day, skips meals, and isn't interested in social activities or conversation. Robin often drinks coffee and smokes, and "won't" follow through with activities of daily living or attending medical appointments.

6. **How would you and your organization assist Robin?**
7. **How might you as a group collectively provide support to Robin?**
8. **Describe the benefits of working collaboratively in this situation.**

SCENARIO 2 – GEORGE

Part 1

Location: Your mental health agency, your Diabetes Education Program, or your primary care setting.

Scenario: George is a pleasant 57 year old single Ojibwe man who is presently on ODSP (Ontario Disability Support Program), and lives in a rooming house with his stepson who also suffers from schizophrenia. His present health consists of a diagnosis of the following: schizophrenia, hypercholesterolemia, hypertension, anginal (cardiac) pain, type 2 diabetes, and intermittent claudication (causing pain in his legs). He reports that he eats one meal/day at suppertime.

George is physically and socially dependent on his stepson to buy the groceries (on a limited income), prepare meals, do laundry, and to drive him to appointments. His stepson works part-time and does not arrive home until 5pm to cook supper. The stepson has said he is finding it draining to care for his father.

1. **What are your immediate concerns?**
2. **What would you explore with George to get a better idea of what support might be helpful?**

Part 2

George's medication regime is as follows: Lantus insulin, Metformin, Diamicron, Januvia, Ramipril, Ramipril, Simvastatin, Ezetrol, Gabapentin, Acetominophen, Spiriva, and WelbutrinXL.

George takes his medication faithfully, including his daily insulin. However, he refuses to increase his insulin or add rapid acting insulin at mealtime, as he is afraid of experiencing hypoglycemia. His HbA1c (test to see how well diabetes is controlled) and blood pressure are both above target, and his kidney function is normal.

George is not consistent in attending his diabetes or specialist appointments that have been scheduled for him. He has limited reading skills, however, he is able to download apps on his phone/computer. He is consistent in emailing his glucometer graphs each month to his diabetes educator.

3. **How might George's psychosocial factors be affecting his/her diabetes self-management?**
4. **What are George's strengths, and how can support be provided to build on them?**
5. **What are the long term goals?**

Part 3

George's schizophrenia has been stable over the past three years, and has recently been informed that he no longer qualifies for community mental health support (agency wants to close client's file).

His daily routine consists of drinking coffee all day and playing video games (Game of War). He complains of weakness and pain in his legs, and uses a wheeled walker when he goes out. He also experiences frequent lower back pain which limits his activity and causes him to feel depressed. He smokes cigarettes 1 pk/day, and does not drink alcohol. He has gained 20 lbs over the past year.

6. **How would you and your organization assist George?**
7. **How might you as a group collectively provide support to George?**
8. **Describe the benefits of working collaboratively in this situation.**

SCENARIO 3 - JOHN

Location: Your mental health agency, your Diabetes Education Program, or your primary care setting.

Scenario: John is a 56 year old male who has been diagnosed with depression, COPD (lung disease) and type 2 diabetes. A year ago, he was involved in the community as a volunteer with seniors, however he has told them he is no longer available. His depression has been worsening in the past three months since his wife died.

Recently John has been isolating himself in his apartment, and has placed a sign on his door that says "Do not disturb". He rarely opens his door unless people have something he needs, such as his case manager who takes him grocery shopping each week, and the individual who sells contraband cigarettes at the end of each month.

He is not interested in using his glucometer, and his worker is concerned because he is not taking his insulin.

1. **What are your immediate concerns?**
2. **What would you explore with John to get a better idea of what support might be helpful?**

Part 2: John smokes approximately 40 cigarettes daily. He uses alcohol most days, and drinks between 6-18 beers/day. He eats mostly cookies, chips, Pepsi, and canned or frozen foods that are high in salt and carbohydrates.

He has been prescribed medications for depression but is not taking them, and he rarely sees his general practitioner. He often thinks about suicide but has no plan.

John's family members have contacted you to see how they can assist John at this time.

3. **How might John's psychosocial factors be affecting his/her diabetes self-management?**
4. **What are John's strengths, and how can support be provided to build on them?**
5. **What are the long term goals?**

Part 3

John's worker convinces him to attend an appointment with a psychiatrist for a mental health assessment. Recommendations for medications to help the depression have been forwarded to his family doctor. John begins to take this medication, and his mood is slowly improving.

He tells you that he is ready to "consider" addressing his diabetes now.

6. **How would you and your organization assist John?**
7. **How might you as a group collectively provide support to John?**
8. **Describe the benefits of working collaboratively in this situation.**

SCENARIO 4 – ANGIE

Part 1

Location: Your mental health agency, your Diabetes Education Program, or your primary care setting.

Scenario: Angie is 32 year old woman who moved to Ottawa a few years ago, and was born and raised in the Yukon. She has a history of childhood neglect and abuse, aggression, and she has been given a diagnosis of paranoid schizophrenia.

She remembers being told that her fasting glucose levels were abnormal about a year ago. She has had regular contact with mental health services for past 10 years; however she does not have a regular primary health care provider.

1. **What are your immediate concerns?**
2. **What would you explore with Angie to get a better idea of what support might be helpful?**

Part 2

Angie is taking Olanzapine and Citolopram and is fairly adherent to her medication regime, although sometimes she runs out of her medications.
Angie admits her eating habits are poor. She often does not eat regular meals, enjoys snacking throughout the day. Angie volunteers at a local community kitchen, and her goal is to go back to school to study nutrition.

Two months ago, Angie had to leave her volunteer placement due to an argument and misunderstanding with another volunteer. Her supervisor told her that she does well in the mornings, but often gets angry in the afternoons.

3. **How might Angie's psychosocial factors be affecting his/her diabetes self-management?**
4. **What are Angie's strengths, and how can support be provided to build on them?**
5. **What are the long term goals?**

Part 3

Angie has been living in a subsidized rental unit in the west end of Ottawa for the past year. Previous to this she was living in shelters or rooming houses, and moving from place to place fairly frequently. She has no immediate family in Ottawa.
Despite being active, she is overweight (BMI 29). She volunteers twice weekly, attends the cultural centre twice weekly, and walks to volunteer program and cultural centre when it is not too cold.

6. **How would you and your organization assist Angie?**
7. **How might you as a group collectively provide support to Angie?**
8. **Describe the benefits of working collaboratively in this situation.**

SCENARIO 5 – CARLOS

Part 1

Time/Day: a typical Thursday afternoon at 2PM

Location: Your mental health agency, your Diabetes Education Program, or your primary care setting.

Scenario: Carlos is 58 year old male who was born in Italy and came to Canada when he was 21. He was diagnosed with diabetes two years ago, and it remains untreated. He also has a history of a retinal haemorrhage, which Carlos understands to be an eye problem due to poor circulation.

He has been diagnosed with major depressive disorder since he was 35, and has had four hospitalizations. He is currently an inpatient. A discharge planning meeting will take place tomorrow in preparation for his discharge home in two days.

1. **What are your immediate concerns?**
2. **What would you explore with Carlos to get a better idea of what support might be helpful?**

Part 2

Carlos is quiet and reserved and enjoys gardening. He has worked as a tradesman for different employers over the years. He once owned his own painting business. Since his last hospitalization he has had no employment, and has moved to a rooming house. He has two grown children who live out of town and he and his wife separated five years ago.

He has a small group of friends. He chooses not to disclose his mental health diagnosis with either his friends or his children. He has recently been evicted from his housing, and is now living in a rooming house.

3. **How might Carlos' psychosocial factors be affecting his/her diabetes self-management?**
4. **What are Carlos' strengths, and how can support be provided to build on them?**
5. **What are the long term goals?**

Part 3

He enjoys cooking when he is healthy, however his room only has a microwave and a toaster.

He does not like "doing exercise" or going to the gym. His BMI is 31.

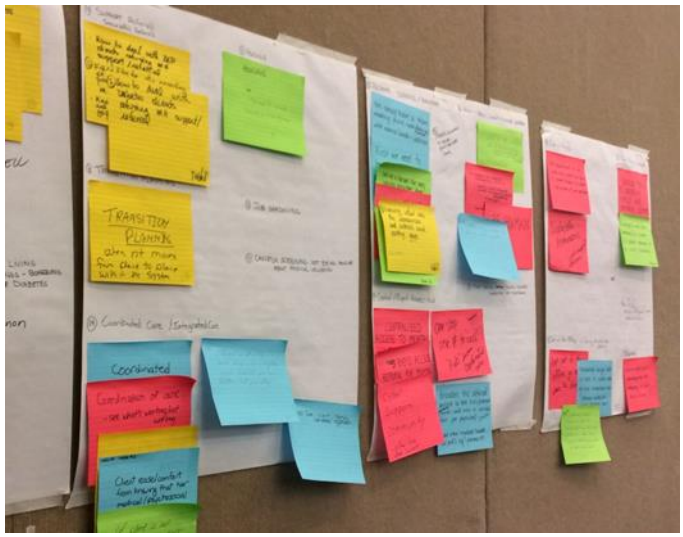
Recently he has been spending most of his time in his room because he does not feel safe around his neighbourhood, due to drug dealers in the area.

6. **How would you and your organization assist Carlos?**
7. **How might you as a group collectively provide support to Carlos?**
8. **Describe the benefits of working collaboratively in this situation.**

Appendix E – List of Ideas, Insights and Opportunities

The following list summarizes all of the ideas, insights and opportunities identified in the table facilitators' notes as well as those identified in plenary discussions.

- Better communication
- Diabetes and mental health survival skill workshop for clients to better manage in a crisis situation
- Diabetes Anonymous - 24/7 support after hours
- Access to EMR between hospital and community
- Acknowledge unique needs in rural vs urban areas e.g. rural transportation issues
- Annual diabetes and mental health conference
- Balancing responsibilities/Full scope of practice
- Be human
- Book appointments on day & time that works for them to prevent/reduce no-shows & perception of non-compliance.
- Broaden the referral process so that RN's/outreach nurses could refer to services (not just physicians) and other regulated health care professionals e.g. pharmacists.
- CANRISK Screening – Not being passive about physical wellbeing
- Care meetings for providers between mental health and diabetes
- Case conferences between client, family, CMHA (or similar), Diabetes Education Program, Vascular Team Rep. – clarify goals, what resources are available, one-stop-shopping, develop action plan, identify future needs/expert help.
- Central/Rapid Access/Hub
- Centralized access to mental health services
- Chart in the home (until EMR)
- Client Chart is where all providers document, client includes on goal and agrees with plan
- Client ease comfort from knowing that her medical/psychosocial history known by providers in circle of care (and common approach by all providers)
- Client/family brings chart to specialists, doctors appointments etc.
- Clients: have the information they need, case conferences
- Collaborative planning breaks down silos and integrates social/medical priorities



- Collaborative planning, holistic approach to client goal setting
- Communication with education, access and training to relevant screen tools (evidence-based), what to use and when
- Community diabetes program to come to hospital psychiatry when complex patients need diabetes follow up (just as CMHA/ACT Teams would come to create a bond)
- Client/Family Resources
- Connect to community health representative
- Coordinated Care

- Coordinated integrated care from all providers, based on client's needs, requirements, goals, to prevent relapse.
- Coordination of care, see what's working/not working
- Cyber support community – after hours, peer support
- Developing tools to bring in family and natural supports
- Diabetes education to mental health providers
- Different levels of learning seminars
- Ease of Access
- Education
- Educational opportunities at large
- EMR – Technology
- EMR on all systems
- Facilitate the creation of networks of practitioners (diabetes & mental health) both ways
- Family – Person – Client – Cultural Centred Care
- Family to have access to plan with patient's consent
- Find Creative Ways to involve families
- First we need to learn about resources and who does what "There is a lot of confusion" e.g. Pamphlet from Renfrew County Addictions Treatment System – list of services.
- Follow up with no-shows, why, what are the trends
- General challenges of balancing responsibilities between group homes/primary care/diabetes educators
- Get out of the office, go to where the client is
- Give client credit/acknowledgement for managing his/her disease/illness.
- Health care provider, who's working on what, don't want to duplicate
- Health Information, Research, Evaluation at a System's level
- Holistic client goal setting
- How can an EMR be set up that any provider from any agency in the city can access?
- How do we address under treatment in a systematic way
- How to deal with DEP clients refusing MH support/referral
- How to deal with diabetes clients refusing MH support/referral
- Identify cultural resources
- If client is not connects to a FHT or CHC how can services be coordinated in community?
- Include family in care planning following client's consent
- Info sharing
- Integrated Care: "Creating peanut butter cups"
- Job Shadowing
- Knowing what are the resources and criteria and existing gaps
- Knowing what are the resources and criteria and existing gaps
- Links between providers: share goals, share concerns
- Look at data - how better to provide services (esp. those underserved)
- Look at the person as a holistic being, spiritual, mental health, physical, emotional health
- Meeting between organizations to be aware of services each provide to be able to refer clients between each (common repository of knowledge).
- More listening to client perspectives

- Navigators, Bank accounts, find out where the client wants to go
- Need to know who is involved with the client,
- NIHB funding
- No more repeating stories
- One coordinator
- One stop, one # to call “Hub” – info share, coordinated care
- Out of the Office, Going where the client is
- Outreach diabetes/MH support to remote towns?
- Patient may need to focus on one area at a time (establish priorities)
- Platform for knowledge exchange
- Province wide access to electronic medical records. Share info and know who to contact (who is in the circle of care) – currently we are all in silos.
- Rapid access referral form mental health services in EMR – 1 click
- Release of info to work collaboratively to best serve the needs of the client
- Resource Sharing/Knowledge Exchange
- Rewards
- Set up a forum for care/service providers from each sector to refresh/remind of each other’s skills to promote a more holistic approach.
- Shared care – client/family centred approach.
- Shared client info between providers, case conferencing, but not more paperwork
- Sharing assessment tools, interventions, and evaluation between sectors to promote holistic approach (e.g. CANRISK)
- Spiritual/cultural support (if aboriginal: sweat lodge, talking circle, traditional healing)
- Strategies for those living in difficult settings, boarding houses, and helping to manage change.
- Subsequent events like today to facilitate knowledge exchange between sectors and organizations
- Support Referrals/ Successful Referrals
- Supports: If lab on site or outreach labs or weekly lab services on site.
- The need to include housing in circle of care
- These types of collaborative meetings / Trade shows (share what each other can provide)
- Transition Planning
- Transport
- Under Diagnosis
- Use better what we have
- Utilize NPs & Pharmacists to maximize potential/use full scope of practice
- Virtual meetings & teams
- We should have a team meeting (rural-west-Renfrew, Pembroke etc.) with mental health and addictions workers and diabetes services.
- When a patient moves from place to place within the system
- Who is the case manager, NP etc.; then we can connect
- Work with indigenous identity