

Mental Health and Drug & Alcohol Shared Care Coordinator
Pilot Project Clinical

Shared Care

The Way To Go !

Helen Golightly

- The Mental Health /Drug Health Shared Care Project funded by GP NSW For a 12 month Pilot Project
- Commenced March 2011

Aims

- To increase the number of GPs willing to prescribe medication for patients with opioid dependence
- To increase the number of Physical Health Assessments for patients referred from Community Mental Health Services and Drug Health Services

- Establish communication and Referral pathways between GPs Mental Health and Drug Health Services
- Support Patients and GPs through the Transition Period

Referral

- Referrals to the Shared Care Project:
- Canterbury Community Mental Health
- Camperdown Mental Health
- The Royal Prince Alfred Drug Health Service
- GPs within the CSGPN

Health Concerns for Target Group

- Major physical health problems
- Higher incidence of Blood Borne Viruses

Contributing factors - Patients

- Smoke tobacco
- Engage in harmful use of alcohol
- High Fat and salt, low fibre diet
- Financially disadvantaged
- Unemployed
- Socially isolated
- Homeless
- Dental problems
- More frequent admissions to Emergency Departments
- Overweight [this could also be due to medication]
- Not participate in regular exercise

Patients point of view

- Patients may have had poor past experiences with GPs and surgery staff
- Doctor shopping
- Labelled a drug user
- Fear of rejection
- Not being listened to
- Not having a regular GP
- Under Use of GPs
- Lack of interest from GPs

Planning Care

Assessment

Identify Needs

Trust

Communication

Shared Care Clinical Coordinators role

- Collaborate
- Provide
- Co-ordinate
- Support
- Assist
- Educate

Case History

- 55 year old Female
- Drug Health Referral
- 11 years in Treatment
- Prescribed Methadone
- Hepatitis C positive
- Depression/anxiety
- No GP

- Assessment of patients needs including
- Physical Health
- Mental Health
- Drug and Alcohol use
- Social

Finding a GP

- Needed to be convenient for the patient
- Female
- Willing to prescribe and be interested in patients with addictions
- Have an interest in Mental Health Disorders

Health Needs identified

- Overdue PAP smear
- Mammography
- Bloods for Hep C status, LFTS & Genotype
- Fibroscan
- Dental
- ECG

Mental Health

- Depression management
- Referral to psychologist
- Ongoing support from SCCC
- The patient stated that at times when her depression was bad she felt invisible and unable to express herself. She also felt bad that she was neglecting herself [physical and mental health]

The Benefits of Shared Care

- Best of both worlds
- Good quality holistic care
- Increased accessibility
- Social inclusion
- Team approach to problem solving
- Pooling of expertise
- Reduced chance of patients being “left in limbo”
- Positive progression for patients
- Improve communication
- Increased support for GPs from specialist services

'Safety Net'

- It has been agreed between services that should a patient relapse or condition deteriorate to an extent that is not manageable within General Practice. The patient will be referred back to the original service provider without fuss

Contact Details

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