THE FUNCTIONAL HEALTH ASSESSMENT TOOL (TFHAT) & THE INTERFACE BETWEEN PEOPLE WITH AN INTELLECTUAL DISABILITY & GENERAL PRACTITIONERS

2009 NZASID Conference Hamilton New Zealand

Henrietta Trip

RN, MHealSc(Nursing)

Intellectual Disability Community Team

Specialist Mental Health Service, CDHB

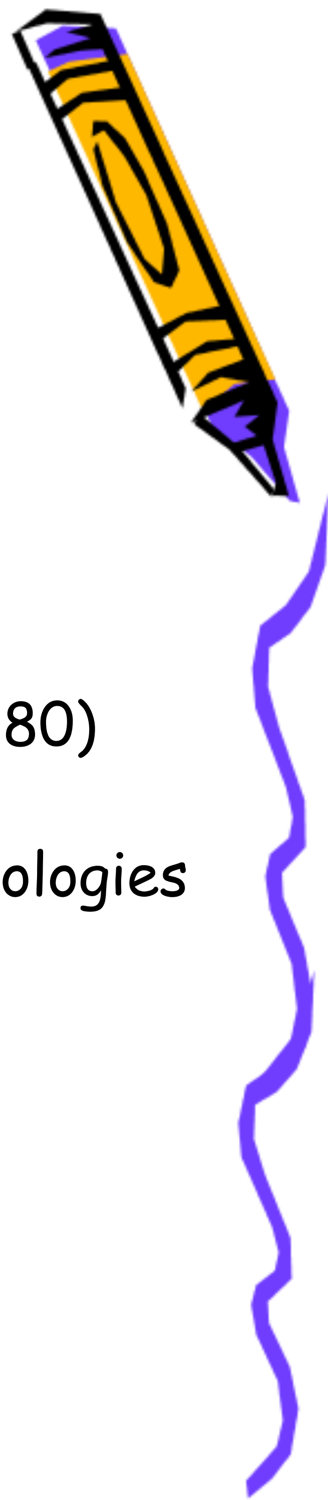
Centre for PG Nursing Studies, University of Otago,

Christchurch, New Zealand

Thesis Overview

This research set out to study the extent to which The Functional Health Assessment Tool (TFHAT, Trip, 2005) contributed to the interface between people with an intellectual disability & their GP when supported by direct-care staff

Changing Models of Deinstitutionalisation



- Prisons of Protection (Willer, Goldberg, & Intagliata, 1980)
- Deinstitutionalisation challenged governing medical pathologies of sickness & incapacity (Fergusson, 2004)
- Therapeutically preferable to reside in the community (Mitchell, 1864)

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Health Needs of People with Intellectual Disability

- Higher level of ill health than the general population

(Knibbe & Van Hoeve, 2005)

- Social disadvantage impacts on physical/mental health (Emerson, 2006)

- Lack of co-ordinated approach in PHC contributes to poor outcomes

(Kerr, 2004)

- A lack of awareness of health conditions more common in this population

(Sowney & Barr, 2004)

- Staff training is insufficient (van Scronjenstein Lantman-de Valk, 2005)

- Health needs may be masked or exacerbated by presenting behaviour (Davis & Mohr, 2004; Lennox & Eastgate, 2004)

New Zealand Perspective

- The Primary Health Care Strategy (MoH, 2001)
- The New Zealand Disability Strategy (MoH, 2001)
- To Have An Ordinary Life – Kia Whai Oranga Noa (MoH, 2003)

~ Is intellectual disability a forgotten specialty ~
(Clark, 2006)

Trip (200[illegible])

Methodology : Phase 1

1. Non-probability purposive sampling (Polit & Beck, 2004) was used to approach 15 direct-line managers of residential providers for people with intellectual disability in the Canterbury region of New Zealand

1. A Pre-Implementation Questionnaire was completed by direct-care staff and the GP of a person with intellectual disability with whom they work & were going to complete The Functional Health Assessment Tool with (TFHAT, Trip, 2005)

Methodology : Phase 2

1. An education session was held for the responding group of direct-care staff regarding the implementation of TFHAT

2. Direct-care staff then completed TFHAT with client & forwarded a copy to the GP

3. Incidental GP appointment was anticipated. Follow up with the respective direct-line managers established the likelihood of this occurring prior to Phase 3

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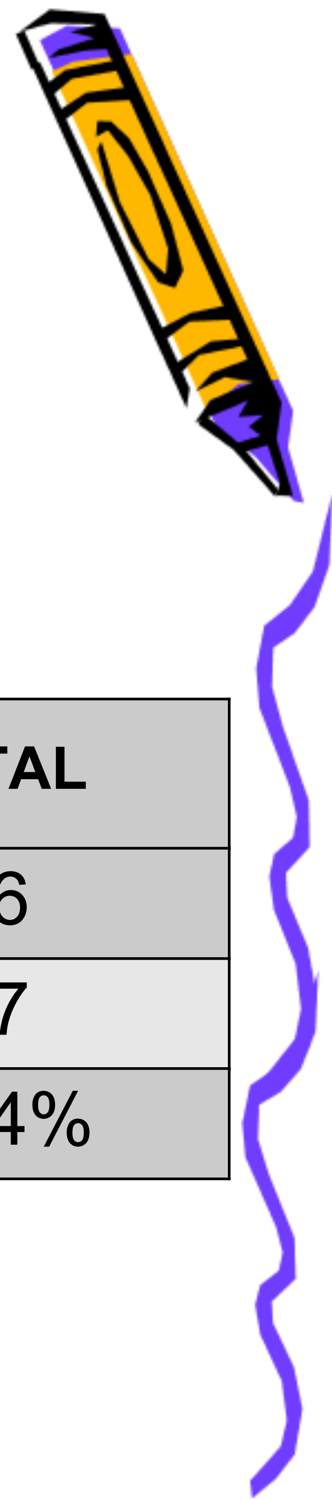
Methodology : Phase 3

1. Post-Implementation Questionnaire was distributed for the direct-care staff & GPs who were part of Phase 1

2. Semi-structured interviews were to be conducted with people who have an intellectual disability & who were part of TFHAT Implementation (Phase 2)

Results Phase 1
Pre-Implementation Questionnaire



RESPONDENTS	STAFF	GPS	TOTAL
Sent	15	11	26
Returned	12	5	17
Response Rate	80%	45.5%	65.4%

Phase 1: Pre-Implementation Questionnaire Short Answer Section

- Support required to access GP
- Difficulties experienced by people with intellectual disability in having their health needs met by GP
- Involvement of the individual during GP appointment
- Factors which could improve the interface between people with intellectual disability & their GP
- Information available to GP regarding functional & cognitive abilities of individual
- Training on the health needs of people with intellectual disability

Pre-Implementation Questionnaire: Likert Scale Responses

- Difficult to have health needs met : GP 80% Staff 58.3%
- Some conditions more prevalent : GP 100% Staff 50%
- Able to express health concerns : GP 0% Staff 25%
- Difficult recognise health changes : GP 60% Staff 50%
- Staff have good knowledge of ind. : GP 60% Staff 83%
- Overview of function would assist : GP 80% Staff 100%
- Health record to improve interface : GP 80% Staff 100%
- There is sufficient time for appt. : GP 40% Staff 25%
- Behav. impacts on health support : GP 80% Staff 58.3%
- GP is skilled to meet health needs : GP 40% Staff 33.3%
- Staff facilitate communication : GP 100% Staff 91.7%
- GP consults directly with PWID : GP 20% Staff 8.3%
- Have sufficient education/training : GP 20% Staff 50%
- Need for more education/training : GP 60% Staff 75%

Results Phase 3
Post-Implementation Questionnaire

RESPONDENTS	STAFF	GPs	TOTAL
Sent	12	8	20
Returned	6	1	7
Response Rate	50%	12.5%	35%

Post-Implementation Questionnaire
Client Demographics with whom TFHAT was Completed

Male (2) NZ Maori (1)

Female (4) NZ European (5)

20-30 yrs (2) 31-40yrs (2)

41-50yrs (1) 51-60yrs (1)

Mild ID (2) Autism (1) MH (1)

Mod ID (4) Cerebral Palsy (1)

Contact Frequency with GP Monthly (1) 3Monthly (3)

6Monthly (1) Annually (1)

Post-Implementation Questionnaire: Short Answer Section

- Health information identified through implementing TFHAT
- Advantages of implementing TFHAT
- Disadvantages of implementing TFHAT
- Usefulness to the interface between people with ID & GPs
- Recommendations for using TFHAT in the future
- Education/training requirements to improve health outcomes for people with an intellectual disability

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The People Themselves ~ Sam, Jo & Leslie ~

- Only Sam had choice to decide when to see GP
- GP speaks to Sam & Leslie directly, but not always to Jo who would like this to happen more often
- Staff talk with Sam & Leslie about appointment - Not so for Jo
- Sometimes the GP listens to Jo who reported not having the opportunity to ask questions

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The People Themselves ~ Sam, Jo & Leslie ~

- Leslie & Jo reported that they often felt hurried
- Jo usually shares the appointment with flatmates
- Staff noted that Jo's GP could be more thorough
- Sam & Leslie thought the information that staff wrote in TFHAT was useful as did their GP
- Sam identified a goal of trying to "get a little more independent"

Summary

Utility of TFHAT (Trip, 2005):

- Future health screening measures can be put in place

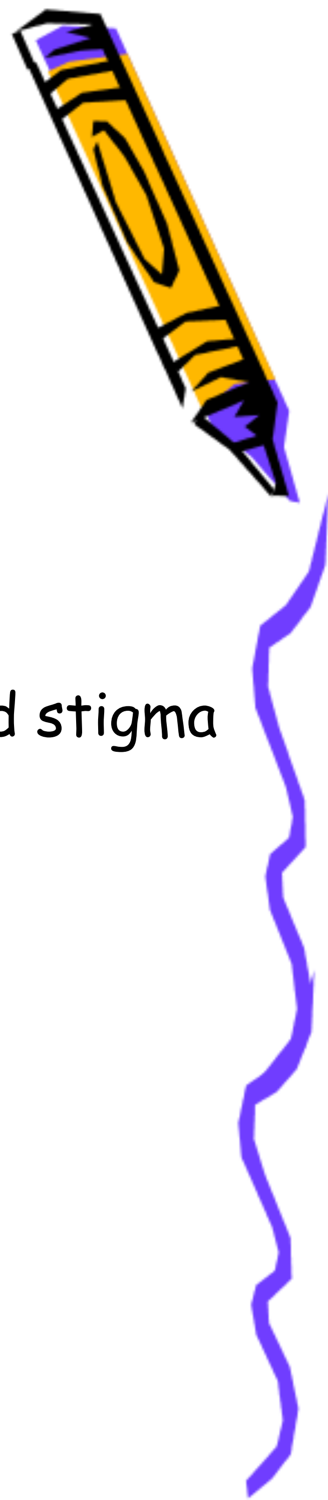
- Historical, social, family medical & health history is of value

- Knowing how a person usually presents & functions would assist in recognising changing health needs in people with ID

- Up to date health records would improve the health interface between people with intellectual disability & GPs

Limitations

- Recruitment method
- Role of research participants
- Complexity of the research process
- Narrow the scope of the research aim/angle
- Application for other cultural/social settings
- Clients transferring between GPs during the research
- Timeframe required for collation of TFHAT



Discussion

- Normalisation:

- Barriers identified do not exemplify social norms
- Roles captured in this research are suggestive of continued stigma for this population

- Social Role Valorisation:

- Client : Spectator / Recipient
- Staff : Taxi Driver / Interpreter / Facilitator
- GPs : Revered / "The Qualified One" / Powerful

The Social Model of Disability

- Union of the Physically Impaired Against Segregation (1976) Fundamental Principles of Disability distinguished between physical disability (impairment) and disability as a socially constructed phenomenon (Richardson, 2001)

- Seeks to identify, adjust / remove barriers which prevent or limit health care access for people with intellectual disability (Mansell & Northway, 2003)

Recommendations

- Implement the principles identified in To Have an Ordinary Life – Kia Whai Oranga Noa (National Advisory Committee on health & Disability, 2003)
- Target health education for health professionals including medical, allied & disability service providers.
- Liaison is required between PHC & intellectual disability service providers. The same standards of service provision should be envisioned for those residing in the wider community independently or with family/whanau/caregivers

Trip (2008)

Recommendations cntd.

- Arranging appointments
- Inclusion of the individual in decisions pertaining to their own healthcare to the extent possible
- Subsidy for longer (individual) appointments and/or for annual comprehensive health review to enable comparisons against baseline documentation

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Thank You & Go Well

henrisplace@actrix.co.nz