Connecting Mental Health and Addictions to Primary Care

A Priority Project of the

Lanark, Leeds and Grenville Ontario Health Team

March 10, 2022

Background of the Project: An integrated system of care

Purpose:

The Connecting MHA to Primary Care Project Team (the Team) is a working group established by the Leadership Committee of the Lanark, Leeds and Grenville Ontario Health Team (LLG OHT). The purpose of this team is to create a connected continuum of mental health and addiction services available within or through primary care settings.

Responsibilities and Opportunities:

- Identify all mental health and addictions assets (across the lifespan) in Lanark, Leeds & Grenville
- Define "connecting" to primary care collaboratively with primary care and patients/ clients
- Develop a phased plan to increase the effectiveness, accessibility & integration of mental health and addiction services to primary care models within the LLG OHT
- Implement the plan to attach mental health and addiction services to primary care models within the LLG OHT
- Evaluate the implementation plan.

Background of the Project: Maximize MHA patient/client "connectedness" within and across primary care and other health and social service sectors

Evaluate Current State

- Develop survey and distribution strategy
- Sufficient response
- System-level snap-shot of current state, geographical variability, gaps, areas of concern

Understand Evidence-Based Best Practice

- Conduct literature review
- Evaluate best practices based on goodness of fit, evidentiary strength, impact and resource intensity
- Develop framework

Prioritize and action top value-for-money best practices

- Categorize top best practices as short, medium, long terms based on feasibility and needs
- Identify performance indicators for each initiative
- Develop multi-year workplan

Evaluate Current State

Preliminary service mapping completed

3 surveys and distribution plan developed

High level qualitative reports prepared

Gather input from broader community partners

NOTE: We are currently in the investigative phase, and are looking for ideas, not solutions

Primary Care Survey Results

65 surveys returned

Services Provided:

- mental health assessment (86.2%)
- pharmaceutical treatment (83.1%)
- providing diagnosis (72.3%)
- counseling treatment (53.9%)

Service Provider Survey Results

27 surveys returned

Services Provided:

- counseling/therapy (66.7%)
- information & referrals (59.3%)
- psychoeducation (55.6%)
- mental health assessment (44.4%)

People with Lived Experience Results

355 surveys returned

- 72% had accessed service; Split equally between L and LG ; 30% urban/60% rural
- Experience with MHA
  - 63% helpful or somewhat helpful
  - 37% not helpful
- Needs met:
  - 58.4 met or somewhat met
  - 32% not met
- Satisfaction: 51.3% variations of dissatisfied
- Barriers to service:
- 53.7% wait list; not knowing what services or programs were available (38.1%), programs/services being too short, or time limited in duration (35.8%)

Challenges– Primary Care

- Current **capacity and waitlists** make referrals to community providers challenging for urgent matters
- **Waitlists** make it unlikely individuals will be seen in timely fashion
- Individual is **no longer open** to accessing services following long wait times
- Centralized intake processes and **standardized forms** for specific reasons (e.g. refractory PTSD)
- Many partners providing **similar services** makes it challenging to know who to refer to
- Greater **awareness of scope of services** available is needed
- **Unsure who to refer to for certain programs,** such as urgent/rapid response care, detox for substances, addictions treatment, etc.

Challenges– Service Providers

- Long **wait times** limit the window for collaboration as there is significant delay between the point of referral and access to service. As a result, primary care may not be aware services have initiated and it is up to the client to communicate updates within their care team.
- Lack of **awareness of programs** among primary care and confusion about what agency offers what service.
- Quick access to **additional information from the primary care** or expanded third party referrals to better support clients. Sometimes when requests for information are made, there are long delays for follow up which can slow progress for their patients.
- **Doctor's want to talk to other Doctor's**, some don't credit mental health and addictions workers with experience and knowledge.
- Referrals where primary care identifies a **specific type of treatment** can create difficulties when the agency have assessed a different course of treatment to be potentially more helpful, but the family of the client insist on what the doctor recommended.
- Lack of support to help **contact patients** when services are being coordinated.
- Lack of **communication and coordination** leading to conflicting messaging to patients and duplication of services.
- Primary care is often the first point of contact for mental health and addictions concerns but **they may not make referrals** or actively follow up with the patient to monitor their wellbeing.
- Time can be a big challenge. **Opportunities to consult and collaborate** especially if not in the same physical space are by necessity fast and furious and constantly changing. **Clients are often left having to navigate and coordinate their care** when they are too ill to manage.
- **Many patients do not feel comfortable bringing up issues of addiction or mental health to their physicians.** Some physicians still have outdated, stigmatizing world views around addiction and mental health, while others do not have the time or comfort to address these concerns within their practice.

Challenges– People with Lived Experience Results

- Lack of **timely support** through publicly funded services
- **Stigma** associated with accessing services
- **Navigation challenges**
- Lack of **continuity** of service providers, with a focus on drop-in service over maintaining a therapeutic relationship with a single provider
- Lack of **virtual services**
- Lack of **in person** programing throughout pandemic
- Need for **level of service** greater than what is accessible
- Lack of **long-term** service
- Lack of **crisis support**
- Difficulty accessing **psychiatric assessments**
- Difficulty finding the **right support**, whether individual counselling or group-based programs
- **Too many band aid supports without support to address ongoing needs to meet goal**s

Priorities
Primary Care Survey Results

Priorities for Improving Connection of Mental Health and Addictions Services with Primary Care

- sharing information (62.5%)
- service coordination (53.6%)
- updates on programs and services available (46.4%)
- system navigation (42.9%)
- coordinated care plans (28.6%)
- transition plans from hospital care (19.6%)

Priorities
Service Provider Survey Results

Priorities for Improving Connection of Mental Health and Addictions Services with Primary Care

- information sharing (57.7%)
- service coordination (53.9%)
- updates on programs and services available (50.0%)
- system navigation (42.3%)
- coordinated care plans (30.8%)
- transition plans from hospital care (30.8%).

What is needed to improve “connectedness”? Primary Care

Communication:

- Improved communication with primary care on the status of the individual’s care and progress (currently only receiving from psychiatry)Increased awareness of primary care teams on services available
- Shared electronic records, especially for counselling
- Use of platforms such as Ocean to support communication
- Improved communication regarding wait times for accessing services.

Timely Access and Capacity for Care

- Centralized access to allow for quick assessment and streamlined access to appropriate services
- Increased resources (HHR and funding) to provide timely and advanced services
- Rapid triage to coordinate services based on acuity of need
- Increased access to crisis services and urgent care, especially in community
- increased access to psychiatric consultations and psychotherapy
- Rapid response of intake workers to patients with clear information regarding timelines for clinical assessment and care
- Providing more than just a one-time consultation for more complicated patients
- Greater access to counselors capable of doing therapy
- Access to reliable and consistent care in the community
- Modernize psychiatric care models to along for long term follow up for complex patients and partnerships with primary care

Integrated Care Delivery

- Improved integration of services with co-location within the primary care office to improve referrals and collaborative care
- Inter-professional consultation to help bridge care while awaiting services
- On-site access to counselling and psychiatry services within the primary care office (part-time)
- Common basket of services offered in primary care, regardless of funding model
- Access to urgent care
- Leverage virtual care and remote monitoring tools to allow for more proactive follow up and clear information on referrals/appointments
- Collaborative teams where mental health is prioritized the same as primary care and clinical judgment recognized
- Open communication and understanding of the role, limitations and operating model for primary care and mental health/addictions services
- Embed psychiatry, psychology and social work within the OHT to improve access

What is needed to improve "connectedness"? Service Providers

- Ensure there is commitment on both sides to deliver more **collaborative care**
- Make a personal connection and take the opportunity to put a face to the name, with ongoing opportunities to connect
- Build open and transparent **communication channels**
- Have regular meetings between primary care and mental health and addictions to **share updates and discuss** what is working well, what needs to be adjusted and next steps
- Openness of both parties to embrace **integration** and change in how service is delivered to build a more collaborative care model
- Build **awareness** of the various services available to support the continuum of mental health and addictions needs, as well as wait times, service duration and what is needed from the primary care provider during the course of treatment
- Engage in **joint appointments** with clients or **case conferences** where possible to ensure open communication and to build a client-centred treatment plan with clear roles and responsibilities. The 'Shared Care Discussions' between Primary Care and Addiction and Mental Health providers in FLA OHT are working well to the benefit of clients.
- Having a **direct contact** within each organization to communicate on client progress, challenges, address questions on referrals, etc.
- Recognizing that counselling is **client-centred** and voluntary. While providers may see the value in counselling, a client may not be ready or may have a different area they wish to focus on

What is needed to improve the system? Lived Experience

- Help support access to **local services**, especially in rural areas – whether primary care or for mental health and/or addictions
- Focus **service models on individual need** and their holistic care vs. a diagnosis
- Ensure that services are **available** when an individual needs support and open to support
- Ensure ongoing **follow up from referral** through to service and beyond
- Improve **wait times** to service or bridging services
- Increase access to qualified, competent, empathetic staff in all settings who are culturally sensitive and support individuals in meeting their goals
- Ensure reception and intake staff are train**ed, sensitive and able to respond effectively**
- Improve access to **crisis services** with no stigma, as well as mobile and after-hours services
- More **proactive** services and counselling compared to services only being accessible if a person is at 'rock bottom'
- **Equitabl**e access to services across LLG
- **Empower individuals in their care vs. promoting victimization**
- Improved **intake processes** and **access to assessment/diagnostics**
- **Brief services** are an important first step for some individuals
- Provide **holistic care** with greater access to wellness and mindfulness supports, with less emphasis on pharmaceuticals
- Greater **continuity in care** with a focus on ongoing counselling vs. only walk in
- Improve access to programming sensitivity to the needs of **unique populations**
- Improve access **regardless of location, age or income**
- Continue to **offer telephone and virtual services** as an option to improve access for those who cannot travel or have limited time available
- Increased access to supports in the **primary care setting**
- Improve **relationship between mental health services and police**, including training for police to manage situations effectively and joining calls for crisis
- Improved **communication** and coordination within the **primary care team and mental health and/or addictions supports,** including having a clear plan for ongoing support when discharged from programs

Evidence-Based Best Practice of an Integrated System of Care

Gather local experts in mental health and addictions across Lanark, Leeds and Grenville

Conduct a literature review

Consider alternative models

Gather input from broader community partners

NOTE: We are currently in the investigative phase, and are looking for ideas, not solutions

Evidence-Based Best Practice: An integrated system of care

Best practice to achieve integration of mental health, addictions with primary care may be approached from different perspectives. Regardless of the differing foci of the attributed resources, there remains consistent recommendations across the space. These include:

- High frequency and quality of communication
- A strong governance body to provide effective oversight
- Person-centred care
- Navigation to support successful migration across transitions of care delivery
- Data tracking with focus upon outcomes achieved
- Continuous quality improvement
- Participation of people with lived experience to inform innovation
- Improved learning opportunities from participants and organizations to understand constraints upon other providers
- Funding models that support primary care engagement

Priorities and Actions

What will we do over the next 3 years?

How can we work collaboratively to prioritize the work for best result?

How can we ensure our work is based on best practice and offers good value for money?

Gather input from broader community partners

NOTE: We are currently in the investigative phase, and are looking for ideas, not solutions

Next Steps

- Work of the Implementation Planner and the Project Team will include:
  - Deeper dive into the survey results
  - Additional service mapping
  - Data collection and analysis
  - Creating an implementation plan for approval by the OHT Collaboration Council by June 30, 2022

Consultation

Survey results

- What (if anything) surprised you?

Best Practice

- What (if any) ideas presented made you think “I wish we could try that?”

Priorities and Actions

- What opportunities do you see in connecting to mental health and addictions to primary care in Lanark, Leeds and Grenville?
- If you were asked to redesign a mental health and addictions system with a strong connection to primary care, what would it look like?

Thank You from the Connecting Mental Health and Addictions Project Team

Do you want to be informed or engaged as we move forward? Please reach out.

- Jane Torrance, MHA Implementation Planner
- Lorena Crosbie, Co-Chair
- Jane Coyle, Co-Chair
- Sheyi Badmos, Executive Lead, LLG Ontario Health Team

We are creating a roadmap for LLG which optimizes MHA and primary care “connectedness” and contributes to achievement of a high performing healthcare system.