# Integrated Mental Health Services Panel

## Best Practices Network Conference

June 15 & 16 2017

Andrea Levinson, MD MSc FRCPC
David Lowe, MD CCFP (SEM)

# THE UNIVERSITY OF TORONTO: OUR CONTEXT

- 3 campuses: central downtown campus 60,000 students
- 25% graduate students, 15% international students
- Surrounded by several major tertiary care hospitals to support acute inpatient care; little access to longitudinal care for transitional youth
- 2015-16 Health & Wellness: over 57,000 visits; 14,000 students seen in centre; 12,619 students seen in primary care; 3,677 seen in mental health; 20% shared between family medicine and mental health.
- 64% female, 36% male, <1% trans/other
- 75% domestic, 25% international; 42% U/G; 22% professional faculty; 34% graduate

# Drivers for Change

- The integration of services at HWC was a direct response to our **Mental Health Framework**, student feedback and best practices to ensure student have quicker, direct access to health and mental health services.
- **Centralized intake** involves a first appointment where students are assessed by a nurse or a family physician, and referred according to their needs-ensuring that each student receives the right care at the right time with the right wellness professional, program or service.
- The **"one-door approach"** simplifies the pathway to care, reduces fractures to care and provides ongoing monitoring. Taking a holistic approach, family physicians and nurses assess student needs, consider their overall well-being and as necessary connect them to the best-matched services.
- **Stepped care:** services range from health promotion activities to psychoeducational workshops to groups or individual counselling or psychotherapy to shared care and to interim outpatient psychiatric consultation and treatment.

# OUR JOURNEY

- In 2009, 2 separate mental health clinics merged to form CAPS. Health services remained separate.
- The EMR was shared between health services and CAPS (2009-10), with a staged approach, with initial viewing of the schedule, then a common medical record and one shared EMR.
- 2013-2015: "transitional integration'' with more guided referrals between health & mental health & shared care service initiated.
- Expansion of lower-intensity services:  in-person & online CBT workshops, embedded counselling program
- Expansion of group programming
- Initiation of formal shared care program
- Annual retreats focussed on interdisciplinary care
- Next steps: Strengthen communication; consolidation; more transparency with explicit description around model & processes, facilitated by new EMR (summer 2017).

# OUR CHALLENGES

- Short time-frame to execute integration
- Medical team assuming INTAKE role for integrated service
- Space constraints with split-level clinic
- Large team of part-time clinicians
- Cultural differences and impact on integrated/shared care
- Impact on family practice appointment availability and nature of work
- Interdisciplinary roles with perceived loss of discipline's unique professional identity
- Funding model constraints

# KEY LESSONS LEARNED

- Training needs: didactic & experiential for GPs and admin team specifically
- Community model used as example with GP as “manager of care’’ providing active monitoring of student’s pathway and risk management with a STUDENT CENTERED approach
- Interdisciplinary training, meetings, education are KEY
- Case conferencing: formal, informal, quick huddles, EMR sharing
- Facilitate constructive questioning/challenging and foster interdisciplinary champions