Innovation in Primary Care:
Integrating mental health services in primary care

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Introduction

Innovative Interprofessional Collaboration to Improve Access to Mental Health Services and Outcomes for Patients

The College of Family Physicians of Canada (CFPC) is pleased to release the fourth issue in its Innovation in Primary Care series.[1] The series aims to foster collaboration, sharing, and learning among family physicians in different provinces and territories.

For this issue the CFPC has partnered with the Canadian Psychiatric Association and the Canadian Psychological Association to highlight how best to influence patient, provider, and system outcomes by highlighting case examples that address common challenges and barriers to integrating mental health services.[2,3] The issue pays particular interest to psychological and psychiatric services in community-based practices.

Family practices are often the first point of access for patients seeking mental health services. However, many family doctors currently do not have the necessary supports, resources, or time to treat patients with mental illnesses or to meet the service demand.

The CFPC supports integrating mental health services as a crucial part of community-based primary care. Comprehensive and continuous team-based care through interprofessional collaboration is a central tenet of the CFPC's Patient's Medical Home (PMH) vision for family practice in Canada.[4] More information about the PMH vision is available at the website.

The case examples presented in this issue are from Nova Scotia, British Columbia, Ontario, Quebec, and Manitoba. They demonstrate how family physicians, psychiatrists, psychologists, and other health care providers can work together

to improve access to mental health services for patients in their communities:

- Co-location of mental health and primary care services: The Queens Family Health Team in Nova Scotia enhanced their ability to deal with complex care patient encounters and provide access to mental health counselling services for their patients in a familiar environment
- Access to mental health services and support for patients with mild to moderate mental health issues: The Mood Disorders Association of British Columbia (MDABC) model of care offers a "one-stop shop" for psychiatric assessment and follow-up services for family physicians. It improves efficiency and reduces costs per patient visit.
- Access to mental health services and support for patients with concurrent mental health and substance use problems: The Rapid Access Addiction Medicine (RAAM) integrated care model in Ontario is led by a psychologist and family physician in consultation with community partners. It shares some impressive gains including eliminating wait times (i.e., patients are treated the same day they present), reducing alcohol-related emergency department visits, and increasing patient connections to additional community services.
- Shared-care model: The STAT-C approach to occupational health in Quebec is delivered by family physicians, psychologists, and social workers for interprofessional management of leaves of absence from work due to mental health issues. It addresses gaps in training and demonstrates how shared care supports patients to play a key role in their own recovery.
- Mental health services for Indigenous patients: Indigenous Cree communities in Manitoba have benefited from a collaborative psychiatric referral service program. It was established to better serve their health care needs and address the challenges of frequent medical staff turnover.
- Mental health services for youth: The Foundry initiative in British Columbia provides youths with integrated mental health and substance use services based on a stepped care approach. It has seen significant growth in the number of youths accessing services with a high level of satisfaction and positive intervention outcomes.
- Communication/improving mental health intake: Led by its psychologist, the Huron Community Family Health Team in Ontario developed a reliable and efficient intake process for mental health assessment. It integrated an online resource (Myndplan app) that is convenient for patients and for the inter-disciplinary team of health providers to deliver. Reduced wait-list time and better matching of therapists to patients are key benefits.

It is important to note that content and considerations for this joint issue were developed prior to the onset of the evolving COVID-19 pandemic. No doubt innovations in family practice and mental health care are emerging rapidly from the pandemic and may be featured in a subsequent edition.

Co-Location of Mental Health and Primary Care Services

Shared mental health in action: Experiences from Queens Family Health in Nova Scotia

Who was involved?

The team included four family physicians, one nurse practitioner, a family practice nurse, a clinical therapist, a social worker, a pharmacist, and clinic front staff. A visiting psychiatrist provided consults monthly.

What needed improvement?

When the Queens Family Health team in Liverpool, Nova Scotia, created a collaborative care model, they identified shared mental health care as a key founding goal. Previously, mental health services were provided by referral. There was little on-the-ground communication between providers in the primary and mental health care systems. As a result, providers felt siloed. Both primary and mental health care staff felt they could better serve the needs of their population, and be nimbler in providing service, by co-locating these providers.

What was done?

The team created a model of care where any of the providers could serve as a referral point for patients wanting counselling. Administrative

staff scheduled patients to see the mental health counsellor, who dedicated fixed practice times to the clinic. Initial contact and most counselling started in the same clinic where patients receive their primary care. This eliminated the need for patients to be in an unfamiliar environment and removed a barrier to access. The mental health counsellor had access to the patient's primary care electronic medical record (EMR) and to the primary care providers. This allowed the team to establish context and review the patient's situation prior to or following counselling.

What was gained?

The ability to access care quickly and seamlessly has made a huge difference for patients. Mental health issues are often embedded in a myriad of health concerns. Primary care providers at Queens Family Health can now deal with a complex encounter and offer a timely assessment, often within days to a few weeks, with a trusted mental health colleague. Patients had been reluctant to travel for a counselling appointment or see a provider they had not met before in a separate clinical setting. They now seem much more likely to accept the initial visit when it is in a familiar place and is organized by staff they know well.

The program has been set up mainly as a short-term intervention with the mental health counsellor, who also works in the formal mental health referral system. The counsellor can transition patients who have more complex needs to the formal system and/or arrange for psychiatric consultation. Likewise, primary care providers can still refer to psychiatry as needed.

What was learned?

All providers in the Queens Family Health clinic concur that this is a better way to provide mental health services to patients. Advantages and benefits include:

- Team members can discuss patient cases and goals of care with colleagues with whom they have an ongoing working relationship and see regularly
- Patients can be offered timely access to supportive services in a location they know and find comfortable
- Interventions can easily be dialed up or down depending on the patient's response to treatment, and care providers can communicate quickly with each other

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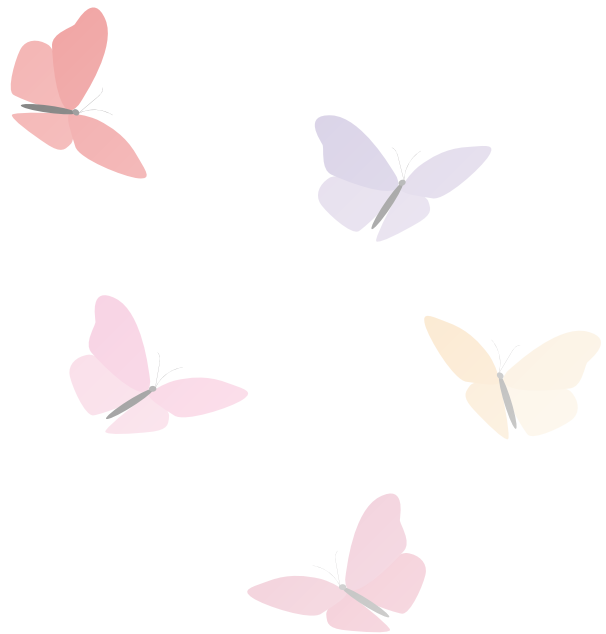

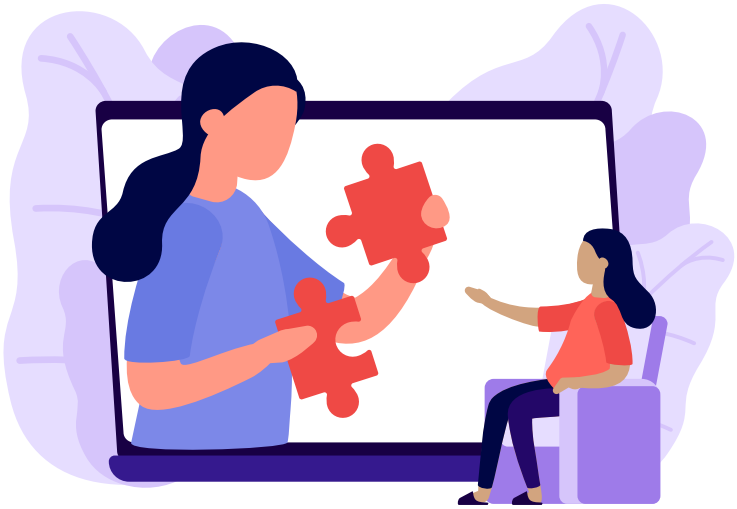

Mental Health Services and Support for Patients With Mild to Moderate Mental Health Issues

Improving psychiatric access and offering long-term follow-up care for patients with mild to moderate mood and anxiety disorders in British Columbia

Who was involved?

The medical director and staff of the psychiatric clinics of the Mood Disorders Association of British Columbia (MDABC).

What needed improvement?

Family physician access to psychiatric assessment of their patients for mild to moderate mood and anxiety disorders is limited, if available at all, throughout Canada. Psychiatric departments/outpatient centres developed rapid access programs to help address the problem.[5] They offer a rapid (typically 24 hours to less than one week) psychiatric assessment with limited (fewer than five) follow-up visits.

While this helps busy family physicians, it does not address the fact that mood and anxiety disorders are chronic illnesses with remissions and relapses.

When patients relapse they must go to the back of the line and be referred again to the program, which may or may not still exist. The new referral includes a reassessment by a new psychiatric practitioner. This type of care is inefficient and costly. Potential relapses might be averted if long-term follow-up psychiatric services were available for patients, and questions from family physicians regarding long-term treatment could be quickly addressed earlier in the patient's care.

What was done?

Based on the MDABC model of care developed for mild/moderate mood and anxiety disorders in 2008, MDABC clinics began offering psychiatric assessment and follow-up services for family physicians in British Columbia.

The MDABC model demonstrated that using newer technologies (e.g., emails among patients, psychiatrists, and clerical staff; online booking programs) and offering mostly group-based follow-up services resulted a fivefold increase in new consultations for one quarter of the costs when compared to psychiatric care in mental health centres and/or in private psychiatric practices.[6] Further, patient and family physician satisfaction with the MDABC model was high.[7]

A 2016 re-evaluation found that costs for providing this outpatient clinic model of care decreased as the use increased: December 2015 – $411/patient visit; May 2016 – $394/patient visit; December 2016 – $223/patient visit. The decreasing costs are even more impressive when compared to the 2016 rate of $845/patient visit for a hospital-based outpatient clinic.

The model has continued to expand since 2015, offering a one-stop shop for psychiatric services. Patients have an initial assessment to determine whether a mood/anxiety disorder is present and whether the patient is interested in treatment. Interventions available under the MDABC roof include three different types of psychotherapy, ongoing medication monitoring, evidence-based nutritional and exercise treatment intervention, and repetitive transcranial magnetic stimulation.

What was gained?

The MDABC model is a unique medical specialty clinic (psychiatry) housed in a not-for-profit agency. Virtually all delivered health care in British Columbia and Canada is in the public sector (e.g., hospitals, health authorities, private practitioners). Only a small amount is delivered in the private sector (e.g., private fee-for-service surgical centres). One significant disadvantage is that not-for-profits depend on outside grants or donations for funding and do not have the inherent regular income source of most public-funded programs.

In 2015 the access to psychiatric care for moderate mood/anxiety referrals by family physicians was good. The MDABC clinic had an adequate psychiatric staff (3.1 FTE) and could assess and offer follow-up for 50 new consultations each week. Unfortunately, in 2016 the MDABC clinic lost 50 per cent of its funding, and within a year could not maintain level of services. This highlights the dependence on external (possibly public) funding to maintain such helpful programs.

In recent years there has been a renewed interest in public sector funders (e.g., health authority) partnering with not-for-profits to expand the services offered. This recognizes some of the efficiencies in off-loading services not typically offered in their domain.[8]

What was learned?

In British Columbia, the development of primary care networks (PCNs) is designed to meet patient needs and offer access to a family physician. PCNs include access to required non-medical health

care interventions (e.g., physiotherapy, dietary, etc.) as well as to timely consultations with other specialists and ongoing care. The MDABC model appears to be an ideal "outer ring" for the PCNs with the ability to offer psychiatric consultation, long-term follow-up care, and a variety of evidence-based mental health interventions for patients.* Such a connection is a natural fit with the CFPC's vision of the Patient's Medical Neighbourhood, providing access to services while maintaining connections with the primary care practice.[9]

While learning is ongoing, lessons to date include:

- No single mental health funder can provide all services to all patients
- Increased cooperation and collaboration between public funders and smaller organizations such as not-for-profits offers unique opportunities for both organizations, but primarily for those who are served by these organizations—the patients
- The MDABC model may offer insight into how other medical specialists and non-medical services might work together to provide more efficient and accessible services for other chronic diseases (e.g., dementia, chronic pain, etc.)

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* To continue long-term with the MDABC, the patient only needs to attend a one-hour shared medical appointment every 12 months. By fulfilling this requirement, the patient has immediate access to any and all MDA psychiatric care should relapse occur, as well as access to any new programs offered (e.g., exercise, nutrition, etc.).

Services and Support for Patients With Concurrent Mental Health and Substance Use Problems

Rapid Access Addiction Medicine (RAAM) integrated care model improves treatment access and health outcomes in Ontario

Who was involved?

Dr. Kim Corace (clinical psychologist) and Dr. Melanie Willows (family physician) collaborated with hospital (i.e., emergency departments) and community partners to create the Rapid Access Addiction Medicine (RAAM) Clinic. The clinic was developed, implemented, and evaluated to improve treatment access for alcohol and/or opioid use problems, mental health problems, and related physical health conditions. Patients and families were also actively involved in the clinic development. They continue to be involved in continuous quality improvement activities and program evaluation.

What needed improvement?

Problematic substance use is a leading cause of disease, disability, and mortality. From January 2016 to June 2019, there were nearly **14,000 opioid-related deaths** in Canada.[10] In Ontario, there was a **70 per cent increase** in opioid-related deaths between 2016 and 2018.[11] Alcohol, the most common substance used by Canadians, contributed to nearly **15,000 deaths** in Canada in 2014.[12] In 2017, there were **17 hospitalizations every day in Canada due to opioid poisoning and 227 hospitalizations every day entirely caused by alcohol**.[13] Alcohol- and opioid-related emergency department visits also continue to rise at alarming rates.[11,14]

Compared with individuals without a substance use problem, people with alcohol and/or opioid problems are more likely to have concurrent mental health and physical health problems. Despite the prevalence and burden, patients with concurrent mental health and substance use problems face numerous barriers to accessing care. This is in part due to the silos of primary, mental health, and substance use care and services. Treatment is fragmented, wait times are long, and access to evidence-based treatment is limited. As such, patients often cycle (and recycle) through the emergency department due to gaps in care. This adds to health care system burdens, resulting in poor health outcomes.

Given the unmet needs of individuals with concurrent substance use and mental health problems, societal costs, and the impact on patient health outcomes, novel models of care to provide timely access to integrated treatment were needed.

What was done?

In 2016 the RAAM clinic—a multidisciplinary, walk-in, integrated care model located in a mental health centre in Ottawa, Ontario—was launched. It integrated primary care, mental health care, and substance use services to address system gaps, improve access to quality care and patient outcomes, build system capacity, increase system collaboration and coordination (including connection to primary care), and reduce emergency department use.

The RAAM clinic is staffed by a team of family physicians, psychologists, psychiatrists, nurses, social workers, addictions counsellors, and a system navigator. It provides collaborative inter-agency care, with rapid access facilitated through seamless care pathways such as emergency departments, community agencies, and primary care providers. It offers primary care services, substance use assessment and treatment (i.e., alcohol withdrawal management, opioid agonist therapy), mental health assessment and treatment, screening and care for infectious diseases, and harm reduction services. It also provides navigation and connection to community services.

The RAAM clinic has daily walk-in hours. Clients can self-refer or be referred by a primary care provider, emergency department, or community agency. There are no wait times for the clinic. It also offers capacity building, training, and mentorship for primary care providers, psychiatrists, and psychologists, along with on-site observerships and workshops, to improve primary care providers' skills to assess and treat substance use and mental health problems. Rotations for primary care, psychology, and psychiatry residents and fellows are offered to train the next generation of providers. Program evaluation is integrated into the clinical service.

What was gained?

The RAAM clinic patients were evaluated at intake and at 30-day follow-up. Patients completed measures of sociodemographics, substance use, mental health, and overall satisfaction. Clinical information was collected via medical chart review.

Some impressive results and gains include:

- **Emergency department visits (30-day):** For patients served by the RAAM clinic, there was an **82 per cent reduction in 30-day visits** and revisits to the emergency department for alcohol-related issues. There was an overall **10 per cent reduction in visits, and 8.1 per cent reduction in revisits.**[15]
- **Wait times:** Since the launch of the RAAM clinic in 2016, there are no wait times for services. Patients are treated the same day they present.
- **Substance use and mental health:** Upon presentation to the RAAM clinic, patients reported harmful and hazardous alcohol use **(90 per cent)**, polysubstance use **(85 per cent)**, intermediate to severe drug use **(43 per cent)**, and moderate to severe symptoms of depression **(77 per cent)** and anxiety **(69 per cent)**. At follow-up, clients reported reduced opioid, alcohol, cannabis, and cocaine use, and improved depression and anxiety symptoms (ps <.05).[16]
- **Connections: 61 per cent** of patients were connected to additional community services.[15]
- **Client satisfaction:** This was rated high **(99 per cent)**. Patients reported they received the type of help they wanted **(98 per cent)** and that most or all of their needs were met **(94 per cent)**.[16]
- **Capacity building:** Primary care providers increased their capacity to serve patients with substance use and mental health issues.
- **Knowledge translation:** The RAAM model can be adapted to other regions to improve primary care and mental health integration and patient health outcomes. To facilitate uptake in other regions, this work has been disseminated provincially, nationally, and internationally, as well as through peer-reviewed presentations and publications.

What was learned?

The RAAM clinic evaluation demonstrated that integrating primary care, mental health care, and substance use services filled a significant system gap. This increased access to care, improved health outcomes, and reduced emergency department use.

Key lessons learned include:

- Strong, joint leadership by a primary care physician and a clinical psychologist is crucial to successful integration activities of primary care and mental health
- Collaborative, intra-agency, interprofessional partnerships are important to facilitate system coordination and bridge gaps—we get nowhere unless we work together
- Seamless care pathways are needed to enable rapid access to care. The system needs to wrap around the patient, rather than have the patient navigate the system.
- Meaningful engagement of people with lived experience (i.e., patients and families) is key to meaningful evaluation, quality improvement, service delivery, and system change
- Ongoing evaluation is vital to guiding our efforts, responding to changing patient needs, and growing our services in helpful ways
- System change efforts can be challenging; focusing on shared goals (i.e., patient care) helps us move forward

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Shared Care Model for Managing Occupational Health

Collaborative management of leaves of absence from work due to mental health issues: The STAT-C approach to mental health in Quebec

Who was involved?

This project began with a presentation at the May 2016 conference at Laval University's Department of Family Medicine and Emergency Medicine as part of the workshops offered by professionals. Four members of the Regroupement des psychologues et travailleurs sociaux enseignants en UMF (group of psychologists and social workers teaching in family medicine groups [FMGs]) partnered with a family physician to develop a workshop on interprofessional collaboration in managing mental health-related leaves of absence from work. The initial team was made up of a psychologist, a family physician, and three social workers.

A comprehensive literature review was conducted and experts were consulted. Following that, further improvements were made to the workshop and several requests were received to share the approach at the local, regional, and provincial levels.

What needed improvement?

Every week, family physicians see patients who require leave from work because of a transient mental health issue. These issues (adjustment disorder, anxiety disorder, depression) account for 30 to 50 per cent of work leaves.[17] This represents almost 70 per cent of short-term disability costs.[18] The World Health Organization predicted that depression would be the second leading cause of disability worldwide by 2020.[19]

However, a large proportion of physicians have limited knowledge of the parameters with respect to work.[20,21] In fact, they are not specifically trained in planning sick leaves from work, have no treatment protocol or guidelines, and do not have easy access to occupational medicine recommendations. In the current political climate, which requires that patients be seen rapidly and pressures physicians to manage more and more patients, interprofessional teamwork is becoming a vital tool for making the best possible use of time and resources for the benefit of the population.

It was in light of these facts that the Suivi Thérapeutique d'un Arrêt de Travail en Collaboration (STAT-C) approach was developed.

What was done?

STAT-C presents an alternative approach given the absence of consensus about, or clear practical guidelines for, the interprofessional management of sick leaves from work due to mental health issues. It aims to ensure that the absenteeism period focuses on recovery and allows the worker to understand what is affecting their mental health and to develop strategies that support their return to work and prevent relapse.

The approach views the return to work as part of the recovery. The process hinges on three phases of treatment: crisis and understanding, awareness, and implementing strategies and preparing to return to work.[22] The consultation is offered by an interprofessional team that includes the family physician and a psychosocial counsellor.

In each phase, the worker, physician, and counsellor have tasks to complete. The active involvement of the person on leave is at the heart of the treatment. They are encouraged to regain control of their situation. Several tools support the assessment and the pathway to recovery: worker reflection form; list of stressors; interprofessional treatment of a therapeutic leave of absence from work for common mental health reasons; medical assessment of the worker; assessment by the social worker at the FMG; and a guide to depressive symptoms versus functional impairment.[23]

Given the extent of the participants' appreciation and the need for training, Dr. Cynthia Cameron and Ms. Annie Plamondon have been invited on several occasions to give the workshop. This evidence-based approach has not yet been scientifically validated. However, the clinical experience has been convincing and has met the stated goals. The feedback received during the presentations from family physicians and psychosocial counsellors confirms that the content is relevant and meets their needs for training and improving their clinical practice.

What was gained?

- A comprehensive literature review that is regularly updated
- Better knowledge of the tools for assessing and managing the patient and following their progress
- A more comprehensive assessment of the worker and an ability to highlight the obstacles that led to the leave of absence from work
- Better knowledge of the medico-administrative tasks associated with work leaves
- Improved collaboration between all stakeholders: patient, physician, health professionals, insurer, employer

What was learned?

The topic of work must be at the heart of discussions with the patient from the start of the leave. In addition, the return to work is not the end but an integral part of the mental health recovery process. Reconnecting with the benefits of working often helps patients achieve full recovery.

Mental health and primary care providers must go beyond individual consultations centred on psychopathology and medical treatment (of symptoms) to take an integrated approach to occupational health. That is, take into account situations at work that may have contributed to the deterioration of psychological health.

Interprofessional collaboration and communication allow for the workload to be shared and the patient to be supported in their journey as they play a key role in their own recovery.

Increasing knowledge of workplaces and the circumstances relating to insurers will allow physicians and other health professionals to support the patient as they go through the administrative procedures associated with the leave from work.

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Mental Health Services for Indigenous Patients

Connecting mental health services to primary care for adults in Indigenous Cree communities in Manitoba

Who was involved?

This project was a collaboration between Natawiwewak Clinic, Indigenous leadership, the University of Manitoba Department of Psychiatry, and four Indigenous Cree communities in northern Manitoba: Manto Sipi Cree Nation (God's River), Manto Sagihekan Cree Nation (God's Lake Narrows), Bunibonibee Cree Nation (Oxford House), Chemawawin Cree Nation (Easterville). [24]

What needed improvement?

Mental health services for adults living in Indigenous Cree communities in northern Manitoba are sparse, poorly integrated, and uncoordinated for many reasons. Mental health care is carried out by primary care providers who deliver itinerant services that may be transient and infrequent, and who often lack the confidence to manage serious mental health issues. Community programs exist but are not well equipped to manage serious mental illness and are typically not well integrated with medical services. Gaps in care lead to unnecessary suffering among patients, with undiagnosed and undertreated

mental illness and a deterioration in health that results in negative individual, population, and system-level outcomes. Individuals have poor access to services and do not receive treatment they need, populations are sicker, and the system spends more time and money on emergency and hospital care when crises arise.

Serious mental illness and high rates of suicide are critical issues that have ripple effects on the entire community and can extend to neighbouring communities. Inadequately supported health care providers may be less likely to offer treatment to an individual in need and may be overall less inclined to work in these communities.

What was done?

A psychiatric referral service was established with funding from Health Canada. The program launched in July 2019 in the four Indigenous Cree communities. The communities vary in population from 820 to 2,600, and three are accessible by air only. Health care is provided via nursing stations by family physicians, nurse practitioners, or registered nurses under the remote supervision of a physician. Some other specialists (e.g., dentists) provide care on the reserves. Otherwise, individuals attend telehealth appointments or fly out to receive care. Prescriptions are flown in weekly and the nursing station maintains a minimal formulary of urgent/emergency medications on site.

The psychiatric service accepts referrals from physicians, nurses, mental health workers, and other community staff. The service is a hybrid model, consisting of itinerant community visits approximately three times a year, with monthly telehealth clinics in between. The psychiatry team offers consultation and follow-up care and liaises with the primary care and other affiliated health staff in the community as applicable. Mental wellness clinicians work within each community to provide support and monitor patients for treatment adherence and mental well-being. The clinicians are in the community one or two times a month and provide continuity in communication between the psychiatrists, primary care providers, patients and families, other community services, and hospitals. The clinicians also run a week-long day program out of Winnipeg that provides psychoeducation and skill-building for treating suicidal behaviour, anxiety, and depression.

What was gained?

Since the launch in July 2019 until the end of February 2020, the program has delivered six itinerant visits and 15 telehealth clinics. Some of the successes to date include:

- Access to psychiatric care: Fifty-seven individuals have been assessed and managed by the team and are receiving superior mental health services
- Development of collaborative relationships: The team has developed and continues to work on relationships with local medical and other community staff, determining how to optimize scopes of practice and define best ways to collaborate in an often-changing environment with respect to staffing
- Expansion of services: Mental health clinicians were hired to support the psychiatric team and provide more in-community support and mental wellness intervention
- Identification of opportunities for quality improvement: Opportunities to improve care are being identified through clinical involvement, along with engagement of other health care staff in the community; examples range from scheduling strategies (many individuals do not have a telephone) to monitoring long-acting injectables
- Foundation for education and capacity building: As areas needing improvement are identified, along with variation in comfort and skill levels to manage mental illness,

educational initiatives are being created to engage the range of staff and build capacity to better integrate and manage community mental health

What was learned?

- Stakeholder engagement and co-planning are key: Introducing a new service within an established environment requires gathering information about the pre-program state and the fit of the new program within existing roles and processes. Understanding the historical, cultural, socioeconomic, and political factors within communities is also required. Stakeholders need to be engaged for successful rollout of the program. In communities where this was done well, implementation was smoother.
- Role clarity and collaboration are essential but challenging: In remote communities providers are transient, their skill and scope of practice vary, and collaboration is challenged by these inconsistencies. Invested energy in building strong relationships with community leaders and members and all health staff is needed. Flexibility for working with differing skill sets between team members is also necessary.
- Working within teams overseen by multiple funding and reporting structures creates challenges: Health care staff in these communities are overseen and funded by several entities. This has created challenges with practice space, collaboration, confidentiality and information sharing, accountability, and capacity to improve processes. Change is required across staff managed under different structures. Finding common goals and clarifying reporting structures can help overcome these challenges.
- Stigma exists on multiple levels and takes effort to overcome: Stigma toward those who suffer from mental illness, toward the program, among health care providers, and within communities is present. Efforts to address these issues continue through community education, establishment of relationships, responsiveness to community needs, and evidence of positive impact.

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Mental Health Services for Children and Youth

Innovating youth health services in British Columbia: Foundry BC

Who was involved?

In 2014 a proposal about changing access to health and social services for youths in British Columbia was submitted to the Select Standing Committee (SSC) on Children and Youth by a team at St. Paul's Hospital. The proposal called for the creation of a branded network of health and social services centres across the province. The goal was to provide the province's young people with integrated mental health and substance use services.[25] In 2015 the Graham Boeckh Foundation and St. Paul's Foundation, with a matching commitment from the British Columbia government, agreed to fund the initial planning outlined in the proposal to realize the network of centres. Funding commitments were then made by the Michael Smith Foundation for Health Research. The funders formed a governing council with a promise to establish the BC Integrated Youth Services Initiative, which later became known as Foundry.

What needed improvement?

Mental illness affects approximately one in four Canadian youths, with those ages 12 to 24 experiencing the highest incidence of any age group.[26] Fewer than 50 per cent of youths with a substance use disorder will receive mental health or substance use treatment.[27] In April 2013 the British Columbia (BC) Representative for Children and Youth report *Still Waiting: First-hand Experiences with Youth Mental Health Services in BC* highlighted a recurrent theme of existing youth services lacking accessibility and integration.[28]

What was done?

Foundry modified an evidence-based youth integrated service model from Australia (headspace) to prototype the Foundry service model.[29] It is a stepped care approach (Figure 1) that includes multiple care pathways that match the intensity of service based on the needs of young people and their families. These services (Figure 2) are delivered within an integrated service delivery framework, where young people, families, and multidisciplinary health professionals work together to support the recovery journey.[30]

Figure 1. Foundry Stepped Care Model

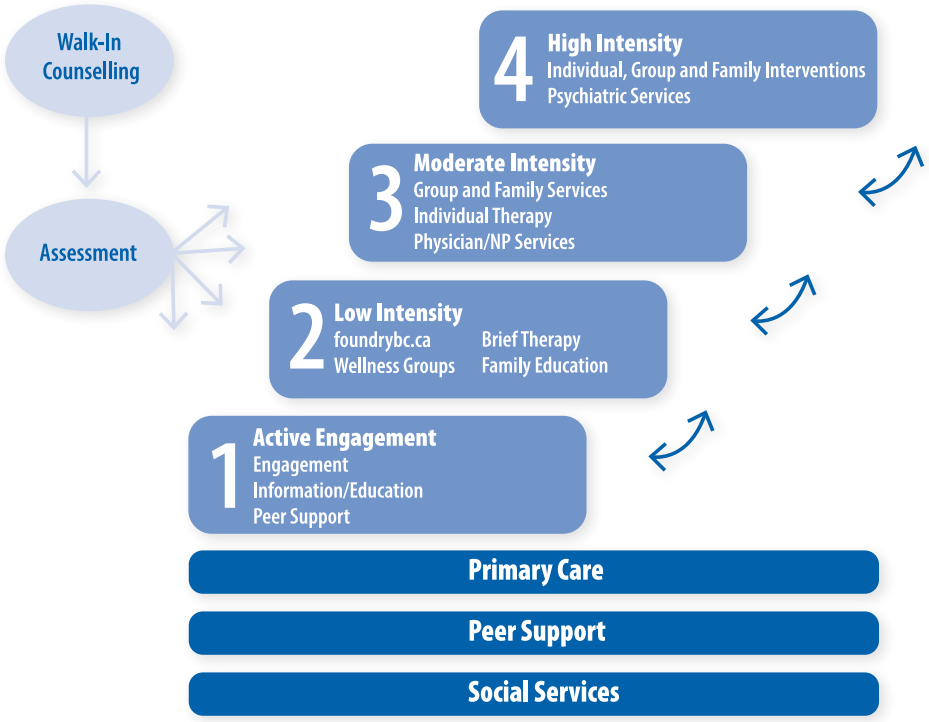


Figure 2. Core services offered at Foundry

Foundry opened their prototype centre in downtown Vancouver—then known as the Granville Youth Health Centre—in March 2015. After a successful proof-of-concept phase and a provincial request for proposals, Foundry partnered with lead organizations from five communities in the province to open five Foundry centres by March 2018. These are in Abbotsford, Campbell River, Kelowna, North Vancouver, and Prince George. A lead organization is an existing organization with the community already providing youth health and/or social services. Partnership with Foundry gives financial support to lead organizations to deliver expanded services under the Foundry service model.

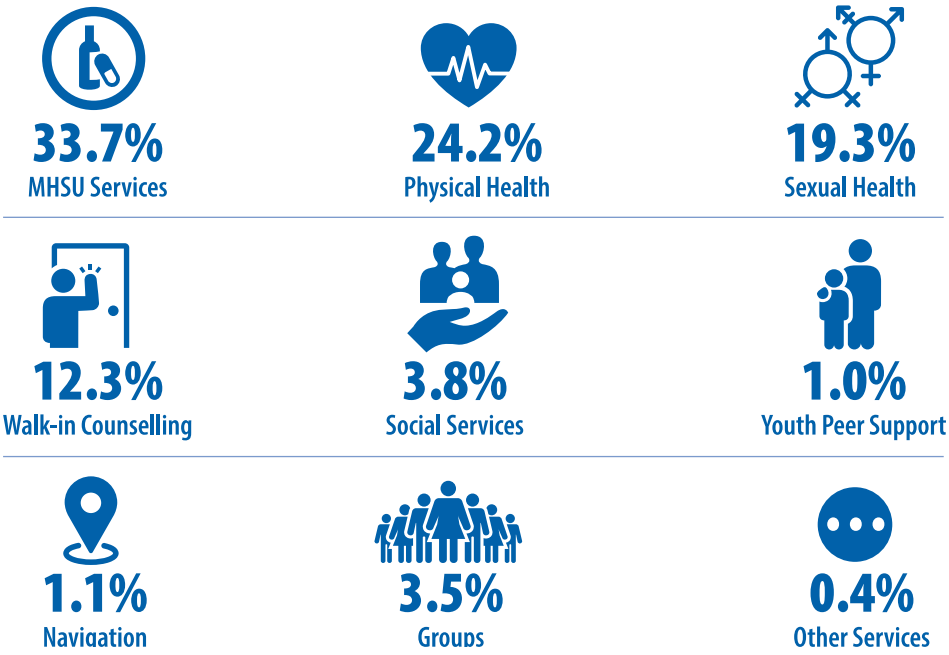
With support of the Foundry Central Office, a team that oversees all Foundry centres, each centre develops partnerships with existing local community service providers to integrate youth services by housing them under one roof. Foundry centres are supplemented with the website Foundrybc.ca.[31] It is an online platform, released January 2018, directing youths and their families to services, resources, and information.

In 2018 Foundry announced five more communities receiving centres: Penticton, Richmond, Ridge Meadows, Terrace, and Victoria. In 2019 the provincial government released *A Pathway to Hope*, which announced funding to expand to a further eight communities, the first step of their 10-year vision for addressing mental health and addictions issues.[32] Foundry received 40 applications from communities in British Columbia interested in opening a Foundry centre. Through a rigorous selection process, Burns Lake, Comox, Kimberly-Cranbrook, Langley, Port Hardy, Squamish, Surrey, and Williams Lake were invited to the network.

What was gained?

- Increase in youths accessing services: Foundry has served 13,407 unique youth visitors. Services accessed are described in Figure 3. A total of 51,717 visits and 65,565 services were registered to date. When asked where youths would have accessed service without Foundry, 44 per cent said they would have gone "nowhere."

Figure 3. Services accessed by type (n = 65,565).



- High level of youth satisfaction with services, centres, and approach: Satisfaction with Foundry was high (94 per cent strongly agree or agree). Most youths reported a high sense of comfort with Foundry services (91 per cent) and feeling welcome (93 per cent). They indicated that staff were respectful (92 per cent), youth-centred (92 per cent), and strength-focused (88 per cent). Ninety-five per cent of youths reported that they would recommend Foundry to a friend or family member.
- Positive intervention outcomes: Initial findings demonstrate promising results regarding improving youths' experience of care and achieving positive outcomes. Youths felt that their views and worries were taken seriously (96 per cent), that staff listened to them (95 per cent), and that staff talked to them in a way that they understood (95 per cent). Youths who participated in the evaluation of walk-in services experienced positive results, both in terms of their experience of the counselling session and their self-rated improvements in functioning over the two-week period after the session.
- Increased access of online health information: The Foundry website provides health information and resource direction as part of the stepped-care framework. More than 371,670 unique visitors have viewed the website for a total of 1.45 million page views. Information content extends to areas including mental health, substance use, healthy living, and everyday life challenges. Foundry also promotes health information through interactive social channels.

What was learned?

- Finding common ground and having a shared vision among partners are key to integration and relationship building. Foundry centres cumulatively have more than 200 community partnerships in every corner of British Columbia. Each partnership is based on mutual understanding of a common goal to provide youths the best possible services. Integrating services requires partnership and meaningful data collection, which cannot be achieved by one organization on its own.
- Actively engaging youths and families is essential to the delivery of effective integrated services. The purpose of integrating services is to support youths and their families. Without their perspectives, this is not possible. Every aspect of Foundry—from the centre designs, to hiring decisions, to organizational direction—is informed by the leadership of youths and families. Initiatives attempting to integrate youth services need to prioritize the engagement of these groups.
- The Foundry centre space facilitates integration via staff-to-staff engagement while also housing all the services under one roof. Staff identify the creation of clear pathways to care, and the ability to collaborate in new ways between services and systems that was facilitated by being "under one roof" as an indicator for system transformation.

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Overcome Silos Among Disciplines and Improve Wait Times for Referrals, Consultation, and Assessment of Patients Through Communication

Improving the mental health intake journey: Integrating online evidence-based tools into a primary care team setting in Ontario

Who was involved?

The Huron Community Family Health Team consisting of physicians, nurse practitioners, physician assistants, registered nurses, and administrative staff along with the requisite team of mental health therapists.

What needed improvement?

The Huron Community Family Health Team is a primary care medical centre in the rural community of Seaforth, Ontario, with two affiliated satellite clinics. The mental health team, which included three part-time clinical social workers and a part-time clinical psychologist, was faced with a steady stream of referrals and a rapidly growing wait list that was approaching six months.

The early assessment phase of the intervention required particular attention due to the use of a stepped model of intervention given limited treatment resources. The proper selection of targeted empirically validated treatments requires more precise identification of symptom type and severity. Evidence-based assessment tools (EVAs) are highly recommended in such cases.[33] However, they can be onerous to administer and score, plus the results require expertise to interpret. This can contribute to negative attitudes toward EVAs, particularly among social workers and other non-psychologist counsellors.[34] User-friendly assessment tools were required to support a more standardized intake process and help alleviate patient backlog.

What was done?

The team psychologist built a comprehensive mental health assessment inventory that could be delivered online called Myndplan.[35] In addition to providing clients with access to their results, the app includes a clinician portal that allows any provider approved by the patient to review their information. Procedures were developed to integrate this resource with a new intake process that included the following:

- Medical staff were trained to send a message via their EMR alerting clerical staff that a referral had been made, along with the patient's email address.
- A link was then emailed to the patient along with instructions on how to create their Myndplan account; if the patient did not have an email address, one was provided to them to get started.
- Tablets were made available in the office for patients who did not have access to email and/or a computer. If a patient was not familiar with the tablet, staff provided support and guidance.
- Mental health counsellors left openings in their weekly schedules to conduct intake sessions. Alerts in the Myndplan system administrator account notified counsellors of any new referrals with completed assessments. A telephone interview was then carried out, during which both the patient and counsellor had online access to the assessment results.
- Based on content from the intake interview, a follow-up session was booked with the appropriate therapist or allied health professional and treatment began.

What was gained?

A reliable and efficient intake process that is convenient for both patients and mental health counsellors, with several benefits:

- First contact with patients is much earlier than with the previous method. On average, patients are being phoned within two weeks of their referral for the intake review. This means patients have a better idea of what is happening early in the process, enhancing their sense of control at a time when they are very vulnerable.
- There was a lot of concern about patient buy-in. Several staff had doubts that patients would be willing to complete a lengthy questionnaire. Others were concerned that the online format would be out of reach to many patients. However, the 80 to 90 per cent completion rate is nearly double that of the previous intake package.
- Mild, moderate, and severe cases can more easily be identified because assessment scores are reported using percentile rankings. As one therapist put it, "… it helps us prepare for what we can expect in therapy."

- The process allows for better matching of therapists to patients. For example, the clinic regularly takes on social work students for supervised practice. The students can now be matched with patients whose levels of complexity and distress are appropriate for their skill levels.
- With respect to one of the primary goals of the program, wait-list time has been reduced significantly. Patients are now seen within four to six weeks of their referral, a 75 per cent reduction in wait time.
- Lastly, therapists are happy with the service. Feedback included comments such as "I really like how Myndplan allows me to see how clients view their challenges. This provides a very useful framework for therapy." They were not the only ones happy with the outcome. The team's key clerical support worker noted that "… the program is working extremely well. It is speeding up the wait time process significantly and is much more organized."

What was learned?

- Patients will complete lengthy and detailed psychological testing. However, user experience has a huge impact on patient uptake. Bugs in the app could stall the intake process. At the start of the program, when supplementary instructions were sparse, the dropout rate during the registration process approached 50 per cent.
- Screening questions do more than help streamline the administration of items. People are particularly sensitive when asked questions about sexual issues or drug use that do not apply to them. Patients are much happier when they are asked only about behaviours that are directly relevant to their lives.
- Patients like viewing their own results. In fact, they have indicated that they would like more feedback built into the Myndplan system. For example, a patient survey revealed that close to one-third of respondents ranked additional information on diagnosis as a priority, and a similar number wanted guidance on selecting the best treatment.
- Comprehensive assessments provide data sets that can provide additional useful information. For example, the team can:
    - Identify patients who are less likely to respond to medication and others who are poor candidates for cognitive behavioural therapy
    - Distinguish healthy non-patient, therapy, and addiction/forensic groups with 75 per cent accuracy
    - Screen for potential sleep apnea
    - Predict severity of symptoms at completion of therapy

  The ability to analyze the data is the only limit to extracting insights.

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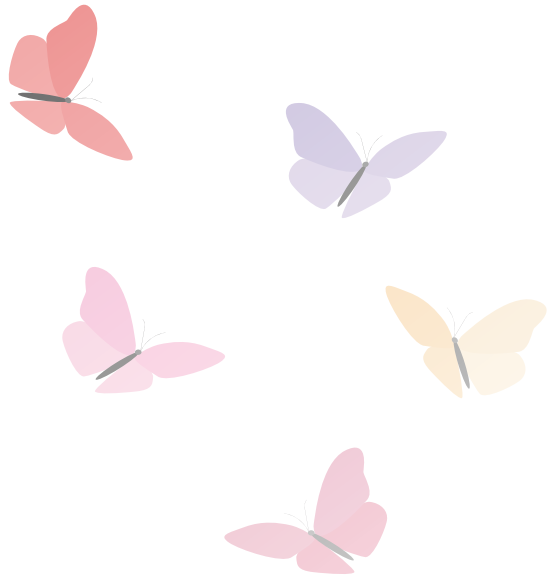

Conclusion

The CFPC, the Canadian Psychiatric Association, and the Canadian Psychological Association would like to thank all those who contributed to this issue to share innovative ways family physicians, psychiatrists, psychologists, and other health care providers can work together to address common challenges and barriers to providing access to mental health services in their communities for optimal patient care.

The case examples presented provide invaluable opportunities for interprofessional learning. We hope that you find them useful for advancing practice and helping support advocacy for better integration of mental health services in primary care in your local jurisdiction.

Key lessons learned include:

- Co-locating mental health providers in family practice settings removes barriers to timely access for patients by providing mental health services in the same clinic environment they are already familiar with and where they are used to receiving their primary care.
- No single mental health funder can provide all services to all patients. Cooperation and collaboration between public funders and smaller community-based organizations offer unique opportunities for family medicine and mental health specialists to develop evidence-based and accountable mental health interventions and to work together to provide access to timely consultation from specialized mental health providers, long-term follow-up care, and a variety of mental health interventions for patients.
- Joint leadership among primary care and mental health providers is crucial to successfully integrate services, facilitate system coordination, and bridge gaps. Seamless care pathways are needed to enable rapid access to mental health support, particularly for patients with substance use disorders. The system needs to serve the patient, rather than expecting the patient to figure out the system.
- Taking an integrated approach goes beyond individual consultations centred on psychopathology and medical treatment of symptoms. Psychological interventions give patients and families tools for self care and to manage what can be long-standing or

recurring health problems. Interprofessional collaboration and communication allows for the workload to be shared and for patients to be supported in playing a role in their own recovery. Actively engaging patients and their families is essential to deliver effective integrated services.

- Team-based care, particularly in remote communities, can create challenges when overseen by multiple different funding and reporting structures. Finding common goals, clarifying roles, and understanding the historical, cultural, socioeconomic, and political factors within those communities can help overcome these challenges.
- Stakeholder engagement, co-planning, and communication are key when introducing new models of care and integrating mental health services within an already established context. Finding common ground and having a shared vision among community partners are key to integration and relationship building.

The cases described in this publication put a strong emphasis on interconnected care between different settings that aligns with the principles of the expanded Patient's Medical Neighbourhood.[9] Stakeholders looking to apply those principles for more streamlined, connected care should refer to the Best Advice guide describing the general principles of that vision and their application in practice.

The COVID-19 pandemic has brought to light the urgency of integrating mental health services in primary care now, more than ever, to ensure that everyone in Canada has timely access to continuous, high-quality, comprehensive care that's inclusive of mental health support to meet their health care needs.

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