The Le Royal
Mental Health - Care & Research
Santé mentale - Soins et recherche

Development of a Model for Coordinated Access for Mental Health and Substance Use/Addictions Services in the Champlain LHIN

Prepared by: Brian Rush, Amanda Eaton, April Furlong, Melanie Willows, Paul Backman, Christine Slepanki & Kim Corace[1]

Submitted by: Dr. Kim Corace, Director, Clinical Programming and Research, Substance Use and Concurrent Disorders Program, Executive Lead Ontario Structured Psychotherapy Program, The Royal Ottawa Mental Health Centre

Date: April 5, 2019

---

[1] **Suggested citation:** Rush, B.R., Eaton, A., Furlong, A., Willows, M., Backman, P., Slepanki, C., & Corace, K. Development of a model for coordinated access for mental health and substance use/addictions services in the Champlain LHIN. Ottawa: The Royal Ottawa Mental Health Centre.

Table of Contents

Acknowledgements viii

Executive Summary ix

1.0 Background and objectives 15

1.1 Background 15

1.2 Provincial landscape 16

1.3 Objectives 18

2.0 Methodology/Data collection strategies 19

2.1 Collaborations and communications 19

2.2 Population needs 19

2.3 Components of data gathering 20

3.0 Key findings by project component 24

3.1 Population and population needs 24

3.2 Environmental scan of existing coordinated access services 30

3.3 System mapping 30

3.4 Primary care provider survey results 32

3.5 Summary of feedback from stakeholder engagement sessions 37

4.0 Synthesis of findings, proposed key elements, and validation process 42

4.1 Needs/issues to be addressed 42

4.2 Proposed key aspects for model design 43

4.2.1 Scope 43

4.2.2 Key functions and related staffing 45

4.2.3 Means of access/technology 46

4.2.4 Connectivity/transitions to and through services (stepped care model) 47

4.2.5 Data for planning, gap analysis and performance assessment 48

4.3 Feedback and validation 48

5.0 Going forward 51

5.1 Collaborative vision 51

5.2 Implementation steps and considerations 53

5.3 Evaluation strategy 57

6.0 Summary and Recommendations 58

7.0 References 60

8.0 Appendices 62

Appendix A: Interview Guides.. 62
Appendix B: System Mapping Key Element Definitions 66
Appendix C: Primary Care Provider Survey 67
Appendix D: Organizations and stakeholders consulted.. 75
Appendix E: CCHS 2012 Criteria for categorization of level of need by severity tier......................... 77
Appendix F: Data tables and qualitative coding - online primary care providers survey.................. 81
Appendix G: Logic model 115

List of Tables

Table 1. Estimated prevalence of mental and substance use disorders among children and youth between the ages of 4 to 17 for Champlain LHIN region ... 25
Table 2. Estimated prevalence of mental and substance use disorders among adults 15 and over for Champlain LHIN region ... 26
Table 3. Summary of in-need population, help-seeking and estimated service demand for mental health and substance use/addictions-related challenges in the Champlain region. ... 29
Table 4. Estimated percentage of clients with challenging mental health and substance use/addictions issues 33
Table 5. Frequency of screening tools used prior to referral to mental health and substance use/addictions services ... 33
Table 6. Comfort level regarding knowledge to address mental health and substance use/addictions challenges among clients ... 34
Table 7. PCP survey - Role/profession ... 81
Table 8. PCP survey - 'Other' comments regarding role/profession ... 81
Table 9. PCP survey - Role/profession - Regional comparisons ... 81
Table 10. PCP survey - setting in which survey respondents work ... 82
Table 11. PCP survey - 'Other' comments - setting ... 82
Table 12. PCP Survey - Setting in which respondents live - Regional comparisons ... 82
Table 13. PCP survey - Services available ... 83
Table 14. PCP Survey - 'Other' comments - Services available ... 83
Table 15. PCP Survey - Services available - Regional comparisons ... 84
Table 16. PCP survey - Estimated percentage of clients that prefer services in French ... 85
Table 17. PCP survey - Estimated percentage of clients that prefer services in French - Regional comparisons . 85
Table 18. PCP survey - Estimated percentage of clients that prefer services in languages other than French or English ... 85
Table 19. Estimated percentage of clients that prefer services in languages other than French or English - Regional comparisons ... 86
Table 20. PCP survey - Estimated percentage of clients that identify as Inuit/First Nations/Métis ... 86
Table 21. PCP survey - Estimated percentage of clients that identify as Inuit/First Nations/Métis - Regional comparisons ... 86
Table 22. PCP survey - Percentage of clients estimated to have challenging mental health issues - Regional comparisons ... 87
Table 23. PCP survey - Percentage of clients estimated to have challenging substance use/addiction issues - Regional comparisons ... 87
Table 24. PCP survey - Most common mental health challenges ... 88
Table 25. PCP survey -'Other' comments - Most common mental health challenges ... 88
Table 26. PCP survey - Most common mental health challenges - Regional comparisons ... 88
Table 27. PCP survey - Most common substance use/addiction challenges ... 89
Table 28. PCP survey - Most common substance use/addiction challenges - Regional comparisons ... 89
Table 29. PCP survey - Frequency screening tools are used prior to referral to mental health services – Regional comparisons ... 90

Table 30. PCP survey - Frequency screening tools are used prior to referral to substance use/addiction services – Regional comparisons 90
Table 31. PCP survey - Types of mental health screening tools used 90
Table 32. PCP survey - 'Other' comments - Mental health screening tools used 91
Table 33. PCP survey - Types of mental health screening tools used – Regional comparisons 92
Table 34. PCP survey - Types of substance use/addiction screening tools used 92
Table 35. PCP survey - 'Other' comments for types of substance use/addiction screening tools used 92
Table 36. PCP survey - Types of substance use/addiction screening tools used – Regional comparisons 92
Table 37. PCP survey - Comfort level regarding knowledge to address mental health challenges among clients – Regional comparisons 93
Table 38. PCP survey - Comfort level regarding knowledge to address substance use/addiction challenges among clients – Regional comparisons 93
Table 39. PCP survey - Proportion of clients referred for specific mental health challenges – Regional comparisons 94
Table 40. PCP survey - Proportion of clients referred for specific substance use/addiction challenges – Regional comparisons 94
Table 41. PCP survey - Services to which clients with mental health challenges are referred 95
Table 42. PCP survey - 'Other' comments - Services to which clients with mental health challenges are referred 95
Table 43. PCP survey - Services to which clients with mental health challenges are referred – Regional comparisons 96
Table 44. PCP survey - Services to which clients with substance use/addiction challenges are referred 97
Table 45. PCP services - 'Other' comments - Services to which clients with substance use/addiction challenges are referred 97
Table 46. PCP survey - Proportion of clients referred for specific substance use/addiction challenges – Regional comparisons 98
Table 47. PCP survey - Referral modalities used 99
Table 48. PCP survey - Referral modalities used for mental health - Regional comparisons 99
Table 49. PCP survey - Referral modalities used for substance use/addiction - Regional comparisons 99
Table 50. PCP survey - Preferred referral modalities 100
Table 51. PCP survey - Preferred referral modalities – Regional comparisons 100
Table 52. PCP survey - 'Other' comments - Preferred referral modality 100
Table 53. PCP survey - Comparison of referral experiences 101
Table 54. PCP survey - Comparison of referral experiences – Regional comparisons 101
Table 55. PCP survey - Specific sub-groups of clients with mental health challenges who have access challenges 102
Table 56. PCP survey - 'Other' comments - Sub-groups of clients with mental health challenges who have access challenges 102
Table 57. PCP survey - 'Other' comments - Sub-groups of clients with substance use/addictions challenges who have access challenges 103
Table 58. PCP survey - Specific sub-groups of clients with mental health challenges who have access challenges – Regional comparisons 104

Table 59. PCP survey - Specific sub-groups of clients with substance use/addiction challenges who have access challenges – Regional comparisons......104
Table 60. PCP survey - Perceptions of wait times for mental health services - Regional comparisons......105
Table 61. PCP survey - Perceptions of feedback for mental health services - Regional comparisons......105
Table 62. PCP survey - Knowledge about where to refer for mental health services - Regional comparisons...106
Table 63. PCP survey - Perceptions regarding whether appropriate mental health services exist - Regional comparisons......106
Table 64. PCP survey - Perceptions regarding processes for mental health service referrals- Regional comparisons......107
Table 65. PCP survey - Perceptions regarding speed of access to mental health service referrals- Regional comparisons......107
Table 66. PCP survey Perceptions of wait times for substance use/addictions services - Regional comparisons 108
Table 67. PCP survey - Perceptions of feedback for mental health services - Regional comparisons......108
Table 68. PCP survey - Knowledge about where to refer for substance use/addictions - Regional comparisons 109
Table 69. PCP survey - Perceptions regarding whether appropriate substance use/addictions services exist - Regional comparisons 109
Table 70. PCP survey - Perceptions regarding processes for substance use/addictions service referrals- Regional comparisons......110
Table 71. PCP survey - Perceptions regarding speed of access to substance use/addictions service referrals- Regional comparisons 110

List of Figures

Figure 9. Schematic diagram of the Collaborative Model for Coordinated Access for Mental Health and Substance Use/Addictions Services for the Champlain region xii
Figure 1. Percentage of the Champlain LHIN population 15 and over (estimated in 2016 at N=1,125,232) meeting criteria for different levels of need for mental health and substance use/addictions services 27
Figure 2. Estimated opioid use disorder and related consumption and risk factor – Canadian level 28
Figure 3. Proportion of survey respondents reporting that wait times are acceptable for mental health and substance use/addictions services 35
Figure 4. Proportion of survey respondents reporting 'a clear feedback loop' between mental health and substance use/addictions services 35
Figure 5. Proportion of survey respondents reporting knowledge about where to refer for mental health and substance use/addictions services 36
Figure 6. Proportion of survey respondents reporting that appropriate mental health and substance use/ addictions services exist 36
Figure 7. Proportion of survey respondents reporting that referral processes for mental health and substance use/ addictions services are effective and efficient 36
Figure 8. Proportion of survey respondents reporting that access to mental health and substance use/ addictions services is 'quick and immediate' 37
Figure 9. Schematic diagram of the collaborative model for coordinated access for mental health and substance use/addictions services for the Champlain region 52

Acknowledgements

The project team (see below) would like to extend its appreciation to our project partners, including the Champlain Mental Health and Addictions Coordinated Access Advisory Committee and its sub-regional planning tables in the Eastern, Western and Central regions. We have also benefited significantly, throughout the process, from the support of Rod Olfert from the Champlain LHIN, especially his guidance in working with the sub-regional planning groups, whose previous work with Rod we have aimed to complement. Our thanks go to the many organizations and individuals who helped organize and facilitate our many engagement and validation sessions. We would also like to thank the LHIN Primary Care Leads: Dr. Aly Abdulla, Dr. Marilyn Crabtree, Dr. Max Buxton, Dr. Kamila Premji, Dr. Thérèse Hodgson, Dr. Lee Donahue, as well as Dr. Kathleen Pajer, Chief of Psychiatry University of Ottawa, and the OSP Royal Leadership Group and community partners. Our thanks also go to Andrea Demers at the Ontario Ministry of Health and Long-Term Care for very helpful conversations at the outset of the project that helped us maximize the value of the project at the provincial level. We are also grateful to Alexia Jaouich and Kendyl Dobbin in the CAMH Provincial System Support Program for their support for the project and initial guidance. Last, but far from least, we extend our heartfelt thanks to the many people and families with lived experience with mental health and substance use/addictions issues who provided such helpful input, as well as to the region's primary care and other service providers and stakeholders who gave their time and expertise through the project's survey, focus groups and interviews.

Champlain Coordinated Access Project team members

Dr. Kim Corace	Executive Lead, OSP, The Royal Ottawa Mental Health Centre
Amanda Eaton	Systems Planner, The Royal Ottawa Mental Health Centre
Christine Slepanki	Operations Director, OSP, The Royal Ottawa Mental Health Centre
Dr. Melanie Willows	Primary Care Lead, The Royal Ottawa Mental Health Centre
Paul Backman	Project Coordinator, The Royal Ottawa Mental Health Centre
Dr. Brian Rush	Systems Consultant, VIRGO Planning and Evaluation Consultants, Inc.
April Furlong	Project Analyst, VIRGO Planning and Evaluation Consultants, Inc.

Executive Summary

Introduction and objectives

In the fall of 2018, The Royal received approval from the Centre for Addiction and Mental Health's Provincial System Support Program (PSSP) to use surplus funds from its Ontario Structured Psychotherapy (OSP) program to develop a model of coordinated access for mood and anxiety services within the Champlain LHIN. Early in the project, the scope broadened to include people experiencing a wider range of mental disorders and challenges, reflecting the need in the region, the current multiplicity of access points for this population, the strong evidence concerning co-morbidity across a wide range of mental health and substance use/addictions issues, and the need for careful integration of the stepped care approach embedded in the OSP program. Key to the model's development was the desire to build upon, and leverage, the existing services and planning efforts already in place, as well as account for, as much as possible, broader developments within the provincial landscape. Together with the development of the model, the project also aimed to identify considerations, opportunities and challenges for the eventual implementation of the model, and its evaluation.

Collaboration and consultation with key stakeholders were central to the project team's approach, beginning with a close partnership between the existing Champlain Mental Health and Addictions Coordinated Access Advisory Committee, and its corresponding sub-region tables. The team also collaborated with stakeholders from other relevant leadership groups and programs in the region, primary care and other services providers, and individuals and families with experience of mental health and substance use/addictions issues.

Methods

To better understand the needs and considerations for a region-wide coordinated access model, the project team adopted a multi-method approach to data collection, including:

- Identification of population need – based on a review of available data on the prevalence of mental and substance use disorders and related challenges, and the estimated proportion of this population likely to seek help from regional services and supports.
- Environmental scan – based on interviews with stakeholders from existing coordinated access services in Ontario that had a primary mandate with respect to mental health and/or substance use/addictions.
- System mapping – to collect information on the status of various functions related to "coordinated access", by organization and program, in the Champlain LHIN.
- Primary care provider survey – an online survey that allowed primary care providers to report on their experience in accessing mental health and substance use/addictions services for their clients, related needs within their practices to support these clients, and recommendations to enhance access to the system.
- Stakeholder engagement – Focus groups and individual interviews with key stakeholders, including service user and family members, primary care providers, and stakeholders from psychiatry, hospital and community-based services.

Synthesis of findings

The findings, which are described in detail in this report, were synthesized in order to identify the specific needs that should be addressed by a coordinated access model, as well as key aspects for model design. These are summarized below.

Needs/issues to be addressed:

- The system is too complex and wait times are too long.
- The system and services lack coordination.
- Emergency Departments are often the default access into the mental health and substance use/addictions system.
- There are gaps in services for specific populations, such as Francophones, 2SLGBTQ+, First Nations, Inuit, and Metis, newcomers and refugees and veterans, as well as for individuals with specific mental health and substance use/addictions concerns.
- Transitions are challenging.
- Access to specialized/regional and fee-for-use services are challenging, particularly in the Eastern and Western sub-regions.
- There are other practical challenges that require attention, including access to transportation and communication technology; concerns related to culture and language; and low literacy levels of some clients served.
- A model needs to include access to information for services beyond mental health and substance use/addictions, including those focused on the social determinants of health.
- The model needs to be staffed by a range of professionals, including regulated health professionals, with skills and experience appropriate to the functions and activities they are required to perform.
- There is a need for more standardization of screening and assessment tools as well for better and more common data for planning, performance measurement and evaluation.

Proposed key aspects for the design of the coordinated access model:

- *Scope of services, supports and populations* – the model should cover the entire Champlain region and be inclusive of all people with mental health and substance use/addictions concerns, along with their families. Important services considered to be out of scope of the model include crisis, housing, and court-ordered forensic services, but with the understanding that there will need to be appropriate linkages to these services. Other access points and pathways that will require close collaborative linkage include the current processes for children and youth, geriatric populations and ACTT/Intensive Case Management.
- *Key functions and related staffing:*
    - provision of basic information - about available resources and how to access them
    - linkages to Primary Care – including for those who are not already connected
    - different levels of screening and triage—using common, standardized tools, as needed
    - stage 1 assessment and service matching—for clients not immediately directed to service
    - provision of supports while on a waitlist—for those services where a wait may be long
    - waitlist management—to support transparent information sharing on wait times
    - feedback—about the outcome of the service match and service provision
    - appropriate staffing—by a range of professionals with appropriate skills and experience consistent with their role, including regulated health professionals
- *Means of access/technology* – including:
    - telephone access - *one region-wide 1-800 phone number* is recommended.

- o e-referral integrated into electronic health records – to allow direct linkages for referrals and to facilitate communication.
  - o online referral form – so that service providers and clients can efficiently provide information relevant to a referral without requiring direct initial contact
  - o walk-in capabilities – that include physical locations for people to access the coordinated model without an appointment
  - o chat/text – to provide a low barrier means of contact
  - o connections to outreach services – to acknowledge the populations who may not access services through any of the above listed methods
  - o communication with coordinated access to service match – using various technology/ database solutions
- *Connectivity/transitions to and through services (stepped care model)* - the model must have built in feedback loops, from the service provider within various sectors to the coordinated access model, as well as to the initial referral source and service user. Feedback should occur at multiple points, and, in conjunction with an easy link-back into the coordinated access model, will provide the means to support the person with the next step in their recovery process and facilitate an overall stepped care approach.
- *Data for planning, gap analysis and performance measurement* – Data will be facilitated by common service definitions, tools and processes, and ideally, an electronic platform of information collection and exchange. Relatedly, there is a need for the model to have capacity for its own evaluation and quality improvement processes, using both internally and routinely collected data as well as periodic feedback from a wide range of stakeholders.

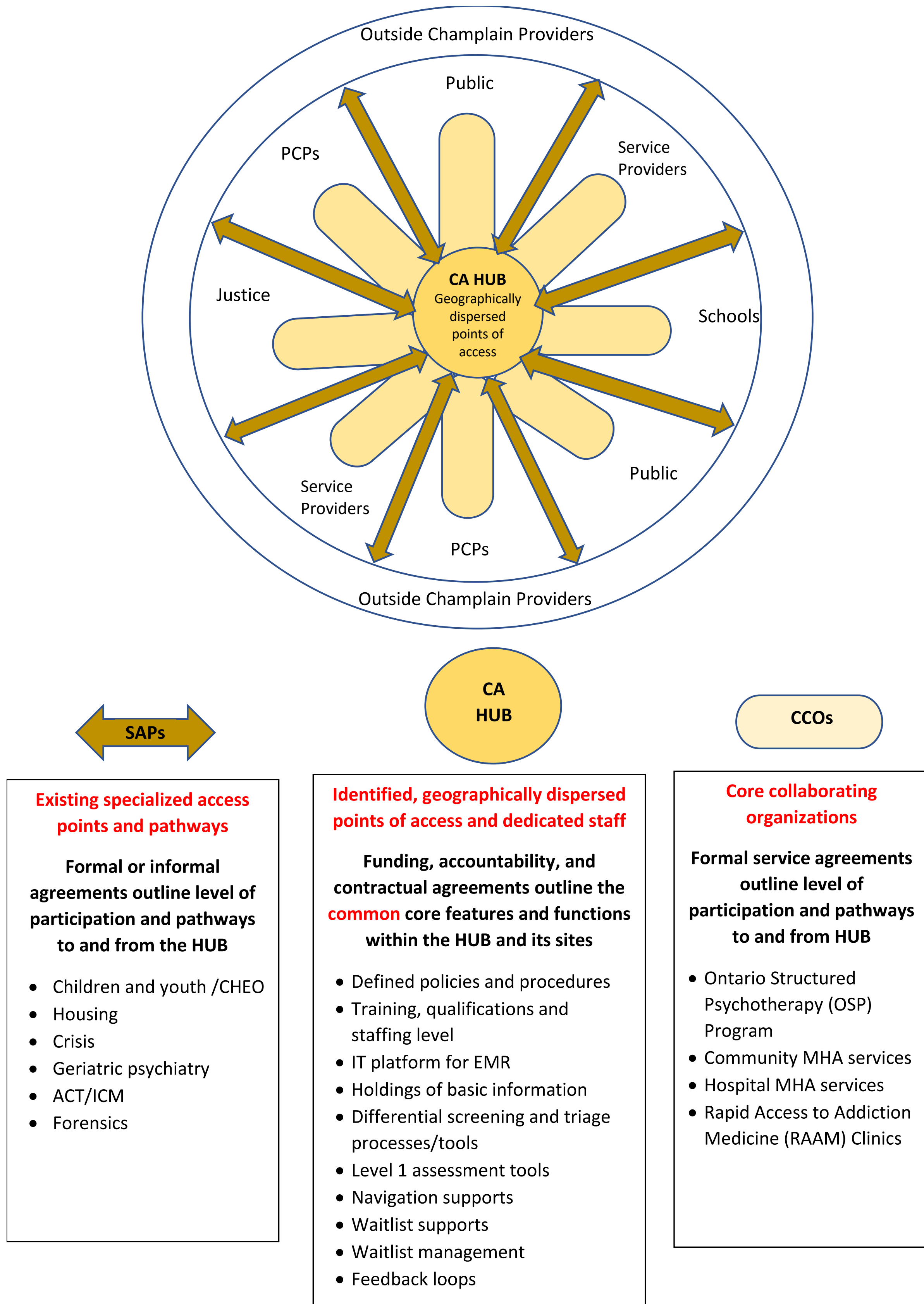
As a final step in the process, the project findings were presented, together with three options for a coordinated access model, to over 85 stakeholders for validation of the synthesis of the feedback received and refinement. While aiming for a balance between the sometimes diverse views that were gathered from a widespread, detailed consultation, **priority was given, when needed, to the expressed needs and opinions of future service users (i.e., people with lived experience), including family members**.

Going forward

Stakeholders broadly supported the identified needs and key aspects for a coordinated access model. They were also most supportive of a "hub and spoke" model. To support operationalization of this model, a conceptual diagram (presented below) was developed to illustrate the following core features:

- *Coordinated Access (CA) Hub* - comprised of geographically dispersed points of access with dedicated funding, staff, and policies and procedures, and with each point of access sharing common essential features, including the elements required for stepped care, such as screening, triage, assessment, matching criteria, navigation supports, and feedback loops, as well as staff qualifications for different roles. To ensure this commonality, the geographically dispersed points of access must be connected by contractual agreements with central oversight.
- *Core Collaborating Organizations (CCOs)* – these represent the various organizations across all sub-regions of the LHIN that will work as the CA hub's closest partners through both formal and informal service agreements.
- *Specialized access points and pathways (SAPs)* – while outside of the CA Hub itself, these will be closely linked to it, largely by informal agreements. Importantly, these SAPS may extend outside of the Champlain region itself, indicating the need for connectivity to and from service providers, and their clients and families, from outside the region.

Figure 1. Schematic diagram of the Collaborative Model for Coordinated Access for Mental Health and Substance Use/Addictions Services for the Champlain region



Implementation steps and considerations

This project team also proposed the following key steps and considerations for the implementation of the identified coordinated access model for Champlain region.

Proposal development – Stakeholders will need to be engaged to develop a concrete and realistic proposal for funding that reflects the key principles related to service design and operations that were articulated during consultations. The proposal will also need to reflect the commonly voiced concern that increasing access to services does not address the ongoing fundamental challenges with system capacity; indeed, capacity concerns may well be exacerbated for a period of time. To this end, the next stage of proposal development should be a more robust assessment of the likely demand for services and the required service capacity and infrastructure to meet this demand, on both a regional and sub-regional basis. Other steps to develop the proposal include:

- engagement/re-engagement with stakeholders from this first phase of model development
- completion of the system mapping exercise
- identification of opportunities to minimize duplicate data entry
- establishment of service delivery pathways specific to different client and family needs
- development and costing of a staffing plan
- clear identification of both service delivery/operational requirements and system planning functions

Challenges and opportunities related to system capacity - Gaps in capacity can be mitigated by leveraging existing provincial resources and technology. There is also an opportunity, when selecting IT solutions for information and communication management, to consider the extent to which any platform can be integrated with those used in the larger health care system.

Needs of specific population groups—In addition to ensuring a population health approach to overall planning and an estimation of required capacity, there are particular groups that will deserve attention during the implementation phase to ensure their needs are considered and addressed. This includes marginalized populations such as those who are homeless, as well as newcomers and refugees; people whose first language is French; First Nations, Inuit and Metis peoples, members of the 2SLGBTQ+ community; veterans; and those who are pregnant.

Change management and leadership—Implementation should adopt a staged/phased approach, acknowledging the complexity of design and the work required to engage and support service partners and community members in new processes. The model will need to be sufficiently flexible to respond to changes in the broader health system, particularly the plans to restructure the system, and the move to bring children and youth services under the umbrella of the Ministry of Health and Long-term Care. There is also a need for a strong communication and marketing strategy to launch the service, and careful attention given to preserving and leveraging existing networks and relationships between service providers.

Collaboration and governance - The coordinated access model will require a clear governance structure, accountability requirements, and other mechanisms to support partnerships, including with service users, their families and primary care providers. This will be particularly important as it relates to specific functions of the coordinated access model, such as common screening, triage, and assessment tools and processes, and waitlist management. Mechanisms will also need to be in place to engage planning bodies

focused on improving access for specific populations, as well as organizations that provide services that are further removed from the coordinated access model, but that have a vested interest in its functioning. Strong leadership, similar to that within the current project focused on model development, will also be crucial.

Evaluation, performance measurement and outcome monitoring—Plans to develop and implement a coordinated access model will need to include mechanisms to collect data for the purposes of evaluation, performance measurement and outcome monitoring. This will require consideration of infrastructure availability, data collection tools and measures, and other infrastructure and resource requirements. The evaluation strategy should include a developmental evaluation approach; a program logic model and related context and contribution analysis; identification of key evaluation questions and corresponding indicators and data collection strategies.

Provincial implications - The most significant provincial implication of the present project is for the provincial roll-out of the OSP program, including coordinated access strategies, to be closely connected to efforts to improve access and coordination to the mental health and substance use/addictions system in Ontario. It also raises important implications for the role of the Youth Wellness Hubs as part of an integrated approach to coordinated access for mental health and substance use/addictions challenges in Ontario. Given the scope of the proposed model of coordinated access across the lifespan and all levels of acuity and severity, there are also implications for the design of other coordinated access models In Ontario, and for identifying the optimal relationship between ConnexOntario and these regional access services.

Recommendations:

Recommendation 1: A process should be put in place to move from this model development phase to a proposal for funding, with the following considerations:

- the conceptual model developed in this project and reported here should form the core component of the funding proposal;
- respecting and addressing the many considerations identified above for both proposal development and subsequent implementation;
- ensuring the same level of engagement and leadership be brought to bear, as was evidenced in the implementation and reporting on this phase of model development.

Recommendation 2: Given several unique features of the proposed coordinated access model, such as the grounding in the OSP initiative and stepped care, the important role expected for primary care, and the full age and severity spectrum to be covered, we recommend that this work be used to inform other coordinated access models throughout Ontario, particularly in the context of ensuring effective linkage of the OSP program to the broader provincial mental health and substance use/addictions system of services.

Recommendation 3: A formal presentation of the project and its results should be made to key audiences, including PSSP in CAMH, the project funders, the Ontario Ministry of Health and Long-Term Care, the provincial OSP Leadership and other provincial stakeholders.

1.0 Background and objectives

1.1 Background

The Increasing Access to Structured Psychotherapy (IASP) Program[2], now referred to as the Ontario Structured Psychotherapy (OSP) program, funded by the Ministry of Health and Long Term Care (MOHLTC) is a provincial, three-year demonstration project (ending in March 2020) designed to enhance timely access to an evidence-based psychological treatment (i.e., Cognitive Behavioural Therapy; CBT) for people aged 18+ across Ontario experiencing mild to moderate depression, obsessive-compulsive disorders, post-traumatic stress disorder, and other anxiety disorders. The Provincial Systems Support Program (PSSP) of the Centre for Addiction and Mental Health (CAMH) provides implementation oversight and support for the roll-out of the program. The program is coordinated through the four specialty mental health hospitals—The Royal Ottawa Mental Health Centre (The Royal), the Centre for Addiction and Mental Health (CAMH), Ontario Shores Centre for Mental Health Sciences, and Waypoint Centre for Mental Health Care—in collaboration with community partners.

OSP for the Champlain region is led by The Royal and delivered in collaboration with Family Services Ottawa, Hawkesbury and District General Hospital, Akausivik Inuit Family Health Team, CMHA-Ottawa, Pembroke Regional Hospital, Cornwall Community Hospital, Hôpital Montfort[3], Lanark Renfrew Health and Community Services, and Jewish Family Services. All therapists in this program are members of appropriate regulated health professions (e.g., social workers, nurses, psychotherapists, etc.) who have undertaken intensive CBT training and are dedicated to helping clients live their best lives. They are trained and supervised directly by PhD Clinical Psychologists with expertise in CBT. The Royal has established a regional intake service for OSP, which is currently receiving 75 to 80 referrals per week.

In the fall of 2018, The Royal received approval from PSSP to use IASP/OSP surplus funds to develop a model of coordinated access for mood and anxiety services within the Champlain LHIN and a corresponding implementation plan. In the earliest stages of planning the project, it was determined that such a coordinated access model needs to be broader in scope to support people experiencing a wider range of mental disorders and challenges. Several factors underpinned the rationale for this decision, including:

- the anticipated requests for service to a well-advertised coordinated access point from the general public for a wide range of other mental health challenges. If you widely advertise a coordinated access opportunity, the general public and various service providers supporting them are likely to call for a wide range of challenges and issues.

[2] https://www.camh.ca/en/your-care/programs-and-services/improving-access-to-structured-psychotherapy-iasp-initiative

[3] Hôpital Montfort is the province's Francophone academic hospital

- the current multiplicity of access points in the Champlain system and its sub-regions, such that one more access point would no doubt add additional confusion for the general public about where to go for help
- the strong evidence concerning co-morbidity across a wide range of mental disorders, including substance use and addictions, strongly suggesting that a narrow response with respect to mood and anxiety alone would not be consistent with best practice for people with such co-occurring disorders (Health Canada, 2001)
- the need for careful consideration of the stepped care approach embedded in the OSP program such that those requiring step-up or step-down services need smooth transitions across a range of services along the full treatment and support continuum. Importantly, as the project proceeded, the scope of the OSP program itself expanded to encompass this wider range of severity. This provides a strong rationale to fold access to OSP into a wider model of coordinated access to support connections and pathways to higher intensity services or to services for clients who do not fit within OSP.

It was this broader model of coordinated access that the wide range of stakeholders who were to be engaged in the project, would be called upon to validate.

In addition to these various considerations, the initial vision, open to subsequent validation, was for the model to span the entirety of the Champlain region. This would anticipate the future expansion of the OSP program itself, and also aim for regional consistency and equity of service delivery for all residents of the region, regardless of sub-region or community. The immediate implication was the need to connect with, and coordinate efforts across, current access points within all sub-regions of the Champlain LHIN, as well as existing planning groups working to enhance access to mental health and substance use/addictions services. The goal from the outset was to build upon and leverage the existing services and planning efforts already in place, while aiming for a Champlain-wide coordinated access model.

1.2 Provincial landscape

In 2011, the Ontario government released a comprehensive, multi-year mental health and addictions strategy entitled *Open Minds, Healthy Minds*. The strategy identified the need for timely access to health and social services—services that are integrated so people have easy access to the right mix of supports—and better coordination across health and other human services. The expressed goals were to reduce wait times for services, decrease the number of repeat emergency department visits and unplanned hospital readmissions, and improve appropriate service linkages and referrals from the justice system (Ontario Ministry of Health and Long-Term Care, 2011, p. 8). The emphasis on access, coordination and service transitions was also highlighted in the report of the Leadership Advisory Council charged with furthering the broad vision and strategic goals of the multi-year strategy (Mental Health and Addictions Leadership Advisory Council, 2017).

Partly in response to this declared priority, coordinated access is now a widely recognized component of the Ontario mental health and substance use/addictions system, with many models developed across the province in the last decade (Rush & Saini, 2016; Rush, Turner & MacCon, 2017). Although there is wide variation in operationalizing core functions, the main tenets of virtually all of these models focus on simplifying access and standardizing the intake processes within a circumscribed circle of treatment and support. Many models utilize standardized screening and assessment tools to determine service matching, priority level, and eligibility for services. As with ConnexOntario, which has had a provincial mandate to support Ontarians' access to mental health and substance use/addictions services since 1991, these various models have, by and large, focused on adult services funded through the Ministry of Health and Long-term Care (MOHLTC).

ConnexOntario holds a deep repository of information on current mental health and substance use/addictions services across Ontario, including the availability of treatment beds, support groups, crisis lines, and other related health services. Over time, it has diversified its services from its original mandate, which focused on facilitating referrals from service providers to alcohol and drug services only, to now providing information on both gambling services and a wide range of mental health services for both the general public and service providers seeking services for their clients. Currently three helplines operate—the Drug and Alcohol Helpline, the Mental Health Helpline, and the Ontario Problem Gambling Helpline. New processes have included warm-line transfer to ConnexOntario from TeleHealth Ontario and new offerings such as a flexible appointment-booking application – called DirectConnex – for service organizations. Two important recent additions to ConnexOntario's portfolio were "the transfer in of mindyourmind (an award-winning youth mental health service), and ConnexOntario's taking on of Thames Valley-based crisis calls via the Reach Out program, which provides after-hours crisis support to the Oxford, Elgin, and London-Middlesex regions." (ConnexOntario, 2017, p. 4). ConnexOntario also receives a wide variety of requests - from provincial and federal governments, Ontario LHINS, social planning bodies, service providers, researchers, other professionals and the general public—for statistical data for the purposes of planning and evaluation related to mental health and substance use/addictions treatment (ConnexOntario, 2019).

The child and youth service sector in Ontario has also identified access to services as an important strategic priority. For example, the provincial report *Moving on Mental Health*, from the Child and Youth Mental Health Lead Agency Consortium, highlighted that lead agencies within this network are "*planning to focus mostly on key processes, particularly centralized/coordinated access and intake*" (Child and Youth Mental Health Lead Agency Consortium, 2017, p. 21). Relatedly, these agencies also recognized the challenge of, and need to prioritize supports for, the transition from the youth to adult sector. The planned shift for the child and youth sector over to the MOHLTC further aligns with this direction, given the priority placed on these transitions in the first phase of the Strategy work. Given these important developments at the provincial level, it was determined at the outset of our project that any assessment of need and design features of a coordinated access model should be inclusive of services across the age spectrum, including access to services for children, youth, and their families or caregivers. Within the Champlain LHIN itself, there has been concerted planning efforts to improve access and coordination of youth services, for example, the work of the Youth Services Bureau and the Children's Hospital of Eastern Ontario (CHEO), and that of the Phoenix Centre for Children and Families.

A significant provincial development focused on improving access to mental health and substance use/addictions services for youth is the implementation of Youth Wellness Hubs, announced by the Ontario government in early 2017, and supported in the recommendations of the 2017 final report of the Provincial Leadership Advisory Council. Ten hubs are now being established, including one in Eastern Champlain, to serve as fully integrated "one-stop-shops" for youth aged 12-25, to address their needs related to mental health, substance use, primary care, education/employment/training, housing and other community and social services.

There has been significant interest and concern with respect to mental health and substance use/addictions challenges among older adults in Ontario for some time (Centre for Addiction and Mental Health, 2006; Canadian Mental Health Association Ontario, 2010; Flint, Merali, & Vaccarino, 2018). Although the MOHLTC 10-year mental health and addictions strategy identified children and youth as a key priority area, in particular for the first three years, the 2016 report of the subsequent Advisory Leadership Council also identified a key focus area on adults and seniors. The identified aim was to raise awareness about resiliency, prevention, early identification and help-seeking among adults and seniors in a range of settings including primary care, homecare, and other community settings. In their final 2017 report, the Council recommended further work to address the specific needs of older adults / seniors to ensure that mental health and addictions services fully reflect the needs of Ontarians across the lifespan. In 2017, the Ontario government announced their commitment over three years towards the implementation of an Ontario Dementia Strategy followed by development of a discussion paper to engage Ontarians in a conversation about how to improve access to quality care for people living with dementia and support those who care for them. In addition, within the Champlain LHIN, there is a draft strategy document developed by a Dementia Working Group and which proposes a 10-year dementia strategy for the region.

Lastly, the province's recently announced changes to health care planning structures and processes, as well as announcements about new investments by both the federal and provincial governments for mental health and substance use/addictions services, provides additional important context for this project. The project team viewed the current and anticipated pace of change in the provincial health system, including within mental health and substance use/addictions services, as an opportunity to contribute findings and lessons learned to inform other work ahead. For example, given several unique features of the anticipated model, such as the OSP initiative and stepped care, the important role expected for primary care, and the full age spectrum to be covered, the project team anticipated that the work would inform other coordinated access models throughout Ontario, particularly in the context of ensuring effective linkage of the OSP program to the broader mental health and substance use/addictions system of services.

1.3 Objectives

This project was guided by the following two objectives:

- Develop a model of coordinated access for mental health and substance use/addictions services across the Champlain region, including considerations for implementation and evaluation.
- Identify considerations, opportunities and challenges for eventual implementation and evaluation of a district-wide coordinated access model.

The project team was in place by early November 2018, and their work ended March 31, 2019.

2.0 Methodology/Data collection strategies

2.1 Collaborations and communications

As noted in Section 1.0, the project team recognized early on in the planning phase of the project that there was an existing group, the Champlain Mental Health and Addictions Coordinated Access Advisory Committee, that had been working on coordinated access for some time. In Fall 2018, this group was working at three separate sub-region tables: Eastern, Western, and Central Champlain. The project team established a collaborative process with each of these sub-regional planning groups, including participation in their meetings and hosting numerous meetings with the co-chairs of these committees who would then take information back to their respective groups for feedback. Steve Vachon, Director, Service Access to Recovery (SAR; formerly OAARS), also participated in these co-chair meetings, given the central role that SAR plays with respect to coordinated access to substance use/addictions services, particularly in Central Champlain. Rod Olfert from the Champlain LHIN also participated, consistent with his central role in coordinating the work of the three sub-regional planning groups and the important role of the LHIN overall in system planning for the region. These various stakeholders all agreed early on to work collaboratively toward a shared end goal; this partnership continued to the end of the project.

Given that the project was funded as part of The Royal's OSP program, a regular series of project updates was also provided to the OSP Royal Leadership Team, The Royal's OSP Partnership Leadership team, as well as The Royal's Mood and Anxiety Disorders Program, Central Intake Program, Senior Management Team and the Board of Trustees. Team members Dr. Kim Corace and Christine Slepanki provided a critical link to the internal programs, including The Royal's Central Intake, as well as to the OSP program. Dr. Melanie Willows provided the same support with respect to communications with important primary care initiatives in the region.

2.2 Population needs

The Champlain LHIN routinely collects and updates information on the population health profile of the region and sub-regions, including population demographics, important health indicators—including social determinants—and some information specific to needs for mental health and substance use/addictions services (Champlain LHIN, 2018). While a full analysis of all data potentially relevant to the development of a coordinated access model is beyond the scope of the present project, some relevant statistics were abstracted from these reports as important background information and context.

Going beyond population data, a search was also made for the most recent information available on the prevalence of mental and substance use disorders and related problems in the Champlain region (or as estimated from Ontario-level data). This information is helpful in approximating the level of need and potential service demand on a new coordinated access model of the scope envisaged; that is, all age ranges and inclusive of all mental health and substance use disorders.

Other relevant information for projecting service need is the current level of utilization of the community and hospital-based services that may collaborate on the operationalization of a coordinated access model. While some data are readily available (e.g., current caseload of the OSP service at the The Royal, which equals 80 referrals per week for an annual projection of about 4000 per year), developing a

detailed and robust estimate of caseload of all potential partners in a coordinated access model is out of scope of the present project. The project team did, however, reach out to selected programs to help augment what was available from OSP. Completing this picture of potential service utilization will be an important part of the next stage of proposal development once the full scope of service providers engaged in model implementation is fleshed out in more detail.

2.3 Components of data gathering

The project adopted a number of methods for gathering information to inform the development and validation of a central access model for Champlain mental health and substance use/addictions services, including OSP. This included an environmental scan, comprised of a document review and interviews with representatives of other coordinated access services in Ontario; a system mapping exercise that aimed to identify current strengths and gaps in the Champlain region with respect to core functions embedded within "access" to mental health and substance use/addictions services; an online survey of primary health care providers, and an engagement process that entailed focus groups and 1:1 interviews with persons and families with lived experience, primary care and other providers, and other key stakeholders. Data collection and analysis also included processes to tease out important sub-regional differences in order to understand perspectives on needs to be addressed and important variability in the required service delivery response. Each of these information gathering approaches is briefly described below.

Environmental scan

The purpose of the scan was to build upon, and learn from, any new developments since the release of two seminal reports: *Evaluation of Coordinated Access Mechanisms in Ontario* (Rush, Turner & MacCon, 2017) and *Review of Coordinated/Centralized Access Mechanisms: Evidence, Current State, and Implications* (Rush & Saini, 2016). These two reports alone provided considerable insight into coordinated access across the province, including not only the high volume of service, but also the high level of variability in core services offered and the challenges in identifying their impact due to the general lack of common data and program evaluation. That being said, the 2017 report also presented an important logic model (see Appendix G) that provided direction for the system mapping exercise, and which will also be important for evaluation of the anticipated coordinated access service for Champlain, as it is for other regions in Ontario.

Beyond review of these key documents, the environmental scan focused on a number of existing coordinated access services that had a primary mandate of mental health and/or substance use/addictions services. Nine interviews, eight by phone and one in-person, were held with a key representative of the following mental health and substance use/addictions coordinated access services that were either fully implemented or in development:

- Here 24/7 in the Waterloo/Wellington region
- The Access Point in the Toronto Region
- Ontario Shores Hospital (coordinated access in development within the Central East LHIN)
- Access Point Northwest in the City of Thunder Bay
- Reachout in London and the Thames Valley area

- East Metro Youth Services, part of the *Moving on Mental Health* initiative in the Toronto Region
- OneLink in the Mississauga Halton Region
- Addiction and Mental Health Services Kingston-Frontenac-Lennox-Addington and Hastings-Prince Edward in the South East LHIN
- Streamlined Access in York Region

These sites were chosen based on a number of criteria, including the scope and maturity of their services, their geographic similarity to the Champlain region, and/or the urban/rural nature of the respective jurisdiction served. The semi-structured interviews covered the instigating factors in development of their services; the range of participants in the design phase; the range of services offered; governance structures such as authority for intake, screening and assessment tools and processes; data systems; staffing; and linkages with other systems. The interview also probed into evaluation methods, reported outcomes, and reported lessons learned (see Appendix A for interview guide).

System mapping

A system mapping exercise was undertaken to collect information on the status of various functions related to "coordinated access" by organization and program in the Champlain region. Working from an existing template provided by Brian Rush, the project team, in collaboration with the Champlain LHIN Mental Health and Addictions Coordinated Access Advisory Committee, developed and deployed a system mapping template in the form of an Excel file. This template and the support materials for its completion, defined the key components of coordinated access, including provision of basic information, intake, triage, screening and brief assessment, navigation supports, and supports while people are on a wait list. Respondents were asked to indicate the availability of each component offered through their organization, populations served by each component, and important nuances in the provision of that service (e.g., hours, pathways or requirements to access). A range of other information about the organization and their sub-programs was also requested, for example, location, contact information, as well as a general description of services provided and populations served. Definitions of the key elements of service access are provided in Appendix B and, given the size of the Excel file, the full template is available on request. The Champlain LHIN Mental Health & Addictions Coordinated Access Advisory Committee was instrumental in disseminating the template and encouraging its completion. Given the relatively short time frame of the project and required deliverables, stakeholders were asked to complete the template within 1.5 weeks. Despite significant flexibility around this timeline and follow up contacts by the project team, the response rate was less than anticipated, with 61% of service providers returning the mapping template or providing an explanation as to why their agency/program should not be included (i.e. services are instead accessed through an existing coordinated access mechanism). Importantly, information was missing from some large service providers. In addition, the level of detail provided was highly variable. Completion of this task should be undertaken as part of the implementation phase (see below section) and, to that end, the information received to date has been bound as a separate supplementary deliverable.

Other material was also provided which is relevant to the system mapping work, for example, previous scoping of core services by the Champlain LHIN, and a mapping of children and youth services by the Lead Agencies for Child and Youth Mental Health Services in Champlain, including that created by the Youth Services Bureau as part of their role as lead agency within Ottawa for Moving on Mental Health.

Primary Care Provider Survey

An online survey was developed to allow for primary care providers (primarily physicians and nurse practitioners) to report on their experience in accessing mental health and substance use/addictions services for their clients[4], the needs within their practices in supporting clients with mental health and substance use/addictions issues, and how access to the system could be changed to better support them in caring for their clients. See Appendix C for a copy of the survey. The survey was available in both English and French and was accessible via SurveyMonkey for 19 days. A reminder email was sent part way through the survey period further encouraging participation. Attempts to identify all existing primary care providers failed to yield a comprehensive list from which to sample. As a result, a snowball process was relied upon to distribute the survey. The initial distribution list was generated from multiple sources, including the Champlain LHIN, the three sub-region tables, and the referring physician list through The Royal. Those receiving the survey were encouraged to pass on the invitation to participate to colleagues in the region. A link to the survey was also posted on Ottawa Doctors Facebook site. Due to this method of survey dissemination, the final response rate is unknown. There were a total of 149 respondents to the survey, with just over half (N=81) from the Central sub-region, 28% (N=42) from the East sub-region and 17% (N=26) From the West sub-region[5]. Other descriptive characteristics are provided in a subsequent section. Overall, the demographics of the survey respondents yielded a strong impression among the project team concerning the representativeness of sample.

Stakeholder Engagement

Focus groups and individual interviews were held with key stakeholders to understand the current system, areas that need to be improved upon, and what should be maintained in a new access system.

Service user and family members: Participants in the focus groups included 43 service users and 11 family members from across Champlain. One group discussion was conducted entirely in French. There was an even split between participants who had experiences related to substance use/addictions and participants who had experiences related to other mental health challenges, including many participants who reported struggles with both. The groups included:

- Community Addictions Peer Support Association (CAPSA)
- Parent's Lifeline of Eastern Ontario (PLEO)
- Psychiatric Survivors of Ottawa (PSO)
- The Royal's Client Advisory Council
- Children's Hospital of Eastern Ontario (CHEO) Youth Advisory Council

---

[4] The survey referred to 'patients,' since the questions were in the context of a primary health care setting. The term 'clients', however, is used to describe the survey and results, to be consistent with the broader report.

[5] Nine respondents were coded as from the Central sub-region, since they described a service with a central location even if some noted a regional catchment area.

- Citizen's Advocacy Council
- Addiction Treatment Services after-care service user group
- Hawkesbury General Hospital service user group
- Cornwall and Stormont, Dundas and Glengarry Advisory group on addictions
- Child and Youth Parent Advisory Group
- CMHA Champlain East You Matter Program
- Cornwall and District Family support group

The focus group and interview guide explored how service users/ family members accessed mental health and substance use/addictions services in the past, any positive aspects of their experiences of accessing services, and their recommended steps to improve or streamline access (see Appendix A for the detailed guide).

Primary Care Providers: Representing the primary care perspective, 44 physicians and nurse practitioners participated in focus groups and individual interviews (in addition to the primary care survey respondents above). Primary care participants represented various types of organizations including family health teams, community centres, family health organizations and family health groups, among others. The various sub-regions were also well represented, with 22 practicing in the East, 16 practicing in the West, and 17 practicing within the Central region. The focus group and interview guide for the primary care providers covered the same areas as did the Primary Care Survey (see above and refer to Appendix A for the complete set of questions).

Stakeholders from psychiatry, hospital, and community-based services: In addition to people with lived experience and primary care providers, 121 stakeholders from psychiatry, hospital and community-based services were consulted. Stakeholder input was also gathered through presentations at standing meetings and individual phone or in-person meetings. These stakeholders represented a diversity of experience and perspectives in terms of organizational affiliation and sub-region location. The focus group and interview guide covered the scope and core functions envisioned for a coordinated access model; population sub-groups for whom coordinated access would improve access; the intersection of the model with tertiary care services and existing coordinated access mechanisms and other projects within the region; and suggestions to engage local groups, including primary care stakeholders (see Appendix A for the detailed guide and Appendix D for the list of organizations consulted).

It should be noted that there were two key groups highlighted for consultation with whom the project team was not fully able to engage. While there was an attempt to book a focus group with transgender individuals, an important group from which to get input, no participants registered. The second identified group was representatives from First Nations, Metis and Inuit communities. The project team was in contact with the Indigenous Engagement Specialist at the Champlain LHIN but was unable to secure a place on the agenda of the Indigenous Health Circle Forum within the timelines of the project. Notably, First Nations and Inuit individuals were represented at a number of the other engagement sessions and a 1:1 interview was completed with a physician from the Inuit Family Health Team. In a future phase of this project, further connections with both these groups will be important.

3.0 Key findings by project component

3.1 Population and population needs

According to the most recent sub-region population health profile for the Champlain LHIN (Champlain LHIN, 2018), the region has a population of 1.3 million, with individuals aged 65 and older comprising almost 17% of the population and those aged 19 and younger making up 22%. The majority of individuals (approximately 2/3) live in Ottawa, with the remaining population distributed across rural areas (~20%) and cities and towns (~17%). Between 2011 and 2016, the Western and Eastern Ottawa[6] sub-regions experienced the highest population growth. These sub-regions also have the largest proportion of people over 65 years of age. The entire region's population is forecasted to grow, on average, by 1.1% per year over the next 10 years (2017-2026). Compared to other regions in Ontario, the Champlain LHIN region has a much higher proportion of Francophones, particularly in the Eastern sub-region. Central Ottawa is the "most culturally diverse area, with the highest proportion of visible minorities, immigrants, same sex couples, and people with a mother tongue other than English and French" (Champlain LHIN, 2018, p.7).

With respect to population health status for the region, "60.7 % of the population, aged 12 and over, rate their health as very good or excellent, and 70.6 % report very good/excellent mental health" (Champlain LHIN, 2018, p. 8). The estimated proportion of people with mental health/addictions issues was reported to be similar across sub-regions, "ranging from 18.6% in Eastern Champlain to 21.0% in Eastern Ottawa and Central Ottawa. Family members and other loved ones supporting people with such challenges, and often experiencing the need for services and supports themselves, are not included in these estimates. The rates of hospitalization due to self-harm, however, were over 50% higher in Western Champlain and Eastern Champlain compared with the Ottawa sub-regions" (Champlain LHIN, 2018, p. 8). It is also noteworthy that intentional self-harm is among the top three leading causes of death for youth in the overall region (aged 15-24).

Tables 1-3 show more detailed information from various sources that is useful for estimating the size of the population within the Champlain LHIN in need of mental health and substance use/addictions services. Although each table uses slightly different age categories and sources of data, when taken together, they illustrate the magnitude of the in-need population potentially served by a coordinated access model and collaborating organizations.[7] As above, none of these approaches adequately include family members/other loved ones in the estimates of the potential in-need population.

Table 1 provides prevalence estimates for children and youth between the ages of 4 to 17. Importantly, the estimated prevalence of "any mental disorder" is 12.1% or 25,855 Champlain children and youth in this age range. A significant percentage of this population is estimated to be experiencing an Attention-Deficit/Hyperactivity Disorder (2.5%), an alcohol or other substance use disorder (2.4%), conduct

---

[6] The LHIN report from where these statistics were drawn divides Ottawa into two sub-regions

[7] It is not possible to provide comparable data for the various sub-regions due to current data limitations (e.g., detailed population breakdown by the required age categories to estimate prevalence of need).

disorder (2.1%), major depression (1.6%), or a range of anxiety disorders such as PTSD or Obsessive-Compulsive Disorder (combined almost 1%).

Table 2 provides prevalence estimates for mental disorders among Champlain residents 15 years of age and over; estimates derived from the 2012 Canadian Community Health Survey – Mental Health for Ontario (Palay et al., under review) and projected here based on the current 2019 population of that age range in the Champlain region (N= 1,184,269). Notably, there were important exclusions during the design and implementation of this Statistics Canada survey, including First Nations people living in reserve communities, people who are homeless or institutionalized at the time of the survey, as well as members of the Canadian Armed Forces. As a result, the survey information, and any resulting projections from this survey such as provided herein, will *underestimate* the level of need in the Champlain region. In addition, the survey does not cover the full range of mental disorders, for example, Gambling Disorder, Personality Disorders, several specific Anxiety Disorders, and Dementia, and underestimates the prevalence of other disorders such as Attention-Deficit-Hyperactivity-Disorder and Psychotic Disorder, as they are based on self-report only. Opioid Use Disorders are also likely to be underestimated (see below). Lastly, this 2012 Statistics Canada survey was based on DSM-IV-R definitions of mental and substance use disorders and probably underestimate the prevalence of conditions that may now be included as "mild" or "moderate" levels of severity based on DSM-5, which was introduced in 2013. All of these important factors notwithstanding, Table 2 shows a total of approximately 108,650 individuals in the Champlain region meeting criteria for at least one mental or substance use disorder that was covered in the national mental health survey, and who are potentially in need of services and supports.

Table 1. Estimated prevalence of mental and substance use disorders among children and youth between the ages of 4 to 17 for Champlain LHIN region

Disorder (As defined by DSM-IV)	Estimated Prevalence [1] (%)	Sample Age in Years	Projection for Children/Youth Champlain LHIN [2]
Posttraumatic Stress Disorder	0.5%	4 to 17	1,026
Obsessive-Compulsive Disorder	0.4%	4 to 17	821
Attention-Deficit/Hyperactivity Disorder	2.5%	4 to 17	5,130
Any Substance Use Disorder	2.4%	11 to 17	2,466
Alcohol Abuse or Dependence	1.4%	11 to 17	1,439
Marijuana Abuse or Dependence	1.2%	11 to 17	1,233
Conduct Disorder	2.1%	4 to 17	4,309
Major Depressive Disorder	1.6%	4 to 17	3,283
Any Autism Spectrum Disorder	0.6%	4 to 17	1,231
Bipolar Disorder	0.6%	11 to 17	617
Any Eating Disorder	0.2%	11 to 17	206
Schizophrenia	0.1%	11 to 17	103
Any Mental Disorder	**12.6%**	**4 to 17**	**25,855**

[1] International meta-analysis results from Waddell et al. (2014).

[2] Based on 2019 population between ages 11-17 = 102,770 and 4-17= 205,202. Based on 2019 population projections by age from Ontario Ministry of Finance, https://www.ontario.ca/data/population-projections.

Table 2. Estimated prevalence of mental and substance use disorders among adults 15 and over for Champlain LHIN region

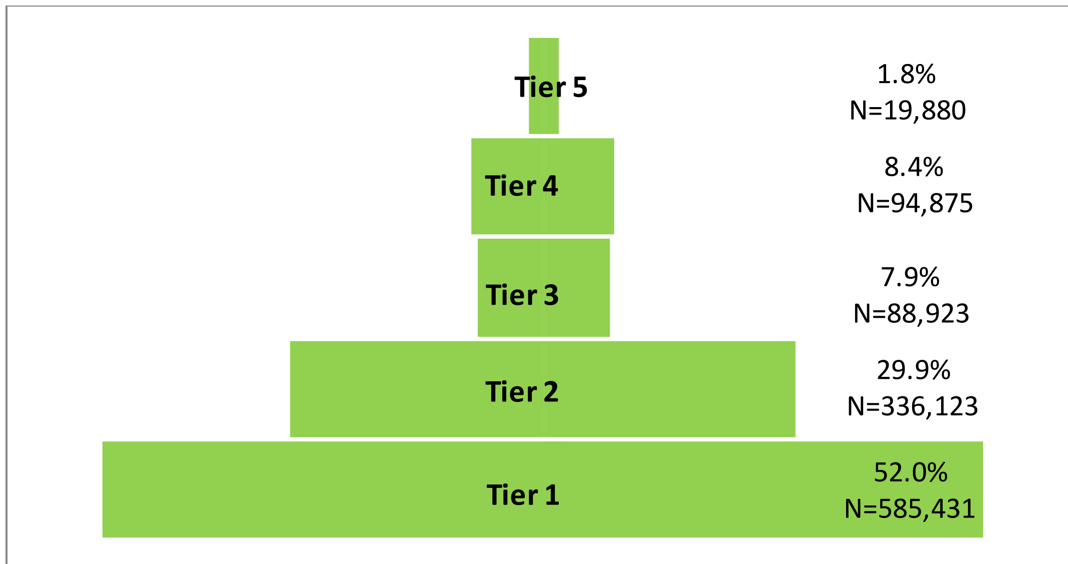
Mental Disorder (as defined by DSM-IV)	Estimated Prevalence [1] (%)	Projection for Population 15+ Champlain LHIN [2]
Major Depressive Disorder	4.85	57,466
Bipolar Disorder	1.76	20,853
Generalized Anxiety Disorder	2.52	29,859
Alcohol Use Disorder	1.87	22,157
Substance Use Disorder	1.68	19,906
Any mental and substance use disorder	**9.17**	**108,654**

[1] Unpublished data derived from CCHS 1.2 Mental Health and obtained with permission from Palay et al. (under review for Canadian Journal of Psychiatry)
[2] Based on 2019 population 15 and over = 1,184,869 (obtained from Ontario Ministry of Finance, https://www.ontario.ca/data/population-projections

A recently completed project by Dr. Brian Rush provided estimates of the need for mental health and substance use/addictions services for all health planning regions across Canada, including the Champlain LHIN. These data are just now available. The method utilized a "tiered approach" that categorized the population aged 15 and over of each region into five categories based on severity and complexity of their challenges related to mental health and substance use/addictions (see Appendix E for the severity criteria). The data are based on the 2012 Canadian Community Health Survey – Mental Health, the most recent survey of its kind in Canada, and are, therefore, subject to many of the limitations noted above. However, unlike prevalence data organized by the unique categories of mental and substance use disorders, these newly available data on population need take into account regional adjustments for age and gender, other population characteristics such as immigration status, and a regional, Statistics Canada-derived Index of Social Deprivation. The results of the estimation process are regional data based on Statistics Canada estimate of 2016 population data.

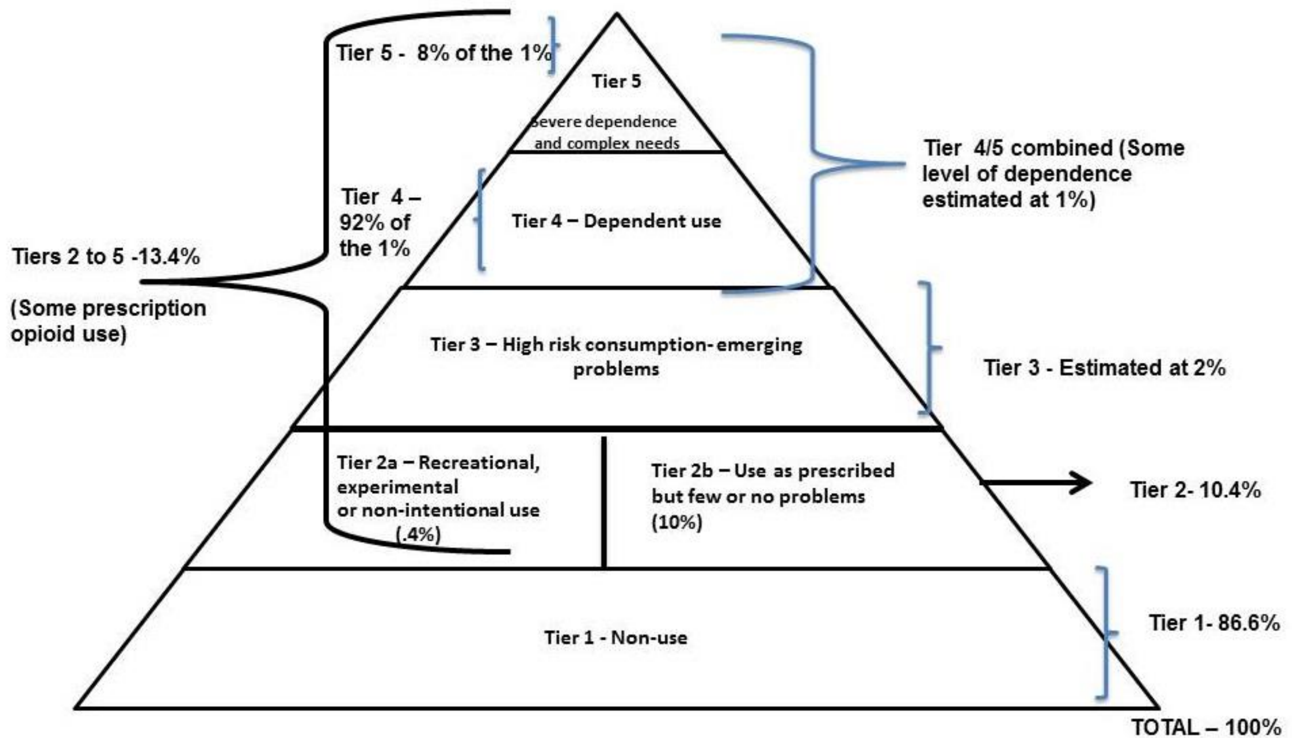
Figure 1 shows the results for the Champlain LHIN organized into a population pyramid. It is important to note that "Tier 1" refers to the target population for primary prevention efforts and not the "Tier 1" population for primary care providers, as in some classification systems used in population health work. The overall results of this approach, however, are important for estimating the full nature and scope of population needs in that they illustrate the very high percentage and numbers of people in the population categorized in "Tier 2" and "Tier 3"—people who are experiencing significant challenges and risk but who may not meet criteria for a mental or substance use disorder as defined in the survey (i.e., by DSM IV-R) and/or who indicated that they had related needs that were not fully met at the present time. This may well include people with mild to moderate levels of anxiety and depression who would be appropriate for OSP services. These data will also include a wider range of substance use-related challenges than presented above in Table 2, resulting, for example, in the inclusion of people exceeding recognized safe limits of alcohol consumption and experiencing some problems related to substance use but not sufficient for diagnosis of a substance use disorder. This population would be very appropriate for brief interventions delivered in primary care settings.

Figure 2. Percentage of the Champlain LHIN population 15 and over (estimated in 2016 at N=1,125,232) meeting criteria for different levels of need for mental health and substance use/addictions services



In the national needs-based planning project noted above, additional estimates were made of the percentage of the Canadian population meeting criteria for opioid use and opioid use disorder. The reasoning behind this was that opioid use was not well covered in the CCHS 2012 Mental Health survey. Working from the data available from the 2015 Canadian Tobacco, Alcohol and Drug Survey (CTADS), which also surveyed people aged 15 and over, a population pyramid similar to that developed for mental health and substance use disorders and related challenges was developed by Brian Rush and colleagues. The national results are shown in Figure 2 and projections made for the Champlain LHIN. Note there will be some unknown level of overlap between the individuals reported in this table and those in the broader population pyramid. Based on the 2019 population data used above for the CCHS Mental Health prevalence estimates (N= 1,184,269), one would estimate Tiers 4 and 5 (opioid dependence at varying level of severity and complexity) to be 1% or about 11,842 individuals. Tier 3 represents another 2% of the population or 23,685 individuals, and Tier 2 and additional 10.5% or 118,427 individuals, of which about 4738 individuals would be in the category of recreational, experimental or non-intentional use. There will be some overlap with the estimates of the number of people with substance use disorders or related challenges from Table 2 and Figure 1 above, to the extent they are using and experiencing challenges with multiple substances.

Figure 3. Estimated opioid use disorder and related consumption and risk factor – Canadian level



In sum, the available epidemiological data indicate that a very significant percentage of the population in the Champlain region, from children and youth, to adults of all ages, are experiencing mental health and substance use/addictions challenges and who are potential callers/clients of a new coordinated access model. Importantly, these estimates do not take into account the fact that a large percentage of individuals do not seek help for their mental health or substance use/addictions challenges. Reasons behind this includes access-related challenges, stigma and discrimination, previous unsatisfactory experiences, transportation challenges, lack of services considered to be appropriate to their needs, and the belief that they can manage without professional help. Estimates of the help-seeking population vary widely, partly by age and gender, and partly by the severity of challenges experienced. Results also vary significantly as to whether services such as primary care are included in the estimates, as this is the most commonly reported source of help, especially for mood and anxiety-related challenges (Urbanoski et al., 2017).

In his recently completed national project, Dr. Brian Rush estimated help-seeking for substance use/addictions services by severity category and yielded a high-medium-low range of estimates for each level of severity. The *medium* range estimates were 12% for Tier 2, 18% for Tier 3, 35% for Tier 4 and 88% for Tier 5, estimates likely below what would be determined for mental health services more broadly.[1] Based on this estimated level of help-seeking, and recognizing the many factors contributing to an underestimation of need in the underlying survey data, including lack of data of family members,

we would estimate from the tiered framework in Table 3, the following potential service demand for adults by tier:

- Tier 5 – 17,495 individuals
- Tier 4 – 33,206 individuals
- Tier 3 – 16,006 individuals
- Tier 2 – 40,335 individuals

To these individuals we can also approximate the level of help-seeking and potential service demand from the opioid-related estimates for those 15 and over (Figure 2), and from children and youth (Table 1). Table 3 presents the overall summary estimates and yields a total of 129,910 individuals, recognizing the potential overlap in some of these estimates, but also the significant exclusions such as family members who may themselves not meet any of the criteria for inclusion, but nevertheless needs some services and supports. Further, the number and proportion of these individuals that may flow through a new coordinated access model would depend highly on the nature of the linkage to primary care providers, since they are the most likely starting place for most people seeking help, as well as collaborative agreements put in place for operationalization of the model (see Section 5.1 concerning implementation considerations). In addition, experience in other Ontario jurisdictions (e.g., Waterloo-Wellington; Thames Valley) indicates that requests for service to the coordinated access service far exceeded initial estimates, in large part because the opening of the service itself prompted people to request assistance, including many people who had never accessed services before. In short, the estimates provided here are based on the best available data but require further estimation based on additional information and experience as they may still be a significant underestimate.

Table 3. Summary of in-need population, help-seeking and estimated service demand for mental health and substance use/addictions-related challenges in the Champlain region.

Population	Estimated Number in need of some service or support	Estimated help-seeking (%)	Estimated Service demand
Adults 15+			
Tier 5 severity	19,880	88	17,495
Tier 4 severity	94,875	35	33,206
Tier 3 severity	88,923	18	16,006
Tier 2 severity	336,123	12	40,335
Opioid -Tier 4/5	11,842	60[2]	7,105
Opioid -Tier 2/3[1]	24,423	15[3]	3,663
Children 4-17[5]	20,167	60[4]	12,100
Total	**596,223**	**21.7**	**129,910**

[1] Excluding those on prescription opioids but few or no problems
[2] Estimated at mid-point between the help-seeking for tiers 4 and 5 in the full tiered-model
[3] Estimated at the mid-point between the help-seeking for tiers 2 and 3 in the full tiered model
[4] Estimated at the mid-point between the help-seeking for tiers 4 and 5 in the full adult tiered-model
[5] The estimate for children and youth in Table 1 has been reduced 22%, based on the overlap with the age category 15-17 in the adult data, and therefore the potential for double counting across the two data sets.

3.2 Environmental scan of existing coordinated access services

The environmental scan highlighted the following areas of need and related considerations with respect to existing coordinated access services.

- *Staffing* – Staff were seen as needing strong customer services skills; a range of staff were also needed and dependent on the functions required of them, for example, responding to basic requests for information versus screening and assessment. For the latter, staff members require significant clinical training.
- *Tools* – Standardized and validated tools are needed for triage and assessment.
- *Core functions* – Sites varied in terms of what core functions are currently provided (e.g., information and referral, screening, triage and assessment). They also varied in terms of what services are included (e.g., crisis, community mental health (ICM, ACT, Housing), community addictions, psychiatric assessments). It was noted that walk-in capabilities would be beneficial in a coordinated access model.
- *Infrastructure* – Strong infrastructure was reported as critical to support service functions. This includes IT platforms with online referral capabilities and strong data reporting functions, as well as a phone system with call-centre level capabilities.
- *Challenges* –
    - *Service Provider Buy-in and Governance* – Buy-in and governance were noted as a challenge, but which can be supported, in part, by funder support and/or collaborative interagency service agreements or formal accountabilities (e.g., via the multi-sectoral accountability agreements (MSAA)).
    - *Capacity in Services* – The overall capacity of services in the region was frequently viewed as a challenge; there are some areas supporting work to look at client flow through the system and providing data on demographics and service gaps to help plan future system enhancement.

3.3 System mapping

The system mapping exercise was undertaken to collect information on the status of functions related to “coordinated access” within the region’s various mental health and substance use/addictions organizations and their sub-programs. The bulk of information received came through completion of the system mapping template distributed by the project team with the support of the key project partners. Other material was also provided which is relevant to the system mapping work, for example, previous scoping of core services by the Champlain LHIN and lead agencies in the child and youth sector.

The resulting information is being bound as a separate deliverable from the project as it will be useful in the implementation stage, and in particular, the development of a proposal for funding. At present, the nature and scope of the information provided, as well as the extent of missing information from some key programs preclude a detailed analysis of all the information obtained. We have, however, used the information to categorize existing access points for mental health and/or substance use/addictions into four groupings – provincial services, regional services, sub-regional services, and organization-specific services.

- ***Provincial services:*** Coordinated access or information and support services that have a provincial mandate. These include:
  - The services offered by ConnexOntario, which are specific to mental health and substance use/addictions)
  - Telehealth and 311 which are not specific to this sector
  - Bounceback which is a skill-building, web-based service
  - Big White Wall which is an online support service

- ***Regional services***: Coordinated access points that have a region-wide mandate to receive incoming requests from across the entire Champlain region (or beyond), and direct people to appropriate resources across the region (or beyond). These include:
  - Ontario Structured Psychotherapy for the Champlain region with access coordinated through The Royal and a specific arrangement with Hawkesbury and District General Hospital
  - Access to children and youth services through the Young Minds Mental Health Centralized Intake Service at CHEO.
  - Regional access to Geriatric Psychiatry via The Royal and Geriatric Psychiatry Community Services of Ottawa (GPSCO)[8]
  - The Royal's mental health central intake services which require a physician referral;
  - The Champlain Mental Health Crisis Line for adults – all the sub-regions contribute to the one line, which is provided for all of Champlain through a service agreement with the Distress Centre of Ottawa.
  - The region-wide Child and Youth Crisis Line through the Youth Services Bureau.

- **Sub-regional services**: Coordinated access points that are fully or primarily focused on access to services in a sub-region, including responding to the population needs and facilitating access to services within the sub-region. Examples include:
  - Access to supported housing through The Registry: The Social Housing Registry of Ottawa and several collaborating service providers, such as CMHA Ottawa and Ottawa Salus and Ottawa Community Housing. Both mental health and substance use/addictions supportive housing are included.
  - Coordinated access to Ottawa's five Assertive Community Treatment (ACT) teams with intake organized by the ACT Central Intake Committee.
  - Access to Intensive Case Management with a central waitlist operated by CMHA Ottawa.
  - Access to substance use/addictions services through Service Access to Recovery (SAR) in Ottawa as well as The Royal's Substance Use and Concurrent Disorder and RAAM program.
  - Coordinated access to mental health and substance use/addictions services in the Western sub-region (RCATS+) which is a collaborative access model between the three sub-regional substance use/addictions services – Pathways Alcohol and Drug Treatment Service (head

[8] If calls come in to the Royal/GPSCO that are not part of the catchment area, contact is made to the local geriatric team (e.g., Tri-county Mental Health Services, Mental Health Services of Renfrew County) to make the connection on behalf of the caller.

office in Renfrew), the Addictions Treatment Service at the Renfrew Victoria Hospital and MacKay Manor, also in Renfrew.
    - For Pembroke, the central referral and intake line operated by Pembroke Regional Hospital.
    - The Distress Centre of Ottawa and Region which operates the Distress Line for Ottawa and, as noted above, the regional Champlain District Mental Health Crisis Line.
    - The single point of access for child and youth mental health services for Stormont-Dundas and Glengarry, including crisis supports, operated at the Cornwall Community Hospital in the Eastern region, as well as the similar access point for Prescott-Russell operated by Valoris.

- ***Organization-specific services:*** Coordinated access points that have a mandate that is fully or primarily focused on access to services within an organization, and for the purposes of this project, within large multi-program organizations. This includes, for example:
    - For the Eastern sub-region, the Community Mental Health and Addiction Centralized Intake, operated out of the Hawkesbury General Hospital.
    - Also, for the Eastern sub-region, the Community Addictions and Mental Health Centralized Intake, Cornwall Community Hospital.
    - The Centre de santé communautaire de l'Estrie, which provides a centralized intake for five of their six sites (Alexandria, Bourget, Crysler, Embrun, Limoges).
    - the Emergency Department at The Ottawa Hospital, which directs people to appropriate in-house mental health services
    - child and youth lead agencies, including Youth Services Bureau in Ottawa and the Phoenix Centre in the Western sub-region
    - CMHA coordinated access to mental health and substance use/addictions services

These results clearly illustrate the large number of access points currently available even recognizing the significant number of organizational-level access points not included here.

3.4 Primary care provider survey results

As noted earlier, there were 149 respondents to the online survey, with the majority (54%) from the Central sub-region, and 28% and 17% from the East and West sub-regions respectively (refer to Appendix F for survey data tables not included in this section). The majority of respondents (63%) were family physicians, followed by nurse practitioners (22%). Approximately three quarters of the respondents were from family health organizations, community health centres and family health teams (with a relatively even split across these three settings). The most common services available in the settings represented by the survey included dietary (57%), social work (52%), and other mental health support (41%) services.

Consistent with the demographics of the sub-region presented in Section 3.1, survey respondents reported a higher proportion of clients in the Eastern sub-region who preferred services in French. Few clients reportedly preferred services in a language other than French or English in all sub-regions. Most survey respondents reported that less than 5% of their client population identify as Inuit, First Nations or Metis. And as noted in Table 4 below, a higher proportion of clients reportedly have mental health challenges (most commonly mood and anxiety), compared to substance use/addictions issues (most commonly tobacco, alcohol, and cannabis).

Table 4. Estimated percentage of clients with challenging mental health and substance use/addictions issues

Estimated percentage	*Mental health issues*		*Substance use/addictions issues*	
	N	*%*	*N*	*%*
Less than 5%	4	2.7	19	12.8
6-10%	16	10.8	57	38.5
11-25%	49	33.1	41	27.7
26-50%	49	33.1	17	11.5
51-75%	16	10.8	7	4.7
76-99%	10	6.8	3	2.0
100%	4	2.7	4	2.7
Total	**148**	**100.0**	**148**	**100.0**

Note: 1 missing response

This discrepancy in estimated prevalence between mental health and substance use in primary care practices may be associated with the higher rate of screening for mental health issues relative to substance use/addictions. As presented in Table 5 below, significantly more survey respondents (75%) reported either 'always' or 'usually' using mental health screening tools, compared to substance use/addictions screening tools (30%). The most common mental health screening tools used were the PHQ9 (87%) and the GAD7 (80%). With respect to screening for substance use/addiction issues, respondents most commonly reported using the CAGE (76%), followed by the AUDIT (17%). Also noteworthy is the fact that survey respondents reported using a much larger number of different screening tools for mental health issues, compared to for substance use/addictions issues.

Table 5. Frequency of screening tools used prior to referral to mental health and substance use/addictions services

Estimated percentage	*Mental health issues*		*Substance use/ addictions issues*	
	N	*%*	*N*	*%*
Never	4	2.7	31	20.8
Sometimes	35	23.5	73	49.0
Usually	53	35.6	31	20.8
Always	57	38.3	14	9.4
Total	**149**	**100.0**	**149**	**100.0**

Relatedly, a significantly higher proportion of survey respondents reported being either 'somewhat' or 'very' comfortable having the knowledge to address mental health issues (84%) compared to having the knowledge to address substance use/addictions issues (50%; see Table 6).

Table 6. Comfort level regarding knowledge to address mental health and substance use/addictions challenges among clients

Comfort	*Mental health issues*		*Substance use/ addictions issues*	
	N	*%*	*N*	*%*
Not at all comfortable that I have the knowledge	2	1.3	13	8.7
Not very comfortable that I have the knowledge	22	14.8	61	40.9
Somewhat comfortable that I have the knowledge	86	57.7	62	41.6
Very comfortable that I have the knowledge	39	26.2	13	8.7
Total	**149**	**100.0**	**149**	**100.0**

Survey respondents were also asked to describe their experiences making referrals to mental health and substance use/addictions services and supports. Not surprisingly, given the higher rates of concern with, and screening for, mental health issues, a higher proportion of clients were reportedly referred to mental health services, compared to substance use/addictions services (see Table 7). The most common mental health services to which clients were referred was outpatient services (66%), community based mental health services (excluding psychology) (65%), psychiatry services (62%), and to a member of the service provider's practice (56%). With respect to substance use/addictions, survey respondents were more likely to report referrals to outpatient services (66%), non-residential community-based services (50%) and residential community-based services (50%).

The most common referral modality used by survey respondents at the time of the survey, for both mental health and substance use/addictions services, was phone/fax referral. The vast majority (81%), however, preferred an electronic referral integrated with their own EMR. And finally, with respect to the ease with which they can make referrals for mental health and/or substance use/addictions issues, most respondents (77%) reported that their experience was "much more challenging" than it is for other services where specialist treatment and/or advice is required (i.e., for physical health problems).

Table 7. Estimated percentage of clients referred for specific mental health and substance use/addictions services

Estimated percentage	*Mental health issues*		*Substance use/addictions issues*	
	N	*%*	*N*	*%*
Less than 5%	12	8.2	42	28.2
6-10%	26	17.8	38	25.5
11-25%	32	21.9	20	13.4
26-50%	32	21.9	26	17.4
51-75%	28	19.2	13	8.7
76-99%	14	9.6	8	5.4
100%	2	1.4	2	1.3
Total	**146***	**100.0**	**149**	**100.0**

* 3 missing responses

In terms of access to services, the most common sub-groups for whom access to mental health services is a challenge were individuals with low socioeconomic status/lack of health insurance coverage (due to prohibiting access to psychologists for mental health services), and individuals with a personality disorder. With respect to substance use/addictions services, access is reportedly most challenging for individuals with low socioeconomic status and those who are difficult to engage and/or are lacking readiness for treatment. And finally, while most survey respondents identified a range of specific issues with respect to service access, these problems seemed to be generally more pronounced for mental health services (see Figures 3, 5-8 below). The one exception was the perceived existence of clear feedback loops between primary care providers and these services, which were generally viewed as poorer for substance use/addictions services (see Figure 4).

Figure 4. Proportion of survey respondents reporting that wait times are acceptable for mental health and substance use/addictions services

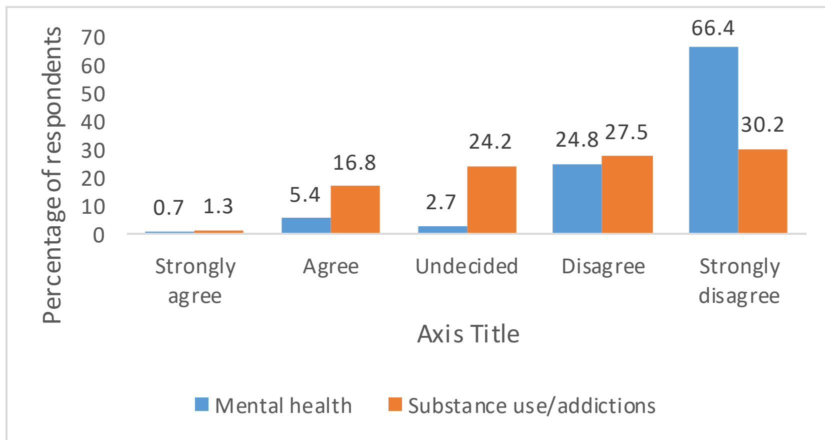


Figure 5. Proportion of survey respondents reporting 'a clear feedback loop' between mental health and substance use/addictions services

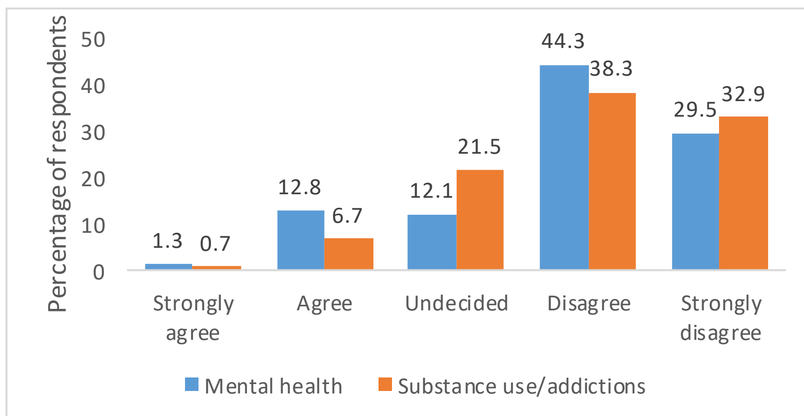


Figure 6. Proportion of survey respondents reporting knowledge about where to refer for mental health and substance use/addictions services

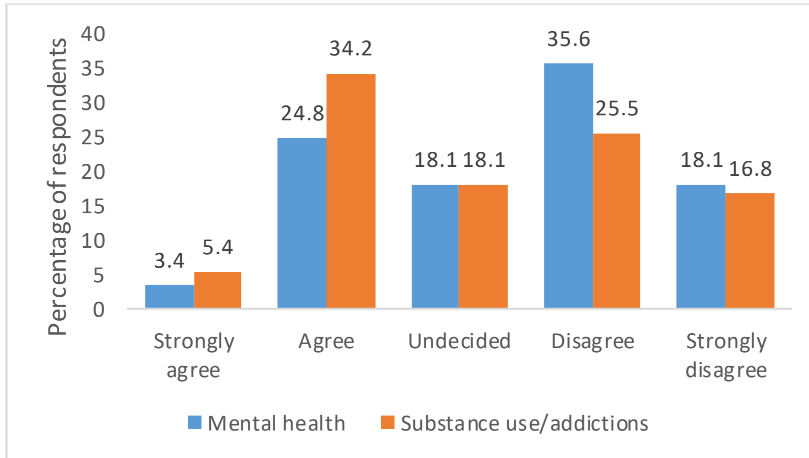


Figure 7. Proportion of survey respondents reporting that appropriate mental health and substance use/ addictions services exist

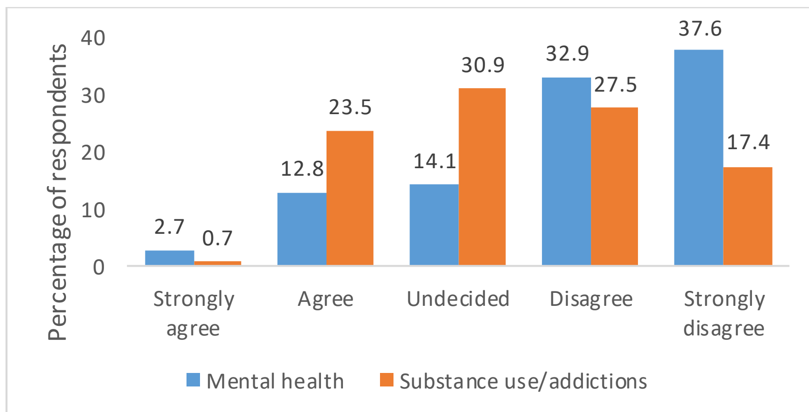


Figure 8. Proportion of survey respondents reporting that referral processes for mental health and substance use/ addictions services are effective and efficient

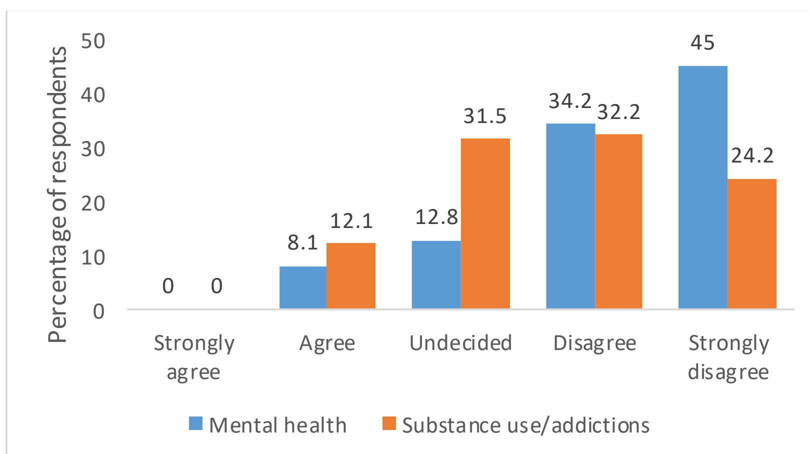
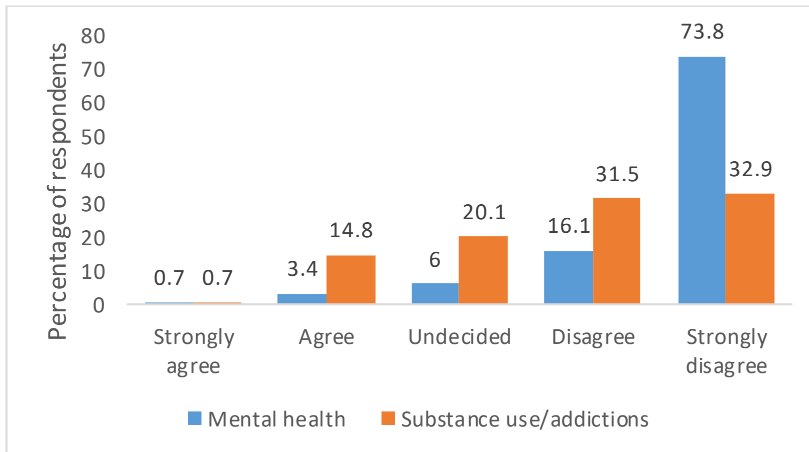


Figure 9. Proportion of survey respondents reporting that access to mental health and substance use/ addictions services is 'quick and immediate'



Survey respondents were also asked to share any other concerns/feedback they had with respect to supporting clients with mental health and substance use/addictions issues. Respondents most commonly focused on the perceived lack of access to psychiatry services and the need for timely access to services and supports to navigate the service system (refer to Appendix F for all coded themes related to this question).

3.5 Summary of feedback from stakeholder engagement sessions

This section presents common themes derived from a qualitative analysis of notes from stakeholder engagement sessions.

In terms of the **scope of a coordinated access model**, stakeholders were generally supportive of going broad, both in terms of the types of services to include ("no categories of services wouldn't fit"; "everything should be included"), and the level of intensity ("from primary care to acute services"). Stakeholders also frequently referred to a "hub and spoke" model as an example of a way that this broad scope could be realized, whereby a core service, accessible through a single point, or multiple, integrated points is inside the "hub", with well-coordinated "out-reach" and "in-reach" from and to services across the region ("the spokes"), including through existing and well-established central access points and pathways such as for Housing and Geriatric Psychiatry.

Expanding on ideas related to scope, stakeholders identified a range of different service and support functions within a new coordinated access model, that from their perspective, would be important in meeting current needs for improved access, as follows:

- **Screening and assessment** (28 sessions, 10C, 6E, 4W, 9R[9]) – Stakeholders identified several benefits to the use of common, standardized and staged screening and assessment tools, including supporting triage and treatment planning, avoiding duplication (including the need for clients to keep repeating their history), and providing a means to monitor outcomes. A 2017 project was noted (Pathways to Better Care) which found that 102 different screening and assessment tools were being used by MHA providers in Champlain. Stakeholders also identified the need for timely screening and assessment, options to complete them (e.g., in-person, over the telephone), and the ability to take into account the client's context.
- **Centralized access** (21 sessions; 9C, 3E, 3W, 6R) – stakeholders generally supported a centralized access model, including one contact number to connect ("*calling separate agencies doesn't work – there are too many resources that have to be contacted separately*.")
- **Intake/Referrals** (20 sessions; 10C, 3E, 4W, 3R) – stakeholders identified the need to keep referral processes as simple as possible (e.g., limited to one page forms) but still allowing for the referrer to provide additional context ("*when referral forms are too standardized, with only check boxes, then you continue to have silos and boxes patients must fit into*"). Mechanisms to "close the loop" on referrals were also recommended (e.g., redirect inappropriate referrals, communication back to the referrer).
- **Information/Navigation** (18 sessions, 8C, 3E, 2W, 6R) – Stakeholders felt that an information/navigation function would be particularly valuable for service users and service providers ("*because the system is fragmented and not integrated").* One stakeholder recommended the use of a "decision-tree" or algorithm to facilitate information sharing/navigation.
- **Collaborative/integrated care** (12 sessions; 5C, 3E, 2W, 2R) – Stakeholders advocated for a number of different examples of collaborative/integrated care including co-location with primary care providers, mechanisms to support shared accountability, access to expert consultations, and development of collaborative care plans ("*where everybody knows what everybody else is doing for the patient").*
- **Crisis supports** (11 sessions, 6C, 2E, 1W, 2R) – Crisis supports, and particularly emergency departments, were identified as the first point of contact for many service users, in their view making them an important function to potentially include in, or be linked to, a coordinated access model. While some stakeholders suggested that the inclusion of this function could potentially minimize duplication in the system ("*does every agency need to have their own crisis line*"?), at least one stakeholder felt that a coordinated crisis function is "*not a great idea to include for Champlain*", given its high cost (and noting how current programs use well-trained volunteers instead of paid staff).
- **Counselling/therapy** (10 sessions; 5C, 2E, 3R) – Some stakeholders felt that specific clinical interventions should be directly available through a coordinated access model (**"***if opening the front door, we need to offer [supports]").*
- **Linkage supports** (10 sessions; 2C, 4E, 4R) – Stakeholders identified the need for a "*warm hand-off between services*" and "*walking with clients throughout the access journey*".

[9] C = 'Central sub-region'; E = 'East sub-region'; W = 'West sub-region'; and R = 'Regional'

- **Peer supports** (10 sessions; 5C, 1E, 4E) – Peer support was identified as an important resource to be integrated into a coordinated access model, not only to facilitate system navigation ("*peers need to know what the resources are*"), but as an important support to service users, for example, while waiting for services).
- **Access to Psychiatric/Psychologist/Specialist Consultations** (10 sessions; 5C, 2E, 1W, 2R) – Stakeholders provided a number of examples of methods and types of access to psychiatric/specialist consultations, including through e-consults and on-call services, for both one-off and ongoing support ("*one appointment is not always enough*"), for follow-up consultation, for expertise in psychopharmacology, and for psychology and community psychiatry.
- **Waitlist management** (9 sessions; 2C, 2E, 3W, 2R) – including feedback on estimated wait times.
- **Hub model** (9 sessions; 6C, 3R) – "*Hub and spoke model is best, no door is the wrong door*"
- **Interim supports** (8 sessions; 5C, 2E, 1R) – Stakeholders identified the need for interim supports to "bridge gaps" between services. Specific examples included suggestions to primary care providers for interim supports provided under their supervision, peer supports, and specific interventions for more complex clients.
- **Walk-in services** (8 sessions; 2C, 3E, 1W, 2R) – e.g., "*We need an open-door place for young people to drop in and connect."; "a drop-in clinic"*
- **Stepped care** (6 sessions; 3C, 1E, 1W, 1R) – Stakeholders identified the need to "*move people in and out of services as people's needs change*" and "a *quick way for people to step back up if/when needed."*
- **Family/caregiver supports** (6 sessions; 1C, 2E, 3R) - "*because they are suffering too*"
- **Education/capacity building** (3 sessions, 3R) – A small number of stakeholders suggested that a coordinated access model could also help build capacity amongst primary care providers in particular, to address mental health and substance use/addictions issues ("*it would be helpful for primary care to be sent emails about rounds, education opportunities around mental health and addiction at The Royal*"), and for service providers more generally ("*an education centre*").
- **Outreach** (2 sessions, 1C, 1R, 1E) – a small number of stakeholders raised concerns that a coordinated access model may not reach the individuals most in need without an outreach component ("*Don't predicate the intake system based on the people who ask for help."; "You need an assertive presence and not a passive intake.")*

Stakeholders were also asked to describe specific population sub-groups for whom access to mental health and/or substance use/addictions services is particularly problematic and/or for whom coordinated access might improve access. The groups/issues identified, beginning with the most common, were:

- severe and persistent/complex mental health problems
- youth ("*confusing points of entry*"; "*more support for addictions than mental health*")
- borderline personality disorder ("*stigmatized from service*"; "*intensive users of the system…everyone's 'hot potato'")*
- the 2SLGBTQ+ community
- older adults
- indigenous/cultural groups
- substance use/addictions clients

- transitional aged youth/young adults (“*when they age out they do not meet the eligibility criteria of the adult system*.”)
- precariously housed/homeless
- developmental disabilities (“*don’t quite fit in anywhere*”)
- autism Spectrum Disorder (“*there is a lot of bounce-back between agencies*”)
- concurrent disorders (“*particularly disadvantaged*”)
- low SES (lack of insurance coverage for services)

Stakeholders also discussed other considerations in developing and implementing a coordinated access model. The most common area pertained to the need to recognize that a coordinated access model will not address (but may help mitigate, to some extent) existing gaps in mental health and substance use/addictions services (including for the sub-groups identified above). Stakeholders also identified the need to address issues related to flow, with one cautioning that “*we don’t want to move the bottleneck down the line*.” Stakeholders were also commonly concerned with the need for locally accessible services and low-barrier admission criteria.

The need for more integration between services was also frequently discussed, both in terms of collaboration (“*break down the silos*”) and with respect to providing more holistic care (“*we need services that will look at co-morbidities*”). Relatedly, stakeholders called for better communication between service providers, and particularly among primary care providers, noting how important it is that service providers are kept abreast of the status of a client’s care journey. It was suggested that the use of an electronic health record (EHR) would support this communication, but it was also acknowledged that this would require significant work to address the privacy issues that would no doubt be encountered when implementing an EHR across multiple service settings (and, in this case, sectors). Among primary care providers, however, EHR solutions remained a strong option, consistent with their feedback in the survey. Stakeholders also frequently highlighted the need for a coordinated access model to be simple and responsive (“*I don’t want to be given another telephone number to call*”), including with respect to referral processes (“*Too many pages and forms. It’s too stressful. They need to make it simple*.”).

Stakeholders, particularly primary care providers and service users and their families, stressed the importance of the coordinated access model to be staffed by people with strong clinical skills: *(“Staff with a minimum SW; regulated health professional might have a place, depends on the trust between the service providers (i.e., do I trust your assessment?) – but if they were doing assessment need a higher level of staffing….*”; “*Staff with vast knowledge of services and clinical sense*”; “*making sure the frontline people assessing are the best, most experienced staff so the triage is a good assessment”; “if they were doing assessment, need a higher level of staffing*”; “*people on the other end of the phone have enough education/training to deal with all situations – especially those with disabilities – need patience and understanding of level of disability”*).

Stakeholders commonly identified the need for a coordinated access model to be informed by a stepped care approach (“*We need the ability to move people in and out of services as people’s needs change*”; “*We need to build in a quick way for people to step back up if/when needed*”). It was also recommended that a model be staffed with clinically trained service providers who also have extensive knowledge of

the service system and who are "kind", "caring", and "non-judgmental." The importance of client choice was also frequently emphasized ("*we need to provide them with a menu of options*").

Finally, with respect to implementation, stakeholders most commonly recommended a staged approach "*to work out the kinks*". Examples included starting the model as a pilot and starting "*with a part of it, then move on to another. Don't build a universal model of everything*").

4.0 Synthesis of findings, proposed key elements, and validation process

This section synthesizes the feedback across the primary care provider survey and the various stakeholder engagement sessions, including those undertaken in the sub-regions. We first summarize the needs to be addressed, followed by the project team's recommendation for core elements of the coordinated access model.

4.1 Needs/issues to be addressed

With respect to areas to be addressed by a coordinated access model, many of the common themes reflect challenges with respect to service coordination and capacity:

- The system is too complex and wait times are too long
    - services, processes, and eligibility criteria are always changing
    - it is difficult to know where to start, or which service is the correct service; there is no main repository of information on services
    - lack of capacity to meet population needs and lack of clarity on wait times

- System and services lack coordination
    - need for more coordination with clear entry points and more clearly defined pathways
    - existing access points operate in silos
    - clients are required to repeat "stories" across services;
    - access processes can be frustrating or a deterrent to acquiring services
    - clear and consistent feedback loops are needed
    - an inefficient system leads to multiple referrals for like services, "to see what sticks"

- Emergency Departments are often the default access into the mental health and substance use/addictions system
    - lack of urgent, but non-emergent, mental health and substance use/addictions services
    - high threshold of need for access to services
    - clients need to "prove" they are sick enough, or are told to return when "sicker"

- Gaps in services for specific populations, such as people with dual diagnosis, concurrent disorders, borderline personality disorder, autism spectrum; and challenges with equal access to services across the Champlain region. This would also include, but not be limited to, other populations such as Francophones, 2SLGBTQ+, First Nations, Inuit, and Metis, newcomers and refugees and veterans.

- Transitions are challenging
    - across the age spectrum
    - between acuity levels
    - between program offerings
    - back into service

- Access to specialized/regional services such as psychiatry and eating disorders is challenging; as well as fee-for-use services such as psychologists and private counselling. Lack of access to

specialized services was reported as particularly challenging in the Eastern and Western sub-regions.

- In addition to the challenge accessing specialized services, some additional challenges noted by stakeholders in the sub-regions included:
    - internet, and even phone access, is not always available (lack of reliable connections, cost)
    - transportation challenges for many people (weather, cost, time required)
    - cultural and language considerations, particularly in the Eastern sub-region
    - low literacy levels of clients served

- A model needs to include access to information for services beyond mental health and substance use/addictions; additional focus is needed on social determinants of health

- The model needs to be staffed by a range of professionals with skills and experience appropriate to the functions and activities they are required to perform, especially a high level of clinical training among those performing screening and assessment functions, and specifically regulated health professionals, such as nurses and social workers.

- There is a need for more standardization of screening and assessment tools as well for better and more common data for planning, performance measurement and evaluation.

4.2 Proposed key aspects for model design

To address the above needs, five key aspects of a coordinated access model were identified across the wide range of information gathered:

- scope of services, supports and populations
- key functions and related staffing
- means of access including technology
- connectivity and supports for transitions
- data for planning, gap analysis and performance assessment

4.2.1 Scope

Populations

The coordinated access model should cover the entire Champlain region, with sensitivity in design to unique features of the sub-regions, and with capacity to respond to requests from outside the Champlain boundaries for regional and provincially-designated services (e.g., residential addictions treatment). Further, the model should be inclusive of all people with mental health and substance use/addictions concerns, with no specific diagnostic exclusions, and include people experiencing challenges across a wide range of acuity/severity levels and across the age continuum. Importantly, the combined feedback strongly suggested that the model include access to services for family members themselves. Also important is the required capacity to deliver fully bilingual services (French and English) and, to the extent possible, in other languages that may be the person's mother tongue. Services, and

the staff who provide them, should be culturally sensitive and competent. There should also be strong linkages to culturally specific services for the region's Indigenous population, as well as for newcomers and refugees.

Services
An essential step in developing a model of coordinated access is to identify which services are to be included and which will be considered out of scope. Important services considered to be out of scope include crisis, housing, and court-ordered forensic services.

Crisis: A decision was made to exclude crisis services from the coordinated access model, despite its salience within the engagement sessions; opting instead for strong two-way linkages between crisis services and the coordinated access model. This reflects the experience of existing coordinated access services that have included crisis services (i.e. the crisis phone number being the same as the coordinated access phone number), whereby the crisis line demanded a considerable amount of staff time and resources, leaving less resources for other types of coordinated access functions. Service users and family members generally felt that keeping the two services separate made sense, but worried that users of the model may not know the difference between a crisis and a service access issue. This highlights an important communications challenge during implementation, and the need for strong connections and clear pathways between crisis services and the access model.

Housing: Many of the housing services within Champlain region are part of existing coordinated access processes maintained by The Registry: The Social Housing Registry of Ottawa and several collaborating service providers, such as CMHA Ottawa, Ottawa Salus and Ottawa Community Housing. This includes mental health and addiction supportive housing. The primary challenges identified in the consultation process were lack of housing stock and lack of coordination of the various health and social services that are provided to people living in the various levels of housing units. These challenges notwithstanding, the access system for housing was generally reported to be running smoothly and it was decided that it is best left out of scope. However, as with crisis services, there needs to be strong two-way linkages between the coordinated access model and housing services. Those accessing the coordinated access model may need housing, or have questions regarding housing, and there will be a need to direct these information requests accordingly. Additionally, feedback from the housing sector highlighted the need for quick access to support services for those within housing who need further supports in order to maintain their housing.

Forensics: Court-ordered forensic services are also excluded from the proposed coordinated access model, since these services have clearly defined pathways of access, and are part of the criminal justice system. Other forensic based services that have more open eligibility criteria and less well-defined means of access, such as the Sexual Disorders clinic and the general forensic clinic, could potentially be included.

In addition to these three current access points and pathways there are other regional and sub-regional coordinated access processes that will need to be remain intact but be well-linked to a new coordinated access model. This includes the current systems in place for children and youth, geriatrics, Assertive Community Treatment Teams (ACTT) and Intensive Case Management (ICM). See also the diagram on page 45 which illustrates the collaborative relationship expected between these existing access points and pathways and the coordinated access model.

4.2.2 Key functions and related staffing

Closely related to the questions and issues related to scope are the service delivery functions proposed for eventual operationalization in the coordinated access model. In reviewing the feedback from the wide range of stakeholders engaged in this project, and the learnings from the environmental scan, the following functions are proposed:

- **Provision of basic information** about available resources and how to access them. This function, noted by all stakeholder groups, including service users, family members, and primary care providers, as lacking within the current system, is critical to a coordinated access model for the region. Provision of information should include services beyond mental health and substance use/addictions, such as financial supports, education and employment resources, housing and shelter information, and services within other service sectors, such as the developmental sector.
- **Linkages to Primary Care** for those who are not connected. Primary care is often a mechanism for accessing mental health and substance use/addictions services and is an ongoing support throughout service provision. As such, the model will also need to account for the additional barrier to accessing services faced by clients without a primary care provider and may provide specific supports to clients, such as assistance to register for Health Care Connect.
- **Differential levels of screening and triage** based on common, standardized tools, but also recognizing that, in some instances, the incoming request for access to services will come with considerable existing information, such as presenting situation, past service trajectory, and assessment results. Thus, it will be important to build into the screening and triage process the option for quick referral to direct services based on immediacy, clarity of need, and match to services, thereby addressing current frustrations voiced by service users and many system stakeholders regarding the need to wait for an assessment even though the service need is already clear and/or assessment information is already available from other services. Such differential screening pathways, however, need to be well-communicated to all concerned parties and built into policy and procedure manuals. In addition, the screening tools and processes need to include provincially mandated tools.
- **Stage 1 assessment and service matching** for those not immediately directed to service (i.e., for those whose needs and appropriate match are not clear after a brief screen). Level 1 assessment occurs within the coordinated access model based on common, standardized assessment tools and processes to support service matching. The person may be linked to other services for assessment if a more complex/specialized assessment is needed beyond the scope of the CA model itself. Both the screening and assessment functions signal the need for clinically trained and competent staff engaged in the delivery of these functions.
- **Provision of supports while on waitlist** for those services where a wait may be extensive. There may be a role for peer and family supports in this function, as well as for technology-based solutions such as Big White Wall, Bounceback and internet-based CBT (iCBT).
- **Waitlist management** to support transparent information sharing, to the people seeking help and service providers alike, on wait times, thereby facilitating equitable access to services among providers. This would entail a specific group of providers reporting to a centralized source on wait times, and client movement through the list. Such waitlist management would

require formal agreements and the scope of this function in the overall Champlain system would depend on the extent of collaboration and/or the nature of the governance model.

- **Feedback from eventual service provider** to staff of the coordinated access model about the outcome of the service match (i.e. whether the person has started service), as well as the outcome of the service provision (i.e., if more service is needed at either a higher or lower intensity level). This function responds to the expressed need for prevention of people falling through the cracks in the system and not accessing the service they need. The function also clearly responds to the need for features of the model to operationalize stepped care (see also section 4.2.4 below).

Also, as noted above, based on stakeholder feedback, and consistent with this full range of access-related functions, the model needs to be staffed by a range of professionals with skills and experience appropriate to the functions and activities they are required to perform, especially a high level of clinical training among those performing screening and assessment functions, and specifically regulated health professionals, such as nurses and social workers.

4.2.3 Means of access/technology

The coordinated access model needs to be ***multi-modal in terms of access mechanisms***, including as many low-barrier means of access as possible. This over-arching strategy reflects the caution voiced by stakeholders that what may work for one person might not necessarily work for another. Likewise, people with lived experience and family members forecasted that even individual clients may prefer different methods depending on what point they are in their recovery journey. Means of access should also reflect the inclusivity of the model, including the ability for people in need and/or family members to self-refer, and ensuring that requests for access to services are not restricted to a small range of referral sources.

- *Telephone access*: ***One region-wide 1-800 phone number*** is recommended, with the number open to anyone who is looking for information on services, including service users and family members, as well as service providers and primary care professionals who are looking for service information for their clients. Beyond information only, the phone line would be one of the mechanisms to begin the next steps in screening and triage for those who are looking for services and supports for mental health or substance use/addictions related challenges.
- *E-referral integrated into EMR:* ***Technology solutions that allow a direct linkage*** between a primary care provider's electronic health record and the coordinated access model was flagged by the primary care providers as being very important for an efficient referral process to the mental health and substance use/addictions sector. This technology could also serve as a mechanism for feedback to the provider regarding the outcome of service matches, wait times and other relevant information. The project team attended two demonstrations of technologies (Ocean and Greenspace) that would allow for this linkage illustrating the current availability of such technology.
- *Online referral form:* Feedback from service users indicated that making the initial phone call to access services can be intimidating at times and may be a deterrent to seeking help. An ***online***

referral form is also needed to allow people to provide some information and receive a call back from the coordinated access model. This mechanism could also be used by community service providers who wish to refer clients for additional services through the coordinated access model.

- *Walk-in capabilities*: The coordinated access model should not be restricted to phone or other technological means of access but also include ***physical locations that are available for people to walk in***, without an appointment, to access information as well as screening, triage and basic assessment (when appropriate). This walk-in capacity could include locations that are a core part of the coordinated access model itself, as well as strong linkages built into existing walk-in services (e.g. Rapid Access Addiction Medicine (RAAM) clinics, walk-in mental health counselling) to allow for people to connect to the coordinated access model in places where they are already accessing services. The screening and assessment functions of walk-in services that are part of the coordinated access model itself need to be consistent with those used in other points of access in the model.
- *Chat/text: **Texting or chat lines*** were highlighted by service users as being particularly low barrier and less intimidating than other means of contact, especially for younger service users. This mechanism of access will need further consideration, as there may be privacy, confidentiality, and other challenges with implementation, including IT-related barriers within key collaborating partners.
- *Connections via outreach services:* Acknowledging that there are some populations that may not access services through any of the above listed methods, pathways need to be built with existing ***outreach services*** (e.g. those working in street outreach, staff within shelters, drop-in centres, etc.) or perhaps through designated outreach staff of the coordinated access model itself, to ensure that the model is truly accessible for all.
- *Communication from coordinated access to service match**:*** Various technology/database solutions can be considered when looking at how the coordinated access model interacts and communicates with its service provider partners to facilitate service matches, ensure feedback loops, and allow for client re-entry. Depending on the extent of the collaboration across community partners, this may include a common IT platform.

4.2.4 Connectivity/transitions to and through services (stepped care model)

As noted above, referrals to the coordinated access model will be open to all, including self-referral, with no exclusion criteria based on referral source. The model will provide information-based services to everyone looking for assistance, and will provide services such as screening, triage, assessment, and waitlist functions to those for whom it is appropriate and dependent on the governance model and scope of collaboration.

To address the areas of needs expressed by stakeholders, including but not limited to considerations of access to the OSP program, key elements of this model are those that facilitate stepped care. To this end, the model must have built in feedback loops, from both the service provider within various sectors to the coordinated access model, as well as to the initial referral source and service user. Feedback can occur at multiple points, including after the initial service match and after service provision. This, in

conjunction with an easy link-back into the coordinated access model, provides the means to support the person with the next step in their recovery process.

4.2.5 Data for planning, gap analysis and performance assessment

One of the important core functions of a coordinated access model articulated in the provincial review of mental health and substance use/addictions central access services (Rush et al., 2017) is the provision of information required for planning, gap analysis and performance assessment. This is greatly facilitated by having the "hub" and core collaborating organizations work together on common service definitions, agreements for common tools and processes, and, ideally, an electronic platform of information collection and exchange. With such common tools and processes in place, the strengths and gaps in the overall system can be rapidly and routinely summarized, over literally hundreds if not thousands of individuals and families seeking services and supports.

Related to this is the need for the coordinated access model to have capacity for its own evaluation and quality improvement processes, using both internally and routinely collected data as well as periodic feedback from a wide range of stakeholders (see section 5.3 below for more on evaluation).

4.3 Feedback and validation

The project team presented the model's key elements for feedback and validation to 84 stakeholders from the following groups:

- The Royal's Family Advisory Council
- Champlain LHIN Mental Health and Addictions Coordinated Access Advisory Committee
- Champlain LHIN Mental Health & Addictions Coordinated Access Advisory Eastern Sub-region Committee
- Champlain LHIN Mental Health & Addictions Coordinated Access Advisory Western Sub-region Committee
- Primary care providers
- Ontario Structured Psychotherapy (OSP) partners
- Hospital representatives
- Community service provider representatives
- Community Addictions Peer Support Association (CAPSA)
- The Royal's Client Advisory Council
- Addictions and Mental Health Network Champlain (AMHNC)
- The Royal's Youth Psychiatry out-patient service user group

This wide range of stakeholders expressed considerable support of the overall scope of the proposed model and the specific populations which can better be served by the model; although some additional populations were emphasized, including veterans, 2SLGBTQ+ and those who are pregnant. The reference to those who are pregnant may reflect many factors, including concern for both pre-and post-natal mental health services, FASD or opioid or other drug use, as well as infant or toddler mental health. There was also considerable support for the proposed key functions (see more below). Three options were presented for how these functions could best be organized, recognizing the need to

balance common standards and processes that would require some degree of "centralization" with the need to allow for some flexibility and diversification to address unique strengths and needs across the three sub-regions. Important context, when considering these options, was the consistent theme expressed from the sub-regional planning tables throughout the project, and reinforced in the validation process, of the importance of acknowledging and building upon the work they had already completed. This became an especially important consideration for the Western sub-region planning group since they had made more progress towards a concrete model of access to their regional services. Essentially, the three options presented during the validation phase to the sub-regional planning groups varied in the degree of required commonality and flexibility among the participating service providers.

Of the three options presented, stakeholders were most supportive of what is best described as a "hub and spoke" model (see Section 5.1), with the "hub" including multiple points of access within and across the sub-regions, with common features such as the 1-800 line, staff experience and competencies and tools and processes, and variability, in terms of walk-in and outreach options. This hub and spoke approach was subsequently well-received by others engaged in the validation process, including service users and families. It was noted that this approach "helps to keep from overloading a particular service" and allows existing pathways to be built into the local "spokes" during implementation. This allayed concerns that the proposed model was going to interfere with, and perhaps disturb, some well-established access points and pathways (e.g., access to Geriatric Psychiatry).

Stakeholders also reinforced other key benefits of the "hub and spoke" model, including its potential for connections to primary health care services, and in particular, with newly proposed Ontario health teams; greater coordination of services; increased access to regional services addressing higher acuity needs; better distribution of services across the LHIN; retention of "*local flavours and diversity of services*"; reduced need for clients to tell their stories multiple times; and better data, system management and overall care for clients.

In addition to validating the multiple access points embodied in the hub and spoke model, stakeholders also validated the need for multiple means of access, including a single, 1-800 phone number for the system (one stakeholder recommended an easy-to-remember, three-digit number) and web-based access (to address concerns related to stigma). Another caution related to regional variations in access to telecommunication networks (i.e. mobile coverage, internet access) within the Champlain LHIN, which may require Champlain-wide mapping during the implementation stage. Stakeholders reinforced that all points should facilitate timely, low-barrier, and equitable access (with respect to both populations and geographic regions) and allow for service users to connect directly (and ideally, anonymously, if preferred).

As alluded to above, stakeholders reinforced that planning and implementation of a coordinated access model will need to be appropriately linked to processes and access pathways already in place in the Champlain LHIN, including Young Minds Centralized Intake (it was recommended that coordinated access staff will minimally need to be able to explain the CAPA assessment and the Choice appointment), Telehealth, housing, crisis services, HealthLinks, Renfrew County Addictions Treatment Service+, Ottawa Children's Treatment Centre's new "The Access Line", and OSP. One stakeholder suggested that the principles for coordinated access may also serve as a model for other areas of the health system (e.g., simplified processes and documentation for inpatient bed transfers).

There was also general agreement that a coordinated access model should be informed by a stepped care approach, which was seen to provide a "*safety net*" for clients, particularly in relation to mechanisms to support re-entry into the system. Strong linkages to primary care providers were seen as particularly important, and would require a team-based approach, acknowledgement that not all service users will have a primary care provider, and implementation of mechanisms, and ideally capacity building, to facilitate follow-up and ongoing support for mental health and substance use/addictions issues within the primary health care context. Relatedly, stakeholders reinforced that stepped care will require good feedback loops between the coordinated access system, service users, service providers and primary health care providers, which would ideally be supported by the implementation of common electronic platforms and/or integration with existing platforms/electronic health records. This, in turn, will require significant planning, including considerations related to privacy.

Stakeholders generally supported the functions proposed for the coordinated access model. With respect to the provision of information about services, stakeholders cautioned that the model will need to include a mechanism to ensure that this information is kept up to date. Stakeholders also reinforced that staff will require an appropriate level of clinical training and expertise, particularly as it relates to screening, assessment and treatment matching. There was also support for a standardized assessment tool/process for treatment matching (no doubt different for primary substance use/addictions and mental health concerns), which one stakeholder group recommended should be an "*implementation priority*." It was also reinforced that implementation of staged screening and assessment will need to acknowledge and account for the fact that many service providers in the Champlain LHIN have already "*spent a great deal of time and resources on implementing screening and assessment*" (in reference to the work on the PSSP-supported screening and assessment tools for substance use/addictions).

Finally, stakeholders provided a number of additional recommendations related to the implementation of a coordinated access model, such as the need for a staged/phased approach. Their feedback is reflected in Section 5.2 below.

5.0 Going forward

5.1 Collaborative vision

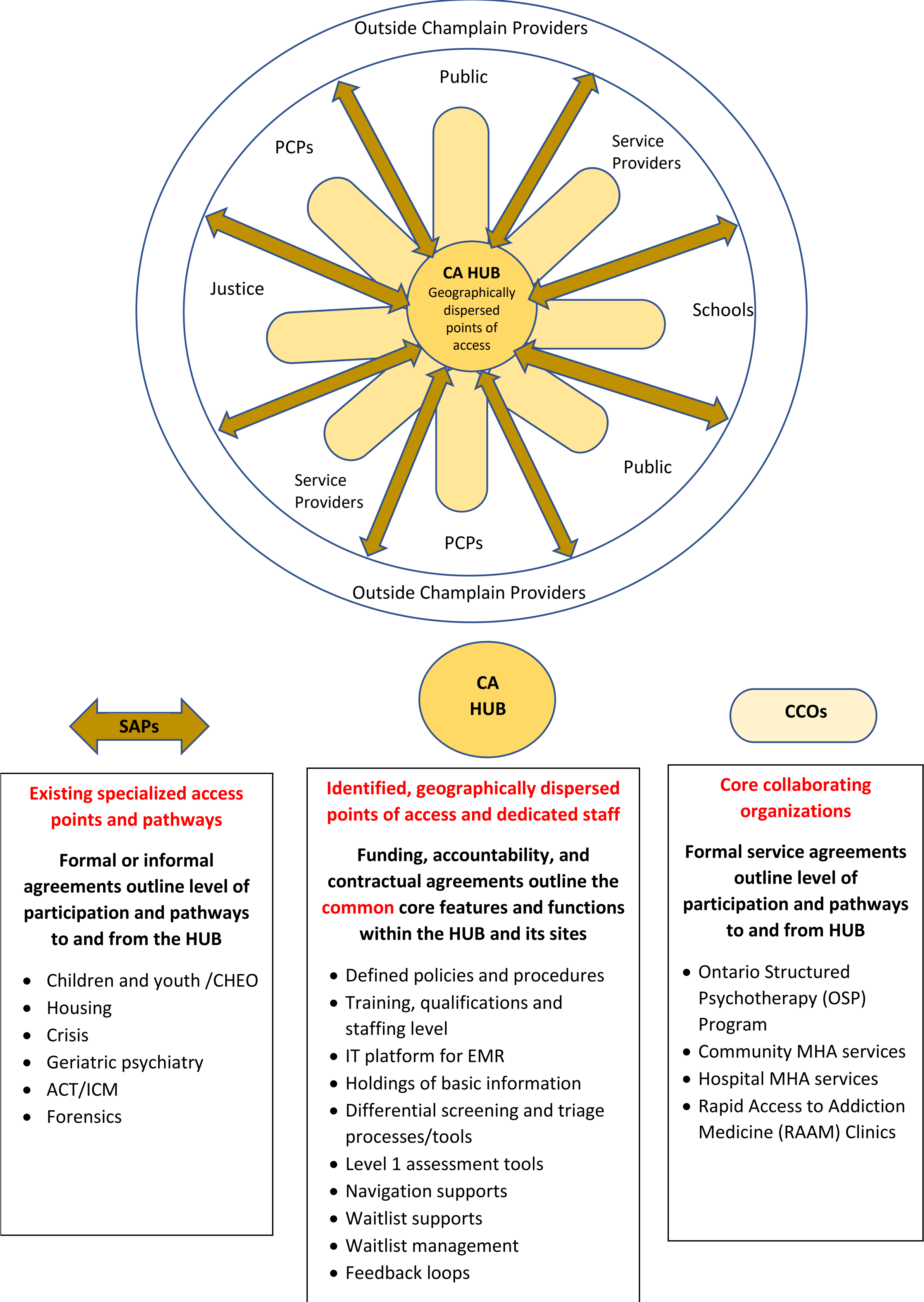
To support operationalization of the "hub and spoke" model that emerged from the data collection, analysis and validation process described above, a conceptual diagram is presented in Figure 9 that illustrates some core features of what is envisaged as a very collaborative, coordinated access model for the Champlain region. The centre of the model, the Coordinated Access Hub, is comprised of identified and ***geographically dispersed points of access*** with dedicated funding, staff, and policies and procedures, including one or more formal accountability agreements to its funder(s). Further, the geographically dispersed points of access must be connected by contractual agreements with central oversight. The main feature to note with respect to these agreements is the commonality of many essential features and components across the dispersed but dedicated points of access within the Hub, including the elements required for stepped care, such as the screening, triage, assessment and matching functions as well as navigation supports and feedback loops. There is also commonality in the use of regulated health professionals for triage, screening and assessment-related tasks.

Closely connected to the Coordinated Access Hub are the inner spokes, representing the various organizations across all sub-regions of the LHIN that will work as its closest partners; referred to in the diagram as Core Collaborating Organizations (CCOs). These organizations would participate in the model through formal service agreements with the Hub as well as, no doubt, a wide range of informal arrangements as time and experience evolves. Large organizations with multiple programs may serve more than one role in the model (i.e., access point plus service delivery). The list of services in the diagram are meant as examples only. Examples of items in these formal or informal agreements would be criteria for matching prospective clients to their services based on the screening, triage and assessment tools; and differential screening pathways for urgent cases or those whose referral has come with considerable information indicating the optimal next step. Participation in wait list reporting and management and other data collection and performance measurement processes would also be part of formal agreements.

The darker arrows in the diagram, or the outer spokes, refer to specialized access points and pathways (SAPs) that are outside the Coordinated Access Hub itself, but which are closely linked to it, largely by informal agreements, although they could be formalized into service agreements if deemed appropriate by concerned parties. Importantly, these arrows may extend outside the Champlain region itself, indicating the need for connectivity of many of these specialized points of access and pathways to and from service providers, and their clients and families, from outside the region (e.g., access to Geriatric Psychiatry). Several examples are listed based on the system mapping exercise, although these are noted as examples only and subject to more detailed information gathered during the implementation process.

Lastly, the larger inner circle contains the people of the Champlain region and its sub-regions, as well as the many potential sources of referral and contact with the Coordinated Access Hub and its collaborators. The service providers within this large inner circle are also potential sources of service and support of people meeting a match to what they have to offer.

Figure 10. Schematic diagram of the collaborative model for coordinated access for mental health and substance use/addictions services for the Champlain region



5.2 Implementation steps and considerations

This section presents key steps and considerations for the implementation of the identified coordinated access model for Champlain region. These considerations are based on the findings from the environmental scan, as well as feedback collected from primary care providers, and other key stakeholders, including service users and families. Insights gathered during the validation sessions are also included.

Proposal development

A key next step will be to seek support to develop a concrete proposal for funding; a proposal guided by the key principles related to service design and operations that were articulated by the stakeholders engaged in this project (e.g., client-centred, accessibility, equity, accountability, collaboration and communication, quality, timeliness, efficiency). It will also be important that the scope of the model, including the functions and populations to be included, be realistic and reflect consistently expressed concerns voiced by stakeholders that increasing access to services does not address the ongoing fundamental challenges with system capacity; indeed, capacity concerns may well be exacerbated for a period of time. To this end, the next stage of proposal development should assess more fully the likely demand for services and the required service capacity and infrastructure to meet this demand, on both a regional and sub-regional basis. Although the estimates provided here are the best possible at the present time, they may well be a significant underestimate of demand on the service after it opens and becomes widely promoted.

The system mapping exercise should also be completed and more fully analysed as this has potential to highlight current resources that might be re-directed from access-related functions towards direct service. Opportunities to minimize duplicate data entry should also be identified as this may also free up resources for service delivery. The preliminary work done during the current project to investigate new technologies, including but not restricted to transfer of information by EMR or other means, needs to be a key part of the next phase of work. Similarly, service delivery pathways specific to different client and family needs must be established and with a view to minimizing or eliminating wait times between stages of triage, screening, assessment and service provision. A staffing plan will also need to be developed and costed, and in a manner consistent with the range of functions to be fulfilled and corresponding staff roles and responsibilities, including those requiring regulated health professionals. In this next stage of proposal development, it will also be necessary to engage/re-engage with stakeholders in this planning phase (e.g., sub-regional planning groups and others actively working to improve services for specific populations such as Francophones, youth, 2SLGBTQ+, First Nations, Inuit, and Metis, older adults/geriatrics). This should also include close communication and coordination with Ottawa Public Health (OPH) which is working with many community partners to increase awareness of mental health and substance use/addictions services and address gaps identified through consultations with youth, young adults, parents, and people with lived experiences. This renewed engagement process would ensure shared expectations during the development of a robust, inclusive funding proposal as well as a continuation of the engagement process that facilitates buy-in and support for eventual implementation (see also below). This includes a strong role for service users and their families, as well as primary care providers in proposal development. Finally, reflecting the defined scope, the proposal will also need to clearly identify both service delivery/operational requirements (e.g., physical space, infrastructure, staffing, technology, and mechanisms) and system planning functions (e.g., data

collection, linkages to planning bodies, and needs-based planning and gap analysis that accounts for changes in population needs and growth).

System capacity – challenges and opportunities

Stakeholders consistently and wisely cautioned that a coordinated access model will not resolve basic capacity challenges, reinforcing the need for reasonable stakeholder expectations (as above), and careful planning and prioritization to ensure that coordinated access does not "*move the bottleneck down the line*." These gaps in capacity can also be mitigated by leveraging existing provincial resources and technology, including, for example, Web-based self-help, skill building and self-management/guided interventions, including Bounceback and Big White Wall, and videoconferencing technologies such as OTN. Implementation of any Internet-based interventions will need to be accompanied by thoughtful communication with service users and their families given expressed concerns from these stakeholders that such interventions are viewed as "inferior". It will also be important, when selecting IT solutions for information and communication management, to consider the extent to which any platform can be integrated with those used in the larger health care system to facilitate referrals, service matches, feedback loops, and client re-entry into the coordinated access hub. This will also ensure that data entry is not needlessly duplicated across different systems, which is a current issue in the system, resulting in resources being diverted from direct service delivery.

Needs of specific population groups

In addition to ensuring a population health approach to overall planning and estimation of required capacity, there are particular groups that will deserve particular attention during the implementation phase to ensure their needs are being considered and addressed. This includes but is not necessarily limited to the needs of marginalized populations such as those who are homeless, as well as newcomers and refugees. The needs of people whose first language is French (and Francophone communities in general), as well as First Nations, Inuit and Metis will also require special consideration. For example, ongoing dialogue with stakeholders planning improvements to services for Indigenous people will be particularly critical. A particular focus will also need to be given to the 2SLGBTQ+ community, as well as to veterans and those who are pregnant. As noted above, this will require some additional consultation during proposal development.

Change management and leadership

Several stakeholders recommended that a staged/phased approach be adopted in implementing the coordinated access model, acknowledging the complexity of design and the work required to engage and support service partners and community members in new processes. Examples offered of phased approaches included the MERIT program, whereby implementation proceeds geographically outward over time, staged implementation by referral source, and focusing first on LHIN-funded agencies. Strong leadership, similar to that within the current project focused on model development, will also be crucial.

Regardless of the approach, the model will need to be sufficiently flexible to respond to changes in the broader health system, particularly the plans to restructure the system that were recently announced by the provincial government and the move to bring children and youth services under the umbrella of the MOHLTC. Clearly, stakeholders closely connected to the child and youth sector need to be closely involved in future planning and proposal development building upon significant work already underway

by the Youth Service Bureau, CHEO and that of The Phoenix Centre for Children and Families. Stakeholders also advised of the need for a strong communication and marketing strategy to launch the service, to ensure that service providers, service users and the general public are generally aware of the service, its scope, mechanisms to access (and re-access) it, referral and intake processes, and intersections with other points of access and service pathways available in the region. Some stakeholders may also require education related to key elements such as staged screening and assessment and stepped care, to ensure reasonable expectations regarding options for treatment matching while also respecting the role of client choice.

Lastly, the change management process needs to be particularly attentive to concerns expressed by stakeholders, particularly in the sub-regions, that service providers have built networks and work closely together to ensure service users are supported. These relationships need to be preserved and leveraged in the implementation phase.

Collaboration and governance

The coordinated access model will require a clear governance structure, accountability requirements, and other mechanisms to support partnerships in operationalizing, and where appropriate, contributing to governance processes, including service users, their families and primary care providers. This will be particularly important as it relates to specific functions of the coordinated access model, including commonality of screening, triage, and assessment tools and processes and waitlist management. While stakeholders were generally supportive of, and invested in, the coordinated access model, some did caution that it will still be important to consider not only building upon current strong partnerships but also past and present challenges with collaborative agreements (e.g., the natural tendencies to protect resources). While this can be supported, in part, by incentivizing engagement (e.g., highlighting the potential for increased service capacity, cost savings), and by clearly defining roles and responsibilities, ultimately, partnerships may well need to be supported by “contractual” arrangements.

Mechanisms will also need to be in place to engage organizations that provide services which are further removed from the coordinated access model (e.g., existing crisis services, housing, geriatrics) but that have a vested interest in its functioning. In addition, there are other present and emerging plans for improving access to services for specific populations and there will be a need to work closely with the responsible planning bodies to ensure maximum coordination. An example includes the work of Ottawa Public Health to enhance communication and system navigation for mental health and substance use/addictions services in the region, especially for youth. Close communication and collaboration with groups working to improve access to service for Ottawa’s Indigenous population will also be important.

Evaluation, performance measurement and outcome monitoring

Plans to develop and implement a coordinated access model will need to include mechanisms to collect data for the purposes of evaluation, performance measurement and outcome monitoring (see also Section 5.3 below). This will require consideration of infrastructure availability (e.g., IT platforms to collect/analyze data; dashboards for reporting), data collection tools and measures (e.g., screening and assessment tools that can measure change over time), and other infrastructure and resource requirements (e.g., human resources). In identifying indicators of success it will be important to consider that a coordinated access model does not necessarily - at least at the beginning - reduce wait times or save costs, but that it should give a clearer understanding of wait times and gaps in service availability.

Provincial implications

From the outset, the nature and scope of this project was grounded in a proposition that Champlain-wide, coordinated access for people with mild to moderate mood and anxiety disorders, the target population for the emergent Ontario Structured Psychotherapy program, was best planned and delivered in the wider context of access to services for a wider range of mental health challenges as well as substance use/addictions issues. The rationale was based on multiple factors, such as levels of co-morbidity, best practice for those with concurrent disorders, and the need for access services to facilitate a stepped care approach. As well it was important to be consistent with a clear recommendation in the final report of the provincial government's Mental Health and Addictions Leadership Advisory Council such that: "*the coordinated access approach should be person-centred and include linkages to the full continuum of Council recommended core services across the lifespan…"* p. 9, 2017). The validity of the project's initial proposition was confirmed consistently by the wide range of stakeholders from which input was sought on model design for the Champlain region, including primary care and other service providers and people with lived experience and their family members. Thus, the most significant provincial implication of the present project is for the provincial roll-out of the OSP program, including coordinated access strategies, to be closely connected to efforts to improve access and coordination to the mental health and substance use/addictions system in Ontario. Consistent with overall systems approach, the present project raises important implications for the role of the Youth Wellness Hubs as part of an integrated approach to coordinated access for mental health and substance use/addictions challenges in Ontario. This includes, but is no doubt not limited to, articulation of the role of walk-in services within Ontario's basket of core services for BOTH youth and adults as well as how best to leverage scarce resources such as personnel, space and other infrastructure that might be combined in an appropriate way to provide services to people across the lifespan without sacrificing the core needs and principles in the Youth Wellness Hub initiative.

Lastly, given the scope of the proposed model of coordinated access across the lifespan and all levels of acuity and severity, there are also implications for the design of other coordinated access models in Ontario, and for identifying the optimal relationship between ConnexOntario and these regional access services. Unquestionably, ConnexOntario has been a significant provincial asset with respect to facilitating access to mental health and substance use/addictions services. The scope of its services has evolved consistent with many expressed needs of Ontario service providers and the people whom they serve. At the same time, however, a plethora of regional coordinated access services have evolved (Rush & Saini, 2016; Rush et al., 2017) responding to local, regional and provincial needs. This includes the often expressed need for access to local, detailed knowledge of complex system nuances; the need for coordinated access services to include a more robust range of clinical functions and staff expertise than is currently available in ConnexOntario; the need for IT/EMR-linkage to primary care providers; and the need for multiple means of access that go beyond phone and Internet-based services such as walk-in. While the Western sub-region has worked closely with ConnexOntario to facilitate access to their services, significant concerns were raised in the other regions about relying on ConnexOntario as the central access point/1-800 line for the whole region and for the reasons identified above. That being said, this only begs the question as to how best to leverage the resources and expertise within ConnexOntario in a way that complements the regional-level coordinated access models, and vice versa. Examples of important provincial opportunities include the application and potential enhancement of tools developed by ConnexOntario and used in selected coordinated access models across the province;

tools such as its call-back feature which has been very successful in reducing no-show appointments in the Thames Valley system.

5.3 Evaluation strategy

As the coordinated access model gets further defined (including scope, stages of implementation, operational details and partnership arrangements), it will be important to develop, refine and embed an evaluation strategy into subsequent proposals for funding. This strategy should include:

- A developmental evaluation process that focuses on the achievement of key outcomes from an accountability point of view, as well as goals related to ongoing, internal quality improvement.
- A program logic model, building upon the provincial model (see Appendix G), and illustrating the core components of the coordinated access model, its key processes, and immediate, intermediate and longer-terms outcomes to be achieved.
- A context and contribution analysis that examines critical aspects of the internal and external program environment that are critical to success, as well as the assumptions embedded in the various linkages in the program logic model and risks associated with false assumptions.
- An evaluation strategy table that identifies and prioritizes stakeholder needs and key audiences, key evaluation questions, and corresponding indicators and data collection strategies, the required evaluation budget, and the internal and external structures and processes for using the results.
- Plans to implement relevant data collection processes, including collection and dashboard display of key service delivery (process) indicators such as:
    - initial response time, and time to service
    - outcome of transitions and efficiency of stepped care processes
    - perceptions of care, as well as direct feedback from service users, family members, and service providers
    - outcome indicators (e.g., wait time reduction, successful service transitions, increased penetration to in-need and high need population)
- Preparation of reports and presentations to key audiences and decision-makers, including linkage to internal quality improvement processes

6.0 Summary and Recommendations

Originally commissioned in the fall of 2018 to focus on improving access to services for people experiencing mood and anxiety-related challenges, the project scope was broadened on the basis of several critical factors, including the wide scope of anticipated requests for service to a well-advertised coordinated access point; the current multiplicity of access points in the Champlain system and its sub-regions; the strong evidence concerning co-morbidity across a wide range of mental disorders, including substance use and addictions; and last, but not least, the need for careful consideration of the stepped care approach embedded in the OSP program such that those requiring step-up or step-down services need smooth transitions across a range of services along the full treatment and support continuum.

Given these important considerations, the project aimed to go beyond mood and anxiety disorders specifically to:

- Develop a model of coordinated access for mental health and substance use/addictions services across the Champlain region; and
- Identify considerations, opportunities and challenges for eventual implementation and evaluation of a district-wide coordinated access model.

The model was to span the entire region, embrace all age groups and levels of acuity and severity, and, as noted, both mental health and substance use/addictions. A collaborative process ensued that engaged Champlain Mental Health and Addictions Coordinated Access Advisory Committee and its sub-regional planning tables in the Eastern, Western and Central regions. The goal from the outset was to build upon, and leverage, the existing services and planning efforts already in place, while aiming for a Champlain-wide coordinated access model. Recognizing the uniqueness of certain aspects of the project, for example, the need to incorporate all age ranges and levels of acuity and severity (consistent with the target population and stepped care goals of OSP), a number of areas were identified that would probably have provincial implications.

A multi-method approach was taken to gather relevant information, including an environmental scan of a number of coordinated access models in the province; a system mapping of current access-related services and functions across the Champlain region; a survey of primary care providers in the region; and an extensive engagement and consultation process that included people with lived experience and families (i.e. potential service users), primary care providers and relevant service providers. First analysing the information from each source separately, and then collating, themes emerged with respect to the needs to be addressed, scope, key functions and related staffing requirements, means of access and issues related to connectivity and transitions (for example, feedback loops). A process then ensued to return to the various stakeholder groups to validate our summary of “what we heard” as reflected in these key features of a coordinated access model. This consultation and validation process resulted in a conceptual model of a Champlain-wide coordinated access model consistent with the objectives of the project and including a wide range of considerations for implementation and evaluation.

In synthesizing the information and decisions regarding the various aspects of the final proposed model, we aimed for a balance between sometimes diverse views gathered from a widespread, detailed

consultation. **But, in the end, priority was given to the expressed needs and opinions of future service users (i.e., people with lived experience), including family members.**

Recommendation 1: In drawing the project to a close, we recommend that a process now be put in place to move from this model development phase to a proposal for funding, with the following considerations:

- the conceptual model developed in this project and reported here should form the core component of the funding proposal;
- respecting and addressing the many considerations identified above for both proposal development and subsequent implementation;
- ensuring the same level of engagement and leadership be brought to bear, as was evidenced in the implementation and reporting on this phase of model development.

During the next stage of proposal development, there are several important steps, including:

- Engagement/re-engagement with key stakeholders and regional planning bodies
- Consultation with respect to some key populations, for example, children and youth, 2SLGBTQ+, Indigenous communities, newcomers/refugees and veterans
- Further work on estimates of need and help-seeking projections
- Completion of the system mapping process
- Development of required formal and informal service agreements with organizations/programs
- Development of service pathways, according to level of need, and ensuring smooth transitions and minimal to no wait time between steps. This includes feedback loops.
- Further work investigating IT and other infrastructure options
- Development of a staffing model consistent with key functions, roles and responsibilities
- Costing the model being operationalized
- Development of a communications strategy
- Development of a change management strategy
- Finalizing an evaluation plan

Recommendation 2: Given several unique features of the proposed coordinated access model, such as the grounding in the OSP initiative and stepped care, the important role expected for primary care, and the full age and severity spectrum to be covered, we recommend that this work be used to inform other coordinated access models throughout Ontario, particularly in the context of ensuring effective linkage of the OSP program to the broader provincial mental health and substance use/addictions system of services.

Recommendation 3: We further recommend a formal presentation of the project and its results to key audiences, including PSSP in CAMH, the project funders, the Ontario Ministry of Health and Long-Term Care, the provincial OSP Leadership and other provincial stakeholders.

7.0 References

Canadian Mental Health Association Ontario (2010). *Mental health and addictions issues for older adults: Opening the doors to a strategic framework.* CMHA Ontario. Toronto, Ontario.

Centre for Addiction and Mental Health (2006). *Responding to older adults with substance use, mental health and gambling challenges: a guide for workers and volunteers / CAMH Healthy Aging Project.* CAMH: Toronto, Ontario.

Champlain LHIN. (2018). *Sub-region population health profiles. Technical report*. Ottawa, ON: Author.

Child and Youth Mental Health Lead Agency Consortium. (2017). *Moving on mental health: Provincial priorities.* Available from: http://www.hnreach.on.ca/service-files/MoMH-Report-EN-Print.pdf.

ConnexOntario. (2017). *ConnexOntario 2016/2017 annual report*. London, ON: Author. Available from https://www.connexontario.ca/annual-reports.

ConnexOntario. (2019). *ConnexOntario services*. Available from www.connexontario.ca/information-services.

Flint, A., Merali, Z., and Vaccarino, F. (Eds.). (2018). *Substance use in Canada: improving quality of life: substance use and aging.* Ottawa, Ont: Canadian Centre on Substance Use and Addiction.

Health Canada. (2001). *Best practice for concurrent mental health and substance use disorders*. Ottawa, ON: Author. Available from http://publications.gc.ca/collections/Collection/H39-599-2001-2E.pdf.

Ontario's Mental Health & Addictions Leadership Advisory Council. (2017). *Realizing the vision: better mental health means better health.* Toronto, ON: Author. Available from http://www.health.gov.on.ca/en/common/ministry/publications/reports/bmhmbh_2017/vision_2017.pdf.

Ontario Ministry of Finance. Population Projections for Ontario's 14 Local Health Integration Networks (LHINs) by Age and Sex, 2018-2041. Last modified July 1, 2018. https://www.ontario.ca/data/population-projections

Ontario Ministry of Health and Long-Term Care. (2011). *Open minds, healthy minds: Ontario's comprehensive mental health and addictions strategy*. Toronto, ON: Queen's Printer for Ontario. Available from http://www.health.gov.on.ca/en/common/ministry/publications/reports/mental_health2011/mentalhealth_rep2011.pdf.

Palay et al. (Manuscript under review for Canadian Journal of Psychiatry). Prevalence of mental disorders and suicidality in Canadian provinces.

Peer Support Canada. (2019). Accessed from http://peersupportcanada.ca/.

Rush, B.R., Turner, R., & MacCon, K. (2017). *Evaluation of coordinated access mechanisms: Evaluation report.* Addiction and Mental Health Ontario. Toronto, Ontario. Available from https://amho.ca/wp-content/uploads/Coordinated-Access-Evaluation-Report.pdf.

Rush, B.R. & Saini, B. (2016). *Review of Coordinated/Centralized Access Mechanisms: Evidence, Current State, and Implications.* Toronto: Addictions and Mental Health Ontario. Available from https://amho.ca/wp-content/uploads/full_report_-_review_of_coordinated_centralized_access_mechanisms-_evidence_current_state_and_implications.pdf.

Urbanoski, K., Inglis, D., & Veldhuizen, S. (2017). Service use and unmet needs for substance use and mental disorders in Canada. *The Canadian Journal of Psychiatry*, *62*(8), 551-559.

Waddell, C., Shepherd, C., Schwartz, C., & Barican, J. (June, 2014), *Child and youth mental disorders: Prevalence and evidence-based interventions*. Children's Health Policy Centre, Simon Fraser University, British Columbia. Available from https://childhealthpolicy.ca/wp-content/uploads/2014/06/14-06-17-Waddell-Report-2014.06.16.pdf.

8.0 Appendices

Appendix A: Interview Guides

Interview Guide for Environmental Scan

Date:

Hub:

Representative name and position:

1. **Expressed need**—probe - mental health and addictions, children/youth/adult; where did the need arise from (e.g., providers versus people with lived experience); geographic region; link to First Nations, opioid crisis.
2. **Type of model**—what was the process for developing? Who was at the table? Type of model – single door, multi-site, hub-spoke, regional lead?
    - **Implementation strategies—**probe - if staged approach how did they stage it (for example, by sector, by target population, by sub-region, physician/psychiatry involvement)?
    - **Core functions** – probe for quick triage, versus screening, versus assessment; wait list management and case management and follow up
    - **Scope of services** – (same as above re screening and assessment); Probe as to capacity for direct booking into other services—MH&SU/A, MH only, community vs hospital-based services; what is under the umbrella? Stepped-care?
    - **Authority for intake** –authority for intake to various providers, do providers have final say?
    - **Demographics** – probe re: expected versus actual and what they plan to track if they haven't started. Any equity considerations? e.g. French /English/other language capacity. Regional? Indigenous population? Youth, adult, seniors?
    - **Assessment tools and processes** – screening versus assessment; probe addictions and mental health
    - **Data systems** -- probe re anticipated use of information for system planning – i.e. gaps in service
    - **Staffing**--# of staff, specialities, clinical, registered health professionals; current versus desired requirements.
    - **Linkages with other systems**—i.e. Connex, other local coordinated access systems
3. **Evaluation methods and reported outcomes**—probe – do they monitor response time? Wait times? Waitlist management?
4. **Reported lessons learned**—What works well? What doesn't work well? If you could do it all over again, what would you do differently?

Interview Guide for Service Users and Family Members

The Ministry of Health and Long-Term Care has asked The Royal to develop a model for Regional Coordinated Access for Mental Health and Substance Use/Addictions Services, working in collaboration with the Champlain LHIN. We are booking meetings with service users and family members to collect feedback on **accessing mental health and/or substance use/addictions services for yourself or your loved one.** This is an opportunity to share your insights about how you currently access services, and how you would like to see access for these services change in the future. This feedback will be integrated into the model development and implementation plan, to be completed by March 31, 2019, and presented to the Ministry for consideration as they plan for the future of health services in Ontario.

Discussion topics:

1. How have you accessed mental health and/or substance use/addictions services in the past? (Probe: modalities, barriers in existing system, special circumstances for sub-populations, knowledge of existing CA models, communication and feedback loops).

2. What have been some of the positive aspects of accessing service? What do we want to ensure we maintain/do not lose when planning for access in the future? (probe: human interactions, modalities, transitions between services, touch points – number of contacts needed for triage and assessment, information flow – communication and feedback loops).

3. What would be some concrete steps we could take to improve or streamline the process of getting services that are needed? (probe: one number/number of “doors”, reduction in barriers, scope of services included, pathways to access – primary care provider referrals, professional service referrals, etc., core functions of access hub, touch-points for triage and assessment, linkages to crisis and other services).

System stakeholder interview guide

Discussion Questions for Provider and Stakeholder Consultations

- What would you see a coordinated access program doing? What would be the core functions (e.g., screening, assessment, triage, system navigation, etc.)?
- What would you see as the scope of the coordinated access program? How do you envision the authority for intake?
- How do we determine scope? What services are incorporated into the model?
- Which population sub-groups are not well represented in the current service populations for whom coordinated access would improve access? What are the current challenges with regards to access? How should we ensure that the model meets the access needs of these sub-populations?
- How is the model going to fit within the hospital programs? What challenges currently exist that should be taken into account in model development?
- What is the role of tertiary care and what would be the benefits of coordinated access to the system?
- How do you see a regional model fitting in with existing coordinated access mechanisms within Champlain? Within the province (i.e., ConnexOntario)?
- How do we engage local groups? What is the best way to connect with primary care?
- How does this align with current projects within the LHIN? What things are on the horizon that need to be accounted for?

Interview Guide for Primary Care Providers

- What percentage of your patients do you think have mental health and/or substance use/addictions issues? How often do you refer them for specific mental health and/or substance use/addictions services? (probe: acuity level, needs, service types, demographics – age, language needs, other barriers, comfort/knowledge in addressing mental health and/or substance use/addictions concerns)

- Where do you currently refer your patients for mental health and/or substance use/addictions services? (probe: types of services, method of contact, options that exist but aren't utilized and why)

- What have been some of the challenges with the existing way to access services? (probe: method of contact, feedback loop, knowledge of resources, barriers to access, wait times, knowledge/understanding of patients' mental health and substance use/addictions need)

- What are some of the things that work well in accessing services currently? (Probe: accessibility, knowledge of mental health and substance use/addictions resources, wait times, feedback loop)

- Do you use any mental health and substance use/addictions screening tools prior to referral? If not, would you be open to using tools? (probe: tools in use, time they can commit to completing a tool, benefits and drawbacks to screening, what could be gained, benefits to patients)

- In a perfect system, how would you assist your patients in accessing mental health and substance use/addictions services? (Probe: method of contact, referral pathways, accountabilities and feedback loops)

- How does your experience of referring to mental health and substance use/addictions services compare to referrals for other services? (Probe: method of other referrals, positives and negatives in other referral pathways, what could be translated to mental health and substance use/addictions service access)

Appendix B: System Mapping Key Element Definitions

Access:

- **Respond to requests for information**: Provision of basic information without engaging in any clinical screening or assessment. This does not include any structured screening, or in-depth assessments and is usually completed by admin/non-clinical staff

Intake to services:

- **Information, basic screening and direct booking to a service:** Initiated in response to a query, taking basic information, redirecting to more appropriate service if easily identified, triaging for crisis, booking into service and prioritizing (recognizing flags) for next step. (e.g. ConnexOntairo)
- **Respond to crisis/crisis intervention**: Includes services that respond to immediate crises (e.g..., Mobile crisis teams, crisis line)
- **Conduct systematic screening:** Screening involves the use of evidence-based procedures and tools to identify individuals with problems, or those who are at risk for developing problems, in order to triage and prioritize them for the next step in accessing services including further assessment.
- **Assessment – Stage 1 – initial matching to services or service sequencing:** Stage 1 is an in-depth assessment, which determines the type and level of service needed and includes the development of the initial service/treatment plan. It provides sufficient information to ensure the person is matched to the appropriate level of care. Triaging occurs for prioritization into services based on severity/risk assessment. Stage 1 is completed only when needed after screening and is not always required before proceeding to Stage 2 assessment (e.g., as currently with the GAIN Q3 by Service Access to Recovery (SAR). This differs from a Stage 2 assessment which is the in-depth clinical and psychosocial assessment completed by the service provider in order to begin service delivery.

Navigation Supports:

- **Supports provided while waiting for service(s):** Service is provided to those who are not yet enrolled in services and are waiting for space to become available. This can include reassessment and prioritization, resource lists, group supports, etc.
- **Peer supports provided (related to accessing services):** Peer support is emotional and practical support between two people who share a common experience, such as a mental health challenge or illness. A peer supporter has lived through that similar experience, and is trained to support others (Peer Support Canada, 2019)
- **Supports provided to family members (related to accessing services):** The program supports family members/caregivers of the primary client, either as a means of supporting the client, or because they are having their own challenges due to a loved one's challenges.
- **Supports provided for system navigation:** Supports provided within the program, which support transitions, and/or follow a client throughout service provision, with ongoing monitoring. The overall goal is to understand the health needs of clients and make sure that they receive optimal care (e.g., care coordination, transitional case management).
- **Feedback loops and communications:** Information on the referral and services offered/provided are relayed back to the referral source. This can include information such as services offered, wait times, service plan provision, and other access-related information.

Appendix C: Primary Care Provider Survey

Primary Health Care Provider Survey

1. What is your role/profession?
    - o Nurse
    - o Nurse Practitioner
    - o Family Physician
    - o Administrator
    - o Other: ___________

2. What setting do you work in? (check all that apply)
    - o Solo Practice
    - o Family Health Team
    - o Family Health Organization
    - o Family Health Group
    - o Community Health Centre
    - o Other: ______________

3. What services are available within your setting (outside of Primary Care)?
    - o Social workers
    - o Psychiatry
    - o Psychology
    - o Other Mental Health support
    - o Substance Use/Addiction support
    - o Dietician
    - o Physiotherapy
    - o Pharmacist
    - o Other: ____________

4. What geographic area(s) do you serve?

    ____

5. What percentage of your patients would you estimate prefer services in French?
    - o Less than 5%
    - o 6 - 10%
    - o 11-25%
    - o 26-50%

- 51-75%
- 76-99%
- 100%
- Unsure

6. What percentage of your patients would you estimate prefer services in languages other than French or English?
    - Less than 5%
    - 6 - 10%
    - 11-25%
    - 26-50%
    - 51-75%
    - 76-99%
    - 100%
    - Unsure

7. What percentage of your patients identify as Inuit/First Nations/Métis?
    - Less than 5%
    - 6 - 10%
    - 11-25%
    - 26-50%
    - 51-75%
    - 76-99%
    - 100%
    - Unsure

8. (a)What percentage of your patients would you estimate have challenging mental health issues? (note we ask separately below for substance use/addiction)
    - Less than 5%
    - 6 - 10%
    - 11-25%
    - 26-50%
    - 51-75%
    - 76-99%
    - 100%
    - Unsure

8. (b) Please rank the four most common mental health challenges you encounter among these patients, with 1 being the most common, and 4 the least common:

1: (Drop down list – see below)
2: (Drop down list – see below)
3: (Drop down list – see below)
4: (Drop down list – see below)

- Mood
- Anxiety
- Developmental
- Psychosis
- Personality
- Other: ____

9. How often do you refer them for specific mental health services?
    - Less than 5%
    - 6 - 10%
    - 11-25%
    - 26-50%
    - 51-75%
    - 76-99%
    - 100%
    - Unsure

10. How comfortable are you that you have the knowledge to address mental health challenges among your patients?
    - Very comfortable that I have the knowledge
    - Somewhat comfortable that I have the knowledge
    - Not very comfortable that I have the knowledge
    - Not at all comfortable that I have the knowledge

11. Where do you currently refer your patients for mental health challenges? (select all that apply)
    - Outpatient mental health programs (through a hospital)
    - Community based mental health programs (through a community-based agency)
    - To a member of your practice (e.g. social worker, therapist)
    - Psychiatry services
    - Psychologist
    - Connex Ontario
    - I don't make referrals
    - Other: _________________

12. Are there some specific sub-groups of these patients with mental health challenges that present particular difficulties when it comes to accessing services on their behalf? (e.g. demographic groups, diagnostic grouping, location in your catchment area)

    - No sub-groups in particular
    - Yes, (please comment)

13. What referral modalities do you currently use for mental health referrals? (select all that apply)
    - Paper referral
    - Phone/fax referral
    - Electronic referral for services
    - Other: _______________

14. How much do you agree with the following statements with regards to accessing mental health services?

5 – strongly agree
4 – Agree
3 – Undecided
2 – Disagree
1 – Strongly disagree

- Wait times are acceptable
- There is a clear feedback loop
- You know where to refer to
- Appropriate services exist
- The processes are effective and efficient
- There is immediate and quick access to services

15. (a)What percentage of your patients would you estimate have substance use/addictions challenges?
    - Less than 5%
    - 6 - 10%
    - 11-25%
    - 26-50%
    - 51-75%
    - 76-99%
    - 100%
    - Unsure

15 (b): Please rank the four most common substance use/addictions challenges you encounter among these patients, with 1 being the most common, and 4 the least common:

1: (Drop down list – see below)
2: (Drop down list – see below)
3: (Drop down list – see below)
4: (Drop down list – see below)

- Alcohol
- Cannabis
- Hallucinogens
- Stimulants
- Opioids
- Sedatives
- Tobacco
- Other: _____________

16. How often do you refer them for specific substance use/addictions services?
    - Less than 5%
    - 6 - 10%
    - 11-25%
    - 26-50%
    - 51-75%
    - 76-99%
    - 100%
    - Unsure

17. How comfortable are you that you have the knowledge to address substance use/addictions challenges among your patients?
    - Very comfortable that I have the knowledge
    - Somewhat comfortable that I have the knowledge
    - Not very comfortable that I have the knowledge
    - Not at all comfortable that I have the knowledge

18. Where do you currently refer your patients for addressing substance use/addictions challenges? (select all that apply)
    - o Inpatient addictions programs through a hospital
    - o Outpatient substance use/addictions programs through a hospital
    - o Residential substance use/addictions programs through a community-based agency
    - o Non-residential substance use/addictions programs through a community-based agency
    - o To a member of your practice (e.g. social worker, therapist)
    - o Psychiatry services
    - o Psychologist
    - o Connex Ontario
    - o Coordinated Access hub for addictions (e.g. SARS)
    - o I don't make referrals
    - o Other: _________________

19. Are there some specific sub-groups of these patients with substance use/addictions challenges that present particular difficulties when it comes to accessing services on their behalf? (e.g. demographic groups, diagnostic grouping, location in your catchment area)

    - o No sub-groups in particular
    - o Yes – Please identify: _________________________

20. What referral modalities do you currently use for substance/addictions referrals? (select all that apply)
    - o Paper referral
    - o Phone/fax referral
    - o Electronic referral for services
    - o Recommend that the patient self-refers
    - o Other: ______________

21. How much do you agree with the following statements with regards to accessing substance use/ addictions services?

5 – strongly agree
4 – Agree
3 – Undecided
2 – Disagree
1 – Strongly disagree

- o Wait times are acceptable
- o There is a clear feedback loop
- o You know where to refer to
- o Appropriate services exist
- o The referral processes are effective and efficient
- o There are immediate and quick access to services

22. How often do you use mental health screening tools prior to referral?
    - o Never
    - o Sometimes
    - o Usually
    - o Always

23. Which mental health screening tools do you use prior to referral? (select all that apply)
    - o GAD7
    - o PHQ9
    - o GAIN-SS (Short screener)
    - o Other: ________________
    - o None

24. How often do you use addictions screening tools prior to referral?
    - o Never
    - o Sometimes
    - o Usually

    Always

25. Which addictions screening tools do you use prior to referral? (select all that apply)
    - o CAGE
    - o AUDIT
    - o GAIN-SS (Short screener)
    - o Other: ________________
    - o None

26. In a perfect system, what modality of referral would be available for your mental health and/or substance use/addictions referrals? (select all that apply)
    - Common paper referral form for all services
    - One number to call for information and access to local and regional services
    - Phone referral
    - Electronic referral integrated into our own EMR
    - Other: _______________

27. How does your experience of referring to mental health and/or addictions services compare to referrals for other services where specialist treatment and/or advice is needed (i.e. cardiology, orthopedics, endocrinology)?
    - Similar experience
    - Much more challenging
    - Much less challenging
    - Comments:____

28. Please add any other comments or suggestions that you think would be helpful to improve access to mental health and/or substance use/addictions services for your patients?
    ____
    ____
    ____
    ____

Appendix D: Organizations and stakeholders consulted

Engagement Sessions

Action-Logement
Algonquins of Pikwakanagan First Nation**
Alliance to End Homelessness
Amethyst Ottawa
Arnprior & District Family Health Team
Canadian Addiction Treatment Centres*
Carlington Community Health Centre
Centre de santé communautaire de l'Estrie*
Centretown Citizens Ottawa Corporation
Centretown Community Health Centre
Champlain LHIN
Children's hospital of Eastern Ontario
City of Ottawa Housing Services
Clarence-Rockland Family Health Team*
CMHA Champlain East*
CMHA Ottawa***
Cornwall & District Family Support Group*
Cornwall Community Hospital*
Counselling and Support Services Stormont Dundas and Glengarry*
Distress Centre of Ottawa
Empathy House
Family and Children's Services of Renfrew County
Family Services Ottawa
Geriatric Psychiatry Community Services of Ottawa
Glengarry Nurse Practitioner-led Clinic*
Hawkesbury and District General Hospital*
Hôpital Montfort
Jewish Family Services of Ottawa
Kemptville District Hospital
Kilaloe Community Resource Centre
Lanark Renfrew Health and Community Services
Lower Outaouais Family Health Team*
MacKay Manor**
Maison Fraternité
Montfort Renaissance***
Ontario Provincial Police
Options Bytown
Ottawa Community Housing
Ottawa Salus
Ottawa Withdrawal Management Centre
Parent's Lifeline of Eastern Ontario (PLEO)**
Pathways Alcohol and Drug Treatment Services**
Pembroke Regional Hospital**
Petawawa Military Family Resource Centre**
Phoenix Centre for Children and Families
Plantagenet Family Health Team*
Prescott-Russell Community Mental Health Centre*
Queensway Carleton Hospital
Rainbow Service Providers Network
Recovery Cornwall*
Renfrew County Addiction Treatment System**
Renfrew Victoria Hospital
Rideauwood Addictions and Family Services
Sandyhill Community Health Centre***
Seaway Valley Community Health Centre*
Serenity House
Sobriety House
South East Ottawa Community Health Centre
Summerset West Community Health Centre
The Ottawa Hospital
The Royal Mental Health Centre
The Salvation Army
Upstream
Valoris for Children and Adults of Prescott-Russell*
Vesta Recovery Program for Women
Wabano Centre for Aboriginal Health
Western Ottawa Community Resource Centre
Youth Services Bureau of Ottawa

*Part of Champlain LHIN Mental Health & Addictions Coordinated Access Advisory Committee Eastern Sub-region table
**Part of Champlain LHIN Mental Health & Addictions Coordinated Access Advisory Committee Western Sub-region table
***Part of Champlain LHIN Mental Health & Addictions Coordinated Access Advisory Committee Central Sub-region table

Model Validation Sessions

Service Providers and other Stakeholders

Action-Logement
Algonquiuns of Pikwakanagan First Nation
Canadian Addiction Treatment Centres
Centre de santé communautaire de l'Estrie
Centretown Community Health Centre
Champlain LHIN
CHEO
Clarence-Rockland Family Health Team
CMHA Champlain East
CMHA Ottawa
Cornwall & District Family Support Group
Cornwall Community Hospital
Elizabeth Fry Society of Ottawa
Family Services Ottawa
Geriatric Psychiatry Community Services of Ottawa
Glengarry Nurse Practitioner-led Clinic
Hawkesbury and District General Hospital
Hôpital Montfort
Jewish Family Services of Ottawa
Kemptville District Hospital
MacKay Manor
Options Bytown
Ottawa Distress Centre
Ottawa Salus
Pathways Alcohol and Drug Treatment Services
Pembroke Regional Hospital
Queensway Carleton Hospital
Renfrew County Addiction Treatment System
Sandyhill Community Health Centre
Seaway Valley Community Health Centre
The Ottawa Hospital
The Royal Mental Health Centre
Youth Services Bureau of Ottawa

Service user and Family member groups

Addictions and Mental Health Network Champlain
Addictions and Mental Health Network Champlain Client Advisory Committee
Addictions and Mental Health Network Champlain Family Advisory Committee
Community Addictions Peer Support Association (CAPSA)
Parent's Lifeline of Eastern Ontario (PLEO)
The Royal Mental Health Centre Client Advisory Committee
The Royal Mental Health Centre Family Advisory Committee
The Royal Mental Health Centre Youth Psychiatry out-patient service user group

Primary care providers

Dr. Aly Abdulla
Dr. Max Buxton
Dr. Lee Donahue
Dr. Thérèse Hodgson
Dr. Kamila Premji
Dr. Marilyn Crabtree

Appendix E: CCHS 2012 Criteria for categorization of level of need by severity tier

Level of Need	Definitions for Mental Health and Substance Use
Tier 1	No CIDI disorder **-and-** No non-cannabis illicit drug use **-and-** Prescription drug use only as prescribed **-and-** No perceived need for care **-and-** Drinking below **(our approximation to)** the low-risk guidelines: Men: Up to 15 drinks per week; Up to 3 drinks per day most days Women: Up to 10 drinks per week; Up to 2 drinks per day most days **-and-** Cannabis use: never, **-or-** just once (past 12m or lifetime), **-or-** more than once > 12m ago, **-or-** more than once in the past 12m **and** frequency was < once a month.
Tier 2	One substance <u>abuse</u> problem (out of 4) related to alcohol **-or-** cannabis **-or-** other drugs excl. cannabis, 12m **OR** Binge drinking (5+ drinks on one occasion), *once a month* **-or-** *2-3 times a month* **-or-** *once a week* **-or-** *more than once a week* **OR** Drinking above the LRDG: Men: **(**> 3 drinks per day on most days **-or-** >15 drinks per week**)** Women: **(**>2 drinks per day on most days **-or-** >10 drinks per week**)** **OR** Any self-reported disorder, current *[schz/psychosis/mood/anxiety/PTSD/learning/ ADD/eating]* **-and- (***no perceived need* **-or-** *all needs met***)**. *[PNCDNEED in (1,2)]* **OR** Any drug use, 12m, excl. one-time cannabis use **OR** Any prescription drug use not as prescribed

Level of Need	Definitions for Mental Health and Substance Use
	OR Cannabis use more than once in the past 12m, **-and-** frequency was once a month or more.
Tier 3	**(**2–4 <u>abuse</u> problems **-or-** 1–2 <u>dependence</u> problems on any one (or more) of alcohol **-or-** cannabis **-or-** other drugs, 12m**)** **OR** **(<u>One</u>** 12m CIDI disorder that is not alcohol, cannabis, other drugs, and bipolar I (counts major depressive episode, bipolar II, hypomania, GAD) **-and-** Sheehan Disability Scale <4. *MHPFINT=2 (not sig. interference)***)** **OR** **(**Any self-reported disorder, current *[schiz* ***-or-*** *psychosis* ***-or-*** *mood* ***-or-*** *anxiety* ***-or-*** *PTSD* ***-or-*** *learning* ***-or-*** *ADD* ***-or-*** *eating]* **-and-** Perceived needs *partially met* **-or-** *not met***)** **OR** Perceived need for care *(needs partially met* **-or-** *needs not met).*
Tier 4	**(**12m alcohol dependence **-or-** 12m cannabis dependence **-or-** 12m drug dependence excl. cannabis**)** [AUDDYD or SUDDYCD or SUDDYOD] **OR** **(<u>One</u>** 12m CIDI disorder that is not alcohol, cannabis, other drugs, or bipolar I (counts major depressive episode, bipolar II, hypomania, GAD) **-and-** Sheehan >=4. *MHPFINT=1 (significant intf).* **)** **OR** **(**2+ CIDI disorders including alcohol **-or-** cannabis **-or-** other drugs, interference not necessary**)** [alcohol abuse or dep. (12m), cannabis abuse or dep. (12m), drug abuse or dep. (12m), major depressive episode (12m), bipolar II (12m), hypomania (12m), GAD (12m)**]**

Level of Need	Definitions for Mental Health and Substance Use
	OR **(**Self-reported schizophrenia **-or-** self-reported psychosis **-or-** bipolar I**)** **OR** **(**Self-reported mood **-or-** anxiety **-or-** PTSD **-or-** ADD **-or-** learning disability **-or-** eating disorder**)** **-And-** **(**Hospitalized overnight for a mental health, alcohol, or drug problem **-or-** Had suicidal ideation**)** **OR** K6 >=13. *(Serious distress.)*
Tier 5	**Four stand-alone sets, separated by 'OR':** **(**12m alcohol dependence **-or-** 12m cannabis dependence **-or-** 12m drug dependence excl. cannabis [AUDDYD or SUDDYCD or SUDDYOD] **-and-** Sheehan Disability Scale >=4.**)** (*AUDFINT=1* **-or-** *SUDFINT=1 (signif. interference)* **-And-** **(**2+ CIDI disorders, 12m, that are not alcohol or cannabis or drugs (counts major depressive episode, bipolar I, bipolar II, hypomania, GAD) **-and-** Sheehan Disability Scale >=4.**)** *MHPFINT=1 (signif. interference)* **-And-** **(**1+ chronic condition *(out of 7)* **-or-** WHO_DAS=high *(90th pctile)***)]** **OR** **[(**2+ CIDI disorders, 12m, that are not alcohol or cannabis or drugs (counts major depressive episode, bipolar I, bipolar II, hypomania, GAD) **-and-** Sheehan Disability Scale >=4**]**. *MHPFINT=1 (signif. interference)***)** **-And-** **(**1+ chronic condition *(out of 7)* **-or-**

Level of Need	Definitions for Mental Health and Substance Use
	WHO_DAS=high *(90th pctile)*)**]** **OR** **[(**Self-reported schizophrenia **-or-** Self-reported psychosis **-or-** CIDI Bipolar I**)** **-And-** **(**1+ chronic condition *(out of 7)* **-or-** WHO_DAS=high *(90th pctile)*)**]**. **OR** **(**12m alcohol dependence **-or-** 12m cannabis dependence **-or-** 12m drug dependence excl. cannabis [AUDDYD or SUDDYCD or SUDDYOD] **-and-** Sheehan Disability Scale >=4.**)** (*AUDFINT=1* **-or-** *SUDFINT=1 (signif. interference)* **-And-** **(**Self-reported schizophrenia **-or-** Self-reported psychosis **-or-** CIDI Bipolar I**)** **-And-** **(**1+ chronic condition *(out of 7)* **-or-** WHO_DAS=high *(90th pctile)*)**]**

Appendix F: Data tables and qualitative coding - online primary care providers survey

Table 7. PCP survey - Role/profession

Role/Profession	N	%
Family Physician	94	63.1
Nurse Practitioner	33	22.1
Administrator	5	3.4
Nurse	5	3.4
Other (see below)	12	8.1
Total	149	100.0

Table 8. PCP survey - 'Other' comments regarding role/profession

Other Responses	N
Social worker	*4*
GP Psychotherapy	*1*
Psychotherapist	*2*
Pediatrician	*2*
Psychiatrist	*2*
MH Counsellor	*1*
MH Crisis worker	*1*

Table 9. PCP survey - Role/profession - Regional comparisons

Region		Role/Profession					
		Adminis-trator	Family Physician	Nurse	Nurse Practit-ioner	Other	Total
Central	Count	3	53	2	16	7	81
	% within Region	3.7	65.4	2.5	19.8	8.6	100.0
East	Count	2	25	2	9	4	42
	% within Region	4.8	59.5	4.8	21.4	9.5	100.0
West	Count	0	16	1	8	1	26
	% within Region	0.0	61.5	3.8	30.8	3.8	100.0
Total	Count	5	94	5	33	12	149
	% within Region	3.4	63.1	3.4	22.1	8.1	100.0

Table 10. PCP survey - setting in which survey respondents work

Role/Profession	N	%
Family Health Organization	43	28.9
Community Health Centre	42	28.2
Family Health Team	39	26.2
Solo Practice	9	6.0
Family Health Group	9	6.0
Total	149	100.0

Table 11. PCP survey - 'Other' comments - setting

Other Response	N
Other community health setting	12
Community mental health agency	3
Emergency Department	2
Retirement/Nursing Facility	2
Rural hospital	1
Community outreach	1
Residential treatment for youth (addictions/mental health	1

Note: 1 respondent identified two settings

Table 12. PCP Survey - Setting in which respondents live - Regional comparisons

Region		Setting				
		Solo Practice	Family Health Team	Family Health Organization	Family Health Group	Community Health Centre
Central	Count	4	17	24	4	23
	% within Region	4.9	21.0	29.6	4.9	28.4
East	Count	3	12	10	0	15
	% within Region	7.1	28.6	23.8	0.0	35.7
West	Count	2	10	9	5	4
	% within Region	7.7	38.5	34.6	19.2	15.4
Total	Count	**9**	**39**	**54**	**9**	**42**
	% of Entire Sample	**6.0**	**26.2**	**36.2**	**6.0**	**28.2**

Table 13. PCP survey - Services available

Role/Profession	N	%
Dietician	85	57.0
Social workers	77	51.7
Other Mental Health Support	61	40.9
Psychiatry	48	32.2
Substance Use/Addiction Support	42	28.2
Psychology	38	25.5
Physiotherapy	38	25.5
Total	149	100.0

Table 14. PCP Survey - 'Other' comments - Services available

Other Response	*N*
Nursing/medical staff	4
Respiratory therapy	3
Chiropractic	3
Chiropody/foot care	3
System navigation	2
Acupuncture	2
Diabetes/chronic disease management	1
Lung health	1
Fitness programming	1
Tobacco cessation	1
Athletic therapist	1
Massage therapist	1
Community developers	1
Community health	1
Primary care outreach	1
Pathways	1

Note: 8 respondents who identified the 'other' category noted that none of the service categories applied to their setting

Table 15. PCP Survey - Services available - Regional comparisons

Region		Setting							
		Social Workers	Psychiatry	Psychology	Other MH Support	SU/ Addiction Support	Dietician	Physio-therapy	Pharmacist
Central	Count	40	30	19	31	20	41	8	23
	% within Region	49.4	37.0	23.5	38.3	24.7	50.6	9.9	28.4
East	Count	24	14	13	19	13	33	24	23
	% within Region	57.1	33.3	31.0	45.2	31.0	78.6	57.1	54.8
West	Count	13	4	6	11	9	11	6	9
	% within Region	50.0	15.4	23.1	42.3	34.6	42.3	23.1	34.6
Total	Count	**77**	**48**	**38**	**61**	**42**	**85**	**38**	**55**
	% of Entire Sample	**51.7**	**32.2**	**25.5**	**40.9**	**28.2**	**57.0**	**25.5**	**36.9**

Table 16. PCP survey - Estimated percentage of clients that prefer services in French

Estimated percentage	*N*	*%*
Less than 5%	70	48.3
6-10%	19	13.1
11-25%	16	11.0
26-50%	11	7.6
51-75%	18	12.4
76-99%	10	6.9
100%	1	0.7
Total	*145*	*100.0*

Note: Missing 4 responses

Table 17. PCP survey - Estimated percentage of clients that prefer services in French - Regional comparisons

Region		Percentage of clients							
		Less than 5%	**6-10%**	**11-25%**	**26-50%**	**51-75%**	**76-99%**	**100%**	**Total**
Central	Count	36	14	11	10	6	2	0	79
	% within Region	45.6	17.7	13.9	12.7	7.6	2.5	0.0	100.0
East	Count	9	4	5	1	12	8	1	40
	% within Region	22.5	10.0	12.5	2.5	30.0	20.0	2.5	100.0
West	Count	25	1	0	0	0	0	0	26
	% within Region	96.2	3.8	0.0	0.0	0.0	0.0	0.0	100.0
Total	Count	70	19	16	11	18	10	1	145
	% of Entire Sample	48.3	13.1	11.0	7.6	12.4	6.9	0.7	100.0

Note: 4 missing responses; percentages may not total 100 due to rounding

Table 18. PCP survey - Estimated percentage of clients that prefer services in languages other than French or English

Estimated percentage	*N*	*%*
Less than 5%	88	62.4
6-10%	29	20.6
11-25%	16	11.3
26-50%	3	2.1
51-75%	2	1.4
76-99%	3	2.1
100%	0	0.0
Total	141	100.0

Note: 8 missing responses

Table 19. Estimated percentage of clients that prefer services in languages other than French or English - Regional comparisons

Region		Percentage of clients							
		Less than 5%	6-10%	11-25%	26-50%	51-75%	76-99%	100%	Tota
Central	Count	34	25	14	2	2	1	0	78
	% within Region	43.6	32.1	17.9	2.6	2.6	1.3	0.0	100.
East	Count	31	4	2	1	0	1	0	39
	% within Region	79.5	10.3	5.1	2.6	0.0	2.6	0.0	100.
West	Count	23	0	0	0	0	1	0	24
	% within Region	95.8	0.0	0.0	0.0	0.0	4.2	0.0	100.
Total	Count	**88**	**29**	**16**	**3**	**2**	**3**	**0**	**141**
	% of Entire Sample	**62.4**	**20.6**	**11.3**	**2.1**	**1.4**	**2.1**	**0.0**	**100.**

Note: 8 missing responses; percentages may not total 100 due to rounding

Table 20. PCP survey - Estimated percentage of clients that identify as Inuit/First Nations/Métis

Estimated percentage	*N*	*%*
Less than 5%	112	77.8
6-10%	19	13.2
11-25%	7	4.9
26-50%	2	1.4
51-75%	0	0.0
76-99%	3	2.1
100%	1	.7
Total	144	100.0

Note: 5 missing responses

Table 21. PCP survey - Estimated percentage of clients that identify as Inuit/First Nations/Métis - Regional comparisons

Region		Percentage of clients							
		Less than 5%	6-10%	11-25%	26-50%	51-75%	76-99%	100%	Total
Central	Count	61	9	4	1	0	1	1	**77**
	% within Region	79.2	11.7	5.2	1.3	0.0	1.3	1.3	**100.0**
East	Count	32	5	3	1	0	0	0	**41**
	% within Region	78.0	12.2	7.3	2.4	0.0	0.0	0.0	**100.0**
West	Count	19	5	0	0	0	2	0	**26**
	% within Region	73.1	19.2	0.0	0.0	0.0	7.7	0.0	**100.0**
Total	Count	**112**	**19**	**7**	**2**	**0**	**3**	**1**	**144**
	% of Entire Sample	**77.8**	**13.2**	**4.9**	**1.4**	**0.0**	**2.1**	**0.7**	**100.0**

Note: 5 missing responses; percentages may not total 100 due to rounding

Table 22. PCP survey - Percentage of clients estimated to have challenging mental health issues - Regional comparisons

Region		Percentage of clients							
		Less than 5%	**6-10%**	**11-25%**	**26-50%**	**51-75%**	**76-99%**	**100%**	**Total**
Central	Count	2	6	23	28	10	8	3	80
	% within Region	2.5	7.5	28.7	35.0	12.5	10.0	3.8	100.0
East	Count	2	7	15	13	3	2	0	42
	% within Region	4.8	16.7	35.7	31.0	7.1	4.8	0.0	100.0
West	Count	0	3	11	8	3	0	1	26
	% within Region	0.0	11.5	42.3	30.8	11.5	0.0	3.8	100.0
Total	Count	4	16	49	49	16	10	4	148
	% of Entire Sample	2.7	10.8	33.1	33.1	10.8	6.8	2.7	100.0

Note: 1 missing response; percentages may not total 100 due to rounding

Table 23. PCP survey - Percentage of clients estimated to have challenging substance use/addiction issues - Regional comparisons

Region		Percentage of clients							
		Less than 5%	**6-10%**	**11-25%**	**26-50%**	**51-75%**	**76-99%**	**100%**	**Total**
Central	Count	11	29	24	7	4	2	4	81
	% within Region	13.6	35.8	29.6	8.6	4.9	2.5	4.9	100.0
East	Count	7	19	5	8	2	0	0	41
	% within Region	17.1	46.3	12.2	19.5	4.9	0.0	0.0	100.0
West	Count	1	9	12	2	1	1	0	26
	% within Region	3.8	34.6	46.2	7.7	3.8	3.8	0.0	100.0
Total	Count	19	57	41	17	7	3	4	148
	% of Entire Sample	12.8	38.5	27.7	11.5	4.7	2.0	2.7	100.0

Note: 1 missing response; percentages may not total 100 due to rounding

Table 24. PCP survey - Most common mental health challenges

Disorder	*N*	*Mean*	*Std. Deviation*
Mood	142	3.29	.73
Anxiety	141	3.45	.64
Personality	127	2.04	.68
Developmental	71	1.35	.66
Psychosis	55	1.29	.66
Other	20	1.80	1.06

Note: Rankings were converted to scores such that a ranking of 1 was converted to a score of 4; a ranking of 2 converted to a score of 3 etc. The means of these scores are presented. The higher the mean, the higher the ranking.

Table 25. PCP survey -'Other' comments - Most common mental health challenges

Other Response	*N*	*%*
Substance use/abuse	4	23.5
Attention/ADHD	3	17.6
Eating disorder	1	5.9
Dual diagnosis	1	5.9
Relationships	1	5.9
Cognitive impairment	1	5.9
Total	17	100.0

* 2 responses missing; 1 response was not codable as the respondent provided multiple issues but did not provide a ranking for each.

Table 26. PCP survey - Most common mental health challenges - Regional comparisons

Region		Disorder				
		Mood	*Anxiety*	*Develop-mental*	*Psychosis*	*Personality*
Central	Mean	3.24	3.40	1.42	1.38	2.10
	N	78	77	38	34	71
	Std. Deviation	.78	.69	.76	.78	.76
East	Mean	3.28	3.62	1.29	1.12	1.85
	N	40	39	24	8	34
	Std. Deviation	.68	.54	.55	.35	.44
West	Mean	3.46	3.36	1.2	1.15	2.14
	N	24	25	9	13	22
	Std. Deviation	.66	.57	.44	.38	.71
Total	*Mean*	*3.29*	*3.45*	*1.35*	*1.29*	*2.04*
	N	*142*	*141*	*71*	*55*	*127*
	Std. Deviation	*.73*	*.64*	*.66*	*.66*	*.68*

Table 27. PCP survey - Most common substance use/addiction challenges

Disorder	*N*	*Mean*	*Std. Deviation*
Tobacco	132	3.30	.96
Alcohol	136	3.04	.82
Cannabis	120	2.48	.87
Opioids	87	1.70	.89
Sedatives	42	1.48	.83
Stimulants	33	1.45	.94
Other	4	2.50	1.73
Hallucinogen	3	1.33	.58

Note: Rankings were converted to scores such that a ranking of 1 was converted to a score of 4; a ranking of 2 converted to a score of 3 etc. The means of these scores are presented. The higher the mean, the higher the ranking.

Table 28. PCP survey - Most common substance use/addiction challenges - Regional comparisons

Region		Disorder						
		Alcohol	***Cannabis***	***Hallucin-ogen***	***Stimulants***	***Opioids***	***Sedatives***	***Tobacco***
Central	Mean	3.18	2.5	1.33	1.45	1.78	1.23	3.14
	N	78	68	3	20	45	22	71
	Std. Deviation	.79	.84	0.0	.94	.97	.43	1.02
East	Mean	2.69	2.47	0.0	1.67	1.74	1.67	3.45
	N	36	32	0	9	23	15	38
	Std. Deviation	.79	.98	0.0	1.12	.91	1.11	.89
West	Mean	3.09	2.35	0.0	1.00	1.47	2.00	3.52
	N	22	20	0	4	19	5	23
	Std. Deviation	.87	.81	0.0	.00	.61	1.00	.85
Total	*Mean*	**3.04**	**2.48**	**1.33**	**1.45**	**1.70**	**1.48**	**3.30**
	N	**136**	**120**	**3**	**33**	**87**	**42**	**132**
	Std. Deviation	**.82**	**.87**	**.58**	**.94**	**.89**	**.83**	**.96**

Table 29. PCP survey - Frequency screening tools are used prior to referral to mental health services – Regional comparisons

Region		*Response*				*Total*
		Never	Sometimes	Usually	Always	
Central	Count	3	19	25	34	**81**
	% within Region	3.7	23.5	30.9	42.0	**100.0**
East	Count	0	11	17	14	**42**
	% within Region	0.0	26.2	40.5	33.3	**100.0**
West	Count	1	5	11	9	**26**
	% within Region	3.8	19.2	42.3	34.6	**100.0**
Total	Count	**4**	**35**	**53**	**57**	**149**
	% of Entire Sample	**2.7**	**23.5**	**35.6**	**38.3**	**100.0**

Table 30. PCP survey - Frequency screening tools are used prior to referral to substance use/addiction services – Regional comparisons

Region		*Response*				*Total*
		Never	Sometimes	Usually	Always	
Central	Count	17	42	14	8	81
	% within Region	21.0	51.9	17.3	9.9	100.0
East	Count	9	17	11	5	42
	% within Region	21.4	40.5	26.2	11.9	100.0
West	Count	5	14	6	1	26
	% within Region	19.2	53.8	23.1	3.8	100.0
Total	Count	31	73	31	14	149
	% of Entire Sample	20.8	49.0	20.8	9.4	100.0

Table 31. PCP survey - Types of mental health screening tools used

Screening tool	N	%
PHQ9	130	87.2
GAD7	120	80.5
GAIN-SS (Short screener)	16	10.7
None	8	5.4
Total	**149**	

Table 32. PCP survey - 'Other' comments - Mental health screening tools used

Other Response	N
Beck Depression Inventory	5
CAGE	5
ASRS	4
Mood disorder questionnaire	4
MOCA	4
Burns Anxiety Inventory	3
SCARED	3
ADHD adult	2
PC-PTSD Screener	2
PTSD	2
Sheehan disability scale	2
Maclean BPD Screen	2
PTSD Screen	1
MDQ	2
MDE	1
4DSQ	1
Adult ADHD self report	1
Other ADHD tool	1
Trauma Symptoms Inventory	1
WEISS	1
BC-CCI	1
cPTSD	1
EDPS	1
Grilles CADDRA	1
Hamilton	1
MADRS	1
MMS	1
LOCUS	1
OCAN	1
MMSE	1
SIGECAPS	1
CAGE-AID	1
ORT	1
PCL-5	1
SDS	1
SNAP26	1
SNAP4	1
Standard Mental Health Exam	1

Table 33. PCP survey - Types of mental health screening tools used – Regional comparisons

Region		Screening tool			
		PHQ9	GAD7	GAIN-SS	None
Central	Count	72	68	12	4
	% within Region	88.9	84.0	14.8	4.9
East	Count	36	31	2	3
	% within Region	85.7	73.8	4.8	7.1
West	Count	22	21	2	1
	% within Region	84.6	80.8	7.7	3.8
Total	Count	**130**	**120**	**16**	**8**
	% of Entire Sample	**87.2**	**80.5**	**10.7**	**5.4**

Note: Percentages may not total 100 due to rounding

Table 34. PCP survey - Types of substance use/addiction screening tools used

MH Screening tool	N	%
CAGE	114	76.5
AUDIT	25	16.8
GAIN-SS (Short screener)	15	10.1
None	24	16.1
Total	149	

Table 35. PCP survey - 'Other' comments for types of substance use/addiction screening tools used

Other Response	**N**
COWS	3
CUDIT	1
ORT	1
CIWA	1
SOAPP	1

Table 36. PCP survey - Types of substance use/addiction screening tools used – Regional comparisons

Region		*Screening tool*			
		CAGE	AUDIT	GAIN-SS	None
Central	Count	63	19	10	12
	% within Region	77.8	23.5	12.3	14.8
East	Count	29	4	3	10
	% within Region	69.0	9.5	7.1	23.8
West	Count	22	2	2	2
	% within Region	84.6	7.7	7.7	7.7
Total	Count	**114**	**25**	**15**	**24**
	% of Entire Sample	**76.5**	**16.8**	**10.1**	**16.4**

Table 37. PCP survey - Comfort level regarding knowledge to address mental health challenges among clients – Regional comparisons

Region		Comfort level				
		Not at all comfortable that I have the knowledge	*Not very comfortable that I have the knowledge*	*Somewhat comfortable that I have the knowledge*	*Very comfortable that I have the knowledge*	*Total*
Central	Count	1	6	49	25	**81**
	% within Region	1.2	7.4	60.5	30.9	**100.0**
East	Count	1	10	22	9	**42**
	% within Region	2.4	23.8	52.4	21.4	**100.0**
West	Count	0	6	15	5	**26**
	% within Region	0.0	23.1	57.7	19.2	**100.0**
Total	Count	**2**	**22**	**86**	**39**	**149**
	% of Entire Sample	**1.3**	**14.8**	**57.7**	**26.2**	**100.0**

Note: Percentages may not total 100 due to rounding

Table 38. PCP survey - Comfort level regarding knowledge to address substance use/addiction challenges among clients – Regional comparisons

Region		Comfort level				
		Not at all comfortable that I have the knowledge	*Not very comfortable that I have the knowledge*	*Somewhat comfortable that I have the knowledge*	*Very comfortable that I have the knowledge*	*Total*
Central	Count	8	30	34	9	81
	% within Region	9.9	37.0	42.0	11.1	100.0
East	Count	4	20	14	4	42
	% within Region	9.5	47.6	33.3	9.5	100.0
West	Count	1	11	14	0	26
	% within Region	3.8	42.3	53.8	0.0	100.0
Total	Count	***13***	***61***	***62***	***13***	***149***
	% of Entire Sample	***8.7***	***40.9***	***41.6***	***8.7***	***100.0***

Note: Percentages may not total 100 due to rounding

Table 39. PCP survey - Proportion of clients referred for specific mental health challenges – Regional comparisons

Region		Percentage of clients							
		Less than 5%	6-10%	11-25%	26-50%	51-75%	76-99%	100%	Total
Central	Count	8	10	21	18	16	5	2	80
	% within Region	10.0	12.5	26.3	22.5	20.0	6.3	2.5	100.0
East	Count	2	12	6	5	8	7	0	40
	% within Region	5.0	30.0	15.0	12.5	20.0	17.5	0.0	100.0
West	Count	2	4	5	9	4	2	0	26
	% within Region	7.7	15.4	19.2	34.6	15.4	7.7	0.0	100.0
Total	Count	12	26	32	32	28	14	2	146
	% of Entire Sample	8.2	17.8	21.9	21.9	19.2	9.6	1.4	100.0

Note: 3 missing responses; percentages may not total 100 due to rounding

Table 40. PCP survey - Proportion of clients referred for specific substance use/addiction challenges – Regional comparisons

Region		Percentage of clients							
		Less than 5%	6-10%	11-25%	26-50%	51-75%	76-99%	100%	Total
Central	Count	20	19	16	10	8	6	2	81
	% within Region	24.7	23.5	19.8	12.3	9.9	7.4	2.5	100.0
East	Count	17	10	3	10	1	1	0	42
	% within Region	40.5	23.8	7.1	23.8	2.4	2.4	0.0	100.0
West	Count	5	9	1	6	4	1	0	26
	% within Region	19.2	34.6	3.8	23.1	15.4	3.8	0.0	100.0
Total	Count	42	38	20	26	13	8	2	149
	% of Entire Sample	28.2	25.5	13.4	17.4	8.7	5.4	1.3	100.0

Note: Percentages may not total 100 due to rounding

Table 41. PCP survey - Services to which clients with mental health challenges are referred

Other Response	*N*	*%*
Outpatient mental health programs (through a hospital)	98	65.8
Community based mental health programs (through a community-based agency)	96	64.4
Psychiatry services	93	62.4
To a member of your practice (e.g. social worker, therapist)	84	56.4
Psychologist	76	51.0
BounceBack	14	9.4
ConnexOntario	3	2.0
I don't make referrals	1	0.7

Table 42. PCP survey - 'Other' comments - Services to which clients with mental health challenges are referred

Other Response	***N***
Web/phone based programs (e.g., Big White Wall, CBT, ementalhealth.ca)	8
Access challenges (esp. inpatient/hospital services)	7
Inpatient/Hospital	3
EAP program	2
Psychotherapy	1
Medical specialist	1
Substance use services	1
Domestic violence services	1
Trauma/ PTSD	1
Catholic and Jewish Family Services	1
Community mental health services	2
General MH services	1
Child MH service	1
IASP	1
Project Upstream	1

Table 43. PCP survey - Services to which clients with mental health challenges are referred – Regional comparisons

Region		Type of service							
		Outpatient mental health programs	Community based mental health programs	To a member of your practice	Psychiatry services	Psychologist	Connex Ontario	BounceBack	I don't make referrals
Central	Count	58	49	40	49	56	3	8	1
	% within Region	71.6	60.5	49.4	60.5	69.1	3.7	9.9	100.0
East	Count	29	28	27	19	11	0	5	0
	% within Region	69.0	66.7	64.3	45.2	26.2	0.0	11.9	0.0
West	Count	11	19	17	21	9	0	1	0
	% within Region	42.3	73.1	65.4	80.8	34.6	0.0	3.8	0.0
Total	Count	98	96	84	89	76	3	14	1
	% of Entire Sample	65.8	64.4	56.4	59.7	51.0	2.0	9.4	0.0

Note: Percentages may not total 100 due to rounding

Table 44. PCP survey - Services to which clients with substance use/addiction challenges are referred

Service	*N*	*%*
Outpatient substance use/addiction programs through a hospital	98	65.8
Non-residential substance use/addiction programs through a community-based agency	74	49.7
Residential substance use/addiction programs through a community-based agency	67	45.0
To a member of your practice (e.g. social worker, therapist)	46	30.9
Inpatient addiction programs through a hospital	43	28.9
Coordinated Access hub for addictions (e.g. SAR)	32	21.5
Psychologist	27	18.1
Psychiatry services	25	16.8
ConnexOntario	1	.7
I don't make referrals	2	1.3

Table 45. PCP services - 'Other' comments - Services to which clients with substance use/addiction challenges are referred

Other Response	***N***
Peer support (e.g., AA)	2
Tobacco cessation	2
Addiction medicine	1
CAMH (community)	1
DART social worker	1
Montfort Renaissance	1
On site Pathways counsellors	1
Royal CDU	1
Sandy Hill Community Centre	1
On-site nurse practitioner	1

Table 46. PCP survey - Proportion of clients referred for specific substance use/addiction challenges – Regional comparisons

Region		Type of service									
		Inpatient SU programs through a hospital	Outpatient SU programs through a hospital	Residential SU programs through a community-based agency	Non-residential SU programs through a community-based agency	To a member of your practice	Psychiatry services	Psychol-ogist	Connex Ontario	Coordinat-ed Access hub for addictions	I don't make referrals
Central	Count	33	56	44	51	30	14	21	1	26	0
	% within Region	40.7	69.1	54.3	63.0	37.0	17.3	25.9	0.01	32.1	0.0
East	Count	6	31	9	14	10	7	4	0	2	1
	% within Region	14.3	73.8	21.4	33.3	23.8	16.7	9.5	0.0	4.8	2.4
West	Count	4	11	14	9	6	4	2	0	4	1
	% within Region	15.4	42.3	53.8	34.6	23.1	15.4	7.7	0.0	15.4	3.8
Total	Count	43	98	67	74	46	25	27	1	32	2
	% of Entire Sample	28.9	65.8	45.0	49.7	30.9	16.8	18.1	0.7	21.5	1.3

Note: Percentages may not total 100 due to rounding

Table 47. PCP survey - Referral modalities used

	Mental Health Referrals[1]		*Substance use/ Addiction Referrals*	
Referral modality	N	%	N	%
Phone/fax referral	109	73.2	92	61.7
Electronic referral	71	47.7	53	35.6
Paper referral	56	37.6	47	31.5
Recommend that client self-refer[2]	-	-	84	56.4

[1] 5 respondents selected 'other' and indicated 'self-referral. 1 respondent indicated that 'no one is accepting referrals'
[2] Response option not available for clients with mental health problems

Table 48. PCP survey - Referral modalities used for mental health - Regional comparisons

Region		Type of referral modality		
		Phone/ fax referral	Electronic referral	Paper referral
Central	Count	63	42	32
	% within Region	77.8	51.9	39.5
East	Count	25	16	16
	% within Region	59.5	38.1	38.1
West	Count	21	13	8
	% within Region	80.8	50.0	30.8
Total	Count	109	71	56
	% of Entire Sample	73.2	47.7	37.6

Table 49. PCP survey - Referral modalities used for substance use/addiction - Regional comparisons

Region		Type of referral			
		Phone/ fax referral	Electronic referral	Paper referral	Recommend that client self-refers
Central	Count	53	32	27	50
	% within Region	65.4	39.5	33.3	61.7
East	Count	23	12	14	18
	% within Region	54.8	28.6	33.3	42.9
West	Count	16	9	6	16
	% within Region	61.5	34.6	23.1	61.5
Total	Count	92	53	47	84
	% of Entire Sample	**61.7**	**35.6**	**31.5**	**56.4**

Table 50. PCP survey - Preferred referral modalities

Referral modality	N	%
Electronic referral integrated into our own EMR	121	81.2
One number to call for information and access to local and regional services	76	51.0
Common paper referral form for all services	38	25.5
Phone referral	15	10.1
Total	**149**	

Table 51. PCP survey - Preferred referral modalities – Regional comparisons

Region		*Referral modality*			
		Electronic referral integrated into EMR	One number	Common paper referral form	Phone referral
Central	Count	66	42	19	9
	% within Region	81.5	51.9	23.5	11.1
East	Count	30	21	12	4
	% within Region	71.4	50.0	28.6	9.5
West	Count	25	13	7	2
	% within Region	96.2	50.0	26.9	7.7
Total	Count	**121**	**76**	**38**	**15**
	% of Entire Sample	**81.2**	**51.0**	**25.5**	**10.1**

Table 52. PCP survey - 'Other' comments - Preferred referral modality

Other	**N**
Good communication with referral source/ primary care	2
Self	2
Services must be available	2
Fax	1
Client direct access	1
If centralized access: Must include all LHIN funded services and highly skilled staff	1
Ocean or Med dialogue	1
Centralized access for different geographic areas	1
Improve accessibility (e.g., outreach, walk-in services, extended hours)	1
Phone access for advice in complicated scenarios	1
On-site referral supports	1

Table 53. PCP survey - Comparison of referral experiences

Response	N	%
Much more challenging	115	77.2
Similar experience	18	12.1
Total	**149**	**100.0**

Table 54. PCP survey - Comparison of referral experiences – Regional comparisons

Region		*Response*	
		Much more challenging	Similar experience
Central	Count	68	7
	% within Region	84.0	8.6
East	Count	27	7
	% within Region	64.3	16.7
West	Count	20	4
	% within Region	76.9	15.4
Total	Count	**115**	**18**
	% of Entire Sample	**77.2**	**12.1**

Comments:

- General concerns with wait times (2C, 1E)
- Concerns regarding access to psychiatry (1C, 1E, 1W)
- Poor communication with primary care (3E)
    - Recommend integration into EMR
- Access to addiction services more challenging than for mental health (1C)
- Specialized services (e.g., psychiatry) should be streamlined (1W)
- Services are fragmented (1W)

Table 55. PCP survey - Specific sub-groups of clients with mental health challenges who have access challenges

Response	*Mental health*		*Substance use/ addiction*	
	N	%	N	%
No sub-groups in particular	35	23.5	78	53.1
Yes	114	76.5	69	46.9
Total	***149***	***100.0***	***147****	***100.0***

* 2 missing responses

Table 56. PCP survey - 'Other' comments - Sub-groups of clients with mental health challenges who have access challenges

Other Response	*N*	*%*
Low SES/Lack of insurance coverage	32	28.1
Personality disorder (particularly borderline)	30	26.3
Children and youth	18	15.8
Lack of access/availability of services (esp. psychiatry; also, counselling, rural areas, follow up, in ER)	16	14.0
Concurrent substance use/ addiction	14	2.3
Acute/ severe MH issues	11	9.6
Need to travel to services (e.g., rural clients)	10	8.8
Complex/ chaotic	9	7.9
Newcomers/ Ethnic minority groups	9	7.9
Trauma/PTSD	7	6.1
Difficult to engage	7	6.1
Developmental/ Intellectual disability	6	5.3
Language barriers	6	5.3
Transition age youth/ young adults	5	4.4
Depression (particularly treatment resistant)	5	4.4
Anxiety	3	2.6
2SLGBTQ+	3	2.6
Older adults	3	2.6
Mobility	2	1.8
Eating disorders (including for men)	2	1.8
ADHD	1	0.9
Autism Spectrum	1	0.9
Behavioural issues	1	0.9
Chronic pain	1	0.9
Dementia	1	0.9
Perinatal mental health	1	0.9
Criminal justice involvement	1	0.9
Socially isolated	1	0.9
All clients	1	0.9

Table 57. PCP survey - 'Other' comments - Sub-groups of clients with substance use/addictions challenges who have access challenges

Other Response	***N***	***%***
Low SES	14	20.3
Difficult to engage/ readiness	10	14.5
Concurrent mental health issues (not otherwise specified)	9	13.0
Need to travel to services	9	13.0
Complex/marginalized (inc. homelessness, criminal justice involvement)	8	11.6
Access/availability concerns (incl. inpatient services, detox)	6	8.7
Chronic pain	4	5.8
Personality disorder	4	5.8
Homebound/ isolated	3	4.3
Youth	3	4.3
Opiates	3	4.3
Older adults	2	2.9
Alcohol	1	1.4
Cannabis	1	1.4
Developmental disorder	1	1.4
Eating disorder	1	1.4
Problematic internet use/gaming concerns	1	1.4
Newcomers	1	1.4
Women	1	1.4
Indigenous clients	1	1.4
Non-Indigenous clients	1	1.4
Language barriers	1	1.4
Tobacco	1	1.4
Polysubstance use	1	1.4
Trauma	1	1.4

Table 58. PCP survey - Specific sub-groups of clients with mental health challenges who have access challenges – Regional comparisons

Region		Response		
		No sub-groups in particular	Yes	Total
Central	Count	16	65	81
	% within Region	19.8	80.2	100.0
East	Count	14	28	42
	% within Region	33.3	66.7	100.0
West	Count	5	21	26
	% within Region	19.2	80.8	100.0
Total	Count	**35**	**114**	**149**
	% of Entire Sample	**23.5**	**76.5**	**100.0**

Note: Percentages may not total 100 due to rounding

Table 59. PCP survey - Specific sub-groups of clients with substance use/addiction challenges who have access challenges – Regional comparisons

Region		Response		
		No sub-groups in particular	Yes	Total
Central	Count	41	38	79
	% within Region	51.	48.1	100.0
East	Count	25	17	42
	% within Region	59.5	40.5	100.0
West	Count	12	14	26
	% within Region	46.2	53.8	100.0
Total	Count	78	69	147
	% of Entire Sample	53.1	46.9	100.0

Note: 3 missing responses; percentages may not total 100 due to rounding

Table 60. PCP survey - Perceptions of wait times for mental health services - Regional comparisons

Region		*Response*					*Total*
		Undecided	Strongly disagree	Disagree	Agree	Strongly agree	
Central	Count	0	57	20	3	1	**81**
	% within Region	0.0	70.4	24.7	3.7	1.2	**100.0**
East	Count	3	27	9	3	0	**42**
	% within Region	7.1	64.3	21.4	7.1	0.0	**100.0**
West	Count	1	15	8	2	0	**26**
	% within Region	3.8	57.7	30.8	7.7	0.0	100.0
Total	Count	4	99	37	8	1	149
	% of Entire Sample	2.7	66.4	24.8	5.4	0.7	100.0

Table 61. PCP survey - Perceptions of feedback for mental health services - Regional comparisons

Region		*Response*					*Total*
		Undecided	Strongly disagree	Disagree	Agree	Strongly agree	
Central	Count	10	23	42	6	0	**81**
	% within Region	12.3	28.4	51.9	7.4	0.0	**100.0**
East	Count	5	13	16	6	2	**42**
	% within Region	11.9	31.0	38.1	14.3	4.8	**100.0**
West	Count	3	8	8	7	0	**26**
	% within Region	11.5	30.8	30.8	26.9	0.0	**100.0**
Total	Count	**18**	**44**	**66**	**19**	**2**	**149**
	% of Entire Sample	**12.1**	**29.5**	**44.3**	**12.8**	**1.3**	**100.0**

Table 62. PCP survey - Knowledge about where to refer for mental health services - Regional comparisons

Region		*Response*					*Total*
		Undecided	Strongly disagree	Disagree	Agree	Strongly agree	
Central	Count	15	18	32	13	3	**81**
	% within Region	18.5	22.2	39.5	16.0	3.7	**100.0**
East	Count	9	6	10	15	2	**42**
	% within Region	21.4	14.3	23.8	35.7	4.8	**100.0**
West	Count	3	3	11	9	0	**26**
	% within Region	11.5	11.5	42.3	34.6	0.0	**100.0**
Total	Count	**27**	**27**	**53**	**37**	**5**	**149**
	% of Entire Sample	**18.1**	**18.1**	**35.6**	**24.8**	**3.4**	**100.0**

Table 63. PCP survey - Perceptions regarding whether appropriate mental health services exist - Regional comparisons

Region		*Response*					*Total*
		Undecided	Strongly disagree	Disagree	Agree	Strongly agree	
Central	Count	10	37	26	7	1	**81**
	% within Region	12.3	45.7	32.1	8.6	1.2	**100.0**
East	Count	7	7	16	9	3	**42**
	% within Region	16.7	16.7	38.1	21.4	7.1	**100.0**
West	Count	4	12	7	3	0	**26**
	% within Region	15.4	46.2	26.9	11.5	0.0	**100.0**
Total	Count	**21**	**56**	**49**	**19**	**4**	**149**
	% of Entire Sample	**14.1**	**37.6**	**32.9**	**12.8**	**2.7**	**100.0**

Table 64. PCP survey - Perceptions regarding processes for mental health service referrals - Regional comparisons

Region		*Response*					*Total*
		Undecided	Strongly disagree	Disagree	Agree	Strongly agree	
Central	Count	8	45	24	4	0	**81**
	% within Region	9.9	55.6	29.6	4.9	0.0	**100.0**
East	Count	7	12	16	7	0	**42**
	% within Region	16.7	28.6	38.1	16.7	0.0	**100.0**
West	Count	4	10	11	1	0	**26**
	% within Region	15.4	38.5	42.3	3.8	0.0	**100.0**
Total	Count	**19**	**67**	**51**	**12**	**0**	**149**
	% of Entire Sample	**12.8**	**45.0**	**34.2**	**8.1**	**0.0**	**100.0**

Table 65. PCP survey - Perceptions regarding speed of access to mental health service referrals - Regional comparisons

Region		*Response*					*Total*
		Undecided	Strongly disagree	Disagree	Agree	Strongly agree	
Central	Count	3	65	11	2	0	**81**
	% within Region	3.7	80.2	13.6	2.5	0.0	**100.0**
East	Count	5	27	7	2	1	**42**
	% within Region	11.9	64.3	16.7	4.8	2.4	**100.0**
West	Count	1	18	6	1	0	**26**
	% within Region	3.8	69.2	23.1	3.8	0.0	**100.0**
Total	Count	**9**	**110**	**24**	**5**	**1**	**149**
	% of Entire Sample	**6.0**	**73.8**	**16.1**	**3.4**	**0.7**	**100.0**

Table 66. PCP survey Perceptions of wait times for substance use/addictions services - Regional comparisons

Region		*Response*					*Total*
		Undecided	Strongly disagree	Disagree	Agree	Strongly agree	
Central	Count	24	27	24	6	0	**81**
	% within Region	29.6	33.3	29.6	7.4	0.0	**100.0**
East	Count	9	11	9	11	2	**42**
	% within Region	21.4	26.2	21.4	26.2	4.8	**100.0**
West	Count	3	7	8	8	0	**26**
	% within Region	11.5	26.9	30.8	30.8	0.0	**100.0**
Total	Count	**36**	**45**	**41**	**25**	**2**	**149**
	% of Entire Sample	**24.2**	**30.2**	**27.5**	**16.8**	**1.3**	**100.0**

Table 67. PCP survey - Perceptions of feedback for mental health services - Regional comparisons

Region		*Response*					*Total*
		Undecided	Strongly disagree	Disagree	Agree	Strongly agree	
Central	Count	17	28	31	5	0	**81**
	% within Region	21.0	34.6	38.3	6.2	0.0	**100.0**
East	Count	11	10	17	3	1	**42**
	% within Region	26.2	23.8	40.5	7.1	2.4	**100.0**
West	Count	4	11	9	2	0	**26**
	% within Region	15.4	42.3	34.6	7.7	0.0	**100.0**
Total	Count	**32**	**49**	**57**	**10**	**1**	**149**
	% of Entire Sample	**21.5**	**32.9**	**38.3**	**6.7**	**0.7**	**100.0**

Table 68. PCP survey - Knowledge about where to refer for substance use/addictions - Regional comparisons

Region		*Response*					*Total*
		Undecided	Strongly disagree	Disagree	Agree	Strongly agree	
Central	Count	17	16	20	26	2	**81**
	% within Region	21.0	19.8	24.7	32.1	2.5	**100.0**
East	Count	9	4	11	13	5	**42**
	% within Region	21.4	9.5	26.2	31.0	11.9	**100.0**
West	Count	1	5	7	12	1	**26**
	% within Region	3.8	19.2	26.9	46.2	3.8	**100.0**
Total	Count	**27**	**25**	**38**	**51**	**8**	**149**
	% of Entire Sample	**18.1**	**16.8**	**25.5**	**34.2**	**5.4**	**100.0**

Table 69. PCP survey - Perceptions regarding whether appropriate substance use/addictions services exist - Regional comparisons

Region		*Response*					*Total*
		Undecided	Strongly disagree	Disagree	Agree	Strongly agree	
Central	Count	18	17	26	19	1	**81**
	% within Region	22.2	21.0	32.1	23.5	1.2	**100.0**
East	Count	16	4	9	13	0	**42**
	% within Region	38.1	9.5	21.4	31.0	0.0	**100.0**
West	Count	12	5	6	3	0	**26**
	% within Region	46.2	19.2	23.1	11.5	0.0	**100.0**
Total	Count	**46**	**26**	**41**	**35**	**1**	**149**
	% of Entire Sample	**30.9**	**17.4**	**27.5**	**23.5**	**0.7**	**100.0**

Table 70. PCP survey - Perceptions regarding processes for substance use/addictions service referrals- Regional comparisons

Region		*Response*					*Total*
		Undecided	Strongly disagree	Disagree	Agree	Strongly agree	
Central	Count	19	23	31	8	0	**81**
	% within Region	23.5	28.4	38.3	9.9	0.0	**100.0**
East	Count	15	8	9	10	0	**42**
	% within Region	35.7	19.0	21.4	23.8	0.0	**100.0**
West	Count	13	5	8	0	0	**26**
	% within Region	50.0	19.2	30.8	0.0	0.0	**100.0**
Total	Count	**47**	**36**	**48**	**18**	**0**	**149**
	% of Entire Sample	**31.5**	**24.2**	**32.2**	**12.1**	**0.0**	**100.0**

Table 71. PCP survey - Perceptions regarding speed of access to substance use/addictions service referrals- Regional comparisons

Region		*Response*					*Total*
		Undecided	Strongly disagree	Disagree	Agree	Strongly agree	
Central	Count	13	31	29	7	0	**80**
	% within Region	16.3	38.8	36.3	8.8	0.0	**100.0**
East	Count	11	10	10	11	0	**42**
	% within Region	26.2	23.8	23.8	26.2	0.0	**100.0**
West	Count	6	8	8	4	0	**26**
	% within Region	23.1	30.8	30.8	15.4	0.0	**100.0**
Total	Count	**30**	**49**	**47**	**22**	**0**	**148**
	% of Entire Sample	**20.3**	**33.1**	**31.8**	**14.9**	**0.0**	**100.0**

Coding for 'Additional Comments' question in PCP survey

- **Access to psychiatry** (25 respondents; 19C, 4W, 2E; *"It is almost impossible to find a psychiatrist in Ottawa that is accepting patients for more than 1 consult. For my very unwell patients with chronic mental health issues it is unacceptable, and I do the best I can as a primary care doctor. I feel like the system has really failed them and made it difficult for me to practice."; "So many stop-gap methods are being put into place and this underlying issue isn't being addressed at all.")*
    - For assessment (including pediatric assessments)
    - To follow complex patients *("I need more than a single, 1 hour visit with a psychiatrist to help care for my clients collaboratively."; "if patients have any substance d/o in addition to their psych issues there are kicked out and told to come back only once they have addressed the addiction, this is not helpful at all, both problems need to be addressed. I feel this is how psych here is "clearing out " their waiting list by saying difficult patients are too hard for them and then bounce them back to primary care. Most people have more than one issue and by saying you will only treat one clear cut problem and not look at the whole patient is reprehensible.")*
        - GPs feel ill equipped to provide the level of support needed by these patients
        - Perception that psychiatrists avoid accepting these clients *("psychiatry abdicates responsibility")*
        - Difficult to refer back to psychiatry if a client decompensates
    - Lack of collaboration *("If I refer to Derm, Ophtho, GI, Gyne or ENT and the referral is declined for wait time reasons or due to nature of referral, they often attach useful contact information about where I can refer the patient. I have had little success finding any community psychiatrists. Referrals get declined with no reason given and no further help.")*
    - To outpatient/community psychiatry
    - To inpatient services
    - In ERs *("Please please please have a psychiatrist ER service that actually does follow-up and arranges care")*
    - eConsults not sufficient

- **General concerns regarding timely access to services** (15 respondents, 7E, 5C, 3W; *"access to these services is atrocious in my community"; "It is almost to the point where the idea of referring someone and telling the client will be seen by mental health specialist is considered harmful given that they will wait for over a year at times to access care."*

- **Challenges related to system navigation** (10 respondents, 5E, 4C, 1W; "*Addictions services are convoluted, it is impossible to understand exactly what is available and how to access it."; "it is very difficult to find the "right door" for people because there may be different doors based on the presenting and most pressing issue at the time")*
    - Difficult to stay abreast of program changes
    - Lack of understanding of acceptance criteria
    - Need education regarding which services are appropriate (e.g., not everybody needs psychiatry services)
    - Especially for adolescents and children

- **Preference for coordinated access system** (9 respondents; 6C, 2E, 1W)
    - *"Strongly consider a single referral triage centre which manages wait lists and appropriately assigns service organizations to meet the needs of each referral"*

- **Need universal coverage for services** (9 respondents, 7C, 1E, 1W*) "If I didn't work in a FHO with a shared mental health team, the vast majority of patients would only have access to private counselling which at least 50% of them can't access."; "the uninsured patient has no reasonable options."*
    - Including for psychology

- **Child and youth services** (7 respondents, 5C, 1E, 1W; *"Access to pediatric mental health services is disjointed in Ottawa with very little effort to provide more seamless service from hospital/specialty services to community services. The resulting downloading of these responsibilities to primary health care is placing an undue burden on providers who are often in the dark as to what service are available, and what would be most appropriate, affordable, etc."*
    - ADHD screening
    - Access to substance use/addiction services

- **Need for better service integration** (7 respondents, 3E, 3C, 1W*)*
    - *"multi-service centre, general walk-in, people present with other issues when the real issue is their mental health or addiction"*
    - *"More collaboration between Psychiatry and therapists to inform pharmacology would be helpful."*
    - *"there should be more shared care in mental health and addictions with better communication between the different health team participants"*
    - *"Take down the silos"*

- **Complex clients excluded from services** (6 respondents, 4C, 1E, 1W; see also 'Access to Psychiatry' above)
    - *"Right now, there is too much burden on Primary Care providers to be the sole Psychiatric supports to very sick patients."*
    - *"Don't say a service exists and then not admit my patient for arbitrary reasons and without explaining why...This is cherry picking or the service doesn't exist"*
    - *"This most vulnerable population does not have access to the support it needs"*

- **Referral processes onerous** (6 respondents, 5C, 1E)
    - ***"****The process to request consultations is often very expensive and demanding, with long hand-written forms that require us to copy from the notes of our patients. This is very expensive, often poorly readable and puts patients at risk due to copy errors."*
    - ***"****The KISS principle would help!"*

- **Challenges accessing hospital services** (6 respondents, 6C)

- **System strengths** (5 respondents)
    - Easy referral process for geriatric population (but waitlists too long; 1E)
    - "Reasonable" wait times and intake processes for some services (3C)

- Access to services within clinic (1C)

- **Referral processes should be integrated into EMR** (5 respondents, 4E, 1C)
  - ***"****If you are setting up an electronic system, it needs to integrate in my EMR. Otherwise I will not be using it unless there is a billing code to remunerate me for the additional time taken."*

- **Communication with Primary Care** (4 respondents; 2C, 1W, 1E)
  - *"Psychiatric services are terrible at sending consult notes to primary care givers making it very difficult to share care of these patients who we will see during decompensation"*
  - *"As a GP I receive reports from the hospital long after my patients have been discharged. We are not kept in the loop of patient care. I would like to know when my patient is discharged so I can offer support in a time that is fragile for relapse or deterioration"*

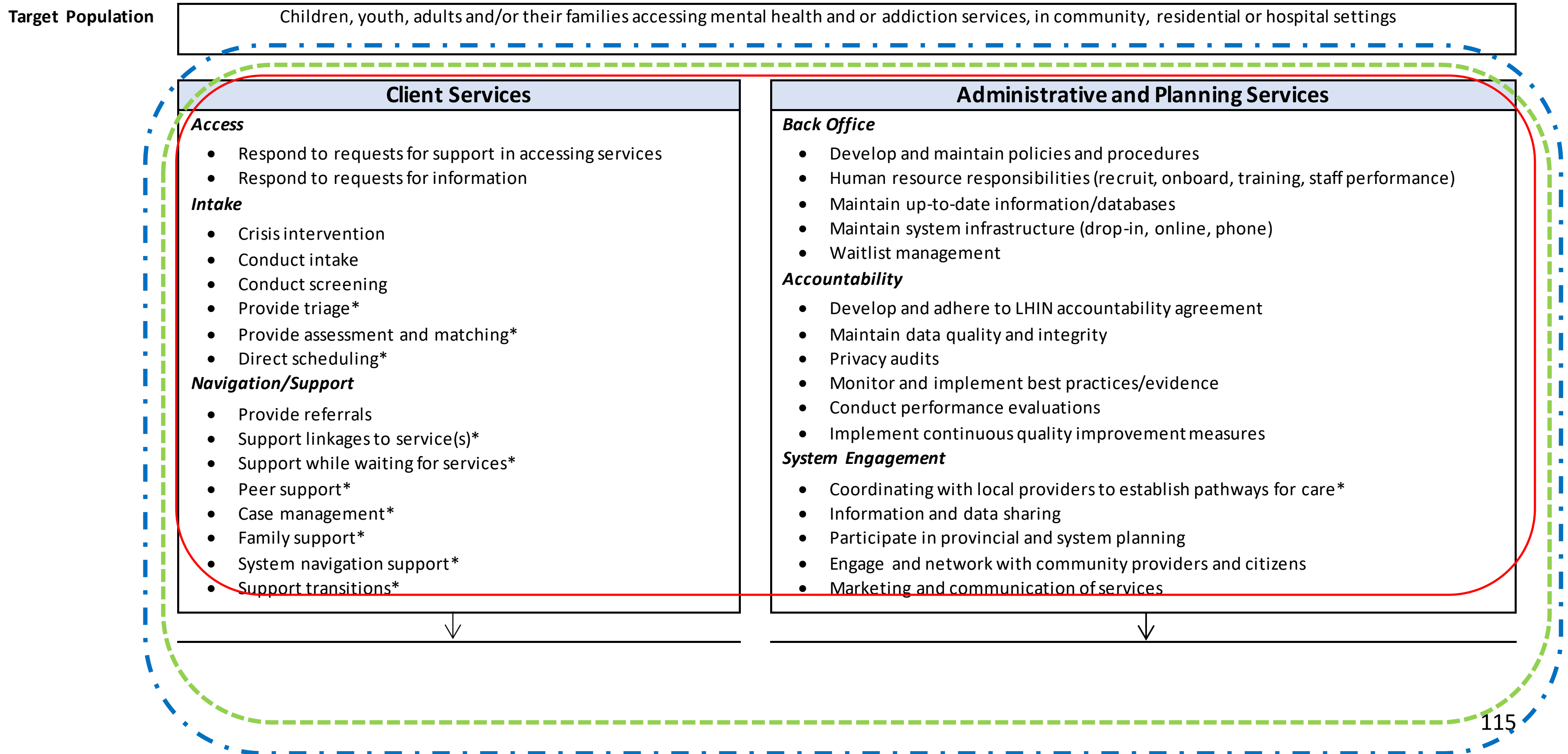
- **Appreciate opportunity to provide feedback** (4 respondents, 3C, 1E; *"I am very appreciative of the opportunity to participate in this survey. It is my hope that this information can result in a significant shift in how we access and provide mental health services to our clients."*

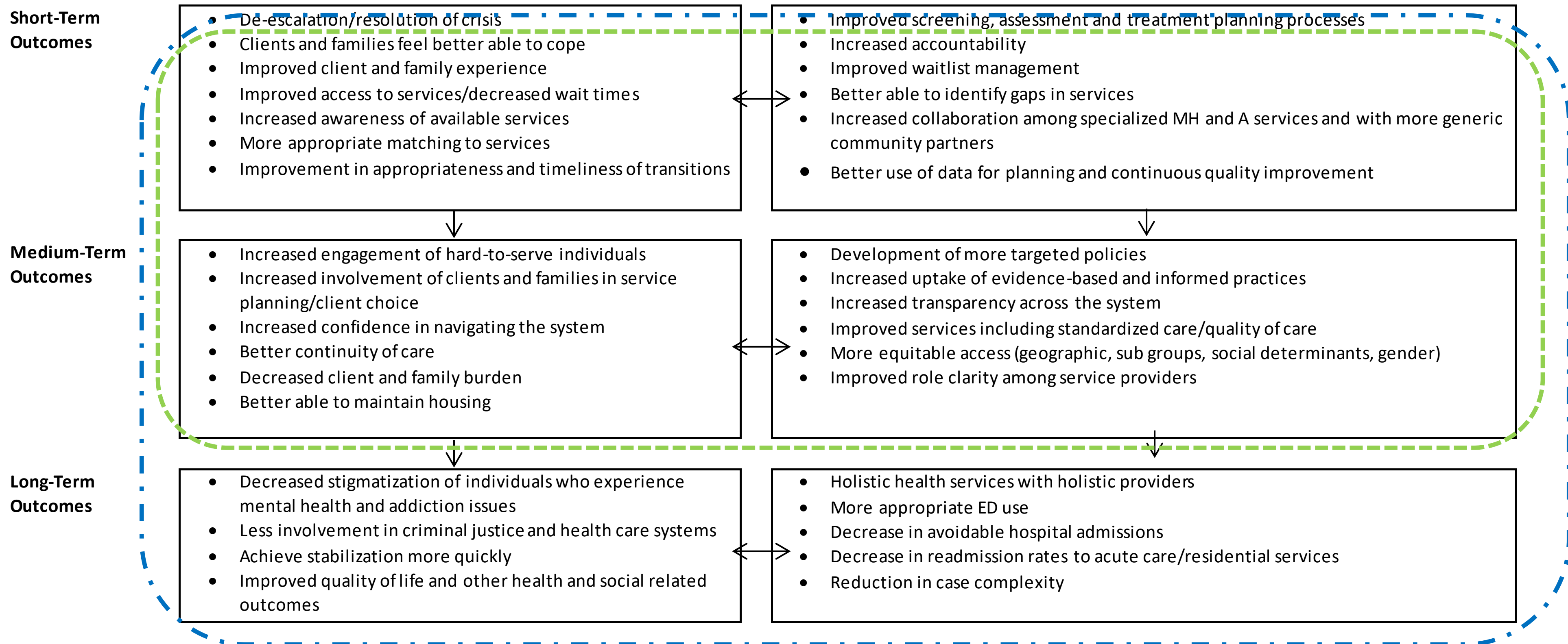
- **Concerns that ER main point of access** (3C; *"Sadly the ER with repeat visits is the most effective to trigger friendly faces to get a worker which is often needed"; "We should not have to wait until a crisis occurs with a client being sent to ER in order to access timely mental health service")*

- **Need for specific services:**
  - Counselling (4 respondents, 2C, 1E, 1W)
  - Addiction services (3 respondents, 1C, 1E, 1W)
    - For women and children and youth in particular
    - *"Services are either non-existent (alcohol detox, dual diagnoses), or only available to those least in need of them"*
  - Psychotherapy (1, 2C, 1E)
  - Eating disorders (2C)
  - Outreach (2 respondents, 1C, 1E)
  - Psychology (2C; see also 'Need universal coverage for services')
  - Older adults (1E; easy to access but wait too long)
  - Peer support (1E)
  - Personality disorders/DBT (3C)
  - Developmental disorders (1C)
  - Social work services (1C)
  - Trauma services (1C)
  - Case management services (1C)
  - CBT (1C)
  - Psychogeriatric services (requires better follow up; 1C)
  - More specialists (1E)
  - Chronic pain services (1C)
  - Outpatient mental health programs (2C)
  - Follow up services for discharged Form 1 patients (1E)

- **Other comments:**
    - *"A comprehensive review of what services are currently available in the region would go a long way to seeing where the holes are, and hopefully, this survey will also help identify where the needs are" (1C)*
    - *"Bravo and thank you for continued improvements" (1E)*
    - *"direct referral by the patient is the best avenue. Direct psychology without referral would be the best-case scenario" (1E)*
    - *'Collaborative Mental Health Care Network' for family doctors a helpful resource (1C)*
    - Explore a model similar to CHEO ECHO program for mental health and addictions (1C)

Appendix G: Logic model




Short-Term Outcomes
De-escalation/resolution of crisis
Clients and families feel better able to cope
Improved client and family experience
Improved access to services/decreased wait times
Increased awareness of available services
More appropriate matching to services
Improvement in appropriateness and timeliness of transitions
Improved screening, assessment and treatment planning processes
Increased accountability
Improved waitlist management
Better able to identify gaps in services
Increased collaboration among specialized MH and A services and with more generic community partners
Better use of data for planning and continuous quality improvement
Medium-Term Outcomes
Increased engagement of hard-to-serve individuals
Increased involvement of clients and families in service planning/client choice
Increased confidence in navigating the system
Better continuity of care
Decreased client and family burden
Better able to maintain housing
Development of more targeted policies
Increased uptake of evidence-based and informed practices
Increased transparency across the system
Improved services including standardized care/quality of care
More equitable access (geographic, sub groups, social determinants, gender)
Improved role clarity among service providers
Long-Term Outcomes
Decreased stigmatization of individuals who experience mental health and addiction issues
Less involvement in criminal justice and health care systems
Achieve stabilization more quickly
Improved quality of life and other health and social related outcomes
Holistic health services with holistic providers
More appropriate ED use
Decrease in avoidable hospital admissions
Decrease in readmission rates to acute care/residential services
Reduction in case complexity