Analysis *of* MHSU Referrals *in* Greater Victoria

A Psychosocial Rehabilitation Collaborative RESEARCH PAPER

SEP 2022

Abstract

The Mental Health Substance Use (MHSU) system in Greater Victoria presents several challenges such as long wait times, lack of services and growing demand in a context of staff and resource limits. There are also opportunities for greater efficiency and effectiveness such as through a shared navigation system. The lack of data about wait lists, demand for services and the practice and experiences of diverse stakeholders is a barrier preventing system re-design and innovation.

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PSYCHOSOCIAL REHAB COLLABORATIVE PARTNERS:

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In a survey of people with lived experience of MHSU people were asked to describe their

IDEAL SYSTEM:

- **Searchable, updated, on-line directory of all services**
- **Screening and self-help options**
- **Navigator/person to talk to**
- **Clear, consstent intake procedures**
- **Check-ins while waiting.**

Psychosocial Rehabilitation Collaborative (PSRC)

The PSRC was formed in 2014 in response to advocacy undertaken by families and people with lived experience that highlighted barriers for people with mental health and substance use (MHSU) challenges to access and engage in recovery-oriented mental health supports and services.

The PSRC is unique in British Columbia's mental health field, bringing together people with lived experience, families and supporters, service providers and Island Health Authority to collaborate on a shared goal: improved social connections for people living with a mental illness in Greater Victoria. The partners' work is grounded in Psychosocial Rehabilitation principles and recovery oriented approaches. The PSRC theory of change (from 2019) is that there are four important strategies needed to accomplish their goal:

1. Create low barrier social gathering opportunities in the region.
2. Engage stakeholders in co-designing and implementing a shared navigation system in the region.
3. Increase the availability of, and capacity and connections among, peer support and outreach workers.
4. Ongoing work to engage stakeholders and deepen collaboration around shared interests.

Over the last few years the PSRC partners have advanced two specific projects:

- Design and engagement around an aligned MHSU navigation system.
    - The Navigation Working Group has engaged up to 124 actors in feeding into this work and there is a smaller core group that leads this work.
    - Related to this work there is also a strong focus on strengthening and establishing a network of peer support, outreach and other "in person" navigators in the system.
- Delivery of "Imagine After Hours" virtual cafe series, in person "pop-up" cafés and a specific physical social gathering place pilot.
    - Related to this work is an active Lived Experience Advisory Group that designs and leads gathering place activities and has a seat at the PSRC Partners table.

The PSRC partners include:

- Island Community Mental Health Association
- Victoria Cool Aid Society
- Family Voices for Wellness
- Island Health
- Mental Health Recovery Partners
- Canadian Mental Health Association
- Members of the Persons with Lived Experience Advisory
- Connections Place

Executive Summary

This research was conducted on behalf of the Psychosocial Rehabilitation Collective (PSRC) in Greater Victoria. The PSRC partners have been working with others in their Navigation Working Group to co-create a shared Mental Health and Substance Use (MHSU) navigation system in the region. The lack of information about MHSU referrals has been a gap in that work. The purpose of the research was to explore three specific questions:

- What are the primary service gateways or navigators and what are their challenges? What do they need to be more successful?
- How are referrals submitted?
- Identify waitlists and document service demand patterns to better understand needs.

Notwithstanding challenges with lack of available data and difficulty engaging with medical professionals, the research has surfaced some useful findings that provide a clearer picture of how the current system works and potential points of intervention to improve it.

SNAPSHOT OF INTAKE AND REFERRAL PROCESS (SUMMER 2022)

The following illustration identifies highlights from the research with some caveats:

- The system is changing rapidly, and efforts are being made to improve it so wait times and services as noted here could be quite different 6 months from now.
- It is safe to assume that the data for 2021/22 fiscal has been affected by the opioid crisis and COVID to some extent.
- This research focused largely on the MH side of the system. While those who are experiencing SU challenges are likely to have similar early touchpoints (crisis teams, emergency and CARES) there is another whole set of circumstances related to wait times and admission to treatment centres that has not been explored.

Notwithstanding these limitations, the research has yielded some useful insights around the role of Family Doctors (or walk in clinic doctors), the redundancy in the intake process for people experiencing challenges and the lack of information on multiple levels.

> “If a cardiac patient was as sick as my psychiatry patients they would be followed by cardiology.”

Many Mental Health Substance Use (MHSU) services require a family doctor's referral:

These services often offer patients a one-time consultation and then refer them back to their family doctor.
Doctors indicate many cases are too complex for the time they have and **those who are not attached to a family doctor often fall through the cracks.**

799 Active Physicians

*College of Physicians and Surgeons 2021/22 Annual Report; includes physicians NOT delivering primary patient care (eg: at hospitals, etc)

18 walk-in clinics serve **25 percent** of the population who do not have a family doctor.
That is 100,000 people!

Physicians often refer patients to one of these three types of MHSU providers.

42 Adult MHSU Specialists

wait times for specialists in the region range from **2-24 months**

island health CARES team

urgent assessment wait times are **1-5 days** and **2-8 weeks** for others

These services will also refer to a diverse range of community services

Community Organizations

some community organizations do not require a referral but may still have a **waitlist due to high demand**

10 weeks is often TOO LONG for someone to wait for services so they end up IN CRISIS and using emergency services.

Island Health reports that in 2021/22:

6804
MHSU presentations at emergency departments in the region

5071
calls for service to the Integrated Mobile Crisis Response Team (IMCRT)

There is a lack of data about case managers, outreach and peer support workers critical roles in the system.

September 2022. *Data is from a Psychosocial Rehab. Collaborative report on the MHSU Referral system in the Greater Victoria Region. It represents a snapshot in time in a complex, dynamic system.*

ISSUES	RECOMMENDATIONS
The gateway of doctor assessment and referral is a significant bottleneck in the system. The lack of family doctor's time, the lack of doctor's period and the requirement for doctor referrals for so many services are all factors.	**Encourage doctors use of pathwaysbc.ca** and work with the Division of Family Practice to support education (about MHSU and services) for family doctors. **Track the impacts of Urgent and Primary Care Centres and the new MHSU Health Consultants**, in particular how unattached patients (no family doctor) are followed-up (if they are) and the impact on family doctor caseloads and referrals. Work with community organizations and Island Health to **explore how to eliminate doctor referrals and use pathwaysbc.ca as a central open referral source** for non-clinical community services.
There are too many different sources of service information none of which are complete or up to date, making navigation difficult for both users and profes-sionals in the system.	**Encourage all family doctors, specialists and community service organizations to register and use pathwaysbc.ca as a shared information platform for the region.** **Develop a strategy to ensure that everyone who wants one has a "navigator or support person" attached to them.**
Follow-up and after care are almost non-existent due to the expectations on family doctors and lack of navigators and case managers. This contributes to poor client outcomes, additional costs and lack of data to inform system improve-ments.	**Gather information about case managers, peer support and outreach workers roles** in navigation, support, follow-up and after care and identify opportunities for shared support, data collection and innovations in the system. Work with Island Health, family doctors and the current "navigators" (above) to **define and implement best practice in MHSU case manage-ment that is holistic, wrap around and that includes more peer and community-based supports** such as peer support, outreach and other in person navigators. Explore how navigator roles inter-face with the medical system and improve patient access and outcomes.
Data about referrals is also not always tracked, integrated across services or used to inform system improvements.	**Create a regional MHSU Data Initiative** that integrates pathways, Island Health and Community Services data and facilitates shared analysis and decision-making about improvements. **Develop a referral data pilot with Pathwaysbc.ca referral tracker**, Family Doctors, Specialists and Community Organizations to test the effectiveness of the tracker and how the information can inform system improvements.

MHSU Referrals Research Project Objectives

The Project Charter and Project Plan was approved by the PSRC Research and Evaluation Working Group in early 2022. These documents outlined the project scope, deliverables, approach to data collection and timelines.

The primary focus of the research was to identify where the longest waitlists are, and if there are any gaps in MHSU services that present challenges for the people trying to access services and support.

The following key questions are being explored:

- What are the primary service gateways or navigators and what are their challenges? What do they need to be more successful?
- How are referrals submitted?
- Identify waitlists and document service demand patterns to better understand needs

Methodology

The Research Specialist created a list of contacts and interview questions and coordinated those with the Research and Evaluation Working Group prior to organizing the data collection. The data collected from survey responses, interviews and collaborative sessions provided the information for this paper and contributed to the recommendations outlined in the last section of the report.

COMPLEX SYSTEM CHANGE

The context for this research is a complex web of inter-connected elements and systems that result in mental health services in the region. The complexity comes from diverse stakeholders perspectives, experiences and roles (from lived experts to families and diverse professionals) including a diverse range of service providers such as government, community based non-profits and the private sector.

Mental health and substance use services in Greater Victoria are provided through Island Health, private psychiatric, counselling, and occupational therapy offices, Ministry of Mental Health and Addictions funded services such as Foundry, and Federally funded programs, community-based organizations, and more recently online service providers, to name a few.

PSR and recovery approaches also bring added complexity because they work to integrate a number of health determinants besides physical and mental health such as housing, food security, recreation, education and employment. Transportation and access to technology are also important elements of this system linked to diverse service delivery options, locations and entry points.

The literature [1]suggests this complexity calls for iterative thinking, acknowledging blind spots, being utilization oriented and integrating quantitative data and qualitative stories.

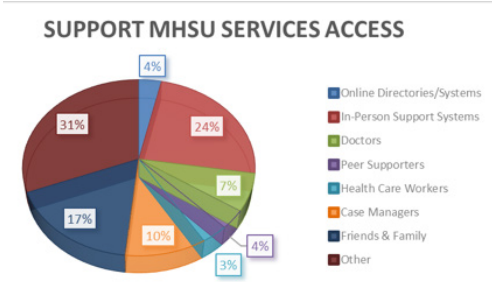
DATA COLLECTION

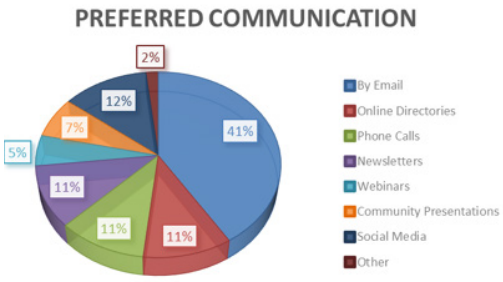
PSRC initiated a Navigation Working Group to address the MHSU navigation challenges in Greater Victoria and in February 2021 this group held a virtual conversation that attracted 187 participants representing families, people with lived experience, government, community based organizations and professionals in the MHSU field. The discussion and presentations from this session [2] have informed this paper including information from: Pathwaysbc.ca, United Way 211 Service, Umbrella Society Outreach services, Mind Map App and the Island Health Intake.

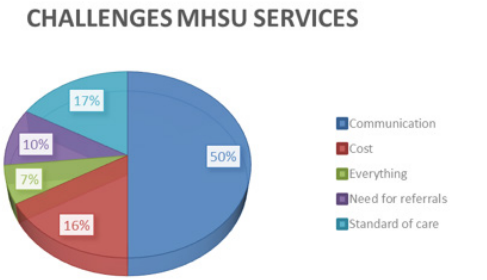
With funding from United Way later that year, the working group also initiated three surveys of 30 people with lived experience, organizational navigators, and information/database providers. These surveys also form part of the data for this report.

In addition, the report has used data from a 2021 survey of 30 family doctors that a private physician conducted (See APPENDIX A).

Information gathering from health professionals in Greater Victoria was a challenge. The ongoing COVID pandemic with changing health protocols and high demand for services were factors that made it challenging to reach and interview family doctors. Interviews were conducted with pathwaysbc.ca, Island Health, a private psychiatry practice, and non-profit PSRC partners.







Overview of MHSU Referral Research Findings

1. USERS EXPERIENCE OF ACCESS TO INFORMATION AND SERVICES

This section of the report summarizes input from lived experts in the Navigation Working Group survey. The data represents the input of 30 users of MHSU services related to their access to information and services.

The respondents were asked how often they found information about MHSU services in Greater Victoria and 60% of the respondents said they sometimes or always found the information they needed with the majority saying "sometimes". 55% of the respondents used a navigator such as friends and family, peer support, outreach or case workers to help them find information and services.

Half of the respondents said that the most challenging aspect of getting access to MHSU services was lack of communication with their preferred methods of communication being email, on-line directories and social media. The Island Health staff who were interviewed also suggested that MHSU service information that if more comprehensive, updated MHSU service information was available on-line it would also support better discharge planning.

2. GATEWAY TO SERVICES: EMERGENCY AND CRISIS ADMISSIONS

Island Health outreach services expanded in 2021 in response to increased demand from COVID and the Opioid crisis. Demand for these MHSU emergency services in 2021 was as follows:

- 5071 calls for service to the Integrated Mobile Crisis Response Team [3] (IMCRT),
- 2266 encounters for the Encampment Outreach Team [4],
- 808 referrals for Substance Use Rapid Follow-up (SURF) [5],
- 723 for the Indigenous Outreach Team.

Many other patients enter the system through a hospital emergency room. In 2021, there were 6,804 MHSU patients who presented at an emergency department (averages to 130/week). At the hospital, an assessment of their symptoms is completed by the admitting physician, the information is transferred to the rest of the MHSU staff via the Island Health internal Pathways Platform and a treatment plan is created by the attending physician. In most cases patients admitted to hospital are eventually referred elsewhere for services (eg: a psychiatrist, counsellor or community service) and many are treated and released without being admitted.

When the patient is discharged, Island Health provides information about the services accessible to the patient and dependent on the specific case, they can be referred to peer support, family or outreach supports. If they have one, a letter is sent to the family doctor regarding how they can support the patient in their recovery and provides information about how to manage the refills on their prescribed medication. Follow up services are described and any referrals to other programs are noted. The family doctor may also identify follow-up services for the patient and ideally all of these referrals and treatment options are input into the Island Health internal Pathways platform.

Patients without a family doctor fall through the cracks early on in this system with no follow-up after a crisis, or after a “one time treatment consultation”.

3. GATEWAY TO SERVICES: FAMILY DOCTORS AND RELATED PROFESSIONALS

In the most common situation, a referral from a family doctor is required for MHSU services delivered by Island Health or Community Organizations. Referral practices follow the guidelines set out by the College of Physicians and Surgeons of British Columbia.

The diagram below illustrates this situation where medical professionals are the primary gateway to access services. This includes family doctors, walk in clinic doctors, nurse practitioners and family doctors available via Telus My Health. The College of Physicians and Surgeons of BC 2021/22 Annual Report [6] indicates that Southern Vancouver Island has 799 active family practitioners and not all of these are providing primary care. Family doctors can only refer to the services they know of, so the extent of their information about services, as well as their information about their patients, becomes a central factor in how well the referral system works, or does not work.

Patients without a family doctor fall through the cracks early on in this system with no follow-up after a crisis, or after a “one time treatment consultation”.

Family Doctor/Nurse Practitioner or Hospital/Urgent Care can:

- **Run tests**
- **Perform assessments**
- **Refer to psychologist, psychiatry intake (CARES) or any other service/supports.**

MSP URGENT CARE

- **811 HealthLinkBC**
- **Central Access & Rapid Engagement Services (CARES)**
- **Urgent Short-term Assessment**
- **BC Alcohol & Drug Referral**
- **Urgent Care Centre**
- **Services from community-based organizations**
- **Medical Apps - Telus Health MyCare, Maple/fees apply**

EXTENDED HEALTH COVERAGE

- **Workplace counselling and family support**
- **Private Counselling (MA, PhD) no referral/no wait**
- **Medication coverage via extended health benefits**
- **WorkSafeBC coverage in case of work-related injury**
- **Telehealth platforms Telus Health MyCare, Maple**

YOUTH

- **Foundry 12-24 yr. Free Drop-in Counselling/Social/Virtual**
- **Post Secondary: Here2Talk 24/7 counselling and referral, on campus counselling, Umbrella housing services**

Figure 1 MHSU System Access Points

MD'S EXPERIENCE OF THE MHSU REFERRAL SYSTEM

Mark Roseman is an individual advocate, writer and author of a book on mental health system navigation, and also the partner of a Victoria psychiatrist. He conducted his own survey of family doctors in Greater Victoria during 2021.

The survey results highlight the challenges of 30 family doctors related to providing mental health care/ referrals to their patients:

- 100% of those surveyed did not think that the mental health needs of their patients were being met
- 86% reported that MHSU patients were too acute or complex to manage within the practice
- 75% indicated patients often had too many concerns to be handled in one appointment
- 50% reported not being confident enough to prescribe medications
- 50% who referred to Island Health psychiatry had patients rejected due to not being acute enough
- 86% who referred to Island Health psychiatry found that ongoing supports (beyond a one- time consultation) were NOT available to their patients
- 86% who referred to Island Health psychiatry had wait times that were too long
- 46% who referred to NON-Island Health services had wait times that were too long
- 32% who referred to NON-Island Health services found that ongoing supports were NOT available
- 79% of those surveyed identified a need for additional counselling services

Note that family doctors are a primary gateway for a majority of MHSU services and they are also a primary after-care provider when people are discharged from hospital. There is a great deal hanging on the time and capacity of Family family doctors to provide both referral and case management in the system. The feedback from family doctors in this survey suggests that they do not have the time or the capacity to support patients who need ongoing supports from MHSU specialists. Family doctors comments speak to this very clearly:

"If a cardiac patient was as sick as my psychiatry patients they would be followed by cardiology!!".

"Often complex patients – bipolar etc. – seen once for a consult and sent back to GP to start meds/manage. This is too complex for us.".

The one-off consultations and repeated assessments can also re-traumatize the person experiencing MHSU challenges to provide precise and brief answers to very personal questions asked by someone that they have just met and often they lack an opportunity to elaborate due to the time constraints of the consultation.

"Getting psychiatry consults in a timely manner when people are in crisis is very difficult (rarely happens). This places a huge burden on family doctors."

This picture of the role and reliance on family doctors in the system suggests a series of inefficient and ineffective investments of time and money. Family doctors are not being used effectively or appropriately and patient needs continue to go unmet which has both human and fiscal costs in the long term.

4. SECONDARY GATEWAYS TO SERVICES

A. ISLAND HEALTH - CENTRAL ACCESS AND RAPID ENGAGEMENT SERVICES (CARES)

Island Health receives all adult MHSU referrals and assigns services through their Central Access and Rapid Engagement Services (CARES) [7]. The intake team includes professionals with backgrounds in social work, nursing, substance use treatment and psychology, with psychiatrist support to make referral decisions. The CARES are also open to "walk-ins" (people without a family doctor referral) several times a week and they deliver free counselling services as well. Referrals and walk-ins are placed in a queue based on the assessed urgency.

The triage of referrals relies on the information in the intake form, which makes the quality of information a critical element for proper prioritization and assignment of services. Family doctors in the Roseman survey indicate referrals being rejected due to not being acute enough and they also express that the majority of mental health patients are presenting with complex issues. The CARES team identifies that depression, suicide risk, anxiety, and substance use are the most prevalent concerns they see, followed by psychosis, bi-polar and a range of situational crisis.

86%

of MD's surveyed reported that MHSU patients were too acute or complex to manage within the practice

In 2021 CARES received a total of 6054 referrals of which 4245 were referrals directly from family doctors or specialists.

In 2021 CARES received a total of 6054 referrals of which 4245 were referrals directly from family doctors or specialists, and the rest were from individuals calling or walking-in. People triaged with urgent needs can be assessed within 1-5 days while others may have to wait between 2-8 weeks. (Note that CARES has not replaced Urgent Short Term Assessment and Treatment (USTAT) but will refer to it). As of August 30th the CARES average wait time is 1-2 weeks.

When the wait time assigned is longer than 6 weeks, a second letter is sent to both patient and referring Family Doctor with the assigned wait time and it also provides information regarding services available through community and services while the patient is waiting for Island Health MHSU services. The number of people placed on wait list changes frequently and therefore was not made available for this report.

In 2021 CARES booked 1900 "Enhanced Collaborative Care" appointments for patients to consult with a psychiatrist or other specialist. These appointments are usually one time, and then phone availability to the primary care provider to further consult if needed.

URGENT AND PRIMARY CARE (UPC) CENTRES

During the summer of 2022 Island Health opened UPC centres in 4 locations in Greater Victoria including Esquimalt, Westshore, James Bay and Quadra locations. The centres will be staffed by multi-discipline teams and family doctors including a counsellor and social worker to respond to minor or moderate mental health challenges. Island Health has targeted over 90 new staff being hired for the centres over time. These centres will be open to walk-ins – they do not require a referral. Time is needed to learn more about the role that these centres are playing in assessment and referral of people with MHSU issues.

ISLAND HEALTH STAFF SHORTAGES BLAMED

There is a shortage of family doctors in Greater Victoria, British Columbia, and Canada . Island Health interview participants spoke to staff shortages as a primary reason for long wait times. At the time of the interviews there were 120 vacant job postings. They described several factors contributing to this including a lack of graduates, the cost of living in Victoria and the cost/lack of housing. The current Strategic Plan targets additional recruitment of psychiatrists as part of the MHSU objective which is focused on increasing access to services.

B. SPECIALISTS

At this time there are **53 MHSU specialists** who are registered with the pathwaysbc.ca referral platform and providing services for Island Health patients for Greater Victoria. 42 of these serve adults and they include both psychiatrists and addiction specialists as highlighted below. Pathways is pro-active in reaching out to specialists and updating their information and they indicate on average 95% of specialists are registered with them in any region. They also advise that the current wait times for specialists are up to 24 months, depending on the specialty. Some are simply not taking referrals.

Victoria and South Island Specialists Resource/referral Options in pathwaysbc.ca
Adult psychiatrists: 28
Child and youth psychiatrists: 11
Mental Health Programs: 234
Addictions medicine: 14
Addictions Programs: 105

C. COMMUNITY BASED SERVICES

Pathways Community-Based registered programs are also shown in the table above and support earlier comments about "hundreds" of programs, all with their own intake and referral systems and practices. Community-based services operate similar to the Island Health model with each office/organization usually requiring their own intake form and assessment process and managing their own wait lists. Likewise, The Foundry and other youth serving organizations hold their own intake and wait list process regardless of the referral source. It was not possible to survey every organization for their wait times and referral sources, and many of the smaller organizations do not track this information, however a few have shared their information below as examples of this element of the MHSU system.

Island Health staff and case managers make a lot of referrals to community-based services such as Employment Programs or Connections Place Clubhouse for example. The pathwaysbc.ca data base lists 234 mental health programs and 105 addictions services in the region (includes all addictions, not only substances).

Connections Place gets the majority of their referrals from island Health staff. Clubhouse staff indicate that generally there is a 2-4 week wait time for people to be accepted as a Clubhouse member and that intakes could be quite stretched out if the prospective member is not motivated to go through the process in a timely manner, for whatever reason, usually anxiety or being directed by a case manager as opposed to wanting to do it for themselves.

The triage of referrals relies on the information in the intake form, which makes the quality of information a critical element for proper prioritization and assignment of services.

Some people in the MHSU system wait up to 3 months to get access to services: from wait times to see their MD (if they have one), to 2-8 weeks for CARES assessment & referral, and another 1-4 weeks to access treatment or a program.

At **Island Community Mental Health Association** (ICMHA) their intake data shows a range of referral sources with about 19% direct from Island Health staff. Wait times are about 1-2 weeks on average. Referrals to ICMHA come from:

- 19% Island Health staff (CARES and other)
- 17% Psychiatrists
- 9% family doctors
- 54% Other (from probation to other community organizations and family members)

From a users perspective, this information suggests that some people in the MHSU system are waiting up to 3 months to get access to services: from wait times to see their MD (if they have one), to 2-8 weeks currently for CARES assessment and referral, and another 1-4 weeks again before they actually get access to treatment or a program. They are also going through 2-3 different intake processes/forms and participating in 2-3 assessments with different professionals which has potential to re-traumatize people over and over.

Some community-based organizations providing MHSU services in Greater Victoria accept self-referral (meaning no diagnosis or medical referral is needed to access the service) and do not have a wait list for services however there is not good information about which services these are and often they are those oriented to crisis or emergency situations (such as Cool Aid, Homeless Shelters, Meal Services). Other community organizations such as Umbrella Society for example offer (open) drop- in programs and require registration for others where they have prerequisites or limited seating, but the program intake is still self-referred versus requiring a medical referral. Services that do not require a medical referral are sometimes referred to as low barrier, but this does not mean they are without limitations or wait times.

UMBRELLA SOCIETY: COMMUNITY BASED SERVICES THAT DON'T REQUIRE MD REFERRALS

At the time of the interview for this project Umbrella offered several specific programs and their staff provide important access to information and system navigation for clients including setting up appointments and going with them if that is required. They also support filling out forms for disability, employment support and various intake forms for services. Umbrella is using an off-the-shelf case management software to document information and generate reporting that supports their needs for information about contacts and wait times. Staff described challenges supporting clients through multiple steps in a referral or intake process and in particular when the client does not have an electronic device.

Housing: Umbrella operates four recovery houses. There is no time limit at any of our houses, residents can stay for as long as they feel it is beneficial to their recovery.

80% of the residents come through referral either from Royal Jubilee Hospital or the Victoria Correctional Centre. The wait times at the time of the interview were between 1 and 6 months.

Family Counselling: The Umbrella team helps family members understand what addiction means, provide coping mechanisms and help bridge the healing process.

Family members self-identify or register for this service. Currently, the Umbrella family counselling is available by donation and the wait time in November 2021 was 1 to 2 months.

Outreach: The team provides outreach services from hospitals and clinics to coffee shops throughout Greater Victoria.

Outreach services are available to anyone and there is no wait time for any of the clients released from the Victoria Correctional Centre.

Groups: Umbrella currently offers 11 different professional led and peer based support groups (in person and virtual) targeting specific industries, populations, challenges including a group for people who are waiting for service on a wait list.

These groups are typically open to anyone and do not require a referral but due to limited spaces they require registration (phone or email) and wait times vary.

Lack of Information

We do not have good information about the number or nature of referrals made by family doctors, other professionals or Island Health CARES team. Many smaller community-based organizations do not track referral sources. There is no integrated data collection across all services; information is spotty at best and non-existent at worst. This means we do not really understand how the referral and assessment system is working and this is a significant handi-cap in our efforts to improve it.

5. PATHWAYS ON-LINE DIRECTORY AND REFERRAL PLATFORM

Pathways is a not for profit society that developed Pathwaysbc.ca in 2017.It is an **online resource that provides family doctors and their teams quick access to current and accurate referral information, including wait times**, about specialists, specialty clinics and other community and health authority services. Currently they get about 5.4 million page views a year. Pathwaysbc.ca has been used for almost a decade by the Divisions of Family Practices in British Columbia and the software has been a valuable element in the referral management and data sharing.

They are also going through 2-3 different intake processes/forms and participating in 2-3 assessments with different professionals which has potential to re-traumatize people over and over.

How Does Pathways Work?

Access to the Pathwaysbc.ca is limited to family doctors who are members of the Divisions of Family Practice across British Columbia, their practice team members, nurse practitioners, and to specialists and their teams. Access can also be given to midwives, clinic managers, Primary Care Network Managers and community organizations.

The information in Pathwaysbc.ca enables family doctors to identify the most appropriate care provider to address their patients' needs in as timely a manner as possible. The site provides detailed referral requirements and wait times for specialists and specialty clinics. The site's filters are user-friendly, and it is easy to pinpoint the required information.

Pathways proactively reaches out to specialists and specialty clinics to curate and update the directory information every 6 months. In addition, the Community & Health Authority Service portion of the Directory, which is open to the public, provides access to thousands of resources and services that is categorized, filterable and searchable.

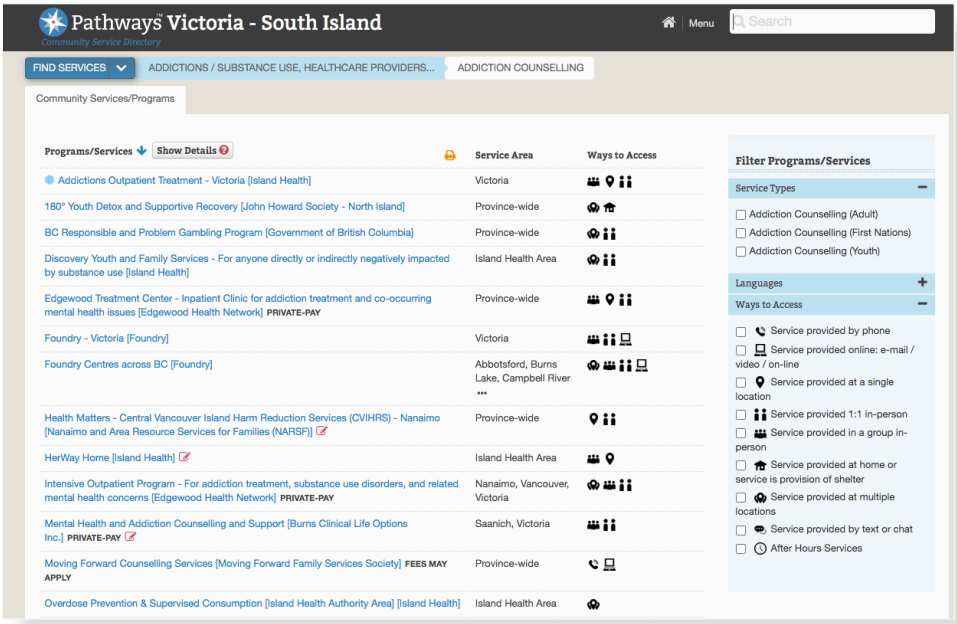
The site also contains an extensive peer-reviewed repository of clinician tools and patient resources such as clinical algorithms, care pathways, diagnostic tools, patient handouts, videos, websites that can be viewed, printed, and emailed from a no-reply email.

PATHWAYS ON-LINE DIRECTORY AND REFERRALS

Doctors register to get access to a directory of specialists and services that Pathways has researched and updates every 6-12 months.

Pathways logins in Greater Victoria indicate that at the time of this report, Pathways **had 1,329 active medical user accounts, 697 specifically assigned to doctors**. Using the College of Physicians and Surgeons 2022 data of **799 active doctors in the region**, this suggests that Pathways – at a minimum – is already supporting access to service information, referrals and creating a single sources of referral data **for 87% of all doctors in the region**.

(Note: An MD log in may be used by other staff in their office, or the login might be registered to a receptionist for example. This data reflects all family doctors, including for example those who do not see patients but perhaps only serve the Emergency ward; the Pathways data includes specialists, while the College of Physicians and Surgeons data does not include specialists.)



PATHWAYS TRACKING REFERRAL DATA

The recently introduced Referral Tracker feature of Pathwaysbc.ca is available to some Divisions of Family Practice and streamlines the patient referral process, which results in more appropriate referrals and thereby more efficient patient care. At the time when this paper was written the Referral Tracker feature was not available to the Divisions of Family Practice in Greater Victoria however we are on a list of potential sites for this upgrade in 2023.

The Referral Tracker allows referrals to be sent and received using pathwaysbc.ca and that supports a collaborative dashboard which shows practitioners the status of referrals in real time. Family doctors can see the wait times in advance and make a more informed decision including thinking about supports for the patient while they are waiting.

The feature also facilitates office to office communication as clinics can securely message each other though the Referral Tracker dashboard. The Referral Tracker feature provides visibility to the referring physician to see if the referral was accepted, rejected, or cancelled and why.

In addition to offering a more comprehensive dashboard of referral activities, the Pathways referral tracker supports electronic patient communication with patients, notifying them when they are waitlisted, booked, and reminded one week and 48 hours before their appointment. If this is made available in Greater Victoria, it could dramatically improve communication and information for users and those doing case management and after care.

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We do not really understand how the referral and assessment system is working and this is a significant handi-cap in our efforts to improve it.

Analysis of Themes from the Research

INSIGHTS FROM USERS

From a **user perspective** what this looks like for many is up to 3 assessments and 2 different referrals over 3 months in the typical scenario before any treatment/services are delivered.

1. A family doctor assesses and makes a referral/sends an intake form to Island Health CARES.
2. The CARES team schedules an appointment for an assessment that is currently 1-2 weeks later for non-critical cases, and then makes a referral for ongoing services.
3. The receiving service or professional then schedules another appointment for the patient and does their own assessment sometime between 2 – 4 weeks after that.

Other users who are referred directly to services rather than to the CARES team (for example counselling or a program at Island mental health for example) are still going through 2 assessment and intake steps – one with their doctor and another with the service provider.

Users also report frustration with the lack of communication about their referral and about program and service options. The standard letter or phone call that Island Health makes to share referral information is not sufficient.

INSIGHTS ABOUT SERVICE GATEWAY AND NAVIGATOR PRACTICES

Family doctors in the Roseman survey and in the press over several years have told a similar story of lack of time resulting in a lack of holistic care and the challenge of MHSU patients who have complex issues that family doctors are not able to assess. The input from the Roseman survey respondents and from Island Health staff also highlights the added pressure on family doctors for after-care and case management of patients who may have had a single consult leading to a treatment plan. In short, family doctors have a role in the MHSU system that they are not able to fulfill.

Community based service delivery organizations are at the front lines so to speak, often having connections with people with a MHSU challenge as well as their family. Community organizations talk about their role in supporting clients to find an MD, who can then refer them, or in filling out complex intake or registration forms. They also identify a growing number of people who have an appointment, but no support during the weeks or months leading up to the appointment. These actors have also expressed that they can't keep up with all the program and service information, contact changes, or wait times and that this impacts their ability to provide core navigation services for people. Having every organization create it's own resource directory is not an effective use of precious time or resources in the system and it also complicates and prevents tracking data about referrals – a critical piece of information for system improvement.

INSIGHTS ABOUT WAITLISTS AND SERVICE DEMAND/GAPS

The research did not yield any valid information about the nature of waitlists across different types of services, of locations of services. We did not learn anything about the nature of demand relative to specific services.

The high level snapshot of waitlist periods for key gateways is useful and reinforces what anecdotal feedback has been saying for some time, that waitlists are far too long and that people are falling between the cracks. This data has resulted in system level opportunities for change that all need to be explored further.

INSIGHTS ABOUT AFTER-CARE AND CASE MANAGEMENT GAPS

Websites and interviews for this research are silent on after-care protocols or services which suggests it is a gap in the system. Family doctors in the survey have identified that this longer term support is not appropriate for their role and Island Health does not have updated information about the number of case managers, caseloads, peer support workers or outreach workers, all of whom play key “navigator and support” roles in the system. The comparison to other medical illnesses is apt here: if the patient was dealing with cancer, joint replacement or cardiac issues they would have an assigned case manager or navigator.

The ongoing case manager or navigator role is critical in particular for those without family doctors, those who may be waiting for services or offered only a one time consultation, as well as those who are experiencing chronic symptoms. Community organizations worry about increased referrals from Island Health staff as a strategy to reduce case management waitlists.

System Recommendations

ISSUES	RECOMMENDATION
The gateway of doctor assessment and referral is a significant bottleneck in the system. The lack of family doctor's time, the lack of doctor's period and the requirement for doctor referrals for so many services are all factors.	**Encourage doctors use of pathwaysbc.ca** and work with the Division of Family Practice to support education (about MHSU and services) for family doctors **Track the impacts of Urgent and Primary Care Centres and the new MHSU Health Consultants,** in particular how unattached patients (no family doctor) are followed-up (if they are) and the impact on family doctor case loads and referrals. Work with community organizations and Island Health to **explore how to eliminate doctor referrals and use pathwaysbc.ca as a central open referral source** for non-clinical community services.
There are too many different sources of service information none of which are complete or up to date, making navigation difficult for both users and professionals in the system.	**Encourage all family doctors, specialists and community service organizations to register and use pathwaysbc.ca as a shared information platform for the region.** **Develop a strategy to ensure that everyone who wants one has a "navigator or support person" attached to them.**
Follow-up and after care are almost non-existent due to the expectations on family doctors and lack of navigators and case managers. This contributes to poor client outcomes, additional costs and lack of data to inform system improvements.	**Gather information about case managers, peer support and outreach workers roles** in navigation, support, follow-up and after care and identify opportunities for shared support, data collection and innovations in the system. Work with Island Health, family doctors and the current "navigators" (above) to **define and implement best practice in MHSU case management that is holistic, wrap around and that includes more peer and community-based supports** such as peer support, outreach and other in person navigators. Explore how navigator roles inter-face with the medical system and improve patient access and outcomes.
Data about referrals is also not always tracked, integrated across services or used to inform system improvements.	Create a regional MHSU Data Initiative that integrates pathways, Island Health and Community Services data and facilitates shared analysis and decision-making about improvements. **Develop a referral data pilot** with Pathwaysbc.ca referral tracker, Family Doctors, Specialists and Community Organizations to test the effectiveness of the tracker and how the information can inform system improvements.

Endnotes

1 https://www.fsg.org/blog/new-article-water-systems-change

2 South Island Mental Health & Substance Use Navigation Convene Event Report & Next Steps, PSRC, February 23, 2021

3 Child and youth mental health clinicians work alongside adult mental health clinicians, social workers, nurses and plain-clothes police officers to provide a rapid, mobile, community-based response to children, youth and families in crisis.

4 The Encampment Outreach Team works to support and advocate for the underserved and unhoused population, often stigmatized in the community. The highly mobile team is responsive and on the ground to address MHSU needs and bridge gaps in accessing health services.

5 This outreach team works with individuals who have experienced a recent opioid overdose and are not connected to a case management or substance use team. The team consists of Island Health Registered Nurses and Umbrella Society Outreach Workers.

6 https://www.cpsbc.ca/files/pdf/2021-22-Annual-Report.pdf

7 https://www.islandhealth.ca/sites/default/files/mental-health-substance-use/documents/cares-brochure.pdf

Appendix A:

SUMMARY OF ROSEMAN SURVEY OF FAMILY DOCTORS: N=30

The mental health care needs of my patients are being well met by the overall healthcare system:

☐ Strongly Agree ☐ Agree ☐ Neutral ☐ Disagree 43% ☐ Strongly Disagree 57%

Check all items below that *significantly* impact your ability to provide mental health care to your patients. Indicate (e.g., circle, star, ...) your top three concerns.

Your Name: _____

(optional; will be kept confidential)

CHALLENGES WITH PATIENTS

- __ can't/won't provide adequate history
- 25% unrealistic expectations
- __ don't understand instructions
- 18% don't follow instructions
- 32% don't arrange/attend followup appointments

ACUITY OF CARE FOR FAMILY PRACTICE

- 36% patients too acute to manage safely
- 86% patients too acute or complex to manage well
- 29% not confident can accurately diagnose
- 4% not confident choosing investigations
- 29% not confident creating treatment plan
- 50% not confident picking best medication options
- 25% not confident managing medication use

PATIENT MANAGEMENT

- 43% no time to adequately assess symptoms
- 11% no time to order investigations, document
- 32% no time to create overall treatment plan
- 14% no time to answer patient questions
- 21% no time to manage followup treatment
- 75% too many problems to squeeze into one visit
- 61% longer appointments needed but unavailable
- 18% challenges with telephone/video appts

write-in answers > 1 occurrences:

21% no-one accepting/not enough psychiatrists
7% PES concerns

ACCESSING PSYCHIATRY (ISLAND HEALTH)

- 50% referrals rejected (patients not acute enough)
- 46% referrals rejected (other)
- 86% patients need ongoing care (only got consult)
- 86% wait time for accepted referrals too long
- 18% not helpful in clarifying diagnosis
- 46% not helpful in managing treatment

OTHER PSYCHIATRY (NON-ISLAND HEALTH)

- 18% referrals rejected (patients not acute enough)
- 32% referrals rejected (other)
- 32% patients need ongoing care (only got consult)
- 46% wait time for accepted referrals too long
- __ not helpful in clarifying diagnosis
- 4% not helpful in managing treatment

OTHER RESOURCES AND ISSUES

- 4% RACE line not helpful
- 79% few accessible/affordable counsellors
- __ lack of useful patient education resources
- 46% financial disincentives
- 7% other priorities
- 50% increased demand due to COVID-19
- 7% prescribing restrictions etc. from College

Appendix B:

INTRODUCTION TO ISLAND HEALTH AND MHSU GOALS

Island Health provides health care to over 800,000 people across a widely varied geographic area of approximately 56,000 square kilometers on Vancouver Island, the Gulf and Discovery Islands, and part of the mainland opposite to northern Vancouver Island.

Island Health works in partnership and shares responsibility with colleagues, clients, communities, municipal and government organizations to integrate services through Community Health Networks that bring together multiple partners to improve community health and wellness.

Community Health Networks enable a societal approach to health by mobilizing the influence and resources of local leaders and partners from across sectors including local governments, local First Nations, educational institutions, Divisions of Family Practice, community-based organizations, business sector representatives, provincial ministries and community members from diverse backgrounds who may not be affiliated with any specific organization.

As per information available on their website, Island Health is currently realigning their program, service, and administrative structures to a more geographic, community-based model. This shift originates from a 2013 strategic planning process that involved Island Health staff, Family family doctors, and community stakeholders. This geographic realignment is an ongoing process that continues to evolve over time.

Each of the four Island Health geographic areas is divided into several community hubs and within each hub there will be a combination of locally delivered and managed health services (e.g., emergency departments, home, and community care) as well as services that are planned and coordinated across Island Health (e.g., mental health and substance use, public health, specialized hospital services). Locally managed and delivered health services are incorporated and integrated at a community level, based on input from local communities, staff and leadership.

Island Health's intent is to build on existing community partnerships and develop new relationships across our service areas that create community networks which support health and care for patients, clients, and residents.

While several of Island Health's programs and services are transitioning to the community-based delivery model, some specialized programs and services continue to benefit from an Island-wide structure and delivery for surgical programs, heart health, renal programs, medical imaging, laboratory, pharmacy, public health, child/youth/family, seniors' programs and mental health and substance use.

Island Health delivers specialized community services for mental health and substance use to better support adults and youth including opioid therapy and outreach teams.

Island Health Goals for MHSU
(excerpt from 2021 – 2023 Service Plan)

OBJECTIVE 1.3: IMPROVE ACCESS TO TREATMENT AND RECOVERY FOR MENTAL HEALTH AND SUBSTANCE USE SERVICES

Mental health and substance use services focus on collaboration across programs, organizations, and sectors to improve services for vulnerable populations. For vulnerable and hard to serve populations, our focus is on severe and persistent mental health and substance use issues. Island Health is strengthening its coordinated access to specialized services for individuals requiring mental health and/or substance use care.

KEY STRATEGIES:

- Establish additional coordinated access to specialized services for people requiring mental health and/or substance use supports and care.
- Redesign the Victoria Mental Health Centre and Intensive Care Management Teams to improve access.
- Advance COVID-19 readiness plans for mental health & substance use clients by increasing virtual care access to services.
- Implement a recruitment strategy for psychiatrists.
- Strengthen outpatient/community addictions services and preventative programs.
- Support timely and appropriate access to acute and tertiary mental health & substance use services for both adults and children/youth.

PERFORMANCE MEASURE

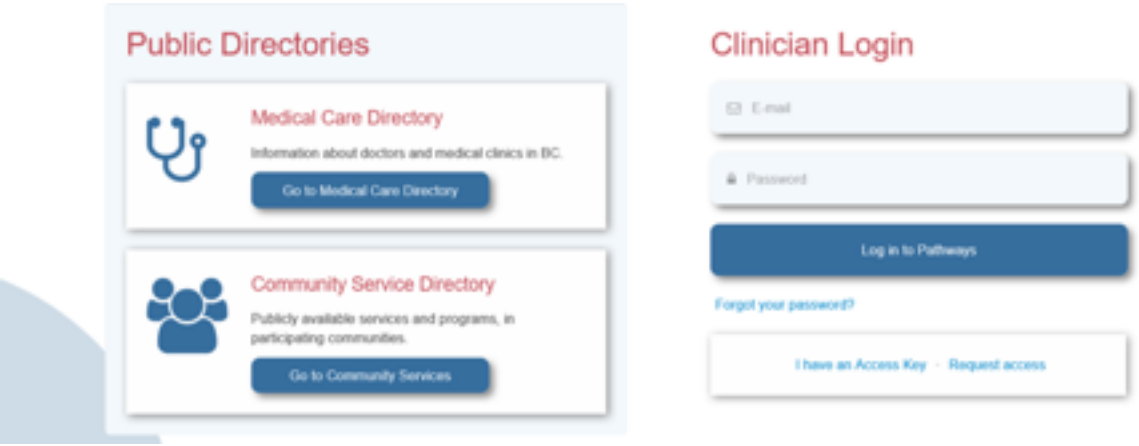
Percent of people admitted for mental illness and substance use who are readmitted within 30 days, 15 years or older

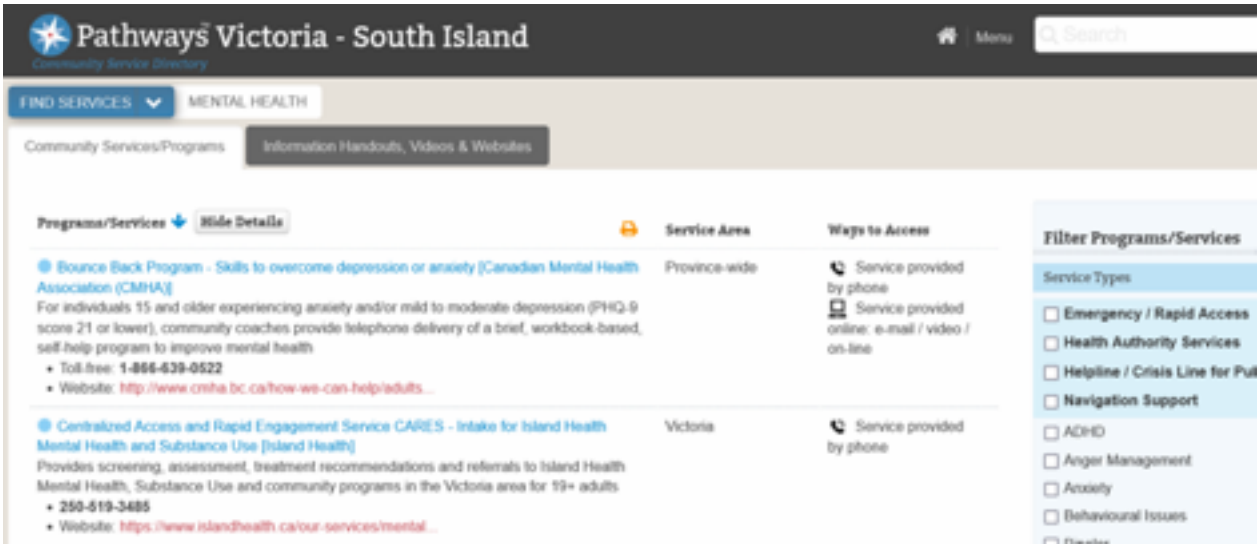
2017/18: ACTUAL 12.5%
2019/20: ACTUAL 14.2%
2022/23: TARGET 12.2%

LINKING PERFORMANCE MEASURES TO OBJECTIVES:

This focuses on one aspect of the effectiveness of community-based supports to help persons with mental health and/or substance use issues receive appropriate and accessible care and avoid readmission to hospital. Other components include good discharge planning and maintaining the appropriate length of stay in a hospital.

Appendix C:
Pathwaysbc.ca Community Service Listings





Appendix D: Literature Review

1. A Pathway to Hope Progress Report, Ministry of Mental Health and Addictions, September 2021
2. A Pathway to Hope: A roadmap for making mental health and addictions care better for people in British Columbia, Ministry of Mental Health and Addictions
3. BC's Mental Health Reform, Best Practices for Psychosocial Rehabilitation and Recovery, Ministry of Health
4. Building an Equitable Foundation: Removing barriers to access for people with mental health and substance use-related disabilities, Kendra Milne and Amelia Hamfelt, September 2019
5. Community Navigator Project, Evaluation Report, Dr. Nancy Hall PhD Alisa Stanton MPH, 2012
6. HealthLinkBC Website
7. Island Health Website
8. Local Health Area Profile, Island Health, July 2018
9. Mark Roseman personal blog
10. Mood and Anxiety Disorders in Canada, Public Health Agency of Canada
11. Pathwaysbc.ca Website
12. PSRC_NAVWG_FocusArea1_Nov.2321_Mapping & Engaging Navigators
13. PSRC_NAVWG_FocusArea2_Nov.2421_AwarenessBuilding
14. PSRC_NAVWG_FocusArea3_Nov.2521_NavigatorForAll
15. PSRC_NAVWG_FocusArea4_Nov.2521_ConveningNavSystemOwners
16. Review of Greater Victoria Psychosocial Rehabilitation and Recovery Oriented Services, Dr. John Higenbottam and Dr. Regina Casey
17. Social Inclusion: The key determinant of mental wellness, Amelia Hamfelt, October 2019
18. Strategic plan 2021-2025 Supporting better mental health and substance use outcomes for all British Columbians, CMHA BC Division
19. The Sooke Navigator project: using community resources and research to improve local service for mental health and addictions, J Ellen Anderson MD MHSc, Susan C Larke MSc, 2009
20. Umbrella Society Website