

**Systems Integration Group for Mental Health and Addictions (SIGMHA)**  
**IHSP Refresh Discussion Notes**  
**Thursday May 7, 2009**

**1. From your perspective, what services would help minimize and/or reduce the early return visits to ER for patients who recently visited the emergency room?**

- centre of excellence for MH&A → user-friendly and accessible
- funding: CSS underfunded for addictions and it show in data i.e. increase ED rates and alcohol and drug use
- better transitional age-sensitive programs in adult-oriented services; need to build skill set accordingly
- urgent care clinic for MH&A
- London Health Science Service – study on using peer support workers in ER- helped individuals integrate back into community and part of discharge plan.
- Appropriate placement of patients
- Primary physicians have some difficult MH&A cases and need help managing them. No specialized services available or long waitlists..
- Need more community support systems and supportive housing (no fixed address, back to ED)
- Not enough MH&A services for youth – up to 1 year wait lists
- Anxiety→ ED visits in the area of CSI; managing anxiety and pain – long wait lists
- Reduce ED visits – with \$130,000 can't do much more; priority to teach self-management needs additional funding
- SIGMHA focusing on hospital services and there needs to be focus also on Community MH&A
- Impact of the economy has increased ED visits
- Lowest funded of all CSS – not much services
- CCAC staff in ED working on MH &A clients work collaboratively for discharge.
- Justice Services serving new clients- programs not accepting new clients due to perceived risk.
- EDU unit at THC –new unit providing 3-5 sessions to ED clients, 2 weeks trying to address issues and get visits with Community services.
- Priority for integration – but funding doesn't reflect – disconnect between priority and funding structure
- CAMH model within the LHIN – centre of excellence for the LHIN
  - CAMH inaccessible to primary care – great for info but can't get anyone admitted
  - Need client driven not research driven
  - public campaign for awareness
- Shared care for capacity building
- Funding more adequate – ACDC – globe budget vulnerable to funding
- Stabilization beds for addictions needed

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- Transitional youth services CVH 19 – 26 years
- Discharge planning – long wait lists → relapsing, many factors pick apart what is contributing to increased ED visits
- Need to drill down to understand the data
- Clients being referred but not connecting to the services
- Diagnosis contributing to repeat visits
- Result of chronic underfunding of the addictions system – no access to Accord funding
- People in addictions and MH...aging
- Training for CIT/clt?
- Need to make business case – net gain, community programs' impact
- Core issues in community- poverty and homeless up- do not have a good support system
- No geriatric community support shelters
- Need for affordable housing.
- Addictions- no fixed address so they go back to ED.
- Lack of ED and MH staff at Milton.
- Need for Follow up phone-call 2-3 days after ED visit
- Services for youth- not enough services in the region. One year waitlist. Nexus has 2 workers. Kids continue to repeat in ED.
- Many go to Toronto where there are services.
- Young addicts (12-15 yrs) cannot access Detox bed till 16 yrs old.
- Transitional youth- do not fit into existing services and become problematic client in the future.
- Task Force for Transitional Aged Youth.
- There needs to be a 24/7 clinic for MH&A.

## **2. How will these results be measured?**

- MOH-LHIN specific data: but may be premature because services are needed first
- COAST at HHS: successful program which brings about a dramatic drop in ED visits for MH&A, funded program will make the difference
- Needs to be a historical trending of where MH&A has been, what has helped, where are the gaps?
- Business plan for Youth 18 – 26 years for MH&A
- what are the services that LHIN 14 did to reduce ED visits?
- What are the trends that contributed to ED visit reduction
- interpret stats in comparisons to other areas (LHINs)
- Access to services are different in other areas (LHINs)

## **3. What integration opportunities could be implemented to improve access to mental health and addiction services across our LHIN?**

- Need to integrate C&Y services – lot of resources but scattered. Peel youth collaborative – need to create a real integrated network.

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\* The problem is Family practice and Telehealth sending patients to ER as part of their after-hours voice message.

- there should be regulation for family practice to have after hours available 5 – 8 pm and 1 weekend day.
- why can't patients get resources from their primary physicians after-hours, which would stop ED visits? There use to be a province Regulation for Physician after hours on call
- Ask the question- Are the services in place rather than increase service efficiency, this would better fix the problem outcomes.