Bridging the Gap from Hospital to School for Students with Mental Health Concerns

Lessons Learned From the NAvigaTe Project

Introductions

- Sarah Bell: Transition Coordinator
- Judy Vorderbrugge: Project Coordinator

Presentation Outline

- Project Context
- Model
- Outcomes
- Considerations for Implementation
- Q & A

The Proposal: Why NAvigaTe?

Students with mental health concerns transitioning between hospital and school:

- Are at high risk for dropping out of school, relapse and re-hospitalization
- Have difficulty navigating and accessing community and post-secondary resources
- Require intensive support from student services and resources
- Encounter difficulty navigating academic requirements and social environments

The Proposal: A Collaboration

- Mental Health Innovation Funded
- Collaboration between Ryerson University, University of Toronto, and York University
- To support students transitioning between GTA hospitals and the 3 schools
- Develop and test a model of transition support

Intended Impact: Students

Post-secondary students who have the support of the NAvigaTe Program will:

- Better understand/manage their illness/issues, medication and symptoms
- Be aware of available resources on and off campus to support their health and academic goals;
- Recognize early warning signs and to seek out support earlier

Intended Impact: System

- Test and develop a program that supports early intervention, decreases risk of relapse and re-hospitalization, increases likelihood of academic progression and decreases intensive need for campus services.
- Test and develop a model for sharing scarce resources across multiple PSEs.

Model: Components

1. **Steering committee** - representatives from all 3 schools, Terms of Reference, MOU
2. **Program staff** - Transition Coordinators (RNs), Program Coordinator, Program Psychiatrist
3. **Communication tools** - program logo, brochure, one page descriptor, business cards
4. **Program Tools** - eligibility criteria, referral forms, care pathway, consent forms, care plans, discharge criteria, evaluation forms, documentation systems

Project Team

Steering Committee

Nursing Clinical Report

Program Coordinator

Transition Coordinators

Program Psychiatrist

Model: Hospitals

Requested them to:

1. Identify when patient is a student of one of the 3 universities
2. Provide information on NAvigaTe Program
3. Explain the referral process and obtain informed consent
4. Involve NAvigaTe in discharge planning where possible and appropriate
5. Provide discharge summaries to the NAvigaTe Program

Model: Eligibility

- Currently enrolled at either Ryerson, York or the University of Toronto (St. George Campus)
- Not well-connected to community mental health and/or academic services
- Recently hospitalized (inpatient or ER)
- At least 16 years of age

Model: Care Pathway

NAvigaTe Care Pathway

Referral to NAvigaTe Program: Referrals from area hospitals and campus services are sent to the NAvigaTe Program via fax (see NAvigaTe Program Referral Form)

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Transition Coordinator (TC) is notified via email of new referral. TC contacts referral source to obtain hospital and discharge records and creates client chart. Completed referral form is shared with program psychiatrist to assess eligibility.

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If, at the time of referral, the student has been discharged from hospital, TC will make contact with student directly to set up an appointment for an intake assessment and completion of any additional consent forms once hospital records have been received.

If referral is received from local area hospital, and student is still in hospital, TC may:

- attend discharge meeting
- make regular contact regarding client's progress with program psychiatrist, client and/or hospital care team
- be provided with a discharge summary/plan

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Intake Assessment & Brief Directed Interview – (BDI) up to two hours in duration, completed/initiated at first appointment with TC, within 72 business hours after receipt of documentation, and includes:

- Overview of the program, scope of services provided
- Review privacy, confidentiality & consent forms
- Consultation with NAvigaTe Program Psychiatrist
- Determine eligibility for admission

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Second Session: Goal Setting Ideally takes place within 72 hours of initial visit (up to one hour in duration) ⇄ Assessment appointment with NAvigaTe Program Psychiatrist

- Identifying Students Goals
- Assessment of Students Current Status: MSE
- Identifying on and off campus resources that may benefit client

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Follow-up Visits: ideally, one face-to face-visit/week for first two weeks, then every other week thereafter. Check-ins by phone or email as needed to assess:

- Status and follow through with care plan
- Connection with resources
- Risk assessment as needed
- Ongoing assessments of mental status (MSE)

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Two Month Reassessment: TC reassesses using short BDI tool, determining students' need for continuation in the NAvigaTe Program (up to 1.5 hours in duration)

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Continued participation in NAvigaTe Program → Discharge From NAvigaTe Program → Program Evaluation at discharge → Program Evaluation at 8 weeks post-discharge

Referral

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- **attend discharge meeting**
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Intake

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Working with Students

Identifying Students Goals

Assessment of Students Current Status: MSE

Identifying on and off campus resources that may benefit client

Follow-up Visits: ideally, one face-to face-visit/week for first two weeks, then every other week thereafter. Check-ins by phone or email as needed to assess:

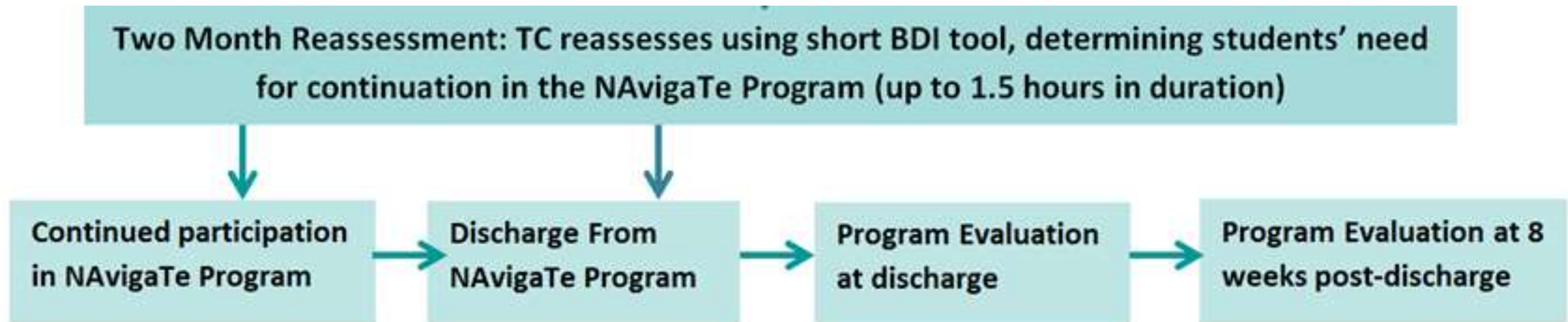
Status and follow through with care plan

Connection with resources

Risk assessment as needed

Ongoing assessments of mental status (MSE)

Reassessment, Discharge & Evaluation



Case Study One

- **20 year old male**, second year, full time studies
- Referred to NAvigaTe from Hospital Urgent Care Clinic
- Emergency visit for **suicidal ideation**
- **Diagnosis:** Tourette's Syndrome, OCD
- On medication at intake to NAvigaTE
- **Connections made:** Disability Services, CMHA Peer Drop-in Centre, Learning Skills Services, community psychotherapy services, Tourette's Clinic at Toronto Western Hospital
- **# of weeks in program:** 42
- **# contacts with client:** 77
- **# of contacts with resources on client's behalf:** 30
- **Outcome:** completed program, connected to resources

Case Study Two

- **20 year old female**, second year, full time studies at intake
- Referred to NAvigaTe from counselling centre
- Recent emergency visit for self-harm, **“too complex for counselling”**
- **Diagnosis:** Depression, ?BPD
- Not on medication at intake to NAvigaTe
- **Connections made:** Disability Services, on campus academic case management, community psychotherapy, DBT skills group, on campus psychiatry, Sheena’s Place, Blu Matter Project yoga study, support with OSAP, access to BSWD grant
- **# of weeks in program:** 24
- **# contacts with client:** 71
- **# of contacts with resources on client’s behalf:** 63
- **Outcome:** completed program, connected to resources

Case Study Three

- **24 year old female**, second year, not currently enrolled at intake
- Referred to NAvigaTe from hospital inpatient unit, discharged AMA
- Admitted to hospital on a form for psychosis
- **Diagnosis:** ?schizoaffective disorder
- Not on medication at intake to NAvigaTe
- No fixed address
- **Connections made:** LOFT Community Services, family GP, case worker at shelter, academic case manager on campus
- **# of weeks in program:** 3.5
- **# contacts with client:** 17
- **# of contacts with resources on client's behalf:** 20
- **Outcome:** re-admitted to hospital (client brought herself)

Data & Evaluation

Methods:

- Data collection: quantitative, qualitative
- Clients: discharge, 8 week follow up survey
- Community partners: end of pilot year survey

Complexity

Diagnosis at Referral	% of clients admitted
Psychosis	18%
Depression/anxiety	47%
Obsessive Compulsive d/o	6%
Borderline personality d/o	6%
Bipolar d/o	12%
Adjustment d/o	18%

Needs at Referral	% of clients admitted
Homelessness	6%
Substance use	29%
Eating disorder	6%
Temporary withdrawal from school	35%

At Discharge from Hospital:

- 30% discharged without psychiatric care in place
- 50% of those without care in place were on a new medication
- Most not connected to campus disability services

Client Evaluation

- Better understand my diagnosis/condition and expected symptoms: **83%** strongly agree **100%** somewhat or strongly agree
- Better understanding of my medication(s) and their possible side effects: **66%** strongly agree **100%** somewhat or strongly agree
- Better able to set goals & identify priorities for recovery & continuing studies: **100%** strongly agree
- Better able to connect with services to support recovery & continued studies: **83%** strongly agree **100%** somewhat or strongly agree
- Helped support recovery & continued academic progress: **83%** strongly agree **17%** neutral

Strengths

- Unique service
- Nursing role
- Continued support to students who were not continuing with school/taking time away
- Being a connector
- Able to take on cases too complex for counselling
- Mobility
- Flexibility

Challenges

- Three different campuses
  - Where do we fit?
- Student complexity
  - three month limit to service inadequate
  - service not robust enough
  - role of psychiatrist as “meet and greet”
  - Universities closed at certain times of year

Challenges

- Shared resources
  - psychiatrist at one site
  - TC at 3 sites
- Relationships with hospitals
  - repeat meetings necessary
- Documentation - are we a separate entity or should we document within school's EMR?
- York University - no medical centre

Intended Outcome of Model

1. Reduce re-admission to hospital
2. Get students to appropriate supports in a timely manner
3. Better collaboration between on and off campus services to support students
4. Support students in making academic decisions that enhance their mental health

Toolkit

Will be found at:

http://campusmentalhealth.ca/project/navigate-nurse-assisted-transition-university-virtual-ward/