CMHO
Children's Mental Health Ontario
Santé mentale pour enfants Ontario

2020 CMHO Virtual Conference

Innovating and Advancing Child and Youth Mental Health

November 23 to December 4

Sponsored by

Ontario Centre of Excellence for Child & Youth Mental Health
Centre d'excellence de l'Ontario en santé mentale des enfants et des adolescents

Housekeeping

- **Your line has been muted**. If you would like to comment or ask a question using audio, please use the ‘Raise Hand’ function.

- A chat function is available to anyone who would like to leave a comment/question.

- To message the host privately select the chat icon and within the area that says “To:”, click the drop-down box and select ‘Host’.

- This meeting is being recorded.

- If you have any questions or concerns, please message the meeting host or **info@cmho.org**

Land Spirit Acknowledgment

Braiding Earth, Spirit, and Self: Wellness Grounding Session

- Opening Session Monday November 24
- Brief video at www.cmho.org/virtual-conference

Thank you to our Sponsor

Ontario Centre of Excellence for Child & Youth Mental Health

Centre d'excellence de l'Ontario en santé mentale des enfants et des adolescents

The best mental health and well-being for every child, youth and family.

cymh.ca

Innovative Models of Mental Health and Primary Care Partnerships

Presented by: Leanne Clarke, Kavita Mehta, Dr. Mario Cappelli, Dr. Kellie Scott

Innovative Models of Mental Health and Primary Care Partnerships

Speakers:

- Leanne Clarke, CEO, Ontario College of Family Physicians
- Kavita Mehta, CEO, Association of Family Health Teams of Ontario

The Complexity of Primary Care Models
Family Physician Practice Types

Fee For Service

- FFS
  Fee For Service
- CCM
  Comprehensive Care Model

Blended FFS

- FHG
  Family Health Group
- FHO
  Family Health Organization
- RNPGA
  Rural & Northern Physician Group

Capitation Based

- FHN
  Family Health Network

Salary Based

- CHC
  Community Health Centre
- BSM
  Blended Salary Model
- NPLC
  Nurse Practitioner-Led Clinic

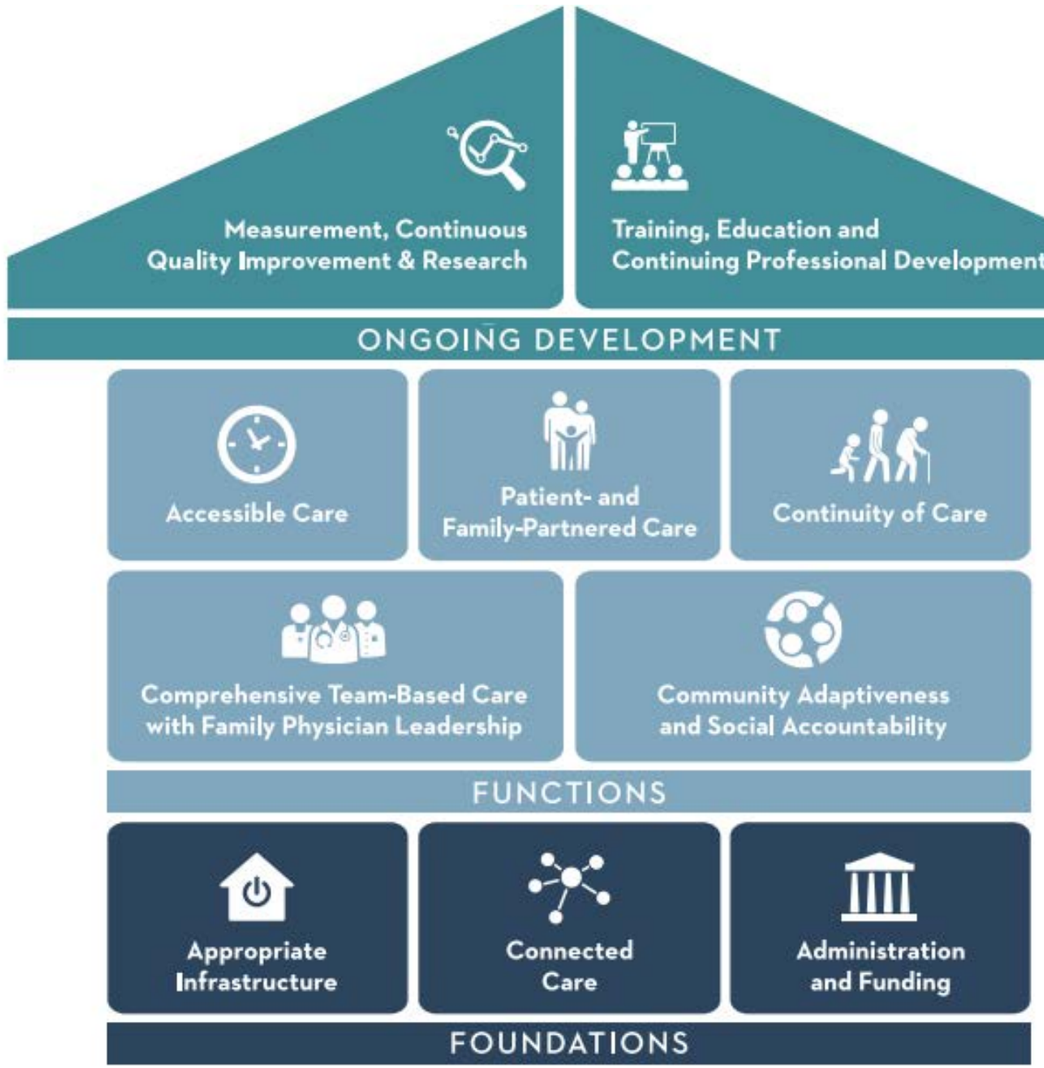
FPs must be in one of these models to be part of a FHT

Other: APP, etc.

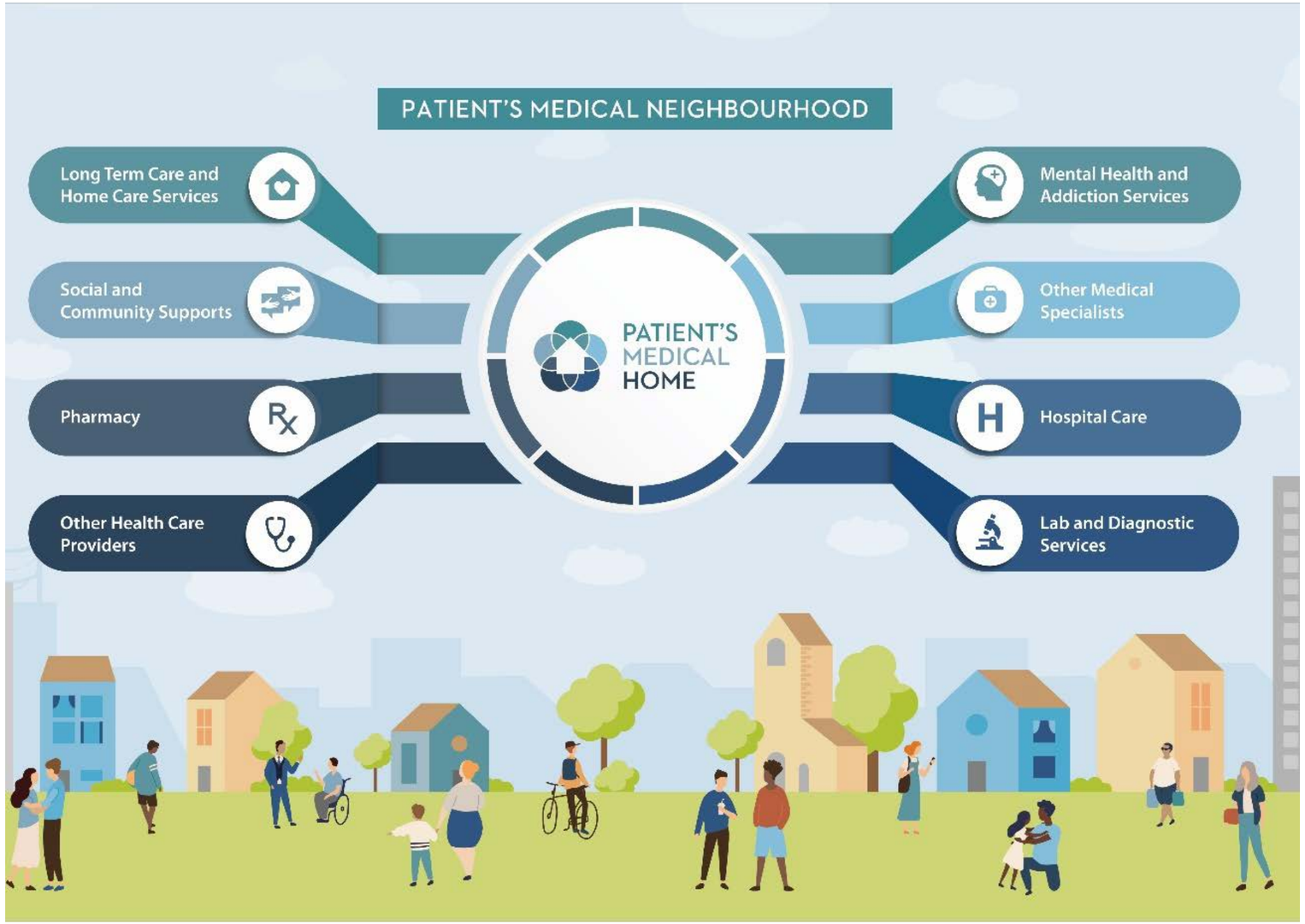
Family Physician by Practice Type

Practice Type	Percentage of Family Physicians
FHO/FHN in a Family Health Team	25% (2,723)
FHO/FHN not in a FHT	25% (2,671)
FHG	24% (2,620)
FFS/CCM	25% (2,784)
CHC/RNPGA/etc.	1% (+110)
Total	100% (11,000 practising members)

- **25%** of family physicians in a FHT with access to funded team-based resources
- **25%** in capitation models working as a group of doctors who pay for their staff
- **50%** in FFS or blended FFS models who pay for their staff



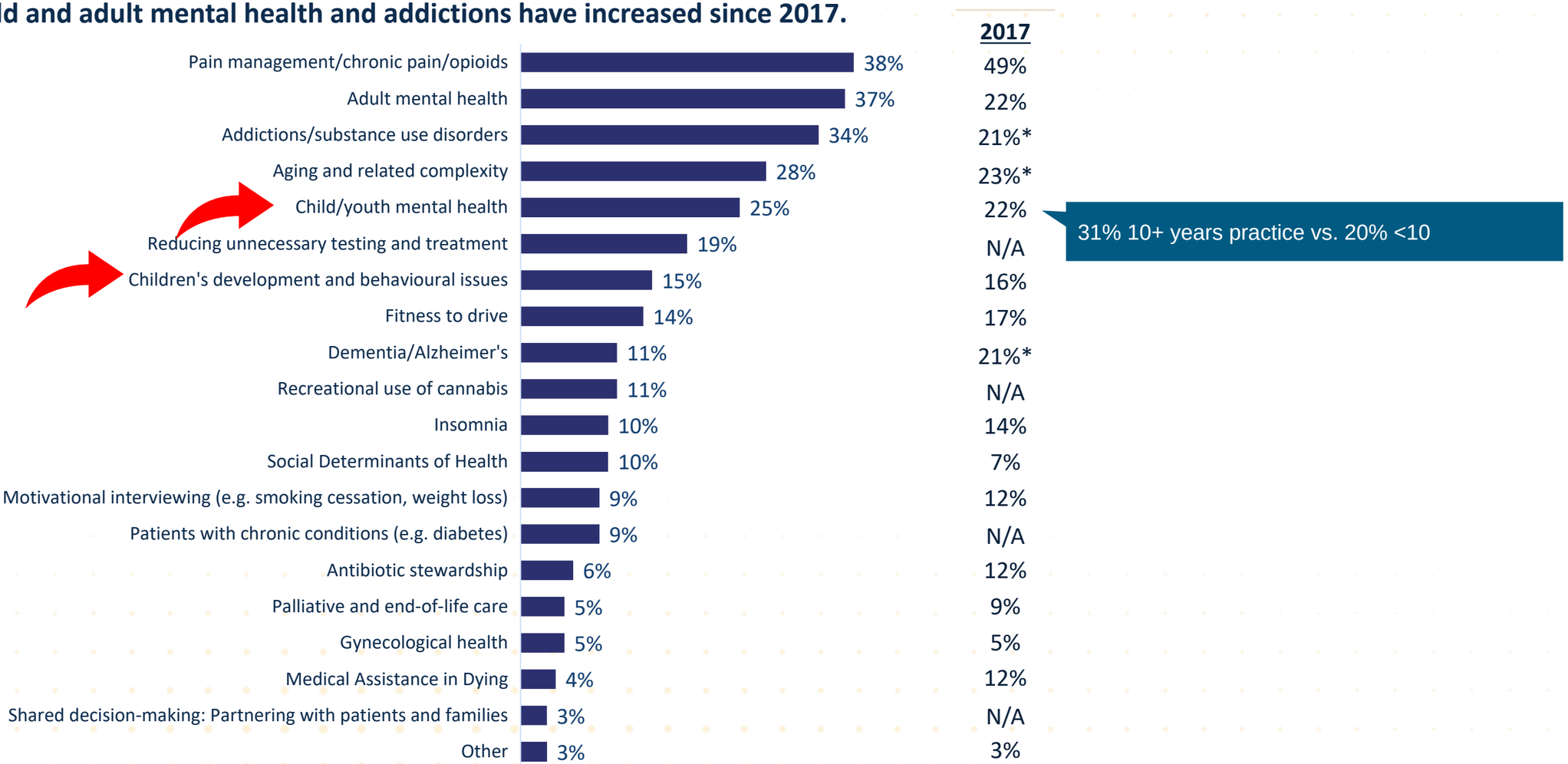
What is the vision in a diverse sector?



Medical Homes for all Connected in a Neighbourhood

OCFP 2019 Member Research: Top Clinical Pain Points

- Pain management/chronic pain, adult mental health and addictions top clinical pain points.
- **Child and adult mental health and addictions have increased since 2017.**



31% 10+ years practice vs. 20% <10

*Different wording used in 2017 survey, tracking imperfect

Q. We would like to discuss potential complex or challenging clinical issues in your practice. Please select the top three clinical issues that are 'pain points' in your practice?

Base: 2019: All respondents (n=900); 2017: All Respondents n=1,480

Role of Primary Care Providers in Child/Youth Mental Health and Addiction Care

- Most often the first point of contact in the health system
- Primary care/family medicine is about trusted relationships over a patient's lifetime
  - Importance of "family" in family medicine
- Collaborative and continuous
  - Cohesion and continuity in the health care system; coordinate care with other health care providers to best meet patient needs for compassionate care

Mental health is a huge part of family medicine and we don't have enough resources for it

Common Challenges for Primary Care and Providers

- Child and Youth Mental Health and Addiction wait list
  - Not enough resources and clinical expertise to support this growing issue
  - Only 30% of Ontarians have access to team-based care (equity issues)
- Lack of awareness of resources available (how to navigate)
  - Multiple organizations – what is their scope of service and programs
  - Organizational mandates and scope of supports and resources
  - Patients are transient and don’t always live in the community in where they seek care

Common Challenges for Primary Care and Providers (con't)

- Fragmented and siloed systems of care
  - Different referral pathways for different organizations
  - IT/EMR/EHR systems do not communicate and are not interoperable
  - Different organizations have different referral forms and are often paper based
  - Feedback loop is often limited to fax out but then maybe fax back with consult note – but more often, there is no communication back to the primary care provider (erosion of continuity of care)

Common Challenges for Primary Care and Providers (con't)

- Trust and Circle of Care
  - Primary care visit of a child and/or youth is often done with a parent in attendance – difficult for the child to express their issues
  - Trust is earned – making a referral to someone who is not known can be difficult
  - Face to face is important (or virtual right now) – building relationships takes time but it is the foundation of primary care and they need to know who is in their patient's circle of care
    - Feedback loop back is so critical!!

Examples of Solutions/Strategies

- Engaging the youth in co-design for supports and services
  - St. Michael's Academic FHT (Toronto)
    - Embed needs of youth in the FHT's strategic plan
    - Outreach and liaise with youth community resources to create referral pathways
    - Youth friendly posters in waiting rooms; youth mental health resources/services in community; Youth specific resource boards in clinics; menstrual products available in washrooms
    - Connected with experts in youth engagement in the community to better understand what works and how to engage
      - Anne Johnston Health Services, Planned Parenthood, East Metro Youth Services
    - Surveyed the needs and wants using platforms and tools youth use
      - OCEANS survey link (sent out by text, email)
    - Youth Advisory Group - youth directed group of 6 to 8 members with some structure but really focused on the issues facing youth (creation of a MH peer group for youth)

Examples of Solutions/Strategies (con't)

- Supporting Youth Struggling in School - School Success Program
  - Couchiching FHT (Orillia)
    - Program for children with mental health issues and learning disabilities
    - The Social Aces program, delivered in partnership with Toronto's Child Development Institute, is the only program of its kind in the region.
    - The group program teaches transferable social skills that the youth can apply in other social settings.
    - School Success Program assesses and helps children and young people who are struggling at school and support their families.
    - With consent, the school and the primary care provider refer the youth and family for:
      - Pediatric Assessment AND/OR
      - Supportive counselling, including short term individual/parent/family/group work as appropriate
    - Program supported through CFHT nurse, social workers and pediatrician – there is a continuous feedback loop between the family – school – primary care team.

Examples of Solutions/Strategies (con't)

- Cross-sectoral collaboration and planning – Families First
  - Caroline and Burlington FHTs (Burlington) with Reach Out Centre for Kids (ROCK)
    - The Caroline Families First program for children and youth with complex mental health issues and uses an evidence-based wraparound model.
      - The child or youth must be diagnosed or have a query diagnosis of a mental health struggle
    - The premise was to design a program to address the fragmented relationship between primary healthcare and children's mental health services and seeks to address the need for more open communication between the two sectors - the program uses a peer support worker (community mental health) who is co-located with referring physicians (primary care) to create a circle of care.
    - The wraparound care is an intensive, individualized care planning process which aims to achieve positive outcomes by providing a structured, creative and individualized team planning process. The process focuses on connecting families to their communities along with other supports and services while building capacity within their own families to manage challenging times.
    - The care coordinators and family support providers help families build capacity for coping with their youngster and navigating the healthcare system.

Examples of Solutions/Strategies (con't)

- Pivoting Funding to meet the needs of the patient roster
  - Central Lambton FHT and St. Clair Child and Youth Services
  - No money for a new hire to meet the deluge of children and youth seeking mental health support in the FHT.
  - Appealed to the Ministry to reallocate under-utilized dietary funding and used those funds to hire a child and youth worker from St. Clair 4 days a week to work onsite.
  - The individual not only provides one on one counselling support but also provides a range of therapeutic services ranging from urgent response to short-term mental health workshops.
  - This not only increases the local capacity to deliver quality mental health services but also enhances linkages to other supports to the residents of rural Lambton County.

Examples of Solutions/Strategies (con't)

- Ontario Health Teams
  - All have identified mental health and addiction as a priority population.
  - Question is how to better bring the child/youth voice into the integration work but also ensure there are further investments (resource and funding).
  - Learning from each other and pushing out sustainable and spreadable solutions will be key – are there best practices already out there that can be emulated?
  - If further mental health investments for children and youth are not being made then are there ways to repurpose funding/supports?
  - How do we keep the communication and feedback loop front of mind to ensure continuity of care and seamless transitions of care?
  - And how do we ensure the voice of the child and youth is heard in the development of care pathways that make the most sense for them?

Primary Care Pathways: Evaluation of a service delivery model designed to improve integration of mental health care for young people and their families in Ontario

Speakers:

- Dr. Mario Cappelli
- Dr. Kellie Scott

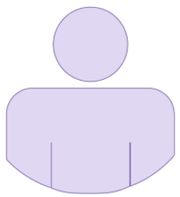
Primary Care Pathways Core Team

KEY contacts

Mario Cappelli, PhD, C.Psych

Senior Child and Youth Mental Health Clinician Scientist

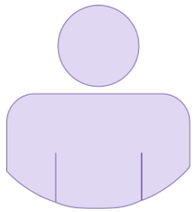
Ontario Centre of Excellence for Child and Youth Mental Health



Purnima Sundar, PhD

Executive Director

Ontario Centre of Excellence for Child and Youth Mental Health



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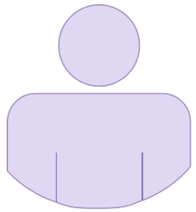
Postdoctoral Fellow

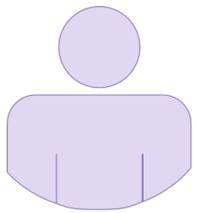
Ontario Centre of Excellence for Child and Youth Mental Health



Paula Cloutier, MA

Research Associate

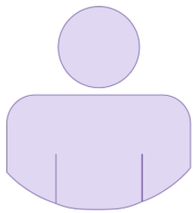
Children’s Hospital of Eastern Ontario



Jaime Brown, PhD

Director, Knowledge Mobilization

Ontario Centre of Excellence for Child and Youth Mental Health



Christine Polihronis, PhD

Senior Data Analyst

Ontario Centre of Excellence for Child and Youth Mental Health

Background

- 62% of families first attempt to access mental health care through their family doctor
- Physicians report feeling ill-equipped to deal with mental health concerns
- Community-based mental health services have long waitlists and inadequate funding; limiting access
- Primary health care reforms underway
- Collaborative partnerships suggested as the answer to improving access to care, quality of care and outcomes
- Child and Youth mental health move to Ministry of Health

It’s a work in progress ….

1. **Policy paper (2017):** Generated 8 recommendations for how to improve interactions between primary care (PC) and community-based mental health service (CB-CYMH) providers in Ontario

2. **Pilot project (2018):** Implemented 3 of the 8 recommendations in 2 communities to assess feasibility

3. **Demonstration trial (2019-2021):** Expanding the evaluation of the 3 recommendations across 7 partner sites

1. Policy paper

PRIMARY CARE PATHWAYS
Connecting primary care and community-based mental health services

CHEO RESEARCH INSTITUTE
INSTITUT DE RECHERCHE

Ontario Centre of Excellence
for Child & Youth Mental Health
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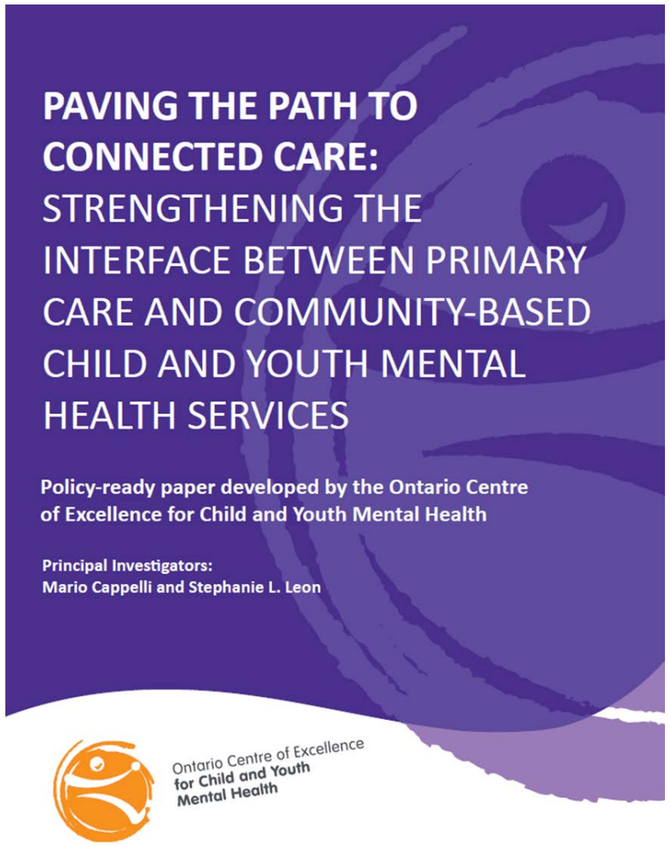
mentale des enfants et des adolescents

1. Policy paper

Goals & Objectives:

- Summarize evidence on the interface between primary care and community-based child and youth mental health service sectors
- Explore evidence-informed models used to guide work in this area
- Hear about what's working and what's not working from children, adolescents, families, and service providers
- Provide policy recommendations to strengthen the way the primary care and community-based child and youth mental health service systems work



http://www.excellenceforchildandyouth.ca/sites/default/files/resource/policy_primary_care.pdf

1. Policy paper

List of Recommendations:

1. Create organizational structures and practices that support inter-provider communication
2. Develop and deliver more effective mental health training for primary care providers to build capacity
3. Provide more opportunities for primary care mental health training for mental health specialists
4. Develop guidelines and standardized clinical pathways
5. Integrate standardized tools in primary care practices
6. Establish effective billing and reimbursement practices that will sustain mental health services
7. Engage families and youth at all levels of the change and monitoring process
8. Support research and ongoing evaluation

2. Pilot project

PRIMARY CARE PATHWAYS
Connecting primary care and community-based mental health services

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2. Pilot project

Goals & Objectives: Pilot three of the policy paper's recommendations:

1. Create organizational structures and practices that support inter-provider communication (based on the Chronic Care Model)
2. Develop guidelines and standardized clinical pathways from PC to CB-CYMH services in each community
3. Integrate standardized tools (HEADS-ED) in PC practices

2. Pilot project

Two pilot sites

1. East Metro Youth Services (Strides Toronto), Toronto
2. Algoma Family Services, Sault Ste. Marie

2. Pilot project

Local advisory committees:

- Based on the Chronic Care Model and need for leadership teams with decision-making power
- Comprised of PC providers, CB-CYMH service providers, other community decision-makers
- Role is to support pathway development, implementation, monitoring, and maintenance

Development of a Pathway

Primary Care /Group Health Centre:

- **Child & youth 6-18 years with mental health and/or addictions concerns**
- **Complete HEADS ED screening tool**
- **Complete PART A of primary care pathways referral form (presenting concerns and family contact information)**

Score of >8 or =8 OR Score of 2 Sucidality AND Clinical Judgement

Urgent /Immediate Care:
Mobile Crisis/Crisis Services-Sault Area Hospital
705-759-3398/1-800-721-0077
Local Hosptials and Emergency Departments

Primary care faxes referral to community AFS Central Intake

Child & Youth Mental Health Agency Central Intake (AFS):

- AFS receives referral and attempts to contact the child/youth/family to complete intake
- AFS completes PART B of the clinical pathway referral form (dates of contact/attempts, outcome of referral, patient anticipated wait time)

AFS completes intake: service booked or referred to other service

AFS faxes completed clinical pathway referral form back to primary care provider (Group Health Centre) to update on status of referral

Community Mental Health & Addictions Services

Algoma Family Services-Intake & Single Therapy Sessions
Mental Health (ages 0-18) / Addictions (ages 14-24)
Sault Ste. Marie: 705-945-5050 Fax: 705-942-9273
Elliot Lake/Blind River: 705-848-0790 Fax: 705-1078
Wawa: 705-856-2252 Fax: 705-856-1046

Algoma Public Health-Addictions (counselling & assessment) (ages 16+)
SSM 705-942-4646 Fax. 705-759-1534
Elliot Lake-705-848-2314 Fax. 705-848-1911
Blind River 705-356-2551 Fax. 705-356-2494
Wawa-705-856-7208 Fax. 705-856-1752

Canadian Mental Health Association
Counselling (ages 16+)
Central Access Information and Referral Service
Tel: 705-759-5989/ 1-855-366-1466 Fax: 705-945-0261
info@cmhassm.com

Counselling Centre of East Algoma
Counselling (ages 12+) / Addictions (ages 12-24)
705-848-2585 Fax: 705-848-9687

Nogdawindamin Children's Mental Health
705-946-3700/1-800-465-0999 Fax: 705-946-3717

Nogdawindamin-Walk In
Families with children (0-18), youth 12-18 Parents and Caregiver

Sault Ste. Marie-123 March Street-Third Floor
Wednesdays 12 noon-8pm

East Algoma-Serpent River
473 Hwy 17, Building "C", Cutler
1st Wednesday of every month 12 noon-8pm

Walk in Counselling-SSM
children/youth/adults/families
Tuesdays-11:30-7:00 last appointment at 5:30
386 Queen Street East, SSM
705-759-5989/1-855-366-1466 Fax: 705-945-0261

Key Elements of the Pathway: 1: The HEADS-ED

- Triage/screening tool developed for health care professionals
- Based on a common pneumonic
- Brief, easy to complete & score, clinically intuitive, valid & reliable
- Used to help guide clinical decision making

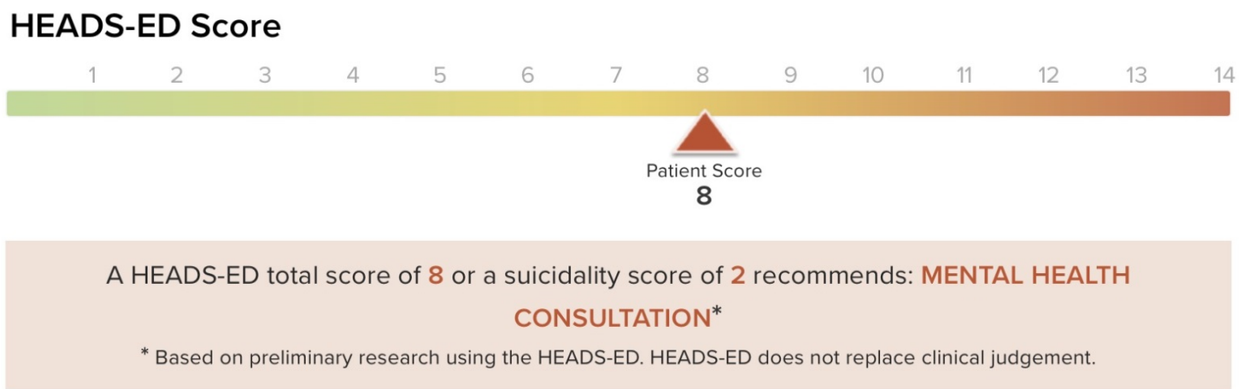
The HEADS-ED

	0 No action needed	1 Needs action but not immediate/moderate functional impairment	2 Needs immediate action/severe functional impairment
Home *Example: How does your family get along with each other?*	○ Supportive	○ Conflicts	○ Chaotic / dysfunctional
Education, employment *Example: How is your school attendance? How are your grades? Are you working?*	○ On track	○ Grades dropping /or absenteeism	○ Failing / not attending
Activities & peers *Example: What are your relationships like with your friends?*	○ No change	○ Reduction in activities/increased peer conflicts	○ Increasingly to fully withdrawn / significant peer conflicts
Drugs & alcohol *Example: How often are you using drugs or alcohol?*	○ None or infrequent	○ Occasional	○ Frequent / daily
Suicidality *Example: Do you have any thoughts of wanting to kill yourself?*	○ No thoughts	○ Ideation	○ Plan or gesture
Emotions, behaviours, thought disturbance *Example: How have you been feeling lately?*	○ mildly anxious / sad / acting out	○ Moderately anxious / sad / acting out	○ Significantly distressed / unable to function / out of control / bizarre thoughts/significant change in functioning
Discharge or current resources *Example: Do you have any help or are you waiting to receive help (counselling etc)?*	○ Ongoing / well connected	○ Some / not meeting needs	○ None / on waitlist / non-compliant

The HEADS-ED is a screening tool and is not intended to replace clinical judgment.

HEADS-ED Administration and Scoring

- No formal administration instructions or probing questions (assumes a basic knowledge of child & youth mental health)
- Add 0,1, & 2 for a total score
- Total score of >=8 or a suicidality score of 2 recommends a specialized mental health consultation (e.g. EDMH Crisis Worker, Psychiatric Consultation)
- A score of 2 on any item, indicates an urgent need for follow-up in that domain



Supporting evaluations of the HEADS-ED

- The HEADS-ED: Evaluating the clinical use of a brief, action-oriented pediatric mental health screening tool, Pediatric Emergency Care, May 2017
- Barriers and facilitator to implementing the HEADS-ED: A rapid screening tool for pediatric patients in emergency departments, Pediatric Emergency Care, December 2017
- Evaluating the HEADS-ED screening tool in a hospital-based mental health and addictions central referral intake system: A prospective cohort study, Hospital Pediatrics, February 2019
- The HEADS-ED: A rapid mental health screening tool for pediatric patients in the emergency department, Pediatrics, August 2012
- A systematic review of instruments to identify mental health and substance use problems among children in the emergency department, Academic Emergency Medicine, May 2017
- A systematic review of management strategies for children's mental health care in the emergency department: update on evidence and recommendations for clinical practice and research, Emergency Medicine Journal, June 2017
- U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. Critical Crossroads Pediatric Mental Health Care in the Emergency Department: A Care Pathway Resource Toolkit. Rockville, Maryland: U.S. Department of Health and Human Services, 2019

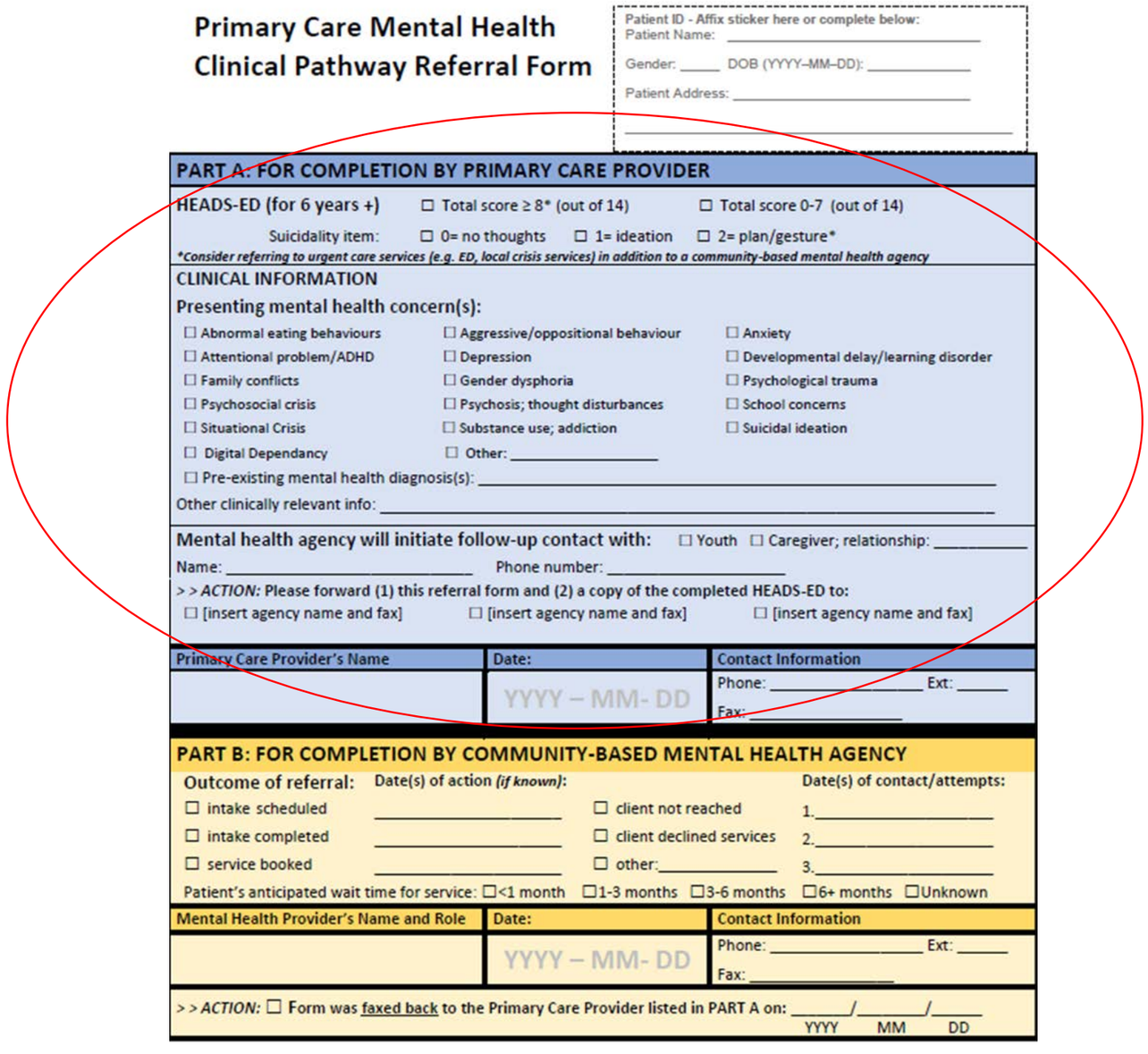
Currently Known Uses

- Creative Commons copyrighted; therefore no restriction to contact us for permission but still get frequent requests about the tool and permission to use the tool

- Hospital centralized Intakes
- Community Centralized Intakes
- School Boards
- Walk-in Clinics
- Ontario ED Mental Health & Addiction Clinical Pathways
- US - endorsed by U.S. Department of Health and Human Services, 2019
- Italy – Implemented in Milan’s EDs

Key Elements of the Pathway

2. **Common referral/ communication form:** Linking primary care and community-based mental health service providers



Primary Care Mental Health Clinical Pathway Referral Form

Patient ID - Affix sticker here or complete below:
Patient Name: _____
Gender: _____ DOB (YYYY–MM–DD): _____
Patient Address: _____
_____

PART A: FOR COMPLETION BY PRIMARY CARE PROVIDER

HEADS-ED (for 6 years +) ☐ Total score ≥ 8* (out of 14) ☐ Total score 0-7 (out of 14)

Suicidality item: ☐ 0= no thoughts ☐ 1= ideation ☐ 2= plan/gesture*

**Consider referring to urgent care services (e.g. ED, local crisis services) in addition to a community-based mental health agency*

CLINICAL INFORMATION

Presenting mental health concern(s):

☐ Abnormal eating behaviours	☐ Aggressive/oppositional behaviour	☐ Anxiety
☐ Attentional problem/ADHD	☐ Depression	☐ Developmental delay/learning disorder
☐ Family conflicts	☐ Gender dysphoria	☐ Psychological trauma
☐ Psychosocial crisis	☐ Psychosis; thought disturbances	☐ School concerns
☐ Situational Crisis	☐ Substance use; addiction	☐ Suicidal ideation
☐ Digital Dependancy	☐ Other: _____	

☐ Pre-existing mental health diagnosis(s): _____

Other clinically relevant info: _____

Mental health agency will initiate follow-up contact with: ☐ Youth ☐ Caregiver; relationship: _____

Name: _____ Phone number: _____

> > ACTION: **Please forward (1) this referral form and (2) a copy of the completed HEADS-ED to:**

☐ [insert agency name and fax] ☐ [insert agency name and fax] ☐ [insert agency name and fax]

Primary Care Provider's Name	Date:	Contact Information
	YYYY – MM- DD	Phone: _____ Ext: _____ Fax: _____

PART B: FOR COMPLETION BY COMMUNITY-BASED MENTAL HEALTH AGENCY

Outcome of referral: Date(s) of action *(if known)*: Date(s) of contact/attempts:

☐ intake scheduled	_____	☐ client not reached	1._____
☐ intake completed	_____	☐ client declined services	2._____
☐ service booked	_____	☐ other:_____	3._____

Patient's anticipated wait time for service: ☐<1 month ☐1-3 months ☐3-6 months ☐6+ months ☐Unknown

Mental Health Provider's Name and Role	Date:	Contact Information
	YYYY – MM- DD	Phone: _____ Ext: _____ Fax: _____

> > ACTION: ☐ Form was faxed back to the Primary Care Provider listed in PART A on: _____/_____/_____
YYYY MM DD

Key Element of the Pathway

3. **Rapid response:** Primary care is informed of the disposition of the referral via community-based mental health service providers

Primary Care Mental Health Clinical Pathway Referral Form

Patient ID - Affix sticker here or complete below:
Patient Name: _____
Gender: _____ DOB (YYYY–MM–DD): _____
Patient Address: _____
_____

PART A: FOR COMPLETION BY PRIMARY CARE PROVIDER

HEADS-ED (for 6 years +) ☐ Total score ≥ 8* (out of 14) ☐ Total score 0-7 (out of 14)

Suicidality item: ☐ 0= no thoughts ☐ 1= ideation ☐ 2= plan/gesture*

**Consider referring to urgent care services (e.g. ED, local crisis services) in addition to a community-based mental health agency*

CLINICAL INFORMATION

Presenting mental health concern(s):

☐ Abnormal eating behaviours	☐ Aggressive/oppositional behaviour	☐ Anxiety
☐ Attentional problem/ADHD	☐ Depression	☐ Developmental delay/learning disorder
☐ Family conflicts	☐ Gender dysphoria	☐ Psychological trauma
☐ Psychosocial crisis	☐ Psychosis; thought disturbances	☐ School concerns
☐ Situational Crisis	☐ Substance use; addiction	☐ Suicidal ideation
☐ Digital Dependancy	☐ Other: _____	

☐ Pre-existing mental health diagnosis(s): _____

Other clinically relevant info: _____

Mental health agency will initiate follow-up contact with: ☐ Youth ☐ Caregiver; relationship: _____

Name: _____ Phone number: _____

> > ACTION: Please forward (1) this referral form and (2) a copy of the completed HEADS-ED to:

☐ [insert agency name and fax] ☐ [insert agency name and fax] ☐ [insert agency name and fax]

Primary Care Provider's Name	Date:	Contact Information
	YYYY – MM- DD	Phone: _____ Ext: _____ Fax: _____

PART B: FOR COMPLETION BY COMMUNITY-BASED MENTAL HEALTH AGENCY

Outcome of referral: Date(s) of action *(if known)*: Date(s) of contact/attempts:

☐ intake scheduled	_____	☐ client not reached	1._____
☐ intake completed	_____	☐ client declined services	2._____
☐ service booked	_____	☐ other:_____	3._____

Patient's anticipated wait time for service: ☐<1 month ☐1-3 months ☐3-6 months ☐6+ months ☐Unknown

Mental Health Provider's Name and Role	Date:	Contact Information
	YYYY – MM- DD	Phone: _____ Ext: _____ Fax: _____

> > ACTION: ☐ Form was faxed back to the Primary Care Provider listed in PART A on: _____/_____/_____ (YYYY MM DD)

2. Pilot project

Implementation and evaluation:

- One-month implementation phase
- Weekly tracking:
- Number of children/youth seen
- Referrals made
- Referrals completed, i.e. seen by CB-CYMH
- Key informant interviews
  - Program Associate conducted 12 interviews
  - CMHA (Toronto = 7, Algoma = 3)
  - PC (Toronto = 1 [not recorded], Algoma = 1)
  - Interviews conducted via Skype; 35-60 minutes in length

2. Pilot project

Logistical lessons learned

Key successes

- Partnership with pilot sites and many community agencies
- Brought PC and CB-CYMHS agencies together to develop clinical pathways
- Established buy-in to use the HEADS-ED to facilitate communication between providers/agencies and help youth get to the right level of service

Limitations

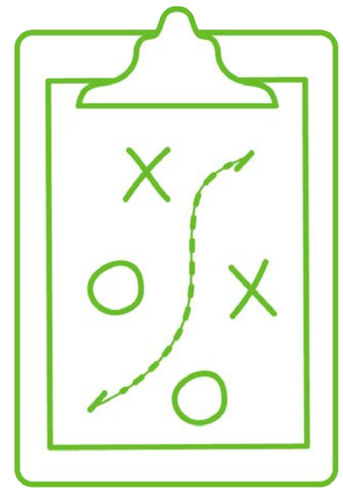
- Short time frame, competing priorities, summer implementation challenges
- Need for more training and coordination support within PC
- Need to evaluate service utilization & clinical outcomes to demonstrate benefit to youth and families

3. Demonstration trial

3. Primary care pathways demonstration trial

Goals and Objectives:

- Seven primary care + community mental health sites partners across the province
- Two-year* quality improvement initiative evaluating:
  1. Whether the model is being implemented as intended
  2. Children/youth/family member experiences navigating the system
  3. Health care provider experiences with the pathway



3. Primary care pathways demonstration trial

SEVEN TRIAL SITES

Stormont Dundas and Glengarry:

- Cornwall Community Hospital
- Cotton Mill Medical Centre

Hastings & Prince Edward:

- Children's Mental Health Services
- Prince Edward Family Health Team

Oxford-Elgin:

- Wellkin Child & Youth Mental Wellness
- Elmdale Family Health Organization
- Elmwood Family Health Centre
- East Elgin Family Health Team
- Elgin Pediatric Clinic

Sault Ste. Marie:

- Algoma Family Services
- Group Health Centre

Windsor-Essex:

- Hôtel-Dieu Grace Healthcare - Regional Children's Centre
- Windsor Essex Community Health Centre

Toronto:

- Strides Toronto
- SCOPE

Pembroke (new site as of March 2020)

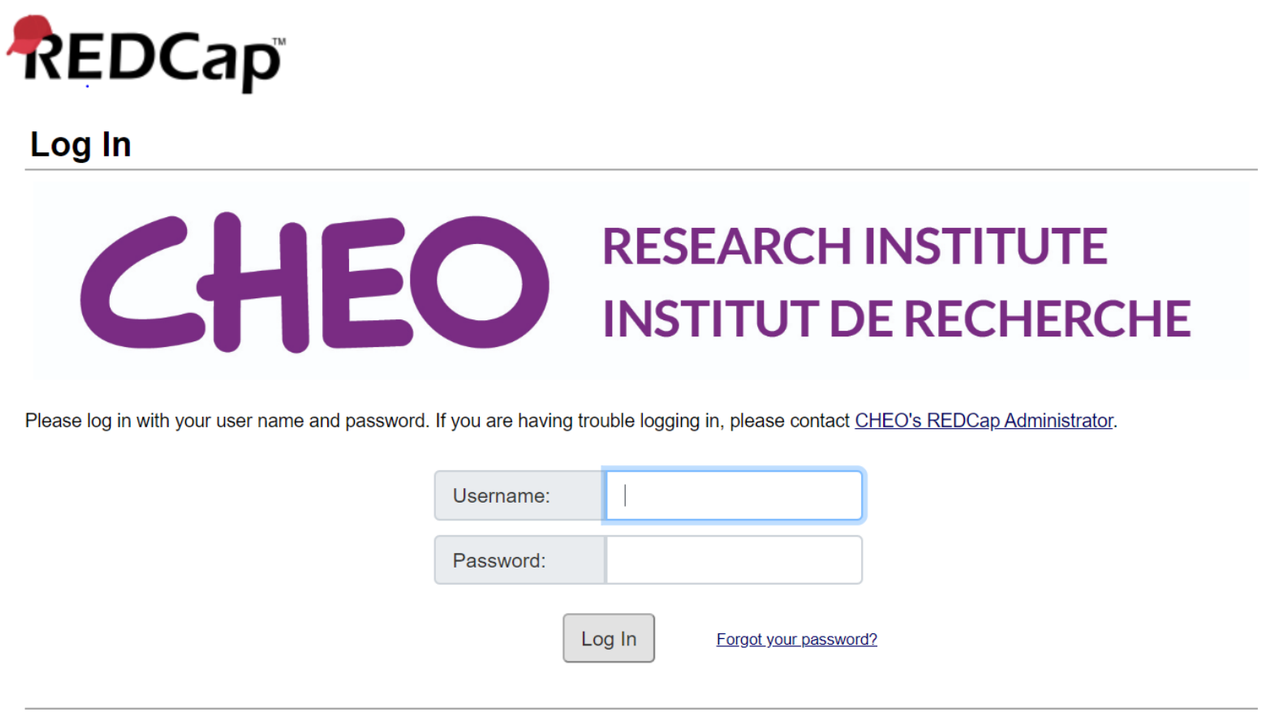
- Phoenix Centre
- Community & Hospital

One month later…

Site contacts families to complete follow-up survey:

- By mail and/or phone
- Experience with the referral process
- Services accessed
- Satisfaction with wait times and access

Data entry:



Started well and then came COVID 19

Site	Community meeting/site visit	HEADS-ED training	Launch date
Elgin-Oxford	✓	✓	September 2019
Algoma	✓	✓	September 2019
Cornwall	✓	✓	November 2019
Windsor-Essex	✓	✓	January 2020
Hastings & Prince Edward	✓	February 2020	February 2020 (anticipated)
Toronto	January 2020	TBD	TBD
Pembroke	TBD	TBD	TBD

Preliminary findings – all sites

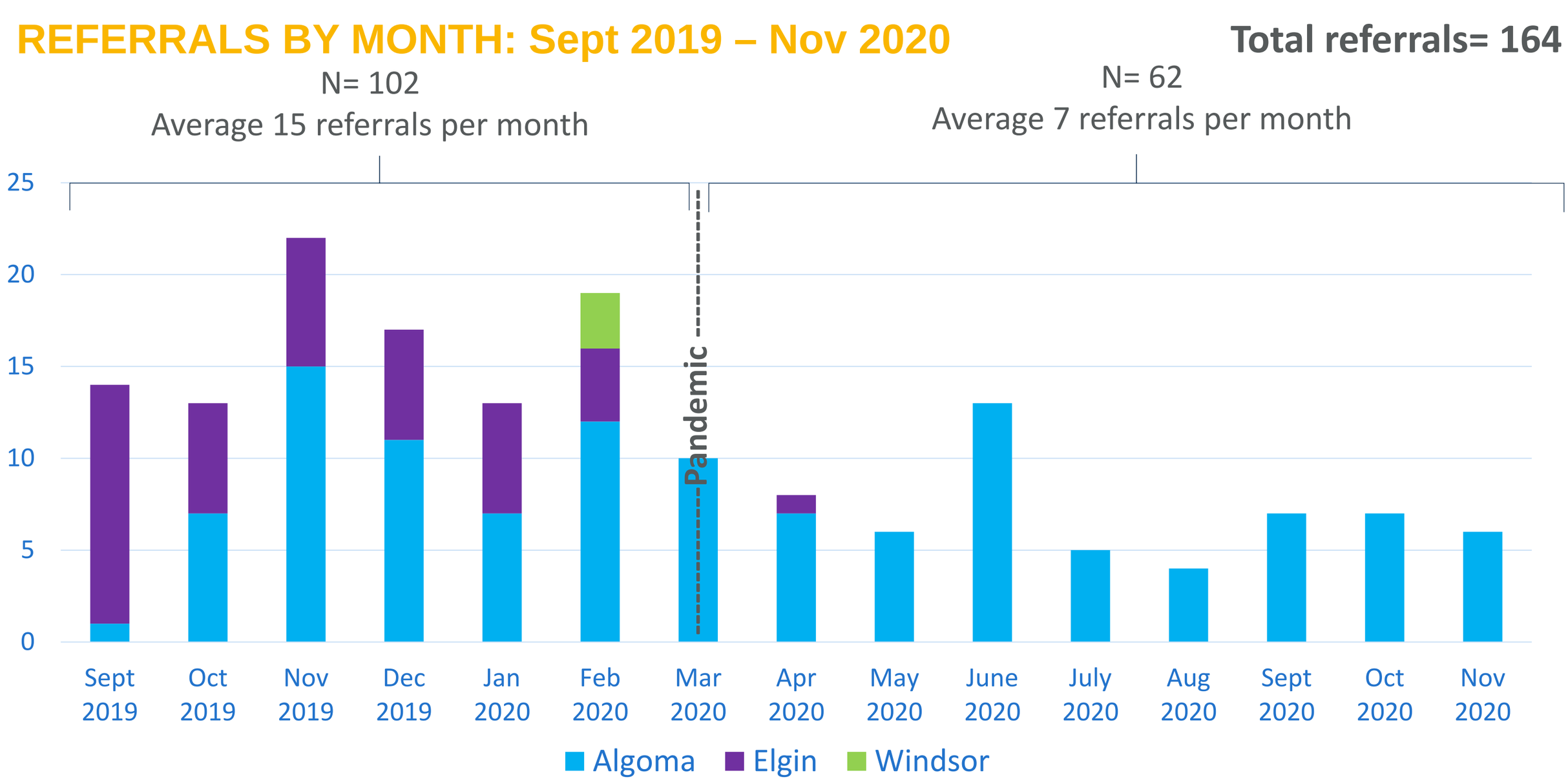
DEMOGRAPHICS

- **Total cases = 164 (3 active sites)**
- Algoma = 118
- Elgin = 43
- Windsor = 3
- **Gender:** 51% (n=84/164) identify as male
- **Age:** Mean = 11.2, Median = 11.0 (2 missing)

Preliminary findings – 3 participating sites

REFERRALS BY MONTH: Sept 2019 – Nov 2020

Total referrals= 164



Preliminary findings – 3 participating sites

PATHWAY UPTAKE AND COMPLETION

	Algoma	Elgin	Windsor
Cases	118	43	3
Part A of Clinical pathway form completed by Primary Care	89% (n = 105)	100% (n = 43)	100% (n = 3)
Part B of Clinical pathway form completed by Community Agency	90% (n = 106)	98% (n = 42)	66% (n = 2)
Part B of Clinical pathway form faxed back to Primary Care	90% (n = 106)	95% (n = 41)	66% (n = 2)

Preliminary findings – 2 sites

PERCEIVED APPROPRIATENESS OF REFERRAL

Reported by children/youth/families on 1 month post-visit survey:

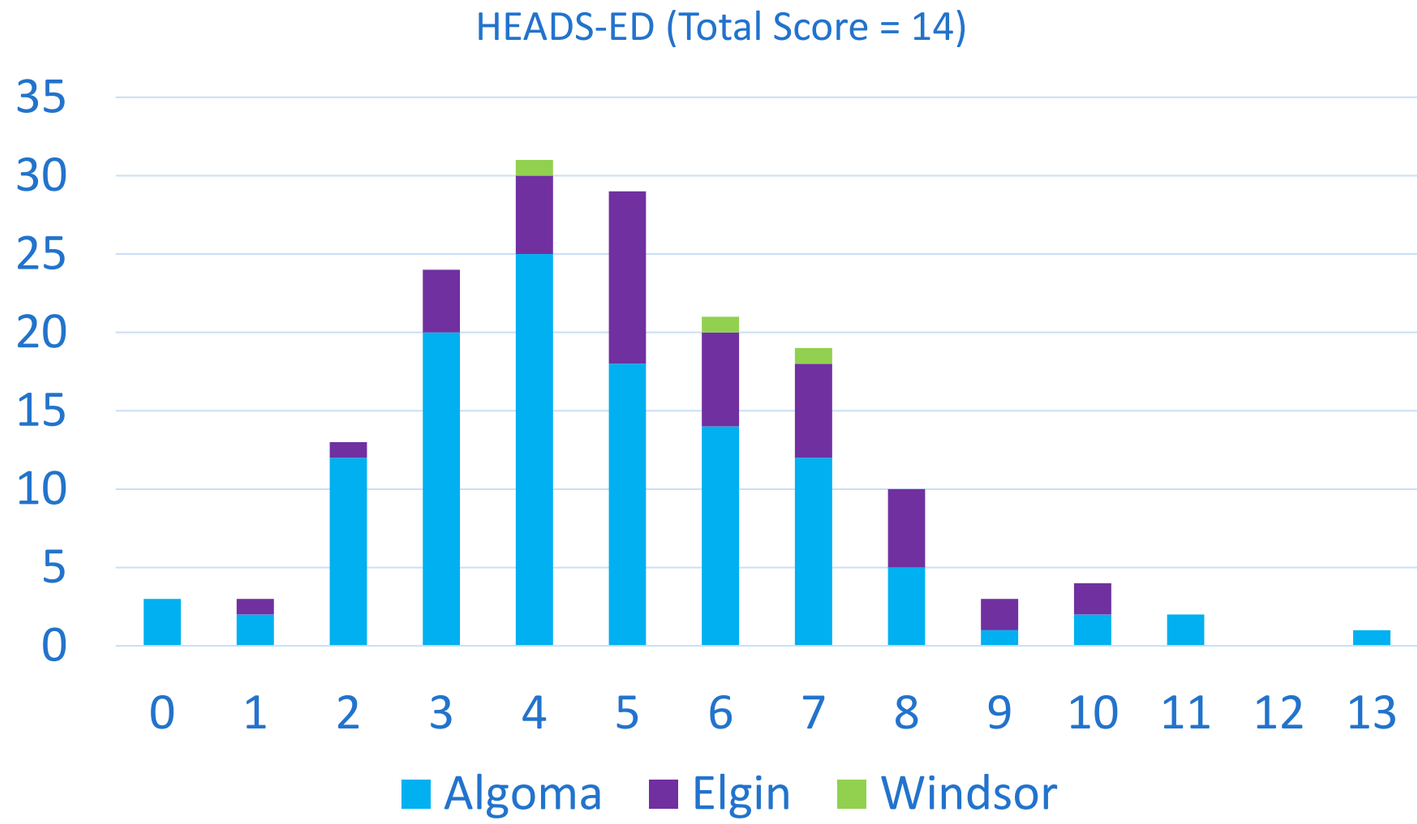
"Do you believe your doctor (or nurse) referred you to the right community mental health services to meet your needs?"

- 39/45 (**86%**) **yes**
- 4/45 **(9%) no**
- 2/45 (**4%**) **n/a**

	Algoma	Elgin	Windsor
Yes	79% (n = 19/24)	95% (n = 20/21)	-
No	13% (n = 3/24)	5% (n = 1/21)	-
Not applicable	8% (n = 2/24)	-	-

HEADS-ED Scores from Primary Care Physician

- **99%** (n= 162/164) of referrals completed HEADS-ED
- 1 was not completed; 1 was partially completed
- Mean total score 4.98 (SD 2.3); median score 5.0
- 12.3% (n = 20) had a total score ≥ 8
- No significant gender difference in mean HEADS-ED scores (p=0.085)
- Mean= 5.3 score for males
- Mean= 4.7 score for females



HEADS-ED scores – 3 sites

HEADS-ED Items needing immediate action – score of 2 (N = 163)

- 63.8% (n = 104) No receiving any current MH&A resources
- 19.6% (n = 32) Emotions, behaviours, thought disturbance
- 17.8% (n = 29) Activities and peers
- 12.9% (n = 21) Education
- 8.6% (n = 14) Home
- 3.7% (n = 6) Suicidality
- 2.4% (n = 4) Drugs and alcohol

Preliminary findings – All 3 sites

MAIN PRESENTING PROBLEM AT REFERRAL

Problem	Overall (n=164) N (%)	Male N (%)	Female N (%)
Anxiety	95 (58%)	36 (38%)	59 (62%)
ADHD/Attentional problems	53 (32%)	36 (68%)	17 (32%)
Depression	46 (28%)	22 (48%)	24 (52%)
School concerns	44 (27%)	31 (70%)	13 (30%)
Family conflicts	41 (25%)	22 (54%)	19 (46%)
Other*	39 (24%)	23 (59%)	16 (41%)
Aggressive/oppositional behaviour	33 (20%)	25 (76%)	8 (24%)
Developmental delay/learning disorder	18 (11%)	12 (67%)	6 (33%)
Suicidal ideation	16 (10%)	9 (56%)	7 (44%)

*Other included: ADHD, OD, LD, anger; acting out, concerns re: self-esteem, flight risk, gaming addiction; peer/adults conflicts, grief, inappropriate sexual comments/harassment, mood dysregulation, helplessness, bullying concerns; parental separation/divorce, OCD, phobias, intrusive thoughts, Tourette's, pseudoseizures, self-harm, safety risk, social anxiety/isolation, withdrawn, sensitivity to textures of food

Preliminary findings – All 3 sites

MAIN PRESENTING PROBLEMS AT REFERRAL

Problem	Overall (n=164) N (%)	Male N (%)	Female N (%)
Psychological trauma	8 (5%)	4 (50%)	4 (50%)
Abnormal eating behaviours	7 (4%)	4 (57%)	3 (43%)
Substance use, addiction	6 (4%)	5 (83%)	1 (17%)
Psychosocial crisis	4 (2%)	2 (50%)	2 (50%)
Situational crisis	3 (2%)	0	3 (100%)
Psychosis	2 (1%)	2 (100%)	0
> 1 presenting problem	117 (71%)	65 (56%)	52 (44%)

Part B Outcomes – All 3 sites

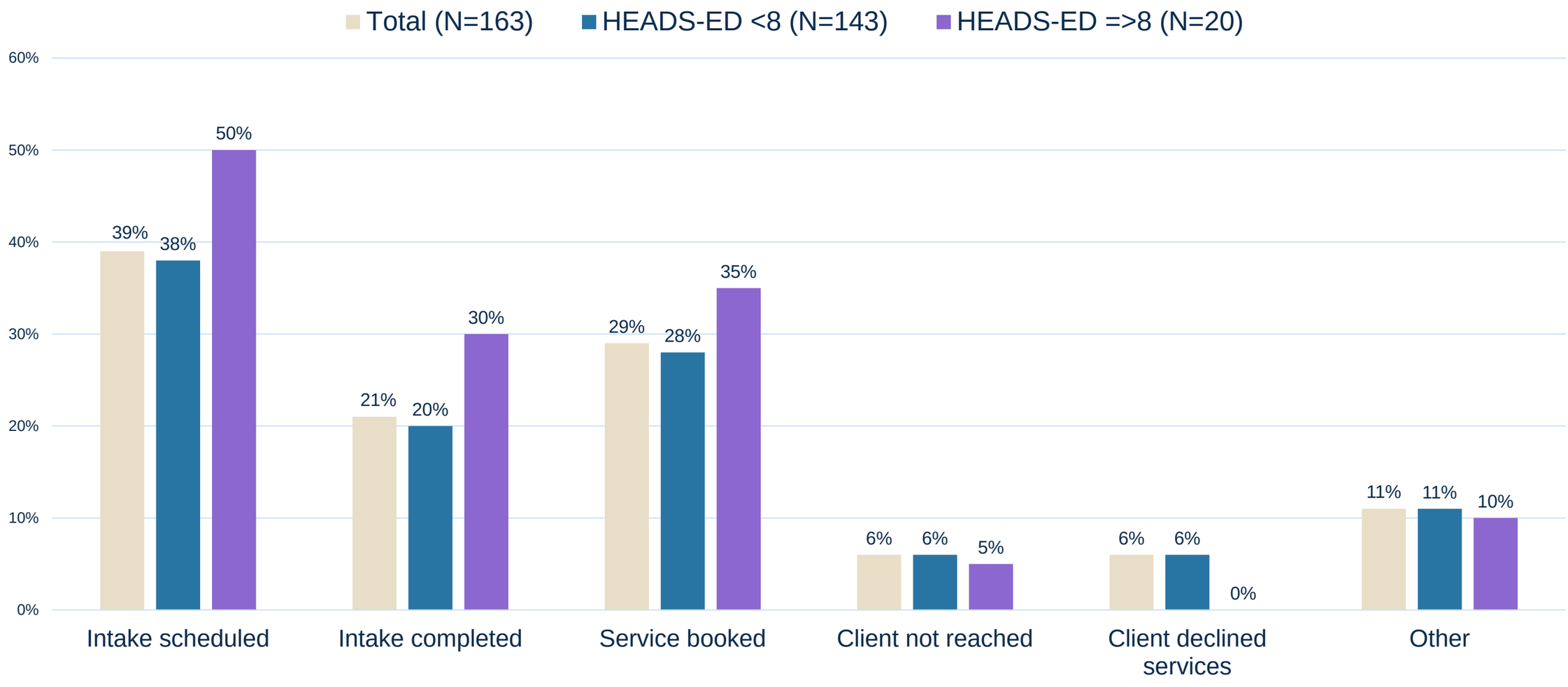
PART B COMPLETION

- 91% had PART B of the referral form completed by the mental health service agency

Outcomes	All clients Median days since Part A completed	HEADS-ED scores ≥ 8 Median days since Part A completed
1st client contact attempt	4 days	3.5 days
Part B completion by CYMH agency	9 days	9 days
Part B faxed back to PCP	13 days	15 days
Delay between completing and faxing back Part B	0 days	0 days

CYMH= Community-based mental health agency; PCP= Primary care provider

PART B Outcomes – All 3 sites



Notes:

- “Other” included referrals to other specialists or programs, already on waitlist, or already receiving services
- Missing 3 total HEADS-ED scores

1 month follow-up survey with children/youth/families

Site staff contacts families to complete follow-up survey:

- By mail and/or phone

1. Experience with the referral process

e.g., Do you believe that your doctor (or nurse) referred you to the right community mental health service to meet your needs?

2. Services accessed

e.g., Have you received any mental health services from the community mental health agency (such as counselling or therapy) in the past month?

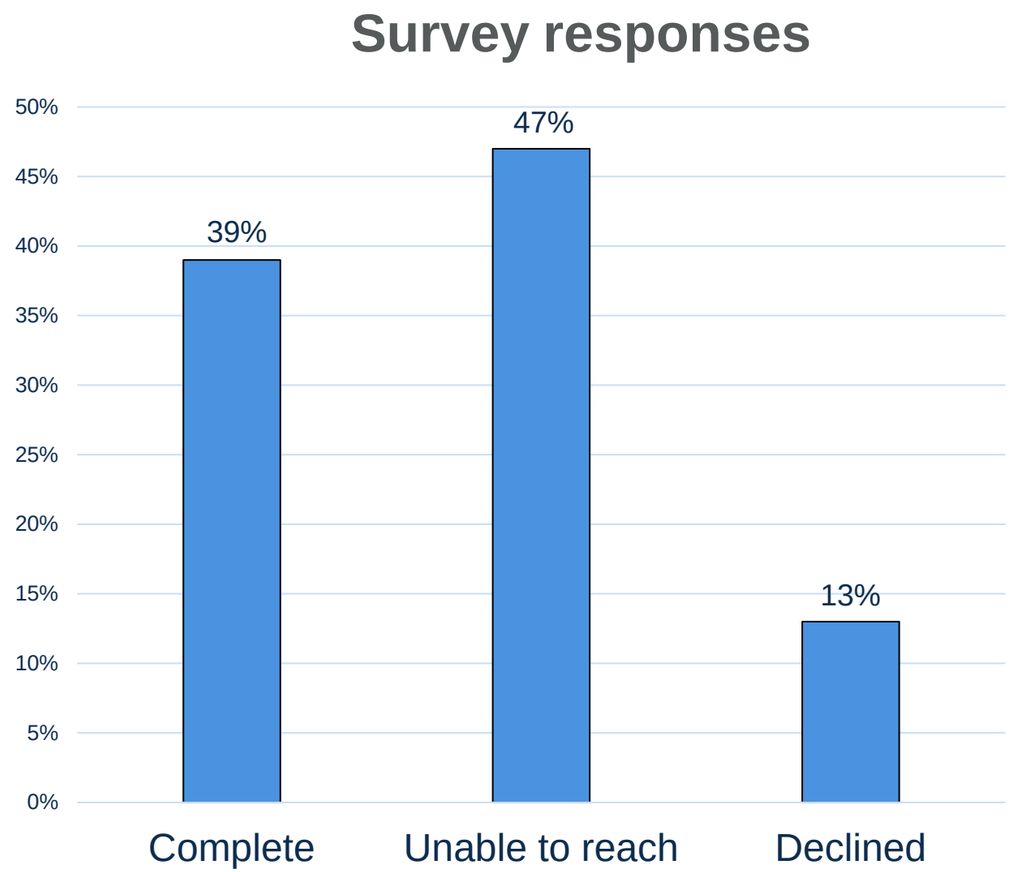
3. Satisfaction with wait times and access

e.g., How satisfied are you with how easy it was to access mental health services in the past month?

1 month post-visit survey with children/youth/families

SURVEY RESPONDENTS (N = 114/164)

- **39%** (n= 45/114) completed the survey
- **47%** (n = 54/114) unable to reach client
- **13%** (n= 15/114) declined
- **30% (n = 50/164)** had no follow up call documented
- Completed by mothers (69%), fathers (9%), youth (13%), other (aunt, CAS case worker, grandmother) (9%)



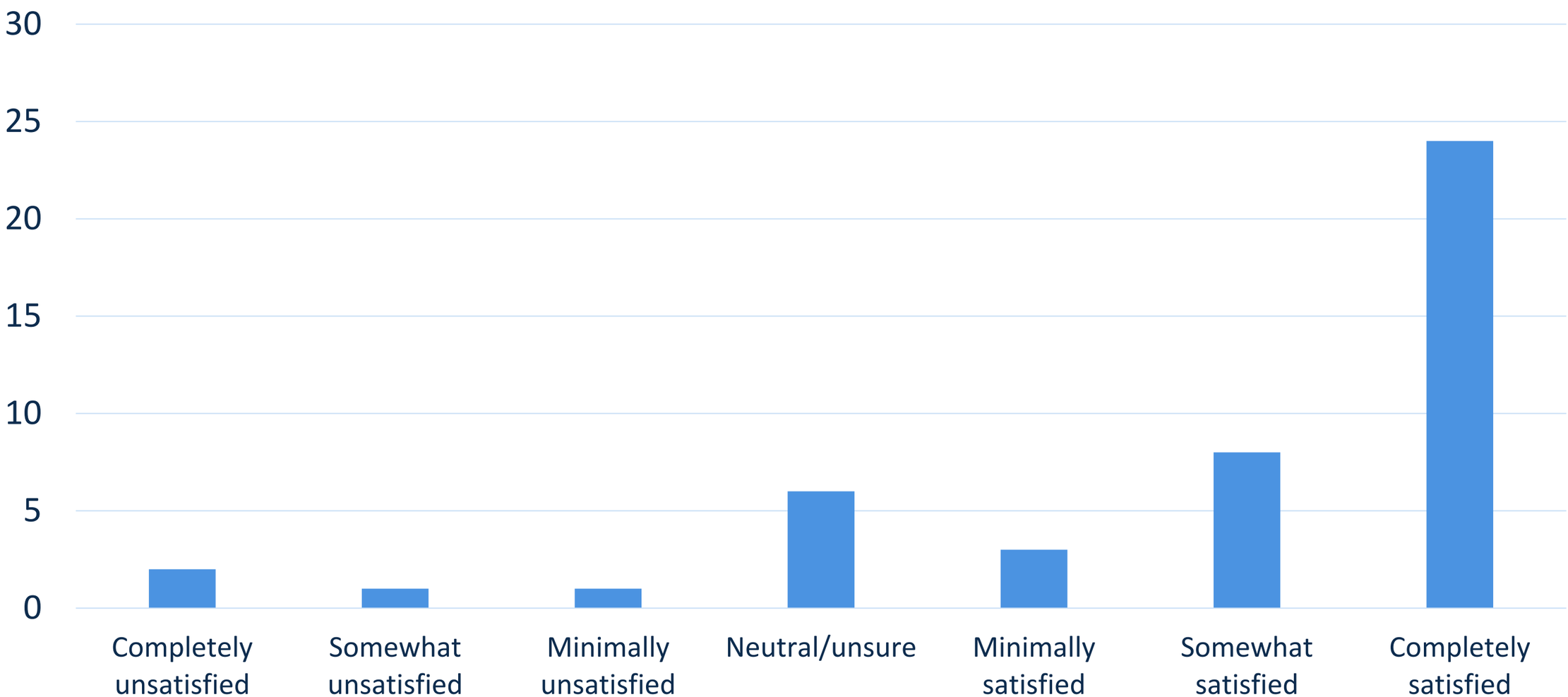
1 month post-visit survey with children/youth/families

EXPERIENCE WITH WAIT TIMES AND ACCESS

- 18/43 (**42%**) wait times were shorter or much shorter than expected
- 15/43 (**35%**) wait times were as expected
- 10/43 (**23%**) wait times were longer or much longer than expected

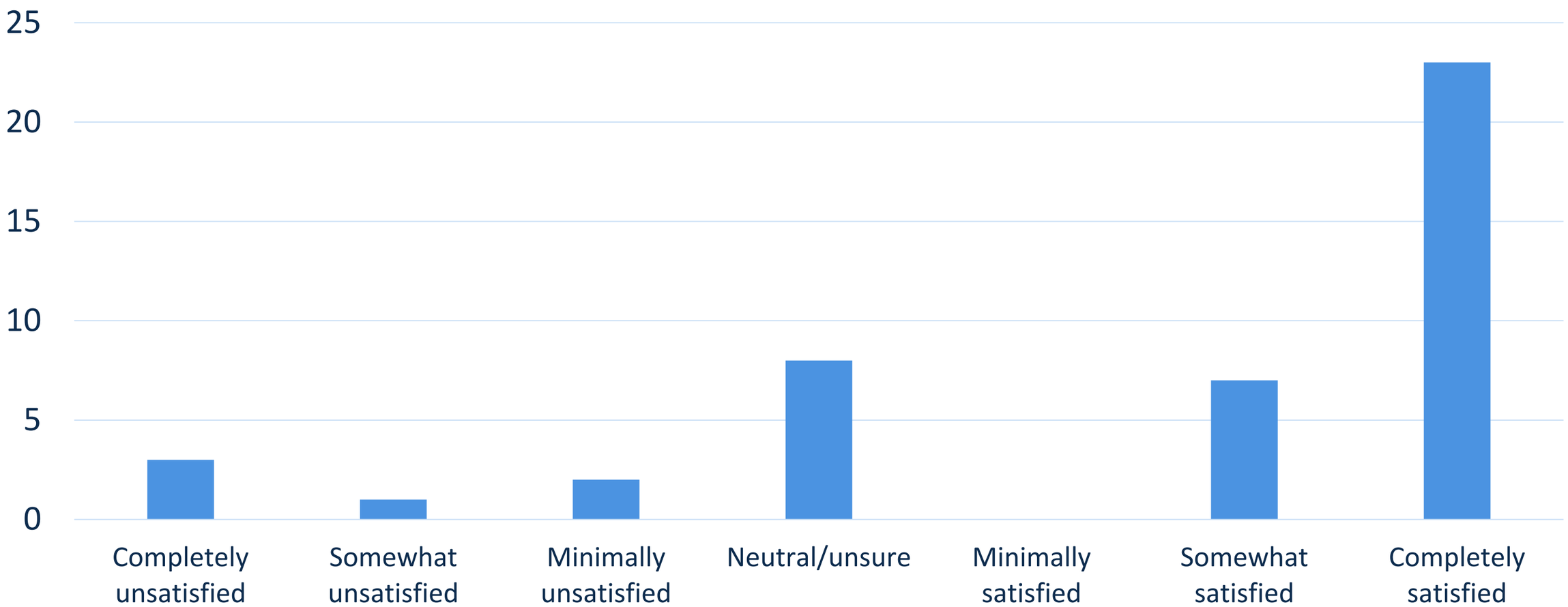
1 month post-visit survey with children/youth/families

24/45 (53%) were <u>completely satisfied</u> with the wait time of the referral process



1 month post-visit survey with children/youth/families

23/45 (51%) were completely satisfied with ease of access to mental health services in the past month



Summary

Pathway:

- There is high uptake of the pathway and HEADS-ED
- The client profile and referral patterns are what we would expect
- Response Community MH&A agency to Primary Care is an average of 13 days

Most families who responded to the survey:

- Believe they were referred to the appropriate service to meet their needs
- Had been contacted by the community mental health agency about the referral
- Were completely satisfied with the wait time to access community-based services
- Were somewhat or completely satisfied with the ease of accessing community mental health services

Next steps

- Delays due to COVID-19
- Memorandums of Agreement re-signed to extend project dates to end of next year
- Sites at various stages of preparation and implementation and we are re-visiting each
- Continuing to adapt to needs of different communities and sites (e.g. Cornwall and OHT – Kids Come First)
- Exploring electronic mediums for the tool and pathway
- Feedback from providers and agencies

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