Re-thinking How we Support Children and Youth with Complex Special Needs

Dr. Laurel Johnson and Shona Casola

Kinark Child and Family Services

Land Acknowledgement

We would like to acknowledge that we are joining from across Ontario from Aboriginal land that has been inhabited by Indigenous peoples from the beginning. As settlers, we're grateful for the opportunity to meet here, and we thank all the generations of people who have taken care of this land for thousands of years. We recognize that Indigenous practices of health and well-being have been in place in this territory for over 10,000 years and are maintained to this day. As healthcare leaders, we have much work to do ourselves to do our part and support the de-colonization of children's healthcare systems.

Knowledge Institute on Child and Youth Mental Health and Addictions

Institut du savoir sur la santé mentale et les dépendances chez les enfants et les jeunes

cymha.ca cymhaon CYMHAOntario @CYMHA_ON

Thank you to our Sponsor

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

BETTER OUTCOMES. TOGETHER.

KINARK

CHILDREN AND YOUTH

Re-thinking How We Support Children and Youth with Complex Mental Health Needs

December 2021

Objectives

1. Overview of Kinark's CYMH re-development

2. The outcomes of this work

3. Lessons learned and implications for the CYMH sector

Drivers for Redevelopment

- Change in agency mission and development of strategic goals really focusing our agency work on "*Helping children and youth with complex needs achieve better life outcomes*"
- Policy context of *Moving on Mental Health*
- Utility and context of CYMH services within the community (and in the sector) of being 'all things to all people'

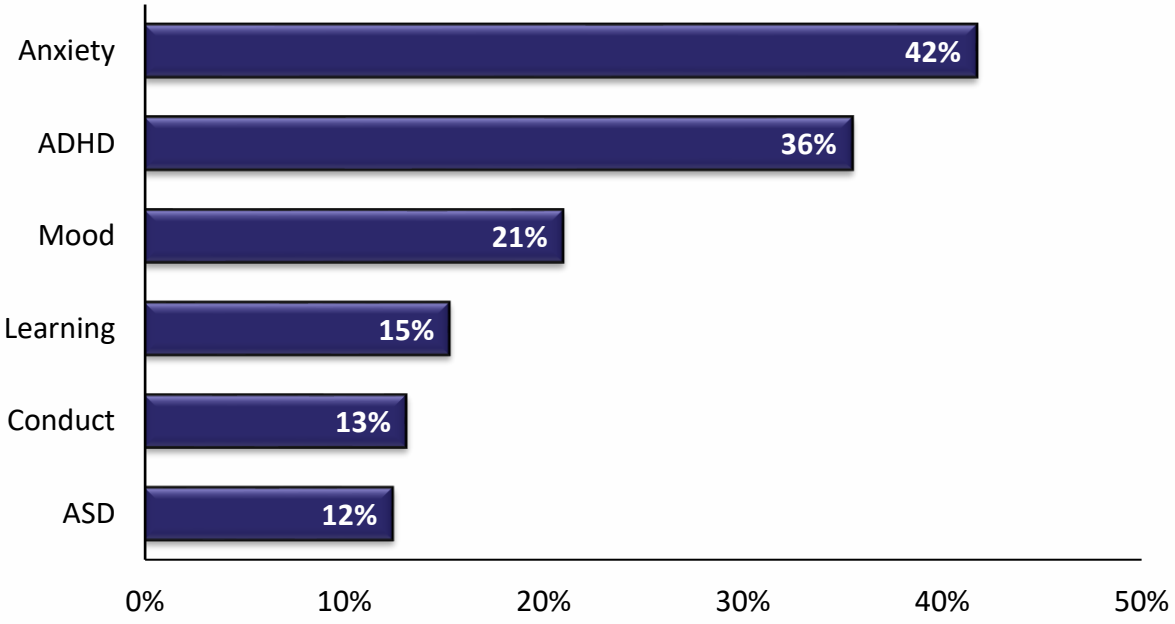
Areas for Improvement

- Inconsistent approaches across internal CYMH programs
  - Clinical assessment and service planning tools
  - Service flow
  - Menu of available services
  - How and when EBPs were being used
  - Inadequate continuity of care
- Lack of measurement / KPIs to assess quality
- Extensive use of manualized programs and reliance on less qualified clinicians
- Presumption of clinical competence (both front line and supervisory)
- Adverse events and poor outcomes

CYMH Clinical Profile January 1, 2019 – June 6, 2021 (*N* = 738)

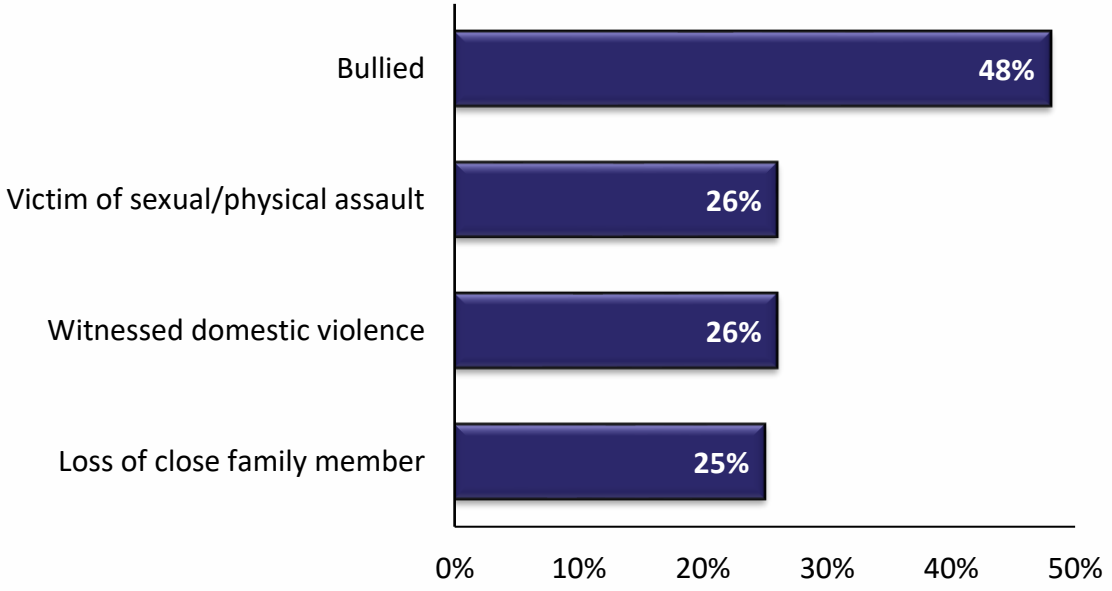
Mental Health Diagnoses

- **31%** of clients had at least 3 or more diagnoses



Traumatic Life Events

- **77%** of clients experienced at least one traumatic event
- **18%** indicated that at least one event evoked a sense of fear
- The most prevalent traumatic events included:



Assessment (interRAI ChYMH) Scores

- **61%** scored high/severe on distractibility/hyperactivity,
- **58%** scored high/severe on depressive severity, and
- **26%** scored high/severe on anxiety

Risk Profile

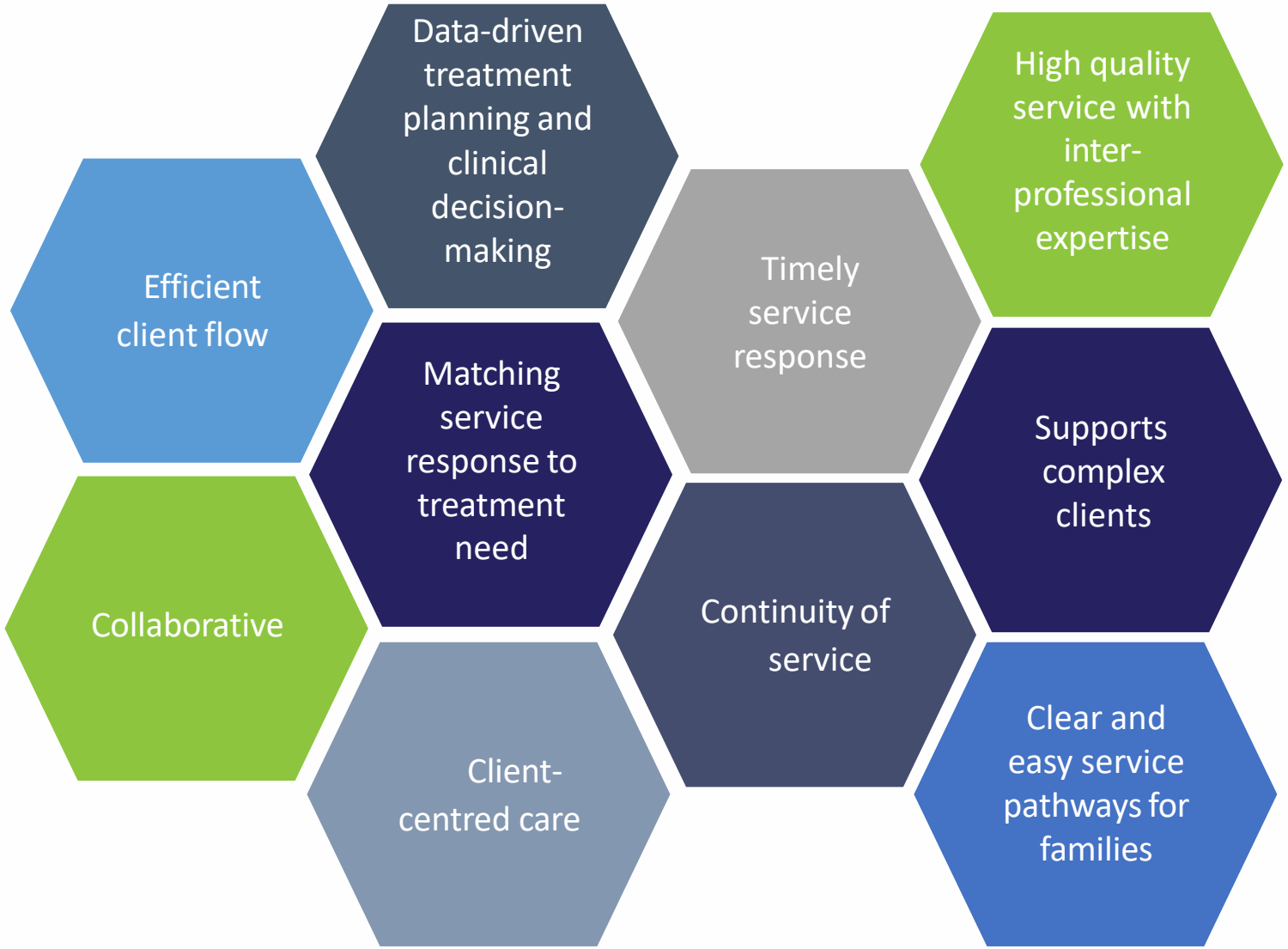
- **50%** were at risk for engaging in property damage,
- **50%** were at risk of engaging in self-harm, and
- **53%** were at risk for harming others

Redevelopment Strategies

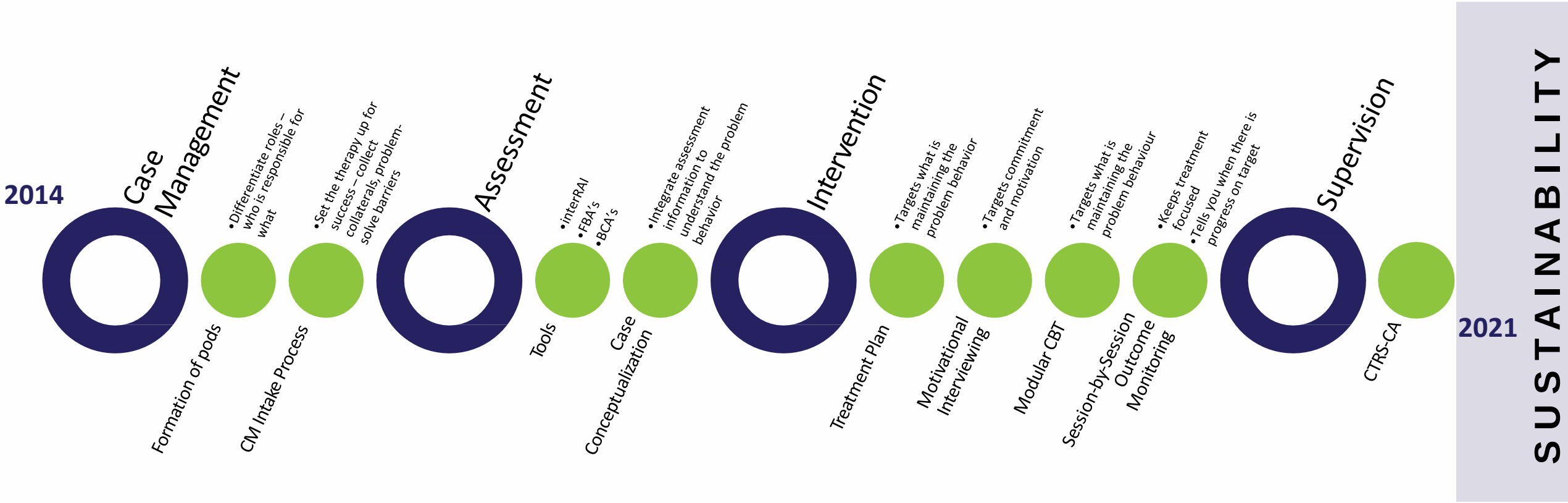
- Workforce planning – define and strengthen clinical roles
- Introduction of standardized, evidence-based tools – define and support the client/family journey
- Move to implement, monitor and maintain evidence-based therapeutic interventions – increase quality of service delivery and strengthen outcomes for client group
- Comprehensive training and clinical supervision model – build and sustain clinical competency to increase quality of service and overall experience for clients and our staff

Redevelopment Model Principles

- Developing our new service delivery model required us to determine the principles by which we would build the model upon
- The 10 principles determined are aligned with our goals



Redevelopment Milestones



Case Management

- **Why?** Focus on case management is required to ensure necessary collateral supports/services that enable the success of CYMH treatment plan are in place at admission and maintained through to discharge.

  - Case management makes a unique contribution towards the integration of health care, social services and other cross sectoral services and supports for children and youth with complex health conditions.
  - A differentiation of roles between therapist and case manager is necessary to ensure sustained focus and competency for each role
  - Case management positions support a single and consistent treatment plan for clients that is inclusive of all collateral programs and services and streamlines process and planning
  - Partnership with therapist to ensure fulsome support for all client/family needs
  - Case management positions support consistent triage of current waitlist and ongoing assessment of risk for clients who are waiting – single point of access for those who are waiting

Assessment - Comprehensive Standardized Tools

Why? A comprehensive standardized assessment tool enables the accurate collection of relevant clinical information from clients that will then inform an effective treatment plan

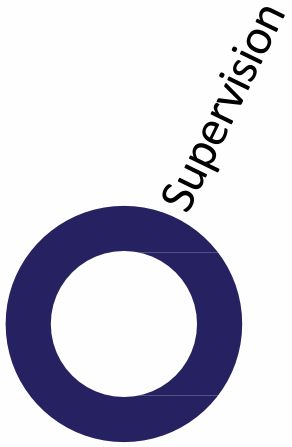
- **InterRAI Suite of Tools:**
  - interRAI Screener facilitates triaging at intake
    - Includes an embedded risk algorithm for safety planning
  - ChYMH assessment (clinical interview) upon initiation of service, when there have been significant changes in the client situation, and at discharge
- **Functional Behavioural Analysis (FBA)**
  - Identification of problem behaviours and formulation of intervention plan
- **Behaviour Chain Analysis (BCA)**
  - Partnership of clinician and client in analysis and intervention

Interventions - Evidence-Based Modalities

- **Why?** Evidence-based interventions support the integration of clinical expertise, client/family values and best research evidence to improve the quality of care being provided, lower costs of treatment and improve the outcomes for those we serve.
  - **Modular Treatment Modalities –** can be individualized based on client need
    - Unified Protocol (UP) – CBT manualized treatment for anxiety, depression and emotional disorders
    - MATCH – CBT manualized approach for anxiety and depression
    - Dialectical Behaviour Therapy (DBT) – manualized treatment for clients who exhibit self-destructive behaviours (personality trait disorders, eating disorders, substance abuse disorders)
  - **Motivational Interviewing**
    - an approach that functions to enhance motivation and commitment to change
      - helpful with hard-to-reach clients
      - treats substance abuse

Interventions - Target Tracking = Measurement-Based Care

- **Why?** Session-by-session progress measurement has been found, in research, to improve outcomes and catch early when therapy isn't working in order to adjust treatment plan/goals and modify the approach, if necessary
    - Clients whose service plan includes target tracking are retained in service 3.5 months longer, and are engaged in on average 18 more treatment sessions, than those not involved in target tracking
    - Caregivers and clinicians of clients involved in target tracking were more likely to report that the child or youth experienced improved symptoms and functioning as a result of treatment
    - Compared to clients not participating in target tracking, clients with targets were:
        - 43% more likely to have the reason for discharge be treatment plans were complete
        - 31% less likely to opt out of service, and
        - 42% less likely to be discharged because they had ceased contact with their therapist.



Competency-Based Supervision Model

- **Why?** Clinical supervision improves and sustains clinical competency in clinician practice, which in turn enhances the outcomes and satisfaction for clients/families and works to support retention and overall satisfaction of staff.
  - **What is it?**
    - Collaborative learning plan developed between supervisor and supervisee
    - Direct review and evaluation of clinical sessions (taped/observed)
    - Utilized Cognitive Therapy Rating Scale – Child and Adolescent (CTRS-CA)
  - **Why was it required?**
    - Needed to strengthen therapists' practice competence to be effective with clients with complex needs
    - Supervision enhances clinical outcomes and client satisfaction
    - Clinical supervision improves staff retention and job satisfaction
    - 84% of supervisees commit nondisclosure (failure to reveal or disclose issues relevant to supervision)

Supervision

Competency-Based Supervision Model - Best Practices

- Clinical supervision echoes principles of CBT practice
  - agenda setting
  - problem definition
  - use of feedback and homework

- Multiple training modes (didactic, modeling, role-play) provides for deeper learning, suits learning styles
- Self-practice and self-reflection
- Positive supervisory alliance that includes collaborative empiricism
- Providing specific corrective feedback to supervisees
- Eliciting and responding to trainee feedback regarding supervision
- Supervisors have ongoing supervision and training to strengthen their clinical and supervisory skills

Competency-Based Supervision Model - Cognitive Therapy Rating Scale – Child and Adolescent (CTRS-CA)

- Friedberg & Thordarson, 2013
- Based on the Cognitive Therapy Rating Scale (CTRS) - the gold standard to evaluate clinician competence in adult CBT (Young & Beck, 1980)
- Evaluates clinician competencies in the treatment of youth with CBT
- 13-item, Likert scale measure completed by a supervisor based on direct observation (live, audio-, or videotape) of a clinician in session with a client aged 5 - 17

General Clinical Stance (6)	Session Structure (3)	Strategy for Change (4)

- Competency = average score of 4 over 13 items = 52 total score

Competency-Based Supervision Model - Evaluation of Model

- Our model was predicated on the evidence that clinical skill must be both observed and evaluated using a standardized assessment in order to determine the clinical competency of clinicians
  - "Apparent competence" is rampant, and generally incorrect

- Following implementation of our new clinical supervision approach
  - 83% reached required competence (scoring 52 or above) after three sessions in the new model
  - most of them achieved competence over the 10-week study period (*n* = 24)
  - five more clinicians met competence between weeks 11 to 18
  - average number of weeks of supervision in new model to meet competence = 7.6 (*SD* = 3.8)

Our Lessons Learned

- It takes longer than planned
  - Our ‘five-year plan’ took seven years

- It costs more than we budgeted
  - training, training, training…..
  - not all clinicians could make the shift

- Standardized, evidence-based tools are a foundation for excellent treatment and objective monitoring
  - appropriate assessment, treatment and discharge planning
  - client/family and staff engagement and satisfaction through the treatment path
  - data informed decision making at the individual, organizational and system level

- Use of evidence-based therapeutic modalities mean that:
  - client/family’ assessed needs do truly drive treatment, means they are more engaged
  - the quality of the service provided is better, OUTCOMES for children, youth and families ARE BETTER!

- Getting to, and sustaining, clinical capacity requires:
  - a comprehensive training plan - includes initial dose, annual booster and supplemental learning plans
  - clinical supervision where clinical skills are directly observed and evaluated to maintain efficacy of treatment and prevent drift from practice

Implications for the Sector

- Changing historical practices is costly, time-consuming and necessary
- Need to create a culture of learning and growth
- Supervision and clinical supervision are not the same
- ‘Deemed competency’ will be likely inaccurate
- Some elements are essential
  - standardized assessment
  - careful identification of evidence-based modalities
  - capacity to observe and evaluate practice
- Redevelopment will make current investment more effective for our clients

Questions, comments, discussion?

Thank you so much for your time and attention!

Please feel free to reach out!

Dr. Laurel Johnson – CYMH Clinical Director | laurel.johnson@kinark.on.ca

Shona Casola – CYMH Director | shona.casola@kinark.on.ca