Canadian Collaborative Mental Health Initiative

Initiative canadienne de collaboration en santé mentale

Establishing collaborative initiatives between mental health and primary care services for *children and adolescents*

A companion to the CCMHI planning and implementation toolkit for health care providers and planners

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A companion to the CCMHI planning and implementation toolkit for health care providers and planners

A Toolkit

February 2006

OUR GOAL

The Canadian Collaborative Mental Health Initiative (CCMHI) aims to improve the mental health and well-being of Canadians by enhancing the relationships and improving collaboration among health care providers, consumers, families and caregivers; and improving consumer access to prevention, health promotion, treatment/intervention and rehabilitation services in a primary health care setting.

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Preface

Welcome to the CCMHI Toolkit Series!

The Canadian Collaborative Mental Health Initiative (CCMHI) is led by 12 national organizations representing community services; consumers, families and caregivers; self-help groups; dietitians; family physicians; nurses; occupational therapists; pharmacists; psychiatrists; psychologists; and social workers. Funded through Health Canada's Primary Health Care Transition Fund, the goal of the CCMHI is to improve the mental health and well-being of Canadians by increasing collaboration among primary health care and mental health care providers, consumers, families and caregivers.

The CCMHI toolkits contain practical tools to:

- Assist providers and planners in the implementation of collaborative initiatives.
- Help mental health consumers and their family members understand mental illness and work with other members of the care team.
- Inform educators of the benefits of interprofessional education and provide tools to teach about collaborative mental health care.

Each toolkit was developed with an interprofessional expert panel and guided by a working group representing a number of key stakeholder groups. We hope that readers of any of the toolkits in the series will recommend them to others (e.g., consumers referring toolkits to their providers and vice versa).

In addition to this series of 12 toolkits, the CCMHI has developed a Charter of principles and commitments that will influence the future of mental health care in Canada and a series of reports that capture the current state of collaborative mental health care. The reports highlight health human resource issues, provide an annotated bibliography, summarize best practices, review initiatives from across the nation and summarize provincial and territorial mental health and primary care reform. These documents guided the development of the toolkits and are available at www.ccmhi.ca.

Implementation toolkits

Collaboration between mental health and primary care services. A planning and implementation toolkit for health care providers and planners is a guide for providers wishing to establish or enhance the mental health services they provide through collaboration. This general toolkit offers readers a guide to all aspects of planning, implementing and evaluating a collaborative mental health care initiative, including assessing need, setting goals and objectives, developing a budget, building a team, maintaining a well-functioning team, managing change and monitoring the initiative.

Eight population-specific toolkits, entitled *Establishing collaborative initiatives between mental health and primary care services,* are designed to be used in conjunction with the general toolkit. They offer tips on adapting the general toolkit for Aboriginal Peoples, children and adolescents, ethnocultural populations, rural and isolated populations,

seniors, individuals with serious mental illness, individuals with substance use disorders and urban marginalized populations. There is some overlap in the toolkits; for example, information about collaborative mental heath care and the homeless may be found in at least three toolkits: individuals with serious mental illness, individuals with substance use disorders and urban marginalized populations. Readers are encouraged to consider all the toolkits that may be relevant to their needs.

The general and population-specific toolkits are not intended as clinical practice guides but offer practical advice on different aspects of establishing successful collaborative initiatives.

Consumer, family and caregiver toolkits

Consumers, families and caregivers developed both of these toolkits for consumers and their loved ones.

Working together towards recovery: Consumers, families, caregivers and providers is intended for all consumers, families and caregivers wishing to know more about mental health and mental illness, how to access services and the type of professionals that can assist them in their recovery. This toolkit also offers an outline of complementary therapies and self-care as well as the contributions and needs of caregivers. Finally, this toolkit includes a guide to "getting involved", describing how government and boards of directors work, and why consumers and families should participate.

Pathways to healing: A mental health guide for First Nations people is a toolkit that offers a basic overview of mental health and mental illness along with a contextual section outlining the impact of history, social, economic and political conditions on the mental health of these peoples. There are tools in this toolkit to foster holistic care.

Education toolkit

Strengthening collaboration through interprofessional education: A resource for collaborative mental health care educators serves as an educational resource to assist in the implementation of educational initiatives and programs that promote collaborative mental health care in primary health care settings. The toolkit is targeted to education program developers in regulatory agencies, professional associations, regional health authorities, family health teams, governmental departments, and educators within both academic (universities and colleges) and care delivery settings.

This toolkit highlights the importance of interprofessional education in promoting collaborative care. It offers four case studies and several activities accompanied by a sample lesson plan and other useful tools to aid educators in the implementation of educational events.

Executive summary

Introduction

Mental health services for children and adolescents have often been developed as an adjunct to adult services. However, the needs of this population are unique and require specialized skills to accurately diagnose and treat.

The purpose of this toolkit is to assist service providers, managers, consumers and other community services in developing and advocating for collaborative primary care initiatives involving mental health services for children and adolescents. Highlights of this toolkit include: suggestions for physician education; special needs of transitional youth; issues in rural and remote family medicine; key points to consider; descriptions of positive practice initiatives; key websites; and useful tools and resources.

Defining the population

This toolkit defines children and youth by age (0-18 years). The prevalence rate of mental health concerns in children and youth is approximately 20%. Close to 10% of children attending primary care present with mental health concerns as their chief complaint. One youth in ten contemplates suicide. Up to 80% of children with mental health needs will not receive any mental health services.

Consultation process

An Expert Panel with expertise in collaborative mental health services for children and adolescents gathered information and sought feedback from a variety of sources, both lay and professional, from across the country representing a wide range of disciplines including psychology, social work, nursing, dietetics, child and adolescent psychiatry, pediatric and family medicine, as well as police youth services, teachers and youth.

Key messages

- **Primary care is an important setting for serving children and adolescents with mental health needs** because most children are seen by a primary health care provider at least once each year. The advantages of providing mental health care within primary health care include knowledge of the family, reduced stigma and consumer preference.

- **Children and adolescents present some unique access issues**. Children and adolescents are typically not self-identifying and are usually brought to the attention of services by others, such as parents, guardians, social service agencies, schools, etc. Services need to include these significant others in order to obtain complete diagnostic information, which, in turn, requires consideration of privacy issues and logistical challenges, e.g., scheduling, location, co-operation of parties who may sometimes be in contentious relationships.

- **Adolescents with mental health needs may be the least well served**. They often do not have much regular contact with the health care system, tending to see health care professionals only for sports injuries or camp physicals, rarely seeking care for mental health problems. In addition, there are few professionals specializing in adolescent mental health.
- **To conduct a comprehensive assessment involves more than one clinician, and traditional medical fee structures such as fee-for-service do not recognize this**.
- **Older youth between the ages of 16 and 24, referred to as 'transitional youth', often 'fall between the cracks' of youth and adult services, and much remains to be done to effectively respond to them**.
- **Youth-centred mental health care is considered a best practice approach and means:** involving youth in care decisions and program design; integrating peer support; recognizing developmental issues and the impact of mental illness on normal development; avoiding treatment-related trauma attached to first diagnosis and hospitalization; identifying the special effects of stigma on youth; focusing on home and community-based care; developing age- and stage-appropriate education about mental illness; addressing the social determinants of health (e.g., gender, education and social support networks); and focusing on wellness and ability.
- **Policies and legislation** have an impact on issues such as confidentiality, privacy, sharing of information and treatment consent, and often present contradictions and inconsistencies in the way services are provided. There is a need for agreements and protocols to enhance collaboration.
- **The educational needs of primary health care practitioners working with children and youth with mental health concerns cannot be met completely with generic training or Continuing Medical Education**. Engaging with this special population, assessing them appropriately and developing appropriate intervention plans all require specific approaches. Educational activities need to commence at the professional training level for all primary/mental health care disciplines and continue throughout the careers of those who work with children and youth.
- **Policy-makers and decision-makers need to be involved** at the beginning in identifying community needs, available resources and gaps in services, and in developing plans and strategies for increasing appropriate services and enhancing collaborative strategies.
- **Issues in rural and remote family medicine** such as supply and demand, lack of training and problems with remuneration create further difficulties in addressing child and adolescent mental health needs.

- **Best practice is facilitated by the involvement of a multidisciplinary team**, with members each having particular tasks and functions, e.g., pediatrician, family physician, nurse, psychiatrist, psychologist, dietitian, pharmacist, social worker, occupational therapist, etc.
- **Collaborative care programs for children and youth need to develop working relationships with other service sectors supporting children,** e.g., child welfare, special needs, education, health, schools, justice, social services, recreation, other community agencies.
- **Pediatric collaborative care programs will be quite different from adult services and different processes need to be used**.
- Examples of **models in child and youth collaborative primary/mental health care** include:
  - Telepsychiatry consultations using multidisciplinary virtual teams
  - Support for rural practitioners and mental health agencies
  - Co-ordinated involvement with other sectors such as education and children's services
  - Care management by specialists that work in primary care settings
  - Care management by primary health care practitioners with specialist support
  - Primary health care interdisciplinary teams
  - Single primary mental health worker positions within a child and adolescent primary health care service

Introduction

This child and adolescent toolkit has been developed to assist service providers, managers, consumers and representatives of community services who are interested in developing collaborative initiatives involving mental health services for children and youth. It may be particularly useful for regions that have not yet been able to establish comprehensive children's mental health services. This toolkit will attempt to address the concerns unique to children, adolescents and their families, and will incorporate information pertinent to planners and practitioners in both urban and rural settings.

The toolkit contains a background literature review of child and youth mental health and provides some examples (although not an exhaustive listing) of programs to illustrate the variety of models that are being developed. While it is not intended to be a clinical practice guide, it does contain practical suggestions that can be useful to practitioners, both urban and rural, who might otherwise find themselves isolated from services because of geography, time limitations or the absence of a team. Above all, it calls for support networks and education programs to be established for professionals, and advocates for the involvement of youth and their families, wherever possible, at all stages in the planning and implementation of these collaborative initiatives.

Mental health services for children and adolescents have often been developed as an adjunct to adult services. However, the needs of this population are unique and require specialized skills to accurately diagnose and treat. Examples of models to be explored in child and youth collaborative care include telemedicine consultations, support for rural practitioners and mental health agencies, and co-ordinated involvement with other sectors that serve children, e.g., education, children's services, etc.

Additionally, the educational needs of primary health care practitioners working with children and youth with mental health concerns cannot be met completely with generic attempts at training or Continuing Medical Education. Engaging with this population, assessing them appropriately and developing intervention plans all require specific approaches. Educational activities need to commence at the professional training level in all mental health disciplines and continue throughout the careers of those who work with children and youth.

Funding and remunerative models that will facilitate the implementation of collaborative care must also be developed and need to be a high priority in administrative planning.

To understand a child's emotional health, a comprehensive review of that child's functioning needs to take place by speaking to parents, teachers and the child himself/herself. This requires a very different funding structure than is available in the traditional health care model.

It is the hope of the child and adolescent toolkit group that this project will begin to identify and address these issues.

Defining the population

Children and youth 0-18 years of age

- The generally quoted figure in the literature is a prevalence rate for mental health concerns in children and youth of approximately 20% (Kataoka et al, 2002; Offord et al, 1987; Steele et al, 2004; Waddell et al, 2002).
- There is a prevalence rate of up to 15% for significantly distressing and debilitating mental health problems among Canadian children aged 4-17; 5% suffer extreme impairment (Waddell et al, 2002).
- One in ten teens contemplates suicide (Adlaf et al, 2002).
- Up to 80% of children with mental health needs will not receive any mental health services (Kataoka et al, 2002; Leatherman & McCarthy, 2004).
- Most of those who do receive services obtain them from their family practitioner (Steele et al, 2004).
- Seventy percent of physicians indicate a lack of preparedness to see mental health problems (Steinhauer, 1999).
- Surveys of youth behaviour show that the doctor is one of the last people that a teenager confides in with emotional concerns. Peers and teachers come first (Abidi & Kutcher, 2005).
- Most physicians do not feel comfortable or skilled in treating mental health problems, especially in young children (Cockburn & Bernard, 2004; Steele et al, 2003).
- There is consensus in the literature that the most common presenting mental health problems in children and adolescents are (in no particular order): depression, anxiety, disruptive behaviour disorders, eating disorders, ADHD and developmental disorders.

Lessons from the literature

Serving children and adolescents with mental health needs in primary health care

There are a number of international articles which address the mental health needs of children and adolescents and make the case for detection, treatment and prevention to be delivered within primary health care (Bower et al, 2001; DeBar et al, 2001; Garralda, 1998, 2001; Kramer & Garralda, 2000; Walker & Townsend, 1998; Wells et al, 2001; Zygowicz & Saunders, 2003).

For additional information on lessons from the literature consult two CCMHI reports available at www.ccmhi.ca:

- *Annotated bibliography of collaborative mental health care*
- *Better practices in collaborative mental health care: An analysis of the evidence base*

Epidemiological evidence is cited by many of these authors and highlights the level of need among children and adolescents:

- Incidence of mental disturbance is 1 in 10 in the general population of children.
- Prevalence rate of psychological disturbance among adolescents is 15% (Walker & Townsend, 1998).
- There is increasing morbidity in all aspects of health during adolescence (Jacobson et al, 2002).
- Many adult mental illnesses have their onset in adolescence, e.g. obsessive-compulsive disorder, panic disorder, antisocial disorder and schizophrenia.
- Depression is increasing among children and adolescents, paralleling the trend with adults; as many as 25% of adolescents have had at least one depressive episode (Jacobson et al, 2002; Wells et al, 2001).
- Adolescent suicide rates are high, especially for males (Jacobson et al, 2002).
- A mental health issue is the main presenting complaint in 2-5% of children attending primary care (Garralda, 1998).
- This percentage increases when others who have psychosocial issues are included (Garralda, 1998).
- Children are known to be higher users of medical services with oppositional-defiant disorder being the most prevalent type among preschoolers, while school-aged children and adolescents present most often with emotional or conduct disorders (Garralda, 1998).
- There is now considerable evidence that there has been a rise in the prevalence of eating disorders, particularly those of the binge–purge variety, in Western and Westernized countries over the past 3 or 4 decades (Dorian & Garfinkel, 1999, Pratt & Woolfenden, 2002).
- Children in the child welfare system have high needs for mental health (Burns et al 2004; Jacobson et al, 2002) and physical health (Blatt et al, 1997).

Primary care is an important setting for serving children and adolescents with mental health needs because most children are seen in primary health care in a given year (Kramer & Garralda, 2000).

Unmet need has major implications:

- The overall number of children with mental health problems who are served in specialty mental health programs is small, meaning that a large number of children go untreated (Cockburn & Bernard, 2004; Garralda, 2001).
- Poor mental health among adolescents has been linked with behaviours that can damage physical health over the short- and long-term as well as with mental health problems in adulthood (Walker & Townsend, 1998).
- "Recent meta-analyses show that opportunities for prevention and early intervention are more extensive in childhood than adolescence, and that enhancing individual skills and building social protective factors may be as important as diminishing individual risk factors" (Birleson et al, 2001, p. 38).
- Additional risk factors associated with mental illness in adolescence include parental disharmony and divorce, physical and sexual abuse, bullying, family history of mental disorder, relationship problems, lower socio-economic status and poor educational attainment (Jacobson et al, 2002).

The role for child/adolescent primary mental health care has also been featured in a number of publications and follows a continuum:

- Early identification of mental health problems (Bower et al, 2001) perhaps including screening (Zygowicz & Saunders, 2003)
- Identifying and attending to children with a disorder (Garralda, 2001)
- Offering appropriate interventions and treatments for milder disorders (Bower et al, 2001; Garralda, 1998)
- Referring to specialist services for children's mental health (Garralda, 2001)
- Supporting the work of specialist services and families after recovery or during relapse (Garralda, 2001)
- Pursuing health promotion and problem prevention (Birleson et al, 2001; Bower et al, 2001; Garralda, 2001; Jacobson et al, 2002; Walker & Townsend, 1998), primary and secondary prevention to adolescents (Walker & Townsend, 1998)

Advantages of provision of services within primary care include:

- The primary care practitioner often has knowledge of the family and its circumstances over time.
- Family practice is seen as less stigmatizing.
- Consumers prefer this option (Kramer & Garralda, 2000).

However, the ability to meet the mental health needs of children and adolescents within traditional primary health care settings is limited by a number of factors. A study by

Cockburn & Bernard (2004) found, in a sample of 324 general practitioners, a continuing need to develop knowledge, skills, competency and training in youth mental health care:

- Many respondents rated as less than satisfactory their competence applied across three age groups of children, feeling least confident about dealing with issues in preschool children.
- Competence varied depending on the type of problem, with higher numbers of family physicians perceiving themselves less able to deal with disruptive behaviour disorders and eating disorders.
- Perceived knowledge was rated less than satisfactory for the nature and course of mental health problems in children and adolescents as well as treatment of mental health problems.
- Few respondents rated the training they received as useful, and more training was requested across a wide variety of topics, such as the use of psychotropic medications, knowledge about treatment/management of child/adolescent problems, assessment of suicide risk and eating disorders.

These gaps in knowledge, skills and competency create uncertainty about what constitutes an appropriate referral to secondary child and adolescent mental health services; they also limit treatment of problems that may be managed within primary care. Mildred et al (2000) reported on an Australian pilot project that suggested establishing specific links between consumers in a public child mental health program and general practitioners, increasing the opportunities for collaborative care.

Only one systematic review of effective interventions for children and adolescents in primary care was found in the literature (Bower et al, 2001). The authors commented that there was preliminary evidence (although many weak studies) showing that treatment by specialist staff working in primary care was effective but there were no data available regarding cost effectiveness. Additionally, there were some promising educational interventions aimed at increasing the skills and confidence of primary care staff, but there were few controlled evaluations and few reports of changes in professional behaviour. Overall, there is little reported about the process of implementing different models in regular practice settings (Macdonald et al, 2004). There is consensus among many authors that a significant program of research and evaluation is required in this area.

Discussions regarding collaborative primary mental health care for children and adolescents are also apparent in a few jurisdictions (e.g., England and Australia) and in other sectors calling for expanded partnerships (e.g., education and youth justice). Generally speaking, these advocates for collaborative care cite many of the same reasons for a collaborative approach as is demonstrated for adults or other specialty groups:

- Emphasis on reaching out effectively to people
- Reducing duplication of costly and scarce services
- Increasing the quality of care by recognizing the skills, expertise and experience that a number of professionals, such as occupational therapists, pharmacists and dietitians,

can bring to the development of a more effective treatment plan for youth mental health
- Shared decision-making and responsibility among providers
- Increased and enhanced communication and negotiation
- Peer supervision and support networks
- Increased sensitivity to other providers
- Broader awareness of clinical and ethical issues (Flaherty et al, 1998)

Models for collaborative approaches with children and adolescents mirror those used with adults and may be viewed within the perspective of strengthening the role of primary care. These are:
- Increased management by primary care and community professionals such as family practitioners and public health nurses (Bower et al, 2001)
- Management by specialist mental health professionals working in primary care (shifted outpatient clinics) (Abrahams & Udwin, 2002; Appleton & Hammond-Rowley, 2000; Bower et al, 2001; Garralda, 2001; Kramer & Garralda, 2000)
- Consultation-liaison approaches where the specialist supports management by primary care practitioners rather than taking responsibility for individuals (attachment models) (Bower et al, 2001; Garralda, 2001; Kramer & Garralda, 2000)
- Primary care interdisciplinary team approaches (Bower at al, 2001; Gale & Vostanis, 2003; Kramer & Garralda, 2000)
- Single primary mental health worker positions within a child/adolescent mental health service offering all aspects of the role to a defined population or selected aspects of the role (e.g., consultation, training and liaison) to a larger population (Gale & Vostanis, 2003)

Bradley et al (2003), in their study of provider trusts in the UK, examined the availability and frequency of work at the primary care – child/adolescent mental health care interface. They found that while a majority of trusts (124 of total of 150 surveyed) had joint training and education with primary services, only one third had implemented any type of joint programs or collaborative work. Specific to general practices, the small percentage of formal programs involved structured clinical consultation, joint casework or shifted outpatient clinics, with the last option having the highest average time spent by workers, though reaching fewer people.

Macdonald et al (2004), in a more in-depth study of six trusts, found three models of primary mental health care worker organization: a) outreach from the specialty service managed by the child and adolescent mental health team; b) based in primary care with some contact with the specialty service; and c) working in teams, managed independently of primary care or the specialty service. Factors key to implementation included:
- Focused preliminary negotiation and planning with primary care staff in setting up primary care worker positions

- Flexibility in the mix of direct work and consultation-liaison in the early stages of service development in order to effect good working relationships and goodwill
- Providing working accommodation for workers close to the primary care staff
- Good interpersonal skills of workers involved in service development, and education and preparation of effective provision of advice and support

Collaborative models and initiatives

The development of a collaborative initiative begins with a clear understanding of who the players currently are and what is still needed. Most communities have directories of services or agencies that assist in locating services. It is recommended that newly evolving collaborative networks work with these resources to identify the key stakeholders, especially if duplications are to be avoided. Key informants in the service community can be very valuable in identifying the major gaps in service networks. It is always advisable to include youth and families in planning, not only to identify what unmet needs exist, but also to make new services 'user friendly'.

Additional information on positive practice initiatives in Canada is available at www.ccmhi.ca. See:

- *Collaborative Mental Health Care in Primary Health Care: A Review of Canadian Initiatives: Volumes*

Appendix B contains descriptions of several collaborative-style programs currently operating in Canada that illustrate the range of service models that are proving to be effective. The descriptions include contact information should readers wish to contact programs directly. These programs demonstrate the variability of capacity-building approaches, including education, consultation and utilization of technology.

There are resources in many Canadian communities to help community-based and non-profit organizations assess community needs and identify best models of collaboration. Two such programs are the Volunteer Leadership Development Program and the BoardWALK Program. These programs are often connected with United Way Agencies in Canada and provide workshops that may be useful in developing governance structures for organizations like collaborative networks of existing but unconnected community agencies. These programs are usually non-profit and low cost. Two examples may be found at:
http://www.unitedwayvictoria.bc.ca/images/vldpprog.pdf
http://www.sjfn.nb.ca/community_hall/S/SJ_Volunteer_Centre/educat.htm

Key elements and fundamentals of collaborative mental health care

Figure 1: Framework for collaborative mental health care

Accessibility

Between 16-20% of children and adolescents have diagnosable mental health disorders (Breton et al, 1999; Fergusson et al, 1993; Offord et al, 1987). Child and adolescent mental health services have been described by Senator Kirby as the 'orphan's orphan' of health services because mental health services in general are woefully inadequate, but child and adolescent mental health services are even less well developed (Standing Senate Committee on Social Affairs, Science and Technology, 2004).

Children and adolescents present some unique access issues. They are typically not self-identifying, and therefore are usually brought to services by others, e.g., guardians, social service agencies, schools, etc. Proper services require inclusion of these significant others in order to obtain complete diagnostic information. However, this requires consideration of privacy issues and treatment consent, especially when the child/youth is not a willing participant. Similarly, the most effective intervention may require the involvement of significant others, presenting some special logistical challenges, e.g., scheduling, location of intervention or co-operation of parties who may sometimes be in contentious relationships.

Adolescents with mental health concerns may be the least well served. They often do not have regular contact with the health care system or seek care for mental health problems in the health system. Moreover, there is a particular dearth of adolescent mental health professionals. As a result, innovative collaborative care models may be most useful in this population.

There are, however, specific challenges to developing collaborative models of care for adolescents:

- Adolescents are not likely to lobby for better services.
- For many mental health problems, the most effective mental health treatments involve some combination of psychotherapy, pharmacotherapy and, in some instances (e.g., eating disorders), medical nutrition therapy.
- Adolescents with mental health problems are difficult to case-find.
- Adolescents with mental health problems are challenging to engage.

Youth workers and mental health clinicians who are not seen to be youth friendly may also be a barrier to access. Youth Net, an organization based in Ottawa, Ontario (see Appendix D), gives youth workers the following free advice:

> *"We are well advised to be open and non-judgmental in our dealings with youth. We should set the ground rules early with clear boundaries around confidentiality, especially with respect to giving information to parents, teachers, etc. We must learn to ask questions and listen to their answers without being judgmental. We should steer gently rather than dictating. We need to be flexible and have fun. We need to be wise and be good role models without being seen as being over-confident and knowing all the answers. We need to be willing to seek out resources and answers to issues. And finally, and I quote from one of the youth themselves, 'Face your fears. If you are scared of youth, face it, and find ways to get over it.'"*

Collaborative structures

Collaborative care initiatives will need to develop working relationships with other systems providing services to children including:

- Child welfare/Children's Aid
- Special needs children's programs
- Health authorities and constituent programs or departments
- School boards and departments of education
- Justice departments and programs
- Social services
- Medical organizations, e.g., primary care initiatives
- Allied health professionals e.g., occupational therapists, pharmacists, dietitians
- Recreational programs
- Other for-profit and not-for-profit organizations

For internal operations, programs will need to articulate:

- Clear definitions of the roles and responsibilities of each member and discipline within a program
- Leadership roles
- Evaluation mechanisms
- Other research initiatives
- Information management procedures – treatment records, protocols, electronic processing and storage, etc.
- Communication procedures
- Referral procedures (internal and external)
- Conflict management protocols
- Compensation mechanisms (interdisciplinary)
- Decision-making processes (including policy makers, managers, physicians, allied practitioners and families)

Pediatric collaborative care programs can be quite different from adult services, and the assumption should not be made that the same processes used to develop adult programs will work with children's services. Similarly, it should not be assumed that clinicians who have worked in adult collaborative care programs can also extend to cover children's services. Advanced skills in child and adolescent mental health are essential to delivering competent service.

Operationally, collateral involvement with systems, most notably schools, child care services and child welfare agencies, will be required in order to complete a full diagnostic assessment of a child or to successfully implement intervention strategies. As well, successful work with a child usually requires some involvement with other family members, especially parents. The extent to which a collaborative care program develops effective working relationships with these collateral systems will influence outcomes. Ongoing participation in consultation and service planning with interagency networks can be an effective method of developing a sound collegial support system that can enhance services.

Richness of collaboration

Best practice is facilitated by the involvement of a multidisciplinary team of professionals. Below is a list of functions which team members can provide. The activities are listed by discipline, although some tasks can be performed by a number of different disciplines, and not all clinicians in a given discipline are trained to carry out each function listed. Some of these roles are specific to youth, for example, the occupational therapist may assess a child's capacity for self-regulation in addition to looking for sensory sensitivities.

The following list does not include tasks and functions common across disciplines, (e.g., assessing suicide risk, reporting suspected abuse or neglect, acting as a resource for other

team members and community agencies). Nor does it include all the health care providers who might be members of the team, or other individuals who often play key roles in the lives of children and youth, such as teachers. Whatever the composition of the team, the child/youth and his/her family should be at its centre.

Social worker

- Assesses well-being of a child in context of family.
- Carries out family assessment.
- Provides case management services.
- Conducts individual, family and group therapy as necessary.
- Is a resource regarding community agencies serving children and youth.

Occupational therapist

- Assesses and optimizes child's ability to adapt to environment using activities as therapeutic tool, self-regulatory capacity, sensory integration, social adjustment, fine and gross motor functioning and adaptation.
- Assesses and offers strategies for how the child processes sensory information and how it might control their affect and behaviour.
- Assesses and sets up programs related to fine and gross motor skills, self-help skills and social skills.

Psychologist

- Examines interplay between mental health/illness and ability to learn, e.g., Is child's difficulty concentrating due to an undiagnosed learning disability such as verbal memory deficit, or is it due to ADHD or depression?
- Conducts psychological, psychoeducational and neuropsychological testing.
- Conducts individual, family and group therapy in various settings as necessary.
- Some, (e.g., neuropsychologists) have specialized training in the assessment and treatment of individuals with both cognitive and mental health problems.

Pediatrician and family physician

Factors common to both

- Both may provide primary care, although some pediatricians see cases only on referral, many (up to 50%) involving mental health concerns.
- In rural areas, family physicians and pediatricians may be providing all of the mental health care for children and youth, establishing a long-term relationship with the child/youth and their family and promoting continuity of care.
- It is important to survey both pediatricians and family physicians to identify perceived learning needs in youth mental health.
- In areas where resources for youth mental health are scarce, a 'champion' from this group could be identified, receive specialized training in the area of child/adolescent mental health and then serve in a teaching role with their colleagues. E-mental health

and telemedicine education should be considered. [See **Physician education** section below.]

Factors that may be unique to pediatricians

- Pediatricians are experts in the normal stages of child and youth development and often focus on differences between normal development and problematic situations.
- Pediatricians have expertise in the diagnosis and treatment of ADD/ADHD; this expertise can be shared with family physicians and parents.

Factors that may be unique to family physicians

- Family physicians may provide care for the child/youth's entire family and therefore understand hereditary mental health diagnoses and have records of medications that have proven effective in biological relatives.
- Adolescents who have a continuing relationship with their family physician may feel more comfortable talking to them about mental health issues.
- Adolescents may perceive a confidentiality barrier if their family physician also provides care for their parent(s). Limits of confidentiality need to be clarified.
- A small number of family physicians choose to specialize in psychotherapy.

Nurse

- Monitors efficacy, side effects and contraindications of medications prescribed for children and youth.
- Monitors inpatients and those being treated for first-episode psychosis who require continued follow-up, especially linkages between hospital and community.
- Some conduct individual, family and group therapy as necessary.
- Provides education, advice and counselling to children/adolescents and families.
- May be the only mental health resource available in rural or remote communities.
- Some (psychiatric and mental health nurses) have specialized training in the areas of mental health and mental illness.

Dietitian

- Identifies nutrition concerns such as poor intake, nutrient deficiencies, weight changes, drug interactions, non-compliance to special diets, lack of money or skills for adequate intake.
- Individualizes nutrition intervention strategies.
- Facilitates psychoeducational groups for food and nutrition.
- Is a vital member of eating disorders programs in mental health.
- Emphasizes the importance of good nutrition for all youth and families.

Psychiatrist

- Assesses and diagnoses mental illness from biological, psychological, social and cultural perspectives.
- Understands differences in psychotropic drug metabolization and brain development between youth and adults.

- Rules out or refers/treats medical causes of some problems, e.g., anemia in a teenager whose menses are not yet regular may be etiologically important in the development of depression.
- Is an expert in the use of psychotropic medications.
- Is familiar with psychotherapies and systemic treatment and is able to incorporate these into a comprehensive treatment plan.

Pharmacist

- Provides counselling, information and education to consumers regarding medications and some general health concerns.
- Works with providers and consumers to achieve optimal drug therapy.
- Monitors outcomes and unintended consequences of drug therapy and ensures that medications are being used appropriately.
- Provides prescribing advice (including risks and benefits, treatment options and cost-effective drug therapy) for health care providers based on the best current evidence.

Consumer centredness

Involving consumers in the design, implementation and evaluation of services is vital to successful initiative planning. Consumer centredness presents some special challenges regardless of age, most likely due to stigmatizing factors related to mental illness. Consumers have not usually been seen as effective self-advocates, and, in particular, children and adolescents may find participation in such activities especially demanding. Attending meetings surrounded by a room full of professionals utilizing unfamiliar jargon can be intimidating. Parents are experts on their children, as youth are on themselves. It is important to discuss with youth and families what is needed to create a consumer-friendly waiting room (e.g., age-appropriate toys and a clean, warm play area). Most children find it difficult to sit still and converse with adults for long periods of time, so assessment-compatible activities need to be built in as part of the child and youth assessment plan.

Consumers have a valuable perspective to contribute. Special attention should be paid to identifying suitable participants and in welcoming them to an environment that invites their participation. For example, the Southern Alberta Child and Youth Health Network, of which the Healthy Minds/Healthy Children Project is an outreach program (see Appendix B for description) created a Child and Youth Advisory Council and has made an extraordinary effort to design activities that enable young people to feel comfortable and supported. Hosting relaxed competitions to design posters, themes, public relations videos, etc. can be effective and enjoyable ways of soliciting the opinions of youthful consumers. Separating out the clinical from the advocacy levels of participation may be crucial to facilitating involvement while maintaining the privacy of personal issues.

Transitional youth – a special population

(This section was prepared with a significant contribution from Dr. JoAnn Elizabeth Leavey, based on "The Gap: Moving Toward Youth-Centred Mental Health Care for Transitional Aged Youth (16-24)" by Leavey et al (2000).

In mental health programs, older youth, usually aged between 16 and 24, often fall between the cracks of the child and adult systems. This population is often referred to as 'transitional youth', in reference to their transition from adolescence to adulthood and from child to adult programs. Much remains to be done to effectively respond to the needs of transitional youth.

Youth-centred supports and services that should be developed to assist in overall independent and interdependent living include appropriate, youth-centred housing; social and recreational activities; peer support; counselling support; medical support; job training; educational opportunities; and, where appropriate, family counselling.

There must be a recognition of the growing prevalence of mood and anxiety disorders, substance abuse and suicide in this population. Although there are some examples of programs to serve youth with these mental health problems, most of the programs and services offered to transitional youth are targeted to those experiencing first-episode or first-break psychosis.

It is critical when providing intervention and treatment for this age group to distinguish typical, age-appropriate risk behaviours from pathological behaviour. It is important to keep in mind youth, their context, their social environment, typical development, family environment and internal environment, when diagnosing the problem(s). Assessment and thorough history-taking by highly skilled professionals are paramount when considering the 'whole picture'.

It is important to ensure that transitional youth are viewed from a holistic perspective and to assist them to deal with their 'personhood' issues as well as their 'mental health' issues. Administrators from child and adult services need to consider creating working groups to ensure seamless transitions from youth to adult services so that youth are not lost to follow-up as they become adults. This group may first be diagnosed as mentally ill during their adolescence, but the exact nature of the mental illness (e.g., bipolar affective illness or schizophrenia) may only declare itself in later adulthood. If child and adult services do not work together, these individuals are at risk of homelessness or, even worse, drug use, suicide or becoming victims of violence.

Adopting a holistic, youth-centred mental health care approach will replace the traditional 'illness lens' with an emphasis on wellness and ability. Upon stabilization of the mental health problem, attempts should be made to re-integrate individuals into their regular social routines as soon as possible. This approach promotes recovery,

rehabilitation and relapse prevention. It is also critical that there be strong linkages between hospital-based and community-based programs to ensure seamless care.

Consumer education for youth is a key component in the prevention of relapse and promotion of rehabilitation. Public education will help maximize acceptance of diagnosis, recognition of symptoms and foster help-seeking behaviours. The demystification of mental illness and the reduction of associated stigma are very important. Enhancing social competence and a sense of control is critical for both recovery and long-term prognosis.

When speaking to rehabilitation programs that assist youth in their social re-integration and recovery processes, they report that social isolation is a key problem for transitional youth post-diagnosis and can be ameliorated through social skills training. Peer helper and peer mentorship programs would be excellent in assisting youth with social support and guidance.

Key principles for youth-centred mental health care

- **Involve youth in care decisions and program design.** This may include integrating youth into treatment choices, reviews of medications and decisions about location and type of care. It also includes youth involvement in creating, modifying and designing treatment and peer support programs. Building internal and group capacity in youth is key to overall reduction of alienation.
- **Integrate peer support and assistance.** This facilitates maintenance of social support, progress through developmental stages and stigma reduction. It also assists in developing capacity in recovered youth via provision of peer support.
- **Recognize developmental issues and the impact of interrupted development.** This puts the developmental challenges and normal aspects of growth and identity formation at the forefront. These are critical in creating a unique transitional youth 'best practice'.
- **Avoid treatment-related trauma attached to first diagnosis and hospitalization.** This emphasizes the preference for home- or community-based psychosocial care and highlights the aspects of interactions with agencies such as police or emergency personnel that can be traumatizing.
- **Identify the special effects of stigma on youth.** This assesses and acknowledges the serious impact of mental health diagnosis and treatment on youth and focuses on ameliorating these effects.
- **Focus on home- and community-based care and fostering family support.** This maintains the youth in her/his regular milieu, and actively involves family and supporters in treatment and advocacy roles.

- **Develop age- and stage-appropriate education about mental illness.** This requires the development (with youth involvement) of relevant and useful means to improve psychoeducation, public awareness and professional education surrounding transitional youth's mental health needs.
- **Address the social determinants of health, particularly gender, education and social support networks.** This requires the application of a gender lens to all aspects of planning and treatment for transitional youth in order to reflect the gender differences. It also requires the development of appropriate program elements to actively address educational attainment and development of social support for transitional youth. This would include programs and peer support regarding normalizing sexual identity questions and concerns, and providing youth peer support programs and counselling regarding sexually transmitted diseases (STDs) and health sexuality when requested by youth.
- **Focus on wellness and ability.** This requires the use of a 'wellness' approach instead of an 'illness' approach, focusing on the strengths, abilities and skills of transitional youth.

Policies, legislation and regulations

A number of different laws govern services provided to children and youth - some provincial, some federal and some municipal. Planners need to be aware of these laws and the legislation that governs mandated intervention with youth and their parents/guardians. Initiatives will have to consider which of the following may affect them:

- Legislation affecting age of majority
- Consent and capacity legislation
- Child welfare legislation (affecting duty to report cases of neglect or abuse, and mandated removal from home)
- Privacy legislation (both federal and provincial, e.g., Health Information Acts)
- Professional regulatory acts
- Professional standards of practice
- Hospital/medical acts
- Public Guardian Acts
- Mental Health Acts
- Canada Health Act
- Physician compensation schemes
- Youth Criminal Justice Act
- Disability legislation
- School Acts
- Canadian Medical Protective Association

The unique multidisciplinary nature of collaborative care initiatives adds to the richness of services provided but, especially when working with children and youth, it also poses some special challenges. Disciplines may have different regulatory obligations and practice standards, and these may vary across provincial jurisdictions. Be aware that professional guidelines or standards may demand different actions from each professional, and initiative protocols will have to take these differences into account. Program planners are well advised to be aware of all relevant federal and provincial legislation.

The development of respectful interdisciplinary relationships is vital to the success of collaborative initiatives, and it is therefore necessary to establish operating agreements and decision-making protocols prior to rolling out service. These agreements will pertain to many basic processes, including but not restricted to:

- How confidentiality, privacy and information sharing will be handled
- How clinical services will be documented and who is responsible for maintaining the records
- How treatment consent will be managed

Confidentiality is an issue of particular concern when working with children and youth. For example, consider the adolescent who may have some personal disclosures to make to the clinician but is concerned about privacy. He/she may not want his/her parents to know or he/she may even ask that his/her physician not be told. This may present a dilemma, especially in a family practice where the entire family attends. In general, youth requests for privacy from parents can be honoured except in cases of risk of harm to self or others, inability to care for self, or abuse. These limits must be clearly delineated to youth at the outset of a therapeutic relationship.

Laws that govern consent to treatment and capacity to give consent are province specific in Canada. There is no formal age of consent for medical procedures or surgery (Quebec is an exception, for most procedures). Rather, a doctor must make a determination that a child understands the procedure being recommended with all of its risks and benefits related to performing or not performing the procedure. If a child is deemed to be capable, then he or she may give consent and, in case of parental disagreement (e.g., a blood transfusion on religious grounds), a children's lawyer or rights advisor will be assigned to act on the child's behalf (see Oberle & Whitsett, 2003).

The concept of ‘mature minors’ (sometimes referred to as ‘emancipated youth’ in the United States) is used when a youth under the age of majority is able to give consent without parental involvement. For example, if a youth approaches a family physician asking for birth control, a physician would conduct an interview to determine the maturity level of the youth and their capacity to make informed and free choices and consent to treatment. The physician should also ensure that the youth is not being abused

by anyone in their life who might be taking advantage of them. The concept of 'mature minors' is not applicable in Quebec.

The Youth Criminal Justice Act is federal legislation that is implemented provincially. This legislation governs youth between the ages of 12 and 17 years who are in conflict with the law. For youth at risk, police departments often have youth detachments where supportive services are available.

Other age-related legal issues of concern to youth include:

- Voting rights
- Right to consume alcohol or attend locations where alcohol is permitted
- Right to choose not to go to school
- Obligation of schools to accommodate specific needs of students
- Age of consent for sexual relationships

Funding

Funding will vary from province to province based on which Ministry is primarily responsible for children's mental health, for example, in Alberta, the Ministry of Health is responsible, whereas in Ontario, it is the Ministry of Child and Youth Services. (The Ministry of Health and Long-Term Care also provides some funding for children/youth mental health.)

If research is going to be implemented in association with a clinical program, a number of granting agencies at different levels should be considered: nationally (e.g., Canadian Institutes of Health Research, Primary Health Care Transition Fund), provincially (e.g., Alberta Heritage Foundation for Medical Research, the Center for Excellence in Child and Youth Mental Health at CHEO in Ontario) and locally (e.g., some municipalities have small research funds or seed funds).

When providing collaborative mental health care, consider who will be funded (i.e., psychologists, social workers, child and youth workers, family physicians, nurses, dietitians, occupational therapists, pharmacists, child and adolescent psychiatrists) and explore different remuneration models (salary, sessional, fee-for-service). Many traditional provincial health funding arrangements provide fee-for-service for direct services only. As much of youth mental health care involves gathering collateral information from schools, making site visits and attending case conferences, alternate funding plans are important to consider when setting up youth mental health initiatives.

Evidence-based research

Generally, collaborative care programs specifically targeting children and youth are relatively new, and an extensive database of evidence-based practice does not yet exist. However, many of the strategies being applied in these initiatives are based on established clinical practices; these are outlined above in *Lessons from the literature* and

Collaborative models and initiatives. See also the CCMHI report: *Better practices in collaborative mental health care: An analysis of the evidence base,* available at www.ccmhi.ca.

Community needs

The following steps are suggested when conducting a needs assessment for a collaborative mental health care initiative for children and youth:

1. **Determine the extent of the problem.**
   - Determine the number of adolescents in the community served by your initiative. This information can be obtained from census data.
   - Determine the number of adolescents who have mental health problems in the community served by your initiative. There may be a relatively recent survey or standard estimates of prevalence from the literature. For example, the Canadian Community Health Survey (CCHS) provides data broken down by age grouping, sex and province. These data are free from Statistics Canada. Some material is accessible on the web at: http://www.statcan.ca:8096/bsolc/english/bsolc?catno=82-617-X. More detailed information can be retrieved by application at regional data centres. You can also conduct a survey of your community. This is the most accurate but most expensive strategy.
   - Determine the number of adolescents within each major diagnostic category who have received care for mental health problems in the community served by your initiative. This information should be available from health service records in your community.
   - Determine the number of youth with mental health problems in each major diagnostic category who are not receiving care. This is the gap between the number of adolescents who have mental health problems and those receiving care.
   - Consider data indicating the potential for future need such as estimates of adolescents with disordered eating behaviours.

2. **Determine the reasons for the gap in service.**
   These may include:
   - The programs do not exist in the community.
   - The programs do exist but are not available and/or accessible due to:
     - Intake criteria, for example, those with dual diagnoses may be excluded from some programs
     - Location and lack of transportation
     - Hours of operation (i.e., not enough after-school times)
     - Limitations on the capacity of the program, for example, only those with the most severe problems may be accepted, leaving the rest unserved
   - The programs exist and are available but youth are not willing to attend because of:
     - Lack of knowledge of the service

- The feeling they would not be welcome
- Stigma (e.g., one Ontario town opened a much-needed Sexual Health Clinic in the city hall building, which necessitated youth walking through a very public foyer in order to use the service)

3. **Determine the resources available for filling the gap in service.**
   Focus groups of experts in adolescent mental health or a cataloguing of resources could determine the resources available. Experts may include:
   - Psychologists
   - Psychiatrists
   - Occupational therapists
   - Community nurses
   - Pharmacists
   - Social workers (in health and community services)
   - Registered psychiatric nurses
   - Dietitians specializing in mental health issues
   - Youth justice workers

   It is also important to identify the adults with whom children and adolescents are in contact. In a recent survey of youth in British Columbia (McCreary Centre Society, 2004), about half (45% of boys and 54% of girls) asked a professional for help. For personal problems, youth most commonly asked school staff for help. Older students were more likely to approach a health professional than younger students, (37% at 17 years, versus 26% at 13 years). About three-quarters of the youth surveyed found their contacts helpful. Contacts may include:
   - Guidance counsellors
   - Family doctors
   - School nurses
   - Staff at teen health centres
   - Sports coaches
   - Clergy

   Policy-makers and decision-makers should be involved from the beginning in all aspects of data collection and planning.

4. **Determine what type of care is needed.**
   Different services will be required for different needs. For example, if youth with dual diagnoses and severe problems are being poorly served, this will require a different program than for youth with mild to moderate problems.

   Criteria for determining priorities should be established. These may include:
   - Severity of the problem
   - Prevalence of the problem(s)
   - Evidence for effective treatment

- Cost of effective treatment
- Potential cost savings if treatment is effective

5. **Plan and implement a strategy for increasing appropriate service to youth.** Given the limited resources that most jurisdictions have available, this will almost certainly involve collaborative care.

Planning and implementation

In the planning and implementation stages of an initiative, liaison and/or partnerships with community agencies and services are essential. These may include:

- Schools
- Children's mental health agencies
- Public Health units
- Children's Aid Societies
- Correctional facilities for children and youth
- Hospitals
- Other profit and not-for-profit organizations
- Crisis services
- Police services
- Community-/lay-led self-help groups

Strategies to collaborate with the community may include:

- Identifing community champions (e.g., health care providers, local agencies, schools)
- Surveying community resources, including conducting a needs assessment
- Identifying duplication and gaps in services
- Enhancing linkages with other programs
- Involving consumers (parents and youth) on advisory or steering committees in program development
- Making programs child/youth friendly - easily accessible, flexible, age appropriate, culturally sensitive

Special issues facing health care providers in rural and remote areas

1. Supply and demand

- The physician shortage in rural and remote areas leaves little time for issues in child and family psychiatry.
- Rural doctors are presently focused on meeting the fundamental needs in surgery, obstetrics, anesthesia and emergency medicine.
- There are many 'orphan' consumers receiving little to no care.
- There are very few, if any, rural doctors willing to 'champion' a new role, i.e. child psychiatry resource person.
- There are also relatively few allied health professionals to whom referrals can be made.

2. Training

- Educational needs for family physicians and primary care pediatricians in child psychiatry are profound.
- Communication between family physicians and pediatricians could be improved at the training stage by providing joint educational seminars and training programs.
- There is little, if any, postgraduate instruction in child psychiatry in the present family medicine residency program.
- Family doctors in rural communities are poorly prepared and lack confidence in the area of child psychiatry.

3. Remuneration and practice

- There are practical disincentives around the management of problems in child psychiatry.
- The present model is not time efficient.
- Managing problems in child psychiatry is poorly remunerated.
- It is very difficult to obtain specialist back-up.
- Nurse practitioners and allied health professionals are not generally available in rural communities.

4. Dilemmas for adolescents

- Teens in rural communities present a special clinical challenge.
- It is difficult for teens to see doctors during school hours.
- As orphans in the system, adolescents' only access point may be the emergency room. Teens often have to 'pass through' many adult hands before they reach a physician. It is difficult for them to maintain anonymity and confidentiality. They may also be exhausted by the process and begin to give up on seeking help.

5. New roles

- Family physicians will need to develop new roles as facilitators and advocates in their own communities.
- Family physicians will need to examine ways of empowering local support groups and other child advocates.

Physician education

Surveys of family physicians conducted as part of collaborative care programs have typically found that these practitioners report feeling unskilled or lack confidence in treating children's mental health problems (Steele et al, 2003). Furthermore, the heavy demands on these practitioners' time and the complexity of their educational needs make regular continuing education in children's mental health a rarity.

A report by Davidson & Manion (1993) reviewed the prevalence of mental illness in children and youth. They reported that 1 of 5 youth in developed and developing countries suffers from one or more psychiatric illnesses. In the Ontario Child Health Study, Offord et al made the observation that only 1 of 6 children with these disorders received mental health services (Offord, 1989; Offord et al, 1987; see also Verhulst, 1997). A survey by Davidson & Dennis (1996, unpublished) of the 16 Canadian family medicine training programs observed that there were no mandatory rotations in child and youth psychiatry, and although all programs identified a theoretical possibility for students to set up voluntary electives, only one program reported one single occasion in which a family medicine trainee took advantage of such an opportunity. (See also Steele & Dickie, 1997.) Needs assessments conducted by Davidson and Spenser[1] in Ottawa, Ontario in 2000 and 2001 (see Appendix D for sample needs assessment), and Steele et al (2003) in rural and underserviced areas of Southwestern Ontario, surveying both trainees and practicing family physicians, reveal a knowledge gap in child psychiatry among front-line physicians (both pediatricians and family physicians), along with frustration among both these groups with respect to having access to timely consultations from child psychiatrists. In Ontario, child psychiatrists are a scarce resource even in urban centres, but are much less available in rural regions. The ratio of child psychiatrists to children with mental health needs in this province was 1:6148 when Steele & Wolfe (1999) conducted their survey but, as they pointed out, more than 50% of this group would be over 65 in 15 years' time.

A needs assessment conducted by Spenser and Davidson[1] in Southeastern Ontario revealed that front-line clinicians uniformly expressed an interest in obtaining more knowledge regarding youth mental illness, particularly as it related to youth with behaviour problems including aggression. Steele et al (2003) assessed the need for a scholarship program in children's mental health for rural family physicians and obtained similar results, with the top three learning needs identified as behaviour disorders, ADHD and problem adolescents. This group test-piloted an innovative teaching program using fellow GPs as opinion leaders to provide youth mental health education. Preliminary findings indicated physician satisfaction with the program and increased confidence in detecting mental health problems, making appropriate referrals and developing management plans (Steele et al, 2004) (see Appendix B for a description of this initiative).

[1] Information from unpublished reports

Models

One of the hopes in disseminating this toolkit is to provide administrators and primary health care practitioners with some examples of innovative ways in which scarce child psychiatry resources can be used more effectively, and information about children's and adolescents' mental health can be made more widely available.

- At the University of Ottawa, a program offers rural family physicians the opportunity to develop expertise in children's mental health through ongoing telephone supervision with a child psychiatrist or a paid elective in a child psychiatry setting. The family physician then returns to their rural community to share this knowledge with peers and build some teaching settings.
- The Guide Lines for Adolescent Depression in Primary Care (GLAD-PC) Project is developing clinical guidelines for primary care providers (including family physicians, nurses, pediatricians and others) to screen, diagnose and treat adolescents (age 10-21) for depression. For contact information, please see Appendix C.
- Treatment recommendations have been developed, based on the existing evidence base, for using antipsychotic medications with young people who could benefit from them. The TRAAY (Treatment Recommendations for the Use of Antipsychotics for Aggressive Youth) Project provides a resource for family physicians and other providers for the appropriate use of antipsychotic medications with youth. For contact information, please see Appendix C.
- The Healthy Minds/Healthy Children Capacity Building Project in Southern Alberta, in partnership with the Faculty of Social Work at the University of Calgary, has embarked on an innovative method of educating family physicians and other clinicians in children's mental health. They have developed a series of web-based online modules in various topics that permit practitioners to log in at times of their choosing and as often as they wish. The format permits participants to post questions to presenters and colleagues and then, at a later time, log back in to follow the dialogue. There are also opportunities for real-time dialogues between presenters and participants to take place using the website. The first round of modules was totally subscribed within a week at a capacity beyond what was expected, encompassing practitioners from all over the province. Initial feedback from participants was very positive, both for course content and for the ease of use of the technology. For a description of the Healthy Minds/Healthy Children project, please see Appendix B.
- Steele & Dickie (1997) and Steele et al (2003, 2004) have outlined several models of teaching child psychiatry to family medicine residents and family physicians.

Reading about children in books and listening to lectures is not a substitute for having an opportunity to interview children with mental illness under the supervision of a child psychiatrist. It will be important for child and youth psychiatrists to expand outreach consultation programs such as the Toronto Telepsychiatry Program (described in Appendix B) which reaches many remote areas Teaching family physicians to feel more confident diagnosing uncomplicated depression and new cases of ADHD will shorten

waiting times for youth suffering from complex, unremitting mental illnesses to be seen by child and youth psychiatrists.

Key points to consider

1. **Scarcity of resources**
   There is an extreme shortage of services and limited availability of experts to treat psychiatric disorders in children and youth. For example, an Ontario study reported a ratio of one child psychiatrist for 6148 children with mental health needs (Steele & Wolfe, 1999). The majority of family physicians and pediatricians identify having had less-than-optimal training in child and youth mental health (Cockburn & Bernard, 2004; Steele et al, 2003).

2. **Unique feature of assessment in youth mental health**
   A comprehensive assessment of a child/youth requires interviewing the caretaker and family and discussion with the teacher regarding observation in the classroom. It may also involve more than one clinician on a multidisciplinary team (similar to geriatrics) given that a child, in particular, is less likely to be able to identify the problem with an adult-like statement, e.g., "I am depressed".

   Assessing a child/adolescent is time consuming as it involves:
   - Behavioural observation
   - Interviewing the child
   - Interviewing the family
   - Seeking collateral information, e.g., from a teacher, Children's Aid Society or police

3. **Clinical remuneration**
   Traditional fee structures such as fee-for-service do not facilitate comprehensive assessment and time spent gathering information from collateral sources such as teachers. Alternate funding plans (AFPs) and other non-traditional funding practices should be considered.

4. **Importance of the multidisciplinary team**
   Best practice is facilitated by the involvement of a multidisciplinary team of professionals. This may include a social worker, occupational therapist, psychologist, pediatrician, family physician, dietitian, nurse, psychiatrist and pharmacist, as well as others who often play key roles in the lives of children and youth, such as teachers. The child/youth (and his/her family, where applicable) should be at the centre of the team.

5. **Province-specific legal complexities for youth**
   Providers need to be aware of legislation that governs mandated intervention with youth. In Canada, this includes complex, province-specific information on consent and capacity as well as confidentiality. This must be clearly explained to youth. The age under which the Child Welfare Act can mandate that a child be removed from

home varies by province, as do the age of attainment of voting rights, the right to drink alcohol, the right to drive and mandated school attendance.

Laws regarding age of consent for youth involved in relationships with older partners and the concept of 'mature minors' or 'emancipated youth' are also relevant to this population.

6. **Youth-friendly programs**
   Include youth in program planning. Data show that although up to 25% of teens suffer from mental illness, they rarely seek help for these problems voluntarily (Youth Net). Adolescents have limited reasons to see a physician, (e.g., for broken bones, camp physicals or sports injuries).

   Focus group information from teens defines what is 'youth friendly' with respect to waiting rooms and doctors themselves (see Appendix D). Youth value active listening, confidentiality, sense of humour and genuineness in healthcare providers. Be direct and upfront about the limits of confidentiality.

7. **Physician education**
   Family physicians surveyed in Ontario identify a wide range of learning needs. High on the list were how to manage aggressive behaviours in youth and how to understand which behaviours are harbingers for psychiatric illness. Specialized service providers need to be cognizant of constraints on family physicians' time and offer practical, time-limited suggestions and practical tools, e.g., tear-off sheets.

8. **Evaluation of change/symptom improvement**
   Find simple rating scales, such as the Global Assessment of Functioning, to track progress and symptoms.

9. **Some suggested models for service delivery**
   - Telemedicine- or videoconference-based services, e.g., the telepsychiatry program offered by the Hospital for Sick Children (Toronto, Ontario)
   - Capacity-building, e.g., Healthy Minds/Healthy Children (Southern Alberta)
   - Physician education, e.g., Healthy Minds/Healthy Children web-based CME
   - Consultation/collaborative care model in family practice training (Ottawa, Ontario)
   - In rural regions, identification of local champion (Ontario)

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Appendix A: Consultation process

The Expert Panel solicited feedback from a variety of sources, both lay and professional, from several disciplines and expresses appreciation to those who provided invaluable input.

- Sarah Brandon, Program Co-ordinator, Youth Net, Ottawa, Ontario
- Canadian Psychological Association
- Dr. Amy Cheung, Adolescent Psychiatrist, Sunnybrook Hospital, Toronto, Ontario
- Dr. Simon Davidson, Chairman, Division of Child and Adolescent Psychiatry, Department of Psychiatry, University of Ottawa; Chief of Psychiatry, Children's Hospital of Eastern Ontario
- Avril Deegan, Social Worker, Team Leader, Adolescent Urgent Team, Calgary, Alberta
- Dr. Peter S. Jensen, Ruane Professor of Child Psychiatry & Director, Center for the Advancement of Children's Mental Health, Columbia University/NY State Psychiatric Institute
- Joint Action Committee on Child & Adolescent Health (pediatric/family medicine advisory committee)
- Dr. JoAnn Elizabeth Leavey, Research Leader, Early Psychosis Prevention and Intervention, Provincial Health Services Authority, Vancouver, BC
- Louise Logue, Youth Intervention/Diversion Co-ordinator, Ottawa Police Service
- Dr. Elizabeth Pappadopulos, TRAAY Project, Columbia University, New York, New York
- Elizabeth Phoenix, Nurse Practitioner, Child & Adolescent Centre, London, Ontario
- Dr. Nazrene Roberts, Psychiatrist, Kingston, Ontario
- Dr. Dianne Sacks, Assistant Professor of Paediatrics, University of Toronto, e-mail: Teendoc75@aol.com
- Julia Singer, Youth Net Co-op student, Ottawa, Ontario
- Aggie Stretch, Teacher, Hanover, Ontario
- Sheila Volchert, Co-ordinator, Second Chance for Kids
- Youth Net Adolescent Focus Group, Ottawa, Ontario

Appendix B: Positive practice initiatives

Teaching children's mental health to family physicians in rural and underserviced areas

Additional information on positive practice initiatives in Canada is available at www.ccmhi.ca. See:

- *Collaborative Mental Health Care in Primary Health Care: A Review of Canadian Initiatives: Volumes I and II*

Program description

In this collaborative care research project (Steele et al, 2004), a child and adolescent psychiatrist and a rural family physician provided educational opportunities for family physicians in 12 rural and underserviced areas.

Based on identified learning needs (Steele et al, 2003), a half-day curriculum was developed to teach family physicians about behaviour problems in children and youth (oppositional-defiant disorder, conduct disorder and attention deficit hyperactivity disorder [ADHD]) and to build interviewing skills. Clear learning objectives addressing knowledge, attitude and skills were identified and used to develop the curriculum. The teaching involved a didactic component and instructional videotapes. The teaching utilized a case-based approach that emphasized the roles of both the family physician and the child psychiatrist. The instructional videotapes were of a child with ADHD and an adolescent with a behaviour problem, both of whom were interviewed by a child psychiatrist. The educators provided handouts containing the key points with appropriate references. The family physicians were able to obtain credits through the Maintenance of Certification program. The curriculum has been evaluated both quantitatively and qualitatively.

Service model

This educational curriculum was intended to build the community capacity of family physicians to assess and treat children and youth with mental health problems.

Factors entering into needs assessment

In a survey of child and adolescent training in Canadian family medicine residency programs, minimal teaching of child psychiatry was noted (Fisman et al, 1996; Steele & Dickie, 1997). In order to determine the educational needs of family physicians in the area of child and youth mental health, a cross-sectional cohort of family physicians living in rural and underserviced areas of Southwestern Ontario was surveyed with respect to their confidence, knowledge and skills in managing children's mental health problems (Steele et al, 2003). Of the family physicians that responded, only 10.3% scored 5 or more on a 7-point Likert scale with respect to confidence in their skills in managing children's mental health problems. Slightly more family physicians (18.1%) felt confident in their knowledge of children's mental health problems. The majority (84.3%) of respondents felt they needed more training in child and adolescent psychiatry. Of these respondents, the

majority suggested: 1) continuing medical education in the community; 2) small-group teaching by a child psychiatrist; and 3) self-instructional packages. When the family physicians were asked to rank topics in child psychiatry in order of importance, behaviour disorders, attention deficit with hyperactivity disorder (ADHD), problem adolescents and interviewing skills were ranked the highest.

Healthy Minds/Healthy Children capacity-building project

Southern Alberta Child & Youth Health Network

Program description

Healthy Minds/Healthy Children (HM/HC) is a capacity-building project funded by Health Canada's Primary Health Care Transition Fund through Alberta Health and Wellness and administered by the Southern Alberta Child and Youth Health Network (SACYHN).

Its mandate is to support the efforts of primary health care providers to meet the mental health needs of children and youth. It covers southern Alberta Health Regions 1, 2, 3, and 4 and participating First Nations of Treaty 7. As urban Calgary has some pre-existing collaborative care programs, HM/HC is tending to concentrate its efforts outside urban Calgary, mostly in rural areas and smaller communities.

Activities include:

- Providing linkages to local secondary levels of mental health services
- A telehealth-based interregional assessment and consultation service utilizing multidisciplinary virtual teams
- Providing consultation to primary health care providers in the area of children's mental health
- Facilitating access to psychiatric consultation
- Supporting referrals to tertiary care services located in larger urban centres
- Providing resources in the area of children's mental health including in-services and a resource kit that includes an innovative, web-based CME program, threaded with a physician's desk reference with diagnostic tools and information prescriptions (resource lists) that providers can distribute to consumers

Wherever possible, HM/HC attempts to construct the supports to primary care utilizing local resources so that when project funding ends, the linkages can continue.

Service model

The literature indicates that while shifted outpatient models of collaborative care (in which consumers are seen in the primary care provider's office by a mental health specialist) make services more convenient and accessible to the public, they do not increase overall mental health service capacity (Gask et al, 1997). Nor do they lead to

changes in physician practice behaviour in terms of direct mental health service provision or referral patterns (Bower & Sibbald, 2000).

The mandate of HM/HC is to build the capacity of primary health care providers to deliver mental health services in Southern Alberta. Given the large geographic area that HM/HC must cover and its limited resources, a consultation-liaison model has been adopted. Thus, most of the contact with primary care consists of consultations to physicians and not direct contact with consumers. The contact involves case-based consultation with a focus on selected topics based on physician input on their greatest needs in the area of skill-building in children's mental health. Frequently, consultations with physicians involve discussion of several cases that have a common theme (e.g., childhood mood disorders). The discussion will include material that the physician may be able to apply in several cases, and thus capacity to manage these cases is increased.

Factors entering into needs assessment

When SACYHN was first formed, it made use of information gleaned from parental feedback around the construction of a new children's hospital which would cover a broad geographic area. Parents frequently indicated that they desired services to be closer to home and linked together to provide more co-ordinated care. A major factor in SACYHN's application to Health Canada's Primary Health Care Transition Fund was to develop an outreach service in the area of children's mental health that would enable children to receive services closer to home (i.e., with their family physician) and to facilitate access if specialized services were needed.

At the commencement of this project, a review of the literature was conducted. In addition, promotional packages were sent to physicians that included a survey of physician need and self-assessment of confidence and skill in the area of children's mental health. Consistent with surveys done elsewhere (Rockman et al, 2004; Steele et al, 2003), physicians indicated that they did not feel particularly comfortable or skilled in managing children's mental health concerns, especially in younger children. As well, they tended to echo other findings that their greatest need for input was in the diagnostic areas of mood disorders, anxiety disorders, ADHD and disruptive behaviour disorders.

Contact

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Telepsychiatry Program

Hospital for Sick Children, Toronto, Division of Child Psychiatry, University of Toronto, Toronto, Ontario

Program description

It is estimated that in Ontario, the ratio of child psychiatrists to children with mental health needs is approximately 1:6148. Furthermore, only 2.6% of child psychiatrists primarily practice in areas with populations of less than 20,000, while approximately 18% of the population in Ontario resides in rural areas (Steele & Wolfe, 1999). Innovative approaches are required to provide psychiatric services to those children and youth in rural and remote communities. The Telepsychiatry Program at the Hospital for Sick Children, Toronto, Ontario and the Division of Child Psychiatry, University of Toronto offers a consultee-centred consultation service to children, their families and mental health practitioners in such remote communities.

The overall funding for this program comes from the Ministry of Children and Youth Services, with the Hospital for Sick Children providing space and some administrative support. To date, the funding is renewed on an annual basis. Currently 14 primary sites and their satellite sites are connected to the 'hub site' (Hospital for Sick Children) via Integrated Services Digital Network (ISDN) lines carried on a maximum of six lines. Implementation of HP bridging will be added in the near future. The service is also accessible by any mental health provider in Ontario with compatible technology. Seventy-five faculty members within the Division of Child Psychiatry at the University of Toronto are potentially available to provide consultation services.

The Telepsychiatry Program functions under five umbrellas:

- Service (clinical) consultations
- Education seminars
- Program consultations
- Evidenced-based evaluation
- Special consultation initiatives

Supporting documentation and referrals of children and youth affiliated with their local children's mental health agency are triaged by presented urgency and matched to compatible consultants with the goal of an appointment within 20 working days. In the true spirit of a consultee-centred consultation, and for medical-legal prudence, it is a requirement that the case manager/primary clinician be present during the consultation. Impressions and recommendations are provided orally immediately after the consultation, and a written consultation report follows. Follow-up consultation is not routinely provided, however it is available if necessary or requested.

As the Telepsychiatry Program moved into its second year, and after consultation with the sites, it became evident that the educational component was valued as much as the

service component. An educational co-ordinator was hired whose mandate was to develop an organized program to better meet unique, site-specific needs. To this end, a needs assessment was completed by all sites and a formalized educational program was introduced.

The purpose of the education initiative is to provide continuing education in child mental health issues for the practitioners at the participating site and in their communities. By providing this training, the clinical knowledge and skills of these practitioners can be enhanced so that they can better deliver current, high-quality mental health care to the children and families in these underserviced communities. Along with interactive, didactic seminars, the Telepsychiatry Program is now providing longitudinal seminars over a 4- or 5-week period in a particular area of children's mental health, (e.g., family therapy, psychotherapy with adolescents, CBT, etc).

For administrators and clinical leaders, some of the most challenging tasks are the design, implementation and maintenance of effective treatment systems. In the child and family area, such systems must foster co-ordination and integration of many professionals' roles: social work, psychiatry, child care, psychology, etc. Some treatment failures can be at least partly attributed to a lack of knowledge and sensitivity to the overall management of the therapeutic effort. Leaders of treatment agencies are often isolated from colleagues and potential mentors. Exigencies of placement pressure and family and staff demands can lead to treatment compromises on the part of often inadequately supported clinical management. While management supervision provided by agency structures is ideal, this is not always available 'in-house'. Experienced clinical and administrative mentoring from an outside and objective source is always constructive.

Qualitative Evaluation

Phase I

- Systematic and critical review of the extant literature
- Consultation series with key stakeholder
- Analysis and synthesis of results of consultation to culminate in evaluation design

Phase II

- An initial study examining the quality of the Child and Youth Telepsychiatry Program to look at the experiences and perspectives of family caregivers and mental health providers with this program

Phase III

- Examination of opinions of key family physicians and pediatricians in host site communities, as well as consulting psychiatrists and trainees, regarding their experiences with the Telepsychiatry Program

Phase IV

- Examination of barriers to implementation of recommendations currently underway

Special Consultation Initiative
Videoconference mental health consultations for child and adolescent firesetters living in rural and First Nations communities
Two child and adolescent psychiatrists conjointly complete these consultations. One psychiatrist is a specialist in juvenile fire-setting and the other is a generalist. Risk for further fire involvement was conceptualized as a function of fire problems. A structured assessment protocol covering fire-specific and general mental health factors was utilized for the consultations.

Summary
Access to health care services is a common yet serious challenge facing smaller communities everywhere. Pediatric telepsychiatry, an outreach program, is a key method of disseminating knowledge related to clinical consultation and education. This program is a critical initiative to confront the shortage of resources in rural and remote Ontario. It is an efficient, cost-effective and user-friendly method providing increased pediatric mental health knowledge and training to distant and underserviced areas of Ontario. Early intervention through this program for children, youth and their families with mental health symptoms can reduce the strain on families, front-line workers, physicians and community institutions, including schools, resulting in improved long-term outcomes.

Contact
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Collaborative Mental Health Care
Calgary Health Region

Program description
The Collaborative Mental Health Care (CMHC) Program offers consultation, brief intervention and education in collaboration with primary care providers (e.g., family physicians, child care centres, child welfare, community agencies) who work with children aged 0 to 5. This collaboration is provided by a team of eight clinicians, including psychologists, social workers, nurses and child psychiatrists. The service is limited to the Northeast quadrant of Calgary.

CMHC clinicians initially meet with the referring primary care provider to discuss their concerns about the child and expectations of the consultation. In some cases, this initial consultation is all that is required. More often, however, the child and family will later be seen for further screening and assessment. Ideally, this assessment occurs with the primary care provider present. Based on findings from the assessment, a treatment plan for the child and family will be recommended. Options for treatment may include referral to other suitable community resources. In some cases, the child and family may

receive brief, time-limited intervention/therapy from CMHC. Program-based recommendations are also provided to programs requesting CMHC involvement (e.g., day care centres, preschools). In all cases, the primary health care provider is supported by the CMHC clinician but remains the primary caregiver.

In addition to clinical case-based consultation, CMHC clinicians work with primary care providers to enhance their knowledge and skills in early childhood mental health. A number of educational and training opportunities are offered throughout the year on both a planned and requested basis.

Service model

CMHC is a primary health care initiative that provides mental health consultation and support to primary care providers in the community. Within this model, specially trained mental health clinicians are available to either meet with the primary care provider (e.g., family physicians) on a regular basis or to respond to specific case referrals. Child psychiatrists are available to consult either to the primary care provider or the mental health clinician on more complex cases.

The range of potential problems for children in this age group includes developmental delays as well as family problems such as family violence, trauma and parental mental illness. In order to address these problems, CMHC also provides access to developmental pediatricians and an adult mental health clinician.

Within this service delivery model, the emphasis is on identifying, assessing and intervening with at-risk children and their families. As these children may or may not show specific signs of mental health problems, assisting providers to focus on risk factors in addition to clinical presentation is a goal of the program.

In order to effectively reach at-risk children, the service is community based. In addition to physicians, clinicians provide consultation to many other providers of children's services. Day care personnel, public health nurses, and community health and social agency workers are often the first point of contact for children and families with mental health-related problems. Implementing a collaborative care model with these groups is a departure from the more traditional collaborative care model with physicians.

Resources guiding design

Steinhauer (1999) identified serious gaps in the provision of mental health services for children in Alberta, particularly at-risk and marginalized children. This report also identified the importance of the 'multiplier effect', an approach that facilitates the development of mental health literacy among less well-trained professionals. Provision of consultation and education creates increased capacity among these providers.

The proposal submitted to request funding for the development of CMHC was also supported by literature such as the National Longitudinal Survey of Children and Youth

that estimates the number of vulnerable children in the general population to be between 26-30% (Human Resources and Skills Development Canada, 2001), and by general supportive literature on the importance of early intervention (Cassidy & Shaver, 1999; Shonkoff & Phillips, 2000; Zeanah, 1999).

Evaluation

A needs assessment was not completed prior to implementation of the CMHC program. Ongoing evaluation of the program has occurred since implementation. This evaluation focuses on the efficiency with which the program team achieved the program's primary goals. These goals included:

1. **To provide mental health consultation, related referral support and education.** Data are collected on contacts. Satisfaction surveys are completed with all referral sources. Written evaluations are completed on all education sessions.
2. **To provide brief intervention.** Changes in clinical severity using the Child Global Assessment of Function and the Parent-Infant Relationship scale are monitored. Clinical goal achievement is rated by the clinician.
3. **To facilitate family referral to primary care providers and services in the community and tertiary service.** Information from the electronic record system is monitored.
4. **To promote seamless continuum of mental health services.** Monitoring of the electronic records provides data on referral to other mental health services.
5. **To integrate a system of evaluation into the program practice via the electronic record system.** The electronic record system database provides data on capacity and outcomes that are integrated with clinical practice.
6. **To optimize program function and development.** Outcome measurement that is integrated into operations produces an acceptable index of clinical and program outcomes.

Cost

The approximate cost to set up and run the program during the first year was $938,000. This included equipment, supplies and staff salaries. The funding for this program initially came from the Alberta Children's Mental Health Initiative.

The current yearly budget for the program is approximately $600,000.

Contact

Ms. Dianne Cully, Team Leader, at (403) 297-4866 or (403) 297-4852
e-mail: dianne.cully@calgaryhealthregion.ca

St. Joseph's Care Group – Eating Disorders Program

Thunder Bay, Ontario

The Eating Disorder Programs offers treatment to youth and adults with anorexia nervosa, bulimia nervosa and 'eating disorder not otherwise specified'. The team includes three mental health clinicians, a family therapist, a regional resource clinician, a registered dietitian, and physician and psychologist consultants.

Treatment in this program involves a two-track approach. The first is geared to the normalization of eating and stabilization of weight in order to eliminate the effects of starvation or chaotic eating patterns, as they can drastically alter personality. The second is focused on addressing the underlying issues that contribute to the onset and maintenance of the eating disorder.

Access to program

Initial referrals are accepted from physicians, private practitioners and other health care providers. However, a physician's referral is a mandated requirement of the program.

Assessment

Upon admission to the program, a consumer will undergo a comprehensive assessment to determine the severity, type, history and associated features of the eating pathology, and whether or not other mental health issues need to be addressed. The information gathered during the assessment includes a description of eating behaviour patterns and associated attitudes as they relate to weight, dieting, binge eating, purging and exercise. The program utilizes a family-oriented approach to outpatient treatment. Depending on the age of the consumer and the risks associated with their eating disorder, the consumer's family can be expected to be involved in the assessment.

Information is also collected regarding:

- The course and history of eating pathology
- Substance use
- Medical, psychiatric and family history
- Life adjustment
- Social functioning
- Personal treatment goal
- Motivation for working towards recovery

Referrals to other agencies

If required, referrals are made to other agencies for drug and alcohol treatment, family therapy, psychiatric consultations or sexual abuse/assault therapy.

Treatment interventions

- **Nutritional Counselling**
  A nutritional assessment and ongoing nutritional management is provided by a registered dietitian to all consumers registered in the program.

- **Psychoeducation/therapy group**
  This group provides a basic education and understanding of eating disorders and explores related therapeutic issues, with the purpose of facilitating attitudinal and behavioural changes.

- **Family/friends psychoeducation group**
  This group is intended for family members, partner/spouse, concerned relatives and close friends of an individual with an eating disorder. Participants must be 16 years of age or older. The group consists of six 90-minute meetings designed to provide valuable information on the nature of eating disorders and to offer suggestions on how to cope more effectively with behavioural and emotional issues that frequently arise. The group sessions are not intended to address individual concerns in detail.

- **Individual therapy**
  Individual counselling sessions are offered to all clients in the program. Sessions focus on the underlying biological, social, psychological, developmental, interpersonal, familial and environmental issues that contribute to the onset and maintenance of the eating disorder.

- **Inpatient treatment**
  Inpatient treatment is available for youth who require hospital admission because of severe or rapid self-induced weight loss, lack of response to outpatient treatment, significant medical complications and suicidal behaviour. Upon admission, a multidisciplinary team comprised of staff from Thunder Bay Regional Hospital and St. Joseph's Care Group work together to meet the needs of the consumer.

- **Family treatment**
  A family-oriented approach is characterized by the sequential use of varied treatment methods, such as education, parent consultation and family therapy. This approach means that the team will always try to work in a constructive and flexible manner with families.

Contact

Kerry Bourret, Team Leader, Phone: 807-343-2400 ext. 2228, e-mail bourretk@tbh.net
Web site: http://www.mha.sjcg.net

Appendix C: Websites

American Academy of Child and Adolescent Psychiatry
http://www.aacap.org

This organization has fact sheets for families such as
http://www.aacap.org/publications/factsfam/index.htm

Healthy Minds Healthy Children is a Calgary-based program described in this toolkit with web-based information prescription and physician education programs.
http://www.sacyhn.ca

The Provincial Centre of Excellence for Child and Youth Mental Health at CHEO (Children's Hospital of Eastern Ontario). Contact: Karen Kidder, Knowledge Exchange Centre Manager, tel: 613-737-2297, ext. 3316.
http://www.onthepoint.ca

Canadian Psychiatric Research Foundation
http://www.cprf.ca
Presentations and publications for providers, teachers, youth and families (e.g., epidemiology of youth mental illness, handbook of strategies and resources for parents and caregivers)

http://www.eMentalHealth.ca
This site, currently under construction, will provide multiple youth mental health resources for families and caregivers of youth with mental health concerns.

Council for Learning Disabilities
http://www.cldinternational.org

Children and Adults with Attention Deficit/Hyperactivity Disorder (CHADD)
http://www.chadd.org
An American-based non-profit organization providing support and information for individuals with attention deficit/hyperactivity disorder (AD/HD), their families, teachers, professionals and others.

Second Chance for Kids
http://ca.geocities.com/secondchanceforkids
A self-help support group for grandparents raising grandchildren and denied-access grandparents

Autism Society Canada
http://www.autismsocietycanada.ca
Resources and links for youth and adults with autism conditions, families, educators, and health and social service professionals

http://www.psychosissucks.ca
Website of the Early Psychosis Intervention Program of the Fraser Health Authority (British Columbia). Promotes early detection and provides education and direction for those seeking help.

http://www.cmha.ca/highschool/english.htm
"Mental Health and High School Website" of the Canadian Mental Health Association

Information about specific programs and projects:

Youth Net
A youth-friendly mental health resource service run by and for youth. See description in Appendix D. Contact: Sarah Brandon, youthnet@cheo.on.ca

Treatment Recommendations for the Use of Antipsychotics for Aggressive Youth (TRAAY Project). Contact: Elizabeth A. Pappadopulos, Ph.D., pappadoe@childpsych.columbia.edu.

Guidelines for Adolescent Depression in Primary Care (GLAD-PC) Project. Contact: Dr. Amy Cheung, amy.cheung@sw.ca

Screening instruments

The Brief Child and Family Phone Interview (BCFPI) has been researched extensively and may be found at http://www.bcfpi.org/bcfpi/Default.asp

Appendix D: Tools and resources

The following is an example of a needs assessment developed to survey family physicians' learning needs re: child & youth mental health

(Developed by Helen R Spenser, Child and Adolescent Psychiatrist, Children's Hospital of Eastern Ontario, Ottawa, 2000; hspenser@cheo.on.ca)

ID Number _____ **Today's Date:** _____

Children's Mental Health Survey for Eastern Ontario

Instructions: Please **circle** your responses unless otherwise specified.

A. Practice data

1. Name: _____
2. Gender: M F
3. Age:

25-30 31-35 36-40 41-45 46-50 51-55 56-60 61-65 66+

4. Years in practice:

0-5 6-10 11-15 16-20 21-25 26-30 31-35 >35

5. If currently in family medicine residency please **indicate** year of training:

First Second Other

6. If in practice, are you:

Full-time Part-time Semi-Retired Other

7. Location of practice (county)_____

8. Population in the main community you practice in:

<1000 1,000-5,000 5,001-10,000 10,001-15,000 15,001-20,000 >20,000

9. How much of your practice involves general mental health services, i.e., counselling and psychotherapy?

Less than 10% 10-20% more than 20%

10. How much of your practice involves child and youth services?

Less than 10% 10-20% more than 20%

B. Training

1. Place of training
   - University of Western Ontario
   - University of Toronto
   - University of Ottawa
   - Queen's University
   - McMaster University
   - University in Canada (specify) _____
   - other (specify) _____
2. Qualifications
   - MD
   - CCFP
   - other (specify) _____
3. Are you receiving or have you received any formal training in child psychiatry?

   Yes No

4. If answer to above is yes, could you briefly outline training experience:

_____

_____

C. Access to child and adolescent mental health services

1. How far:
   a) to your local psychiatrist _____ km
   b) to your nearest children's mental health centre (an agency where social workers or other clinicians provide service, e.g., counselling, parent training, etc.) _____ km
2. Would a session on available mental health resources in your community be useful?

   Yes No
3. Does a child psychiatrist visit your community? Yes No

   If yes, frequency: once per week
   twice per month
   once per month
   once every 2 months
   once every 3 months
   once every 6 months
   once per year
   other (specify) _____
4. Is there a need for child psychiatry consultation visits to your community?

   Yes No
5. Is there a need for an expert GP to do child psychiatry visits?

   Yes No
6. In your experience, how long do you need to wait for a child psychiatry consult?

   _____
7. Is this longer than for most other specialties? Yes No

D. Identification of training needs and interests

1. How confident do you feel with your knowledge of disorders in children and adolescents? (Please record the number in the box.)

Not at all confident			Moderately confident			Extremely confident
1	2	3	4	5	6	7

Depression	from 1-7 [ ]
Assessing suicidal risk	from 1-7 [ ]
Anxiety disorders and school avoidance	from 1-7 [ ]
Obsessive compulsive disorder	from 1-7 [ ]
Abuse/post-traumatic stress disorder	from 1-7 [ ]
Eating disorder	from 1-7 [ ]
Behavioural treatment of enuresis and encopresis	from 1-7 [ ]
Substance abuse disorders	from 1-7 [ ]
Oppositional defiant disorder and other behaviour problems	from 1-7 [ ]
Attention deficit and hyperactivity disorders	from 1-7 [ ]
Psychotic disorders	from 1-7 [ ]
Autism/Asperger's	from 1-7 [ ]
Somatization/conversion disorders	from 1-7 [ ]
Interviewing young children (5-11)	from 1-7 [ ]
Interviewing the adolescent	from 1-7 [ ]
Cognitive Behaviour Therapy techniques for GPs	from 1-7 [ ]
An approach to pharmacology in youth	from 1-7 [ ]

Other: Please mention any other condition in children and adolescents that you wish to gain knowledge about:

_____

_____

_____

_____

2. How confident do you feel with your skills in managing the following problems in children and adolescents? (Please record the number in the box.)

Not at all confident			Moderately confident		Extremely confident	
1	2	3	4	5	6	7

Depression	from 1-7 [ ]
Assessing suicidal risk	from 1-7 [ ]
Anxiety disorders and school avoidance	from 1-7 [ ]
Obsessive compulsive disorder	from 1-7 [ ]
Abuse/post-traumatic stress disorder	from 1-7 [ ]
Eating disorder	from 1-7 [ ]
Behavioural treatment of enuresis and encopresis	from 1-7 [ ]
Substance abuse disorders	from 1-7 [ ]
Oppositional defiant disorder and other behaviour problems	from 1-7 [ ]
Attention deficit and hyperactivity disorders	from 1-7 [ ]
Psychotic disorders	from 1-7 [ ]
Autism/Asperger's	from 1-7 [ ]
Somatization/conversion disorders	from 1-7 [ ]
Interviewing young children (5-11)	from 1-7 [ ]
Interviewing the adolescent	from 1-7 [ ]
Cognitive Behaviour Therapy techniques for GPs	from 1-7 [ ]
An approach to pharmacology in youth	from 1-7 [ ]

Other: Please mention any other area in child and adolescent mental health care for which you wish to gain skills:

_____

_____

_____

_____

3. In the last year, if you think back on the children and adolescents that you have seen, could you describe the circumstances of a case that you felt did not go well, or that you wished that you could find a consultant for immediately?

_____

_____

_____

_____

4. What method of training would you find most beneficial? Please rate your top five choices. Please use number 1 as your first choice and number 5 as your last choice.

_____ Handouts

_____ Continuing Medical Education lectures in your community

_____ Continuing Medical Education lectures at a teaching centre

_____ Small-group peer tutoring

_____ Small-group teaching by a child psychiatrist

_____ Correspondence

_____ A 1-year Fellowship at a university training centre

_____ Telemedicine training

_____ other (specify) _____

5. If you were given the opportunity to do funded training in child psychiatry and become the local child psychiatry "expert", would you take advantage of this offer?

Yes No

If yes, would you please provide us with your name, address, and phone number as well as a fax number and e-mail address if available.

Name _____

Address _____

E-mail address _____

Phone number _____ Fax number _____

6. In considering your multiple learning needs, how high would you rate your training needs in child psychiatry in relation to your needs in other specialty areas?

1 2 3 4 5 6 7 8 9 10

minimal need high need

Thank you for your time in completing this questionnaire. Our aim is to bring together a team in our community to improve mental health service delivery to children and youth.

We would be happy to hear from you with questions or further ideas.

The following survey of family physicians was conducted by the Collaborative Mental Health Care Program, Calgary Health Region. See Appendix B for a description of this initiative.

Toddlers at Risk:

Physician Survey

November, 2001

During the last decade, extensive research in the neurobiological, behavioural and social sciences has led to major advances in understanding the conditions that support optimal development and influence the long-term adaptation of children.

There is now a deeper understanding of:

- The critical importance of early experiences in shaping the life long development of the physical, emotional, behavioural and relationship characteristics of the individual
- How early relationships contribute to or inhibit healthy development
- The powerful capabilities and complex emotions that develop during the early years
- The capacity to increase the odds of favourable developmental outcomes through early identification, planned assessment and intervention

Research indicates that:

- Over 20% of 4-year-olds in Canada have one or more serious, emotional or behavioural problems
- Only 50% of children with these problems will outgrow them
- In young children, these problems are significantly underdiagnosed

Please consider helping us to better understand how the behavioural and emotional problems of young children are managed in primary care settings by completing this short survey.

Your responses and personal information will be kept confidential.

Tear here∃----------

Name:(please print):_____

Street address:

_____

City:_____ Fax: (___)_____

Postal Code:_____ Email: _____

Phone: (___)_____

Question 1

In your practice, approximately what percentage of your consumers are 5 years of age and under?

0-5% 6-15% 16-25% 26-35% >35%

Approximately how many of your adult consumers with mental health problems are parents of young children (aged 5 or less)?

____% (Estimated per cent of current practice) Do not know

Question 2

For the children you see who are aged 5 and under, please indicate which of the following problems you see in your practice.

- ☐ **REGULATION OF BEHAVIOUR** (e.g., over- or under-reactivity to sensory input, difficulties with motor planning and visual-motor organization, attending and focusing, and with emotional organization (e.g., child shifts abruptly from being calm to screaming)).
- ☐ **EXPERIENCE AND EXPRESSION OF EMOTION** *(e.g.,* excessive fears, separation anxiety, depressed or irritable mood with diminished interest/pleasure in activities, diminished capacity to protest, disturbance in sleep or eating).
- ☐ **ATTACHMENT TO A PRIMARY CAREGIVER** (e.g., difficulty using the caregiver as a source of security and comfort when upset, physically ill, or hurt, appearing to both approach and avoid caregiver when distressed, or appearing fearful, wary, or confused in the presence of the attachment figure).
- ☐ **DISRUPTIVE BEHAVIOUR** (e.g., developmentally inappropriate degrees of inattention, impulsiveness, over-activity and or negativistic, hostile, and defiant behaviour (e.g., loses temper, blames others for own mistakes, actively defies or refuses adult requests or rules))
- ☐ **COPING WITH TRAUMA** (e.g., increased social withdrawal, restricted range of emotion, temporary loss of previously acquired skills, night terrors, significant attention difficulties, hyper-vigilance, aggression toward peers, animals, and others, excessive fears and or new fears).
- ☐ **EATING BEHAVIOUR** (e.g., difficulties establishing a regular feeding pattern with adequate food intake).
- ☐ **SLEEPING BEHAVIOUR** (e.g., difficulties settling into sleep and or maintaining sleep. Night terrors and or difficulty developing a predictable sleep-wake schedule).
- ☐ **ELIMINATION BEHAVIOUR** (e.g., difficulties developing bowel and bladder control during the day and night).
- ☐ **COMMUNICATION PROBLEMS** *(e.g., delays in the* development of ***reciprocal social interaction*** and of ***verbal and non-verbal communication skills***. Often there is also ***limited make-believe activity*** and a ***restricted repertoire of activities and interests***, which frequently are stereotyped and repetitive. Suggestive of ***AUTISTIC DISORDER).***
- ☐ **FAMILIAL AND ENVIRONMENTAL RISK FACTORS** (e.g., mother younger than 20, domestic violence, parental mental illness, marital conflict, poverty, lack of psychosocial support).

Question 3

When you need help for a young child with one of these difficulties, what sources of help do you most often seek? (Please check all that apply)

Another Physician: Child Psychiatrist

Pediatrician

Other (specify)_____

Allied professional: (e.g. psychologist, nurse, social worker, OT, etc)

Print Media: (e.g. journals, Internet, textbooks)

Other sources of help: (please specify)_____

Mental Health program/clinic

Other Social Agency

Question 4

How much did you learn about early childhood mental health in your medical training?

Minimal Some Comprehensive [I graduated in 19___.]

Question 5

a) Do you have enough knowledge and support to detect and manage these difficulties in young children?

Yes No

b) How confident are you that you can detect and manage these difficulties?

Very Somewhat Not at all

Question 6

Which of the following services and support would you be interested in if they were available to you and your consumers?

Receiving written information on the problems listed in #2 above

Attending short information updates on these emotional, behavioural and developmental problems

Being able to make a referral to a program specializing in these difficulties

The opportunity to discuss cases with a child psychiatrist

The opportunity to discuss cases with other mental health consultant(s)

Having a mental health consultant visit my practice on a regular basis to assist these children/families

Information on resources and assistance with referrals to health, social and community-based agencies and programs

Please list any other assistance or service you need for these children that is not listed above.

_____

_____

Question 7 *(For Calgary region physicians only)*

Have you heard about the Collaborative Mental Health Care program?

(This team specializes in infant and early childhood mental health)

Yes No

Are you interested in finding out more about this team and how it might assist you and your young at-risk consumers?

Yes No

Thank you for your help.

Additional comments please:

_____

_____

_____

This is a sample of the Strengths and Difficulties Questionnaire. Other versions for other age groups may be found at http://www.sdqinfo.com

Strengths and Difficulties Questionnaire P or T[3/4]

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of the child's behavior over the last six months or this school year.

Child's name ..... Male/Female

Date of birth .....

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	☐	☐	☐
Restless, overactive, cannot stay still for long	☐	☐	☐
Often complains of headaches, stomach-aches or sickness	☐	☐	☐
Shares readily with other children, for example toys, treats, pencils	☐	☐	☐
Often loses temper	☐	☐	☐
Rather solitary, prefers to play alone	☐	☐	☐
Generally well behaved, usually does what adults request	☐	☐	☐
Many worries or often seems worried	☐	☐	☐
Helpful if someone is hurt, upset or feeling ill	☐	☐	☐
Constantly fidgeting or squirming	☐	☐	☐
Has at least one good friend	☐	☐	☐
Often fights with other children or bullies them	☐	☐	☐
Often unhappy, depressed or tearful	☐	☐	☐
Generally liked by other children	☐	☐	☐
Easily distracted, concentration wanders	☐	☐	☐
Nervous or clingy in new situations, easily loses confidence	☐	☐	☐
Kind to younger children	☐	☐	☐
Often argumentative with adults	☐	☐	☐
Picked on or bullied by other children	☐	☐	☐
Often offers to help others (parents, teachers, other children)	☐	☐	☐
Can stop and think things out before acting	☐	☐	☐
Can be spiteful to others	☐	☐	☐
Gets along better with adults than with other children	☐	☐	☐
Many fears, easily scared	☐	☐	☐
Good attention span, sees work through to the end	☐	☐	☐

Signature ..... Date .....

Parent / Teacher / Other (Please specify:)

Thank you very much for your help

401 Smyth, Ottawa, ON K1H 8L1

TEL (613) 738-3915

FAX (613) 738-3917

Youth Net/Réseau Ado

How Youth Net/Réseau Ado Works

Youth Net/Réseau Ado (YN/RA) is a bilingual regional mental health promotion and intervention program run by youth, for youth.
There are sites all across Canada.

Our objective is to reach out and help youth develop and maintain good Mental Health as well as healthy coping strategies for dealing with stress while decreasing stigma around Mental Illness and its treatment. We do this through education and intervention.

In our focus groups, youth can discuss the mental health issues they are facing, their opinions of the mental health system as well as ways the system could better meet their needs.

To help youth feel more comfortable in focus groups, all of our facilitators are youth themselves, generally under 30 years of age. This way the facilitators are not so old that they forget what it was like to be a teenager.

Youth say the main appeal behind YN/RA is that the program is run by youth, and that there is always a safety net of professionals to support them. It utilizes the ideas and experiences of youth, who are the experts on youth issues, to solve problems. It also gives youth the opportunity to share experiences and coping strategies while breaking down the stigma around mental health.

Youth are reached in schools, community centers, treatment centers, detention centers, drop-ins – any place where youth are found in rural and urban areas.

YN/RA initiatives include the following, but we are always looking to support youth who want to start their own unique initiatives:

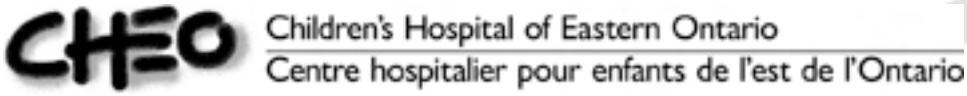
1. Depression and general support groups as requested by youth, in partnership with community organizations
2. Pens and Paints, a 12-week visual arts and creative writing project
3. FreeRide, a 5-week snowboarding program run each winter

4. Youth Fax/Fax Ado newsletters written, designed, and edited by youth for youth on a variety of mental health topics

To increase awareness concerning youth mental health issues, YN/RA makes presentations to professionals and community groups.

As an advocate, YN/RA shares information gathered through our research about youth mental health issues and ideas to those working within the mental health system in the hopes of affecting change. Our aim is to make service providers more aware of youth issues and to show them how to be more youth-friendly.

For more information please contact: (613) 738-3915 or email: youthnet@cheo.on.ca



Appendix E: Glossary of terms and Index of acronyms

Glossary of terms

Best practices – Activities and programs that are in keeping with the best possible evidence about what works [Interchangeable with 'Better Practices', 'Positive Practices' and 'Good Practices'] (Health Canada, 1998).

Chronic disease management (CDM) - A systematic approach to improving health care for people with chronic disease that emphasizes helping individuals maintain independence and keep as healthy as possible through prevention, early detection and management of chronic conditions (British Columbia, Ministry of Health Services, 2004).

Collaborative primary health care - The delivery of services at the first point of contact with the health system by two or more different stakeholders (health professionals, consumers, families, primary health care organizations, community agencies) working together in a partnership that is characterized by:

- Common goals or purpose
- A recognition of and respect for respective strengths and differences
- Equitable and effective decision-making
- Clear and regular communication

in order to:

- Improve access to a comprehensive range of services (treatment, health promotion, disease and injury prevention and management of chronic diseases and self-help), delivered by the most appropriate provider in the most suitable location
- Deliver high-quality and effective health care
- Make the most efficient use of resources
- Improve outcomes for the consumer

Determinants of health – Factors in an individual's living and working environment that can affect their health (e.g. housing, education, income, employment, culture, physical environment, equity).

Health promotion – The process of enabling people to increase control over and to improve their health (WHO, 1986).

Interdisciplinary – A range of collaborative activities undertaken by a team of two or more individuals from varying disciplines applying the methods and approaches of their respective disciplines.

Mental health promotion – The process of enhancing the capacity of individuals and communities to take control over their lives and improve their mental health (Health Canada, 1998).

Mental health specialist **–** An individual with mental health expertise, be it related to health promotion, prevention, diagnosis, treatment or rehabilitation

Prevention – Interventions that target risk factors for specific illnesses in order to prevent the initial occurrence of a disease, arrest or retard an existing disease and its effects or reduce the occurrence of relapses.

Primary health care **–** An individual's first contact with the health system characterized by a spectrum of comprehensive, coordinated and continuous health care services such as health promotion, diagnosis, treatment and chronic disease management.

Primary mental health care – Mental health services provided in a primary health care setting. Settings where primary health care can be delivered include the offices of health care providers, community clinics, workplaces, schools, homes, health care institutions, homes for the aged, nursing homes and day care centres. Primary mental health care may also be available by telephone, health information services and the Internet.

Recovery – A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness (Anthony, 1993).

Index of acronyms

ADD/ADHD	Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder
AFP	Alternate Funding Plan
BCFPI	Brief Child and Family Phone Interview
CBT	Cognitive-Behavioural Therapy
CCHS	Canadian Community Health Survey
CCFP	Canadian College of Family Physicians
CCMHI	Canadian Collaborative Mental Health Initiative
CHEO	Children's Hospital of Eastern Ontario
CME	Continuing Medical Education
CMHC	Collaborative Mental Health Care
HM/HC	Healthy Minds/Healthy Children
ISDN	Integrated Services Digital Network
SACYHN	Southern Alberta Child and Youth Health Network
WHO	World Health Organization

Toolkit Series

This toolkit belongs to a series of twelve toolkits.

Implementation toolkits for providers and planners

1. Collaboration between mental health and primary care services. A planning and implementation toolkit for health care providers and planners

A series of companion documents to the CCMHI planning and implementation toolkit for health care providers and planners. Establishing collaborative initiatives between mental health and primary care services for:

2. Aboriginal peoples
3. Children and adolescents
4. Ethnocultural populations
5. Individuals with serious mental illness
6. Individuals with substance use disorders
7. Rural and isolated populations
8. Seniors
9. Urban marginalized populations

Toolkits for consumers, families and caregivers

10. Working together towards recovery: Consumers, families, caregivers, and providers.
11. Pathways to healing: A mental health guide for First Nations people

A toolkit for educators

12. Strengthening collaboration through interprofessional education: A resource for collaborative mental health care educators

A series of documents examining aspects of collaborative mental health care support these toolkits:

1. Barriers and strategies
2. A framework
3. Annotated bibliography
4. Better practices
5. Canadian initiatives
6. A policy review
7. International initiatives [unpublished]
8. Health human resources
9. Mental health prevalence and utilization
10. Interprofessional education
11. Aboriginal mental health [unpublished]
12. The state of collaborative mental health care

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