Child & youth

Mental Health Series

Today's topic:

The bridge over troubled water…

How are youth with mental health problems crossing over to Adult Mental Health Services?

Speakers:

Maureen Fedorus
Gilles Charron

March 27, 2015

CHEO The Le Royal

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Declaration of conflict

Speaker has nothing to disclose with regard to commercial support.

Objectives:

- 1. To understand the importance of a well coordinated and collaborative process to transition complex mental health youth to AMHS
- 2. What are some of the barriers facing youth with mental health problems
- 3. The essence of a central person's involvement within a shared care model

Statement of the Problem

- The absence of an integrated, coordinated **system of care** between child- and adult-serving mental healthcare is a **significant barrier** to the provision of care to this population (within and between sectors)
- Funding and **service delivery is diluted** and under resourced across multiple agencies (federal, provincial, and private) and lacks coordination and diffuses responsibility
- 60% of known cases, **emerging adults** with on going mental health concerns and continuing needs, **disengage from service during this time** (Harpaz-Rotem et al., 2004)
- Re-engagement to mental health services is usually **crisis driven**

Statement of the Problem

- Peak age of onset of psychiatric diagnosis is 15 to 24
- Only 1/5 of young Ontarians with a mental health disorder have received service for their condition
- **Untreated** children and adolescents with mental health concerns become "**more vulnerable and less resilient**" with time (Wattie, 2003)
- Suicide is the 2nd most common cause of death of Canadian Youth (StatsCan, 2012)

Statement of the Problem

- 70% of **mental health problems** in Canada **begin in childhood or adolescence** (Statistics Canada, 2002)
- More than 75% adults with mental illness onset at an age less than 25 (Kessler et al)
- 15 – 21% of young Canadians have at least one diagnosable mental health disorder (Ministry of Child and Youth Services, 2006)

The Problem

"Public mental health services have followed a pediatric split in service delivery, mirroring general and acute health care. The pattern of peak onset and the burden of mental disorders in young people means that the **maximum weakness and discontinuity in the system occurs just when it should be at its strongest**"

(McGorry, 2007, p. s53)

Local Research Project on Mental Health Transitions-2010

Phase 01: Literature Scan

Phase 02: Policy

- Part A: Meeting with Local Policy Leaders
- Part B: Policy Ready Paper

Phase 03: Stakeholder (Youth, Parents, Providers)

Phase 04: Model Recommendation

Phase 05: Implementation

- Part A: Business Plan
- Part B: Funding and Implementation
- Part C: Evaluation

Phase 03: Findings from Professional Practice Leader Questionnaire

Current Process for Transition from CAMHS to AMHS
"No protocol is currently in place. We work on a case-by-case basis."
"Call colleagues that I know personally and beg them to take on my patient."
"There are no formal mechanisms to transition youth."
"As the 18th birthday approaches, we start to plan discharge to adult services, though the young person often stays past 18."
"Gaps in knowledge of adult resources"
"Poor communication between CAMHS and AMHS – no linkages

Phase 03: Findings from Youth Focus Group

Theme 01: Difficulties Accessing Services/Retaining Care

"I didn't feel better inside I felt like what am I suppose to like do something horrible to myself to make you realize that I'm actually not doing well"

Theme 02: Poor Transitional Planning

"you're in the middle of a crisis and you're in the hospital and because your birthday comes while you're in there they'll wheel you away. And that terrified me so as I got older I would panic."

"It always seems to be like a threat or like blaming it on you in a way. Even though you're going to have to be transitioned anyway, it was always kind of like we can't deal with you anymore therefore you're going to adult."

Phase 03: Findings from Youth Focus Group

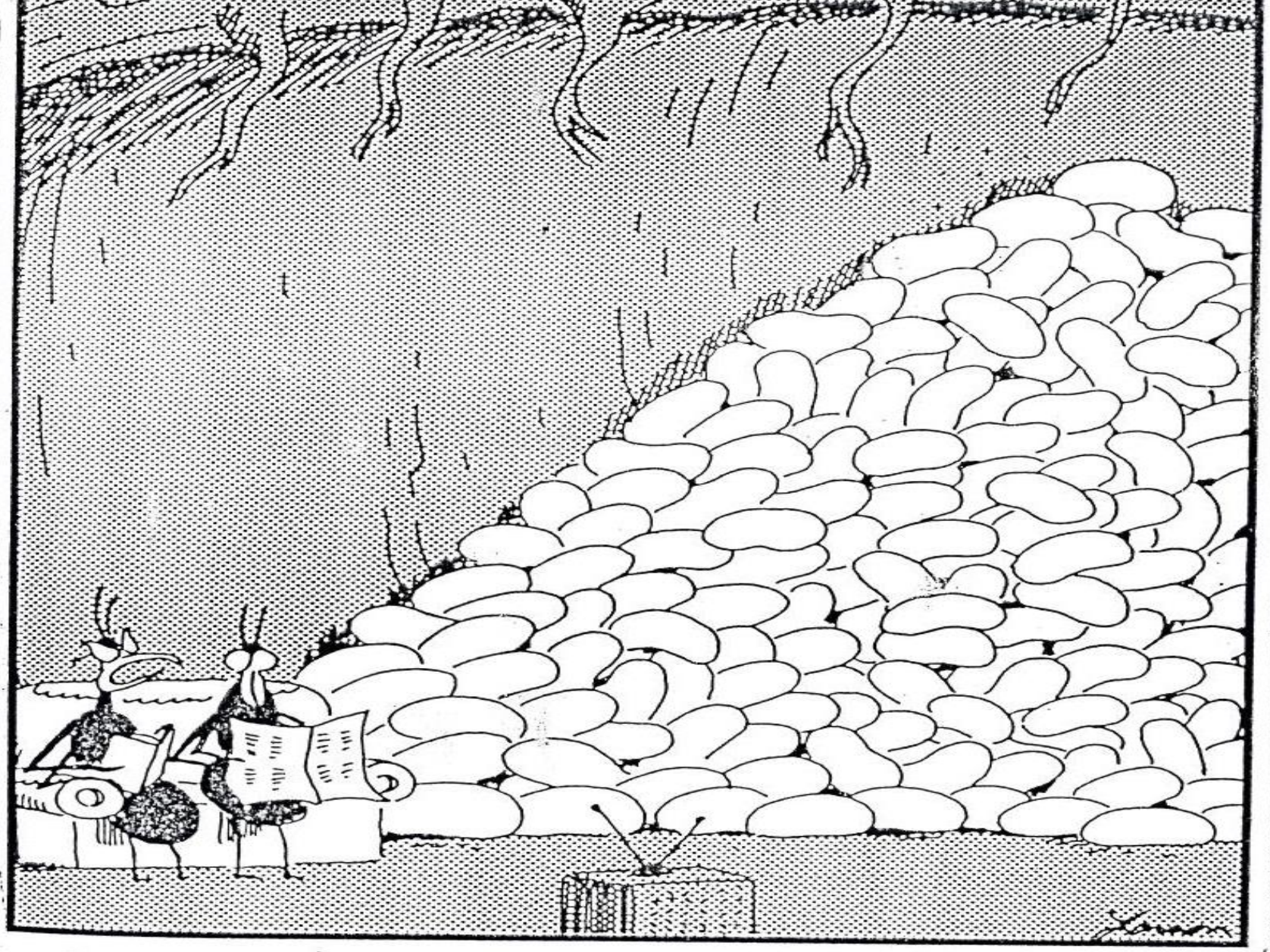
Theme 03: Philosophical Differences
"CAMHS it's more of a lean on me we'll walk down this road where out of AMHS its kind of like take a hike, there's the road that's all you get. You have to depend on yourself a lot more and that can be hard when you don't have a lot of trust in yourself.
"My CAMHS psychiatrist was still talking to me on the phone while I was in the AMHS in a crisis."
"Going to CHEO and then you go to adult, and it's totally different. There's no like in between I guess. Nobody explains how its going to be when you get there."

Phase 03: Findings from Parent Focus Group

Theme 01: Accessing Services
"My son (17 at the time) got very depressed and he was begging for help, he wanted to see a psychiatrist. . . He was talking about suicide all the time, there was nothing to live for. I brought him to CAMHS emergency – couldn't do anything, sent him home. What does he have to do? Does he have to actually try to commit suicide to come in here? "
"You need to be a super-parent, as you all know, to deal with any of this. You're the frontline worker; you're the unpaid frontline worker and every minute of every day."
"The wait time is excruciating. I essentially advise parents to mortgage their house and go get private care."
" . . . there are services but they're fractured throughout the community. "

Program Partners

- Royal Ottawa Mental Health Centre (Youth and Adult Programs)
- Children's Hospital of Eastern Ontario
- Queensway-Carleton Hospital
- Montfort Hospital
- The Ottawa Hospital
- Youth Services Bureau
- Canadian Mental Health Association
- Department of Psychiatry – University of Ottawa
- David Smith Youth Treatment Centre for Addiction



"You know, Vern ... the thought of what this place is gonna look like in about a week just gives me the creeps."

Transitional Youth Program

- Primary goal is to facilitate successful transition of youth (16 to 24 years of age) between institutional and community resources
- Shared management model – Transition Team
- Transitions Coordinator
- In-kind clinical contributions
- Max capacity: 110

Profile of Appropriate Referrals

- Youth between the ages of 16 to 24, currently receiving mental health services from one of the 9 involved partners
- In need of assistance to transition from youth mental health to adult mental health services
- In need of follow up due to complex behaviours associated with their psychiatric diagnosis

Profile of Appropriate Referrals (con't)

- In need of a specialized assessment to clarify diagnosis and presenting symptoms to facilitate a transition to adult services
- Presenting with complex profile such as psychosis, bipolar or severe symptoms in need of transitional services
- Could benefit from another facility's program to better meet his/her needs
- May require more than one service to respond to their needs

Referral Process

1. All referrals are initiated by calling the Transitions Coordinator at 613-737-7600 ext 3510 or sending referral letter. (The referring provider will have discussed with youth prior).
2. The Transition Coordinator and referring provider will discuss the referral and gather information based on the referral form then referring provider will fax referral letter to Intake Coordinator.
3. Referring provider will forward all pertinent reports to the Transition Coordinator

Referral Process (con't)

4. Transition Coordinator will contact youth.

5. Transitions Coordinator will facilitate next steps with other Transition Team members

Transitions Team

- Transitional Coordinator
- Referring provider
- Clinicians from partner agencies and/or hospitals who will be involved in transition of youth
- Transition Team membership will vary based on the needs and strengths of each youth and the availability and access to the in kind clinical contributions.

Role of Transitions Coordinator

- Receive all referrals
- Complete all intake and triage
- Engage youth, family and referring provider into the transitional process
- Assess needs and strengths of youth
- Liaise with shared care partners and coordinate access to Transition Team

Role of Transition Coordinator

- Assure the completion of the GAINS and OCAN by youth
- Transition Coordinator will complete ANSA (Adult Needs and Strength assessment) and develop a summary report of the needs and strength
- Report to the Advisor Committee updates of the program

"I lift, you grab. ... Was that concept just a little too complex, Carl?"

Making it clear and simple for all

- There are many partners to work with…many different ways of doing business
- Understanding each AMHS referral process to access their services
- Making sure resources understands their role and the youth understands why they are being referred
- Making the referral transparent to the youth, family and their mental health resource

In Kind Clinical Contributions

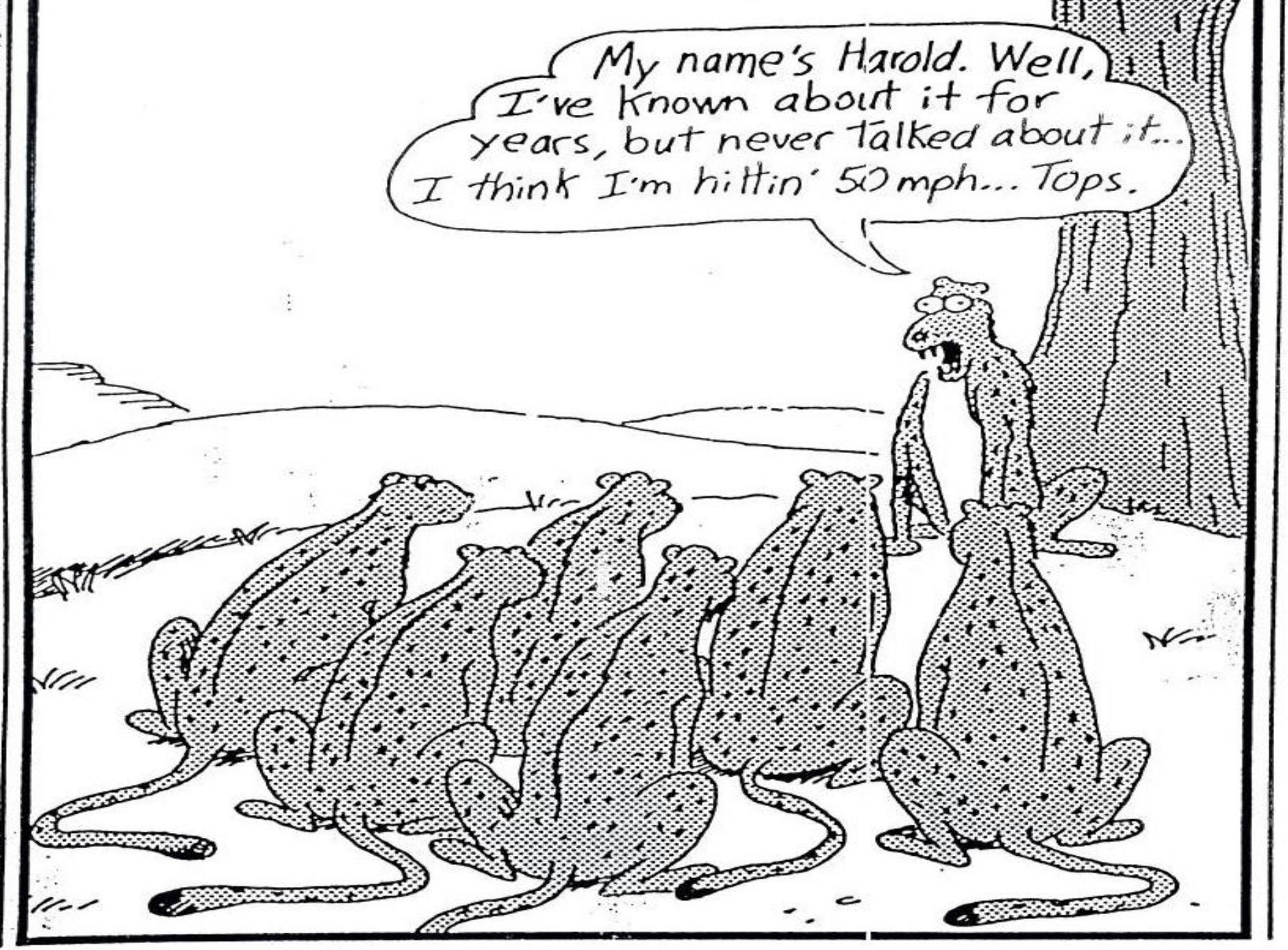
- Each partner will identify specific clinical time and services that will be available as part of the Transitional Youth Program.
- Access to these services will be facilitated/coordinated by the Transition's Coordinator based on the individual needs and strengths of the youth.
- Each partner will identify one key contact person who will be responsible for liaison within their organization about the transition program.

Partner Contributions

Partner	Contribution
Royal Ottawa Health Care Group	Recovery Service Unit Program Urgent Care Consultation Service Mood/Anxiety Clinic Telehealth Clinical Bridging Service to Schizophrenia Team Phone Consultation
Canadian Mental Health Association	Outreach Services DBT Concurrent Disorders Service Intensive Case Management Dual Diagnosis Team
Youth Services Bureau	Walk-in Clinic Intensive Case Management Wraparound Services Counseling Family Therapy
Queensway-Carleton Hospital	Commitment to accept up to 10% of patients enrolled in the transitions program Psychiatric consultations and some allied health involvement
The Ottawa Hospital	ON Track Program Eating Disorder Program
Dave Smith Treatment Centre	Residential and Community-Based Substance Abuse Treatment Comprehensive Substance Use Assessment (including the GAIN Q, the GAIN I and other tools to do an assessment – specifically for problematic use & abuse or dependence) Priority Referrals
Montfort	Psychiatric Consultation Day Treatment Program Short-term Psychiatric Involvement
Children's Hospital of Eastern Ontario	Continued involvement of CAHMS providers during period of parallel care Research Contributions

Clinical Case Reviews

- Each partner will identify a clinician or a physician who will be participating in case reviews with the Transition's Coordinator.
- Purpose of the case reviews is to assist in either the triage of a highly complex referral or to assist the Transition's Coordinator in service planning



At Slow Cheetahs Anonymous

A positive result

- Early problem was identified… “no age appropriate groups for emerging adults”

What to do ????????????

Advisory Committee and the LHIN quickly went into action in the hiring of a social worker to co-facilitate groups with a AMHS clinician

Youth Transition Group

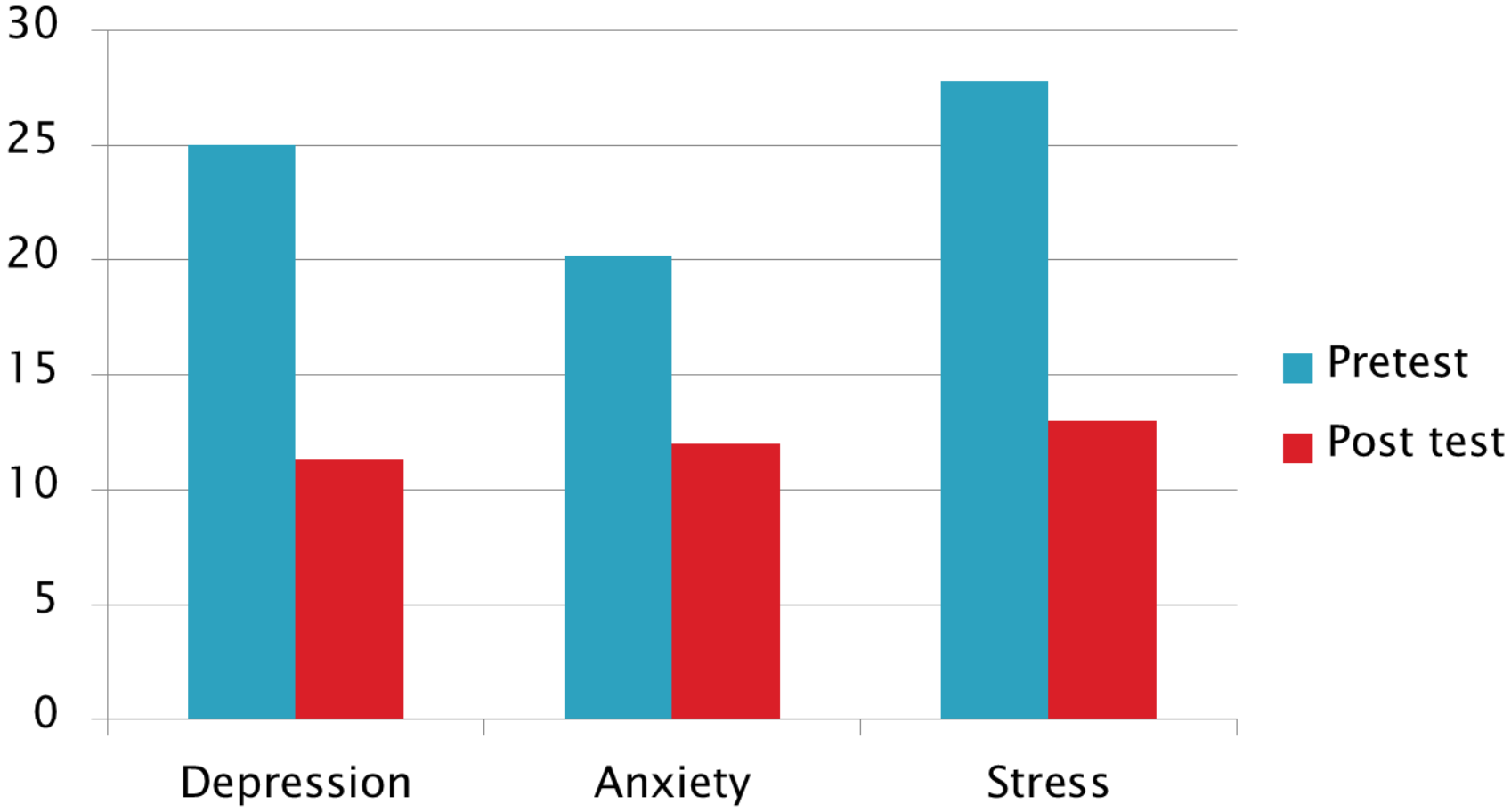
Partners

- TOH Family Health Team
- L'Hôpital Montfort – Clinique pour Adolescents et Jeunes Adultes Resilient Clinic (CAJAR)

Skills Training Program

- 13 weeks
- Stress, depression and anxiety

Youth Transition Group Results



Results: Comorbidity

Number of diagnoses	DX at time of referral to transitions program (%)
1	3.7
2	16.5
3	22.1
4	22.5
5+	35.2

Our Results: Diagnosis

Diagnoses	DX at time of referral to transitions program (%)
Anxiety Disorders	86.9
Mood Disorders	79.9
Substance-Related Disorders	23.6
Schizophrenia and other Psychotic Disorders	15.1
Personality Disorders	14.7
Eating Disorders	6.0
Somatoform Disorders	1.3
Additional (Academic problems/LD, relational problems, PRCP, SI, self-harm, Asperger, ODD)	48.9

Results - Demographics

- 64.1.5% of youth are female and 35.6% are male
- The mean age at time of referral was 17.36 (SD = .1.34)
- 1.9 % of youth had CAS involvement
- 81.1% of youth live with their parents; 4.4% live on their own 3.7% live with a relative or friend; 5.6% live at a shelter/home; 3.3% live in a group home; and 1.9% other
- 82.6% of youth had a family history of mental illness (82.3%; mother; 66.1% father; 57.5% sibling)

Parent Goals for Transitions

"We need to have transition workers who are aware of the different issues. We're all dealing with the need for respite; we're all dealing with the need for continuity of care; safety; we all need some form of education and some part of assisted employment and assisted living. We all need these things."

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Transitional Mental Health Services for Youth

- THANK YOU FOR YOUR ATTENTION

QUESTIONS????

Thank you!

for participating in today's

Mental Health Series

Join us next time:

Anxiety in Youth

with Rebecca McDermott

April 16, 2015 From 12-1PM @ The Royal

mentalhealthseries@cheo.on.ca