TORONTO
moving on mental health
LEAD AGENCY

east metro youth services

# Centralized Point of Access Working Group Report

April 2016

Ontario

United Way

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Toronto Region

# Centralized Point of Access Working Group Report

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# Message from Heather Sproule, Executive Director Central Toronto Youth Services, Chair of the Centralized Point of Access Working Group

Virtually everyone working in the Children's Mental Health sector agrees that changes to our system of care have long been overdue. As such, when Moving On Mental Health was announced, this initiative and in particular the seriousness of its intent, was welcomed.

In Toronto Region, we were immediately encouraged by the speed at which our Lead Agency determined its priorities and engaged our community in a planning process meant to achieve collective impact.

The benefits of a centralized access model had been studiously examined by the Central Table of MCYS Toronto Region in 2011/12 and it was concluded that such a system would deliver appreciable benefits to children and families, if the model was well designed.

I was asked to chair the working group tasked with the development of a model for a **Centralized Point of Access** which we could recommend for implementation in fiscal year 2016 – 17. The model would make consumers and stakeholders better aware of children's mental health services in Toronto and, as important, provide a direct and timely pathway to needed services.

Our mandate involved more challenge and complexity that we may have, at first, assumed. We learned, for example, that while barriers to access were abundantly documented, access models had not been consistently defined or well conceptualized in the literature. We agreed that a centralized access system need not replace existing agency based intake services and should never usurp our clients' right to choice. The announcement of a new and substantial investment in "What's Up" Walk-in services created a broader and even more immediate opportunity to access needed services. As we realized the potential scope of our consideration, we sought to contain a practical framework for our model while recognizing the potential for broader integration in future.

## Core Functions

We determined the core functions to be as follows:

- Screening
- Triage
- Referrals
- Psychoeducational information

Supporting functions were also identified and we engaged the Ontario Centre of Excellence in a literature review which pointed us toward best practices and evidence based tools. Extensive consultations with other organizations and the Toronto CMH Intake Network further informed our recommendations.

## Technology

We recognized the vital and potentially innovative role that **technology** could play including:

- Engaging and educating young people on mental health
- Psychoeducation for families
- Mechanisms for self or online referrals
- Immediate visual location of agencies throughout service area
- Capacity for language translation for referral purposes

Two consultations with Kids Help Phone revealed state of the art technological capability and the real potential for a very exciting partnership opportunity which could save the cost of "reinventing the wheel."

Our report stresses that only a collaborative approach among all stakeholders is the strategy most likely to achieve success. The inclusion of Walk-In services, Centre Francophone and Kids Help Phone could offer solutions to wait lists, French language series provision, technological innovation and immediacy of service, all within the context of exemplary professional standards.

This report provides a much more detailed description of our process and considerations, as well as multiple recommendations.

I wish to thank every member of our working group each of whom contributed creativity, challenge, knowledge, diversity and welcome disruption to our collective thinking. They have been enormously helpful.

Finally, we thank our Lead Agency for the honour of supporting this transformative process.

**Heather Sproule, MSW**
**Central Toronto Youth Services**

# Introduction

Moving on Mental Health is an important part of Ontario's Comprehensive Mental Health and Addictions Strategy. The plan ensures children, youth and families are able to get mental health services in their communities that are accessible, responsive and based on the experiences of the children and youth who need help.

The goal of MOMH is to ensure all children, youth and families in Ontario have easy access to:

- Mental health services in their communities, and
- Mental health services and supports that meet their needs

Strengthening the community-based system for delivering mental health services will bring people and organizations closer together locally and benefit everyone.

## East Metro, Lead Agency Toronto Service Area Collective Impact – A collaborative approach

Collective Impact Framework is based on the belief that no single organization can tackle or solve the increasingly complex social problems we face as a society. The framework based on the premise that multiple organizations need to join together to work toward a common agenda.

John Kania & Mark Kramer first wrote about collective impact in the *Stanford Social Innovation Review* in 2011 and identified five key elements for Collective Impact to succeed. EMYS has adopted these elements to guide and shape our work in leading the transformation of the community-based child and youth mental health sector in this city.

1. **A common agenda**
   Coming together to define a problem and create a share vision to solve it
2. **Shared measurement**
   Agreeing to track progress in the same way, which allows for continuous improvement
3. **Mutually re-inforcing activities**
   Co-ordinating collective efforts to maximize the end result
4. **Continuous communications**
   Building trust and relationships among all participants
5. **Backbone support – East Metro Youth Services**
   Dedicated staff to coordinate, support and facilitate key activities and processes

### Role of Working Groups

The sheer number of organizations both inside and outside the community-based child mental health sector requires a more intentional focus on relationship building and coordinating opportunities to simply engage and build a spirit of collaboration. These time intensive activities are foundational to building a sustainable system change.

To help lay the foundations for Toronto's system transformation, working groups were established to leverage the expertise of the Core Service Providers. In addition to providing the invaluable research, analysis and recommendations to inform the Core Services Delivery Plan and Community Mental Health Plan, there were approximately 60 working group members who contributed greatly to the spirit of Collective Impact and formed emerging relationships across agencies. The analysis, recommendations and research results provided by the working groups will be incorporated into the larger analysis and planning process as we move forward.

## Centralized Point of Access

### Brief description of the need and purpose

Ensuring that those who need access to mental health support for a child, youth, parent or caregiver will be connected to the proper resource continues to be a priority for both the Ministry of Children and Youth Services (MCYS) and Toronto's Core Service Providers (CSPs). Despite considerable efforts and successes in providing services to Toronto's geographic, cultural and linguistically diverse populations, providing an easily accessible pathway into Toronto's child and youth mental health system remains a challenge. The work of the CPA working group is intended to provide evidence-based and practical recommendations to the Lead Agency in the creation of an effective and sustainable access model within an integrated system.

## Working Group Mandate

The mandate of the Centralized Point of Access Working Group was to create and recommend a model that will enable the Toronto Service Lead to move forward with the implementation of a Centralized Point of Access (CPA) for child and youth mental health services in Toronto in 2016. The intent of the CPA is to ensure that children youth and their families and caregivers who need mental health supports are aware of, and connected to, the right resource.

The CPA will not replace existing points of access but will enhance the service system's ability to ensure children, youth and families and the wider service system know where and how to access service no matter where they live in Toronto. Developing a Centralized Point of Access is a key deliverable to successfully transform the system in Toronto. Consideration of the particular features of the Toronto service system and the needs of Toronto's diverse communities also informed the recommendations. (Mandate letter Appendix 1)

## Methodology

### Working Group Meetings (See appendix 2 for membership list)

Membership of the CPA working group represented a cross-section of agencies providing a variety of child and youth core mental health services across the City of Toronto, including those offered in French, youth and adult addictions services and a representative from Toronto Public Health Preschool Speech and Language. Members included EXECUTIVE DIRECTORS/CEOs, program directors and senior managers.

Meeting on a monthly basis, the Chair led the working group through discussion and analysis of key issues, challenges and opportunities brought forward from members' professional experience, as well as from the working group's investigative and research activities.

### Key Informant Consultations (See appendix 3 for list of organizations consulted)

Using a standard questionnaire, members of the Centralized Point of Access Working Group, met with key informants representing various models of access to gather detailed information on the models and to solicit their advice on what the CPA should do to be successful. A roll-up report was compiled containing information on 18 common parameters for each initiative.

### Report on Key Informant Consultations (Appendix 4).

Additional consultation was conducted with Kids Help Phone to gather detailed information on their model and to solicit their advice on building a successful and sustainable CPA model.

### 2016 Literature Review (See appendix 5 for report)

The Ontario Centre of Excellence for Child and Youth Mental Health conducted a literature review titled *Key Components of Intake and Access Systems* to answer a series of practical questions developed by the working group which had not been addressed in previous literature reviews on access.

### Review of relevant reports (See appendix 6 for complete list of reports reviewed)

Previous literature reviews on access conducted by the Centre of Excellence for Child and Youth Mental Health were reviewed. The Working Group also reviewed Central Table Report to Toronto Region, Ministry of Children and Youth Services, June 2012 (Appendix 7)

# Analysis

## Defining a Centralized Point of Access (CPA) for Toronto

The vision as articulated in working group's Terms of Reference is "Optimal awareness of and access to community based mental health services for children, youth and their families throughout the City of Toronto."

Through their discussions and analysis the working group defined parameters of a CPA for Toronto. The working group agreed that the service will focus on securing quick access to appropriate services. Additionally, the working group supports the recommendations from the Central Table Report to Toronto Region, Ministry of Children and Youth Services, June 2012 (Appendix 7)

## Proposed Operating principles

The working group has established a set of proposed principles to guide the development and implementation of an effective CPA:

- *The needs of children, youth and families must be prioritized*
- *Clients retain the right to choose their service provider*
- *Protocols must minimize the need of clients having to repeatedly tell their "stories"*
- *Prospective clients are to be referred to services, not waitlists*
- *Should leverage community knowledge*
- *Needs to ensure the client experience is seamless, expeditious and successful*
- *Ensures a framework of cultural competency*
- *Complies with legislative requirements for French language services*
- *Ensures effective data collection and management to enable referrals and to support system planning*
- *Works collaboratively to foster system-wide shared responsibility*

**Upon review of all relevant documents and rich discussions, the CPA Working Group determined the following core functions for the new access model:**

1. **Screening**
2. **Triage**
3. **Referral**
4. **Psychoeducational information**

**Note: The working group excluded the following functions:**

- **A referral service for fee for service providers**
- **Responsibility for waitlist management**
- **Meant to replace existing pathways to service; clients are not required to access service through the CPA**

**Recommendations:**

- *Consideration should be given to looking at the CPA as the hub of an integrated access system (not as a brand but as a concept)*
- *In addition to providing access by phone, the working group recognized that the use of technology to facilitate online access on a web-based platform/website (e.g. chat and other applications) may be an effective way to provide safe and trusted access*
- *CPA will incorporate the use of translation technology and access the required language services with the goal of providing screening for all clients who enter the system regardless of language.*
- *To ensure equitable access for harder to reach populations, a scan and analysis of available tools and resources should be conducted, including cost.*
- *That the Lead Agency incorporate into its family and youth engagement, a consultation process for input and feedback on the proposed design of the CPA.*

## CPA is part of an integrated system of access

The CPA is not intended to be the sole access point, but rather to act as a key part of a comprehensive system which has multiple access points, primarily targeting those who are unaware of how to access services they need.

- The client's right to choose a service agency is one of the key principles endorsed by the CPA working group
- Existing core service agency processes – the CPA is not meant to replace existing engagement and intake processes of service agencies
- Walk ins have proven to be a successful access point for many children youth and families into the mental health system. There is a need to identify protocols regarding existing referral sources and access points such as walk in services

**Recommendations:**

- *Consideration should be given to looking at the CPA as the integrated access system ( not as a brand but as a concept)*
- *A comprehensive access framework should include walk ins*
- *The CPA at all times must have a complete and up-to-the-minute database of all children's mental health services in its catchment area*
- *The inclusion of web-based psychoeducational information should be an important means through which immediate access to assistance can be achieved*
- *The Lead Agency should incorporate into its mid- to long-term planning implementing standardization within the system of services (common screening, common metrics, data systems etc.)*

## Walk in services as part of an integrated access system

Within the suite of core services, walk-in services are considered a Brief Service. According to the ministry's definition of Brief Services, they are designed to provide timely, effective early intervention and reduce the need for more intensive and intrusive intervention. Currently appointments are not required and wait times are very short. In practice, it appears that walk-in services also provide access to other needed services for many clients. The CPA Working Group felt that walk-ins could be a valuable component of an integrated access system by enabling clients who contact the CPA to be connected with immediate service.

However, the nature of walk-ins as a brief service primarily geared to early intervention should be kept in mind. Walk-ins cannot be expected to serve all new clients who contact the CPA without overwhelming the service and defeating the purpose of the walk-in. Not all clients would be appropriately served by a walk-in (e.g. clients in crisis or those needing intensive services). If clients whose known needs cannot be met by a brief service are referred to a walk-in, a second referral would be required, which may not be in the best interests of the client. Ensuring that clients contacting the CPA are referred to an appropriate service, but not a waitlist, will likely require some innovation on the part of core service providers to accommodate at least an initial meeting with the client in a timely manner.

**Recommendations:**

- *That further discussion take place with the walk-in network and core service providers to discuss the creation of an integrated access system, including the best ways to ensure that clients contacting the CPA are not referred to waitlists.*

# CPA Core Functions

## Core Function #1 Screening

**Recommendations:**

- *Establish eligibility for child and youth mental health services*
- *Where appropriate, the client will be referred to other services outside the core services*
- *Need to get "just enough" information to make an informed referral*
- *Objective is to connect the client to a timely appropriate service without referring to a waitlist*
- *A screening tool would be used to identify level of need and urgency/risk (e.g. self harm)*
- *Recognize that staff need to be skilled enough to identify appropriate services as many clients do not know what type of service will best meet their needs*

## Core Function #2 Triage

Effective triage processes are known to improve client access to appropriate and timely assessment and treatment services. Mental health triage is defined as a process conducted by a clinician at an entry point to service (e.g. intake or walk in) which aims to identify the nature and severity of the presenting mental health issue, the service needed and the urgency of the response required.

**Recommendations:**

- *Ensure that staff are well trained on triage processes*
- *Determine and adopt an evidence informed tool to support triage function*

## Core Function #3 Referrals

**Recommendations:**

- *Incoming referrals will be accepted from youth, parents, caregivers and professionals, including schools, child welfare, health care, youth justice, etc.*
- *The CPA will provide information to professionals in other sectors to assist their clients to access the system.*
- *Referrals from school boards to the Student Focused Workers' program will go through CPA.*
- *Outgoing referrals will be supported through a warm transfer process, where possible and appropriate, to an initial meeting with a service provider in a timely manner.*

Note: The Centre of Excellence for Child and Youth Mental Health defines warm transfer as "an approach to care transitions in which health care providers directly link clients to another health care provider or specialist using face-to-face or phone transfer mechanisms". (See Appendix 5)

## Core Function #4 Psychoeducation

Research has found that web based psychoeducation can increase literacy levels on mental health, reduce stigma and motivate greater rates of help seeking.

(Ontario Centre of Excellence, *Evidence in Sight Request Summary: Key Components of Intake and Access Systems 2016*, Appendix 5)

**Recommendations:**

- *That current relevant and credible psychoeducational educational material be incorporated and maintained on a CPA web site*
- *That other social media vehicles be used for the communication of psychoeducational material*
- *That Bibliotherapy be excluded as it utilizes psychoeducation as a therapeutic tool and is therefore beyond the scope of a screening and referral service*

## CPA Supporting functions

- Collaboration among core service providers and with other community partners
- Utilization of cutting edge technology for educational, operational and client engagement purposes
- Client and agency information management, utilizing up to the minute information
- Performance measurement on multiple dimensions of the CPA's work
- Marketing/communications of the CPA
- Operational management

## Implications for Staffing

While not a comprehensive list, some of the skills and experience that frontline CPA staff must possess are:

- Effective interpersonal and interviewing skills to quickly gain clients' trust and solicit needed information;
- Detailed knowledge of the service system to make appropriate referrals;
- Sufficient clinical training and experience to accurately determine the level of need and urgency/risk presented by a client;
- Competence in suicide prevention and safety planning;
- Competence in dealing with the diversity of Toronto's population who have many different backgrounds, cultures and needs such as francophone, Aboriginal, newcomers, minorities, LGBTQ, persons with disabilities, persons living in poverty; and
- Skill in building relationships with service providers and other community partners.

## Technology: Website and online resources

A website presence is an important component of a CPA. The website should include all core service providers by area of the city, with brief descriptions of their services and links to their websites. The inclusion of psychoeducational material on the website and possibly through other social media is supported by the early literature review conducted by the Centre of Excellence. (See Appendix 8 – *Self-help resources and bibliotherapy, May 12, Ontario Centre of Excellence for Children and Youth Mental Health*)

The CPA should incorporate innovative online approaches. These could include an app to enable clients to chat with staff, screening in various languages and ability for the client to book appointments with the agency to which they are referred. These must be accessible to persons with disabilities as required under the Accessibility for Ontarians with Disabilities Act.

**Recommendations:**

- *That the website containing information about all core service agencies and their services be developed and launched when the CPA begins operation*
- *The CPA should incorporate technological capacity for multiple functions (e.g. self-referral, client and agency information, tracking consents, web-based screening capacity, compiling performance data)*
- *The French Language Services working group should be consulted for guidance on the inclusion of French language content and services*

## Data collection and information management

A data system will be required with capacity to house client and agency information, including metrics for ongoing evaluation of the CPA service to inform continuous quality improvement and community planning

**Recommendations:**

- *Client data should include basic client information, referral source and date of contact, results of screening, client consent to share information, where client is referred and date of first appointment, if known. Ideally, the data system used by the CPA would have the capacity to electronically export the relevant client data and consent to the service to which the client is referred so the client does not have to retell their story. Alternatively, this information could be sent securely by other means.*
- *Agency data should include comprehensive up to date information about services and programing offered by all 33 core service providers and eligibility criteria as well as information about community partners to which clients may be referred; estimated wait times for service, current vacancies and access processes and protocols along with staff contact information for each agency for all relevant services.*
- *The Lead Agency should consider implementing a process for the standardization of tools, metrics, data systems (maximize production of data and control for validity and reliability)*
- *If a common solution for the sector will not be in place when the CPA begins operation, a data system should be chosen for the CPA that would be compatible with a larger solution in the future.*

## Consent and privacy

Consent – The concept of consent requires a clear understand by a client and/or guardian of the nature and parameters of the services being provided well as the legal limits of confidentiality of the information being provided to the service agency.

Privacy – It is important to safeguard clients' personal health information and to adhere to all official requirements with respect to protecting confidentiality and privacy. Consistent protocols and policies are required for disclosing any personal health information to any third party and circumstances where this information is permitted or required to be shared without consent (i.e. situations where there may be risk of serious bodily harm to self or others) or when an agency is required by court order or law).

Agencies providing mental health services for children, youth and families are governed by and/or guided in the areas of consent and privacy by various laws and standards such as the Canadian Centre for Accreditation (CCA) standards, the Personal Health Information Protection Act (PHIPA) and The Personal Information Protection and Electronic Documents Act (PIPEDA)

**Recommendations:**

- *Since the CPA will be gathering and recording personal information from clients that may be shared with service providers, a policy needs to be developed that complies with all relevant legislation, regulations and policy directives on protection of privacy and consent.*

## Further considerations for CPA design and implementation

**Recommendations:**

**A) Design**

- *Linkages with broader sector partners including early years, health care, education, child welfare, youth justice and special needs should be explored*
- *Creation of a CPA should not cannibalize existing access or intake resources*
- *Could or should a CPA system, including standardization and data collection elements be provincial?*
- *The physical location of CPA staff and technological supports (website, telephone etc.) does not, and should not necessarily rest with the lead agency, or even one location.*
- *Implementation of a CPA should include a communications plan and also consider the potential increase on the children mental health system from increased awareness, including walk in services and service providers*
- *As an additional access point which will be promoted to the community, Centre Francophone de Toronto, as the agency primarily providing services in French for Toronto should be consulted about the impact with increased awareness could have on the demand for their services.*
- *Collecting and disseminating real time data requires intensive resources*

**B) Implementation**

- *Obtain approval in principle from the appropriate partners and potential resourcing/funding bodies to proceed to next steps in implementing the proposed model.*
- *Part of this process may involve a more in-depth consultation with the core service agencies, especially about requirements that will impact them.*

## Next Steps

There are many examples of multi-dimensional access systems which incorporate telephone, web-based and other technologies to draw from. Key elements in the design and implementation is capacity of the system to build/adapt a model, identify priorities in the services provided (including intersectoral referrals) and to develop a model which can adapt and grow to meet demand and priorities dictate. Below are the key components to consider when developing the full implementation strategy. (See Appendix 9 for details on a recommended Implementation Strategy)

1. Establish an expert advisory panel and create terms of reference
2. Establish a budget for year one
3. Hire a project manager
4. Engage all relevant stakeholders (including youth and families) to foster collaboration and commitment
5. Hold discussions with the walk-in network and core service providers to discuss the creation of an integrated access system, including the best ways to ensure that clients contacting the CPA are not referred to waitlists.
6. Develop a phased implementation plan (including key performance indicators) and establish priorities for each phase and timetable
7. Identify all areas requiring policy and protocols such as privacy and consent, warm transfers, triage and crisis management
8. Determine the required technology (including social media and a database which is compatible with agency specific systems) and establish information sharing protocols between the access system and service providers
9. Establish a web site to further promote walk in services; map out children's mental health services in Toronto and begin to create psychoeducational material
10. Identify training needs and implement recruitment and training of staff for cultural competency, (and) suicide prevention, screening for client risk, triage competency, and safety planning
11. Develop a communication plan and outreach strategy to reach marginalized populations
12. Create a strategy to estimate regional service utilization (demand)

## KIDS Help Phone: A Promising Opportunity

Established in 1989, Kids Help Phone is a Canadian and world leader known for their expertise and continuous innovation as Canada's only 24/7 counselling and information service for young people. Utilizing telephone, web-based and tablet/smart phone technology, Kids Help Phone has an evidence-based and proven structure and culture of continuous improvement. These qualities were identified by the CPA Working Group as essential to a successful and sustainable CPA model. Initial discussions have begun between the CPA working group chair, lead agency and Kids Help Phone. These discussions have not only reinforced the core elements identified by the working group, but have also highlighted the benefits of developing a partnership or collaborative relationship with an established and successful organization such as Kids Help Phone.

**Recommendations:**

- *Continue discussions with Kids Help Phone to discuss a possible collaboration or partnership*

# Appendices

# Appendix 1

## Centralized Point of Access Working Group Mandate Letter – Page 1

1200 Markham Road, Suite 200
Scarborough, Ontario M1H 3C3
Claire J. Fainer
Executive Director

June 26, 2015

Ms. Heather Sproule
Executive Director
Central Toronto Youth Services
65 Wellesley St., East, 3rd Floor
Toronto, ON M4Y 1G7

Dear Heather,

Thank you for agreeing to chair the Centralized Point of Access Working Group.

The mandate of the working group is to recommend a plan that will enable the Toronto Service Area to move forward with the implementation of a Centralized Point of Access (CPA) for child and youth mental health services in Toronto in 2016. The intent of the CPA is to ensure that anyone who needs to access mental health support for themselves or a child or youth in need will be connected with the proper resource. The CPA might not replace existing points of access but will enhance our ability to ensure people and the wider service system know where and how to access service no matter where they live in Toronto. Developing a Centralized Point of Access is a key deliverable to successfully transform the system in Toronto.

Consideration of the unique requirements of Toronto's diverse communities must also inform the recommendations of each working group. The Communications Working Group will liaise with your working group to guide and support communications and community engagement activities including a specific focus on youth and families.

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# Appendix 1

## Centralized Point of Access Working Group Mandate Letter – Page 2

All working groups will have an initial mandate until March 31, 2016 with the possibility for extension. Working groups will be responsible for developing a Terms of Reference for review at the next meeting of core services agencies (agencies) August 5, 2015 and a work plan for an anticipated September meeting of agencies.

As lead agency, East Metro Youth Services (EMYS) will provide secretariat support to the working group. This includes:

- Assist in development of Terms of Reference and work plan
- Develop and maintain contact lists
- Plan and manage meeting logistics
- Liaise with other working groups regarding areas of shared interest (e.g. communications and community engagement) to ensure consistency and avoid duplication
- Coordinate research and other activities with initiative partners, align strategies and actions, conduct individual outreach and education as needed
- Work with the Director of Lead Agency Strategy to coordinate with other related project and working groups to maintain a full understanding of the current landscape and integrate work with other working groups as required
- Build and maintain relationships with community partners

EMYS will host a meeting of the four Working Group Chairs July 8, 2015 from 10 am – 1 pm at our office Suite 200, 1200 Markham Road to discuss next steps and selection of members.

Attached is the document drafted June 3rd outlining considerations for the working group. EMYS has included comments on this document to clarify our expectations. Also attached is a list of the individuals who have indicated an interest in sitting on this working group.

Once again, thank you for agreeing to Chair this working group. We look forward to working with you.

Sincerely,

Claire Fainer
Executive Director

# Appendix 2

## Centralized Point of Access Working Group Membership

| Name | Position |
|---|---|
| **Heather Sproule** | Central Toronto Youth Services (Chair) |
| **Suzette Arruda-Santos** | Yorktown Child & Family Centre |
| **Chetan Bahri** | Aisling Discoveries Child & Family Centre |
| **Steve Blake** | Child Development Institute |
| **Nadia Brabant** | Centre Francophone de Toronto |
| **Kathy Glazier** | MCYS (retired) |
| **Jonathan Golden** | Jewish Child & Family Services |
| **Pamela James** | Jewish Family and Child Services |
| **Patty Hayes** | Youthlink |
| **Sara Koke** | Toronto Public Health |
| **Dennis Long** | Breakaway Addiction Services |
| **Terry McCullum** | LOFT Community Services |
| **Lydia Sai-Chew** | Oolagen |
| **Gail Smith** | Youthdale Treatment Centre |
| **Darren Fisher** | East Metro Youth Services (Lead Agency liaison) |

# Appendix 3

## List of Organizations Consulted

1. Kids Help Phone
2. Coordinated Access to Addictions Services
3. Centralized Access to Residential Services (CARS)
4. Family Navigation Project
5. The Access Point
6. Toronto Early Intervention Intake Workers Project
7. Peel Coordinated Intake Network
8. Intake Workers Network
9. Children's Treatment Centre of Simcoe-York
10. CITYKIDS
11. Canadian Mental Health Association, Waterloo Wellington Dufferin Branch

## Centralized Point of Access Working Group

## Report on Key Informant Consultations and Documentation

# Appendix 4

## Report on Key Informant Consultations and Documentation – Page 2

**Summary and Analysis of Findings**

Information was gathered on nine initiatives. A standard set of questions was used to interview seven of these. Documentation only was provided by The Toronto Early Intervention Intake Workers Project and the Peel Coordinated Intake Network.

Types of initiatives

Four types of initiatives were reviewed:

1. Centralized access points:
   - Coordinated Access to Addictions Services – adult addictions services
   - CARS – children's mental health residential treatment beds
   - Family Navigation Project – mental health and addictions services for youth aged 13-26
   - The Access Point – mental health support services and supportive housing for adults with mental health and/or addictions challenges, aged 16 and up

2. Common intake ("Every door is the right door"):
   - Toronto Early Intervention Intake Workers Project – special needs, 0-5 years
   - Peel Coordinated Intake Network – children's mental health

3. Coordinated access through formalized networks:
   - Children's Treatment Network of Simcoe-York (CTN) – special needs, 0-21 years
   - CITYKIDS – special needs, 0-12 years

4. Information-sharing network:
   - Intake Workers Network – children's mental health

Common intake forms

Common intake forms are used by:

- Toronto Early Intervention Intake Workers Project
- Peel Coordinated Intake Network
- Children's Treatment Network of Simcoe-York (CFI and CANS)
- CITYKIDS

Tools for determining urgency/priority

Youthdale and Etobicoke Children's Centre have tools for determining urgency/ priority.

Consent

Peel Coordinated Intake Network, CARS and Children's Treatment Network of Simcoe-York use consent forms. Toronto Early Intervention Intake Workers Project uses verbal consent.

Service navigation and warm transfers

Initiatives address service navigation and warm transfers in different ways:

- Children's Treatment Network of Simcoe-York and CITYKIDS use a formalized process for service navigation and warm transfers.
- Toronto Early Intervention Intake Workers Project provides service navigation if there are multiple referrals.
- The Access Point may provide service navigation to families depending on service needs, circumstances and consent issues.

Service navigation and warm transfers (cont'd)

- The Family Navigation Project provides service navigation but the family is expected to make its own connection with the agency.
- Coordinated Access to Addictions Services does not provide service navigation, but sometimes provides warm transfers by phone.

Linguistic diversity

Capacity to provide service in various languages is accomplished in various ways:

- French – Find Help for French, French Service Navigator on staff, referral to Centre de Francophone
- Other languages – Sunnybrook Interpreter Services, service providers, language capacity on staff, three-way phone language translation, Access Alliance Multicultural Health and Community Services

Waitlist management

Only one initiative manages waitlists – The Access Point.
The CTN monitors wait times and CITYKIDS ensures clients are not duplicated on wait lists.

Data systems

Initiatives use different data systems:

- The Access Point – custom database
- Coordinated Access to Addictions Services – CATALYST
- CARS – Filemaker
- Peel Coordinated Intake Network – common database among providers
- Children's Treatment Network of Simcoe-York – shared electronic record among partners (Goldcare) and SharePoint intranet
- CITYKIDS – CYSIS

Key functions

- CPA should have a screening function, brief and intended to provide a

Success factors for the new Centralized Point of Access

Initiatives surveyed suggested a range of practices they thought the new CPA should incorporate to be successful and that would also benefit them. They are organized by category:

Role of CPA

- CPA will need to differentiate itself from other similar access points in Toronto.
- Should be more robust than 211; service should provide more than just information.

Marketing and resourcing

- Need a well-known comprehensive access point with efficient client flow and sufficient resources.

Client experience

- Ensure that connection to clients is quick. Set response time guidelines.
- Establish processes that don't require families to repeat themselves (some database systems can help, e.g. CYSIS, but not everyone is using the same software). Can create a form that can be transferred with referral.
- Don't be too intrusive.
- Maintain choice for clients.

Clients served

- Include infants and very young children.

Data system

- CPA database should be compatible with other databases.

reliable indication of need. Must have capacity to screen for urgency and seriousness. Must be staffed with clinicians. Screening process, if focused, might take only 10-15 minutes.

〈 Should do comprehensive service navigation across a range of services for children, youth and families. Could use a service navigation app.

〈 Would be good to have ability to follow-up and reconnect with clients.

〈 CPA should refer to both publicly and privately funded services.

Crisis/urgent response

〈 Educate other service providers (e.g. family doctors, school personnel) on how to better gauge crisis and where to send youth.

〈 Need staff person who is capable of doing a safety plan with a family/ youth when needed.

〈 Could have a crisis letter with a list of resources to send family as a follow-up measure.

Linkages/coordination across sectors and with other players

〈 Need capacity to deal with complex families that require services from multiple sectors. Should develop formal relationships with other Access Hubs to make it easier for applicants and families to move across sectors when needed.

〈 Should have good coordination with institutional providers.

〈 Incorporate a data system with search and match capacity (i.e. as clinician types in client info, system finds agency matches based on key words, geographic location, diagnosis, age, etc.).

〈 Could develop a common electronic database to track referrals, service plans, wait times, wait lists, length of service, discharges.

Consents

〈 Consents should be easy to transfer; need to be recorded electronically as some places won't take verbal consents.

Knowing the service providers

〈 Should have "up to the minute" information concerning all services, including restrictions such as catchment and diagnoses not accepted, availability and location, including walk-ins. Need a reliable system for gathering and maintaining accurate information (will require agencies to keep their information up to date).

〈 Should have knowledge of waitlists but not manage waitlists.

Feed into continuous improvement for system

〈 Seek feedback from families on service delivery in follow-up.

| Topics | Coordinated Access to Addictions Services | CARS | Family Navigation Project |
|---|---|---|---|
| Description of service provided | *Coordinated access point for people seeking addictions treatment services, providing primarily screening and triage<br>*Housed at St. Michael's Hospital | *Provides centralized access to mental health residential treatment beds for children and youth<br>*Housed at Delisle<br>CARS accepts referrals from service providers for:<br>1. Residential treatment beds in the child/youth mental health transfer payment system<br>2. Quick Access beds for child welfare clients<br>3. Latency-aged Enhanced Home/School programs<br>4. Children's MH centres, Young Parents/Infants | *Provides service navigation for youth 13-26 and their parents/caregivers who live in the GTA for mental health and addictions services.<br>*Help youth and their families access services quickly.<br>*Services can be publicly and/or privately funded.<br>*Most calls come from parents and caregivers.<br>*Housed at Sunnybrook Hospital<br>*Project funded by RBC. In 3rd year of funding in a 3 yr. cycle. |
| Service functions | *Intake form is sent to receiving agency.<br>*Does not provide assessment, service coordination or waitlist management | *Referral and tracking. Does not manage waitlists. | *Intake, assessment, service navigation and follow-up.<br>Not a crisis service. |
| Staffing and training | 2 FTES trained by SMH withdrawal management staff | 1.5 FTE program coordinators, 1.0 FTE admin assistant<br>0.4 FTE director who has IT skills | *All Navigators have Master's level education in Social Work, Psychology or Counselling plus several years experience in mental health and addictions and in case management. Medical Director is a psychiatrist.<br>*10 F/T staff, including 1 Project Manager, 1 Intake/ Admin, 7 Service Navigators, 1 Medical Director.<br>P/T staff doing post-doctorate work and research.<br>*Hiring an Information/Data Specialist and Director of Strategy and Partnerships. |
| Call volumes | Quite low and can be managed with 2 FTEs | From Sept 2014- Sept 2015, 362 referrals plus 44 STEP applications | About 44 new calls/emails per month. Since November 2013, project has received 800 calls/emails from families. |
| Budget | | | $1.1 million last year from RBC plus other smaller donations. |

| Topics | Coordinated Access to Addictions Services | CARS | Family Navigation Project |
|---|---|---|---|
| Service flow | When clients are referred, standardized intake form is sent to receiving agency through CATALYST (DATIS system) | Steps:<br>1. Service provider refers child/youth<br>2. CARS sends to appropriate program<br>3. Program responds within 5-7 days with "waitlisted", "accepted" or "rejected"<br>4. CARS tracks agency responses<br>5. CARS tracks discharge | Steps:<br>1. Call or email received by project.<br>2. Intake/Admin returns calls within 2 days<br>3. Intake/Admin books time to speak with parent or youth for initial screening<br>4. Parent or youth passed onto Service Navigator who calls within 2 days<br>5. Service Navigator assesses situation.<br>6. Service Navigator provides info to family and works with them until they connect with the services.<br>7. Service Navigator follows family on average 4-6 mo. |
| Intake community | Addiction services of TCLHIN informed through email and regular meetings of the Addiction Services Working Group | Service providers - see above under description of service | Youth and families |
| Use of technology, data system and maintenance | *CATALYST through the DATIS system managed by CAMH | *Filemaker, created by Delisle. Live web link to update vacancy information | Project does not have a database. Uses hospital's record system. New IT staff will develop a system. |
| Intake interview, tools | *Use a "triage" form developed with service partners | *Referral forms used created in 1999 by the ministry. | *Use a screening tool and an assessment tool.<br>Assessment takes 1.5 hours.<br>Includes areas such as psycho-social, family history, client history, behaviours, communication, what has been tried, etc. |
| Linkage with agencies | *By phone and through CATALYST | | |
| Waitlist | Do not manage waitlists | Do not manage waitlists or provide support during waiting period. | Do not manage waitlists |
| Service navigation and warm transfers | *Do not provide service navigation. When warm transfers required, handled primarily by phone | N/A | Family makes its own connection with agency. |
| Decision trees re urgency/priority | * In urgent cases, client is referred to a Withdrawal Management Service that can respond within 24 hours | *Not formalized, based on relationships and trust built over time. Programs have complete autonomy over admissions.<br>*YJ referrals have strict timelines which CARS highlights on the referral form | *Not done as Service Navigator calls family within 4 days |
| | | | |

| Topics | Coordinated Access to Addictions Services | CARS | Family Navigation Project |
|---|---|---|---|
| Barriers to accessing services | *Service has a low profile<br>*Service gap for concurrent disorders<br>*Lack of services for transitional age youth that offer immediate response and system navigation | | |
| Linguistic diversity | * Use Find Help for French and other language assistance | *Rely on service providers who make/receive referrals<br>*STEPS funding has been used to provide translation, ASL training or language-specific staffing to residential programs | Use Sunnybrook interpreter services but very few clients do not speak English. Refer families to a service provider with language capacity if needed. Intake/Admin staff speaks Spanish. |
| Consent and privacy | | *Youth age 12 and under must sign consents for referral to proceed; parents of children under 16 must also sign consents; wards of child welfare do not sign consents - only CW signs as the guardian<br>*Referrals are emailed, faxed and/or couriered | * A family's personal information is not shared with agencies so no consent is required.<br>*In cases where personal information is shared, use Sunnybrook's consent form. Use specific consents for a specific agency. |
| Success factors for CPA | *Need a well-known comprehensive access point with efficient client flow and sufficient resources<br>*Better coordination with larger institutional providers | *Flex funding supports access to services (e.g. if transitional staffing or staff training is needed to meet a child's needs)<br>*Community tables can be convened if a child's needs are challenging without going to formal Service Resolution. | *Fast response time helps avoid bottlenecking at access point.<br>*We recommend both publicly and privately funded services. Important to really get to know private services as they can be tricky to use.<br>*Services can be in GTA or further away.<br>*Seek feedback from families on service delivery in follow-up. |

| Topics | The Access Point | Toronto Early Intervention Intake Workers Project (from written material only, no interview) | Peel Coordinated Intake Network (PCIN) (from written material only, no interview) |
|---|---|---|---|
| Description of service provided | *A central coordinated access point to Individual Mental Health Support Services and Supportive Housing for people living with mental health and/or addictions challenges throughout the City of Toronto<br>*Serves ages 16 and up<br>*Network of 52 mental health and addictions service providers<br>*Provides streamlined access to multiple services through one application form and process.<br>*Designed to remove barriers to access and reduce duplication of services<br>*"No Wrong Door" policy. Applicants can start anywhere in the system. | *Participating agencies that serve children with special needs use a common intake form. Age range is 0 - 5 yr.<br>*The agencies are: Community Living Toronto, Holland Bloorview Kids Rehab, City Kids Mothercraft, Special Needs Services of the City of Toronto's Children's Services, Toronto Preschool Speech and Language, Toronto Public Health, Adventure Place and Centennial Infant and Child Centre.<br>*Concept is "every door is the right door."<br>*Longer term, would like to use the form in a shared database format where information taken by one agency could be shared electronically with another agency to minimize families having to repeat the same information as they move from one service provider to another.<br>*This is a pilot project. | *A coordinated system of children's mental health service providers and a gateway to service for children, youth and families<br>*Client choice of service is paramount<br>*"Every door is the right door" - multiple gateways for access<br>*Use common intake assessment information and tools that are strengths-based<br>*Network partners ensure effective linkage with ongoing service<br>*Network partners develop a support plan with clients and the preferred service provider when clients are placed on a waiting list for service<br>*Network partners convene regularly to discuss intake best practices and facilitate information-sharing to address service system issues |
| Service functions | Accept a common application form, assess eligibility and level of need, waitlist mgm't, information and referral, matching to available services. | Intake, referral, service navigation | Intake and referral, support while waiting for service |
| Staffing and training | *20 staff - 11 Service Navigation staff, 1 Peer Support Worker, 4 admin staff, 2 Team Leaders, 1 Database Analyst and 1 Director.<br>*New staff receive orientation to internal processes and database. Service Navigation staff also oriented to assessment process and shadow experienced Service Navigators. | Intake workers are not centralized. | *Network partners participate in staff training activities for intake staff |
| Call volumes | On average there are 3000 calls per month | Not tracked. No common database. | |
| Budget | Annual budget approx. $1.3M | No information | |
| | | | |

| Topics | The Access Point | Toronto Early Intervention Intake Workers Project (from written material only, no interview) | Peel Coordinated Intake Network (PCIN) (from written material only, no interview) |
|---|---|---|---|
| Service flow | *Applications are received, reviewed, applicant is contacted for assessment, alternative contacts and referral source may also be contacted for additional information.<br>*If applicant is eligible, he/she is placed on waitlist. When an appropriate service is available, applicant is matched to the service. | *Self-referral from family member or referral from service provider received.<br>*Family is contacted and intake interview results in completion of common intake form.<br>*Referral(s) are made to appropriate service provider(s). | |
| Intake community | Persons aged 16 and up with mental health or addictions problems | Family members, service providers | |
| Use of technology, data system and maintenance | *Custom database developed for our needs.<br>*Applicants can apply online. Their information is then imported into the database.<br>*File moves through a variety of different statuses until they are placed into service.<br>*Database developer works on a consulting basis. A full-time database analyst maintains the system. It is always up to date.<br>* All data fields in the application form are captured in the database plus decision times, wait times, referral and call volumes. | No common data system. Each agency uses its own. | *Information database available to all providers<br>*Web-based tools are integral to the system allowing ease of information-sharing |
| Intake interview, tools | *Have created screening tools for the various services (intensive case management and assertive community treatment). | Fairly extensive intake interview using a standard form. Contains detailed information on child's strengths and needs. | *Common form for incoming referrals<br>*Common intake form |
| Linkage with agencies | | Referrals in and referrals out. | Through Intake Network |
| Waitlist | We do manage waitlists | | *Do not manage waitlists, but develop plan to provide support to client while waiting |
| Service navigation and warm transfers | Depending on service needs, circumstances and issues of consent, may help families to navigate the service sector. | Service navigation if multiple referrals. | |

# Appendix 4

## Report on Key Informant Consultations and Documentation – Page 11

| Topics | The Access Point | Toronto Early Intervention Intake Workers Project (from written material only, no interview) | Peel Coordinated Intake Network (PCIN) (from written material only, no interview) |
|---|---|---|---|
| Decision trees re urgency/priority | Applicants meeting the Health Link Complexity definition are prioritized into services. In addition, there are a number of preferred referral agreements that prioritize some populations into service more quickly (e.g. people with criminal justice system involvement, problematic substance abuse, and homelessness). | | |
| Barriers to accessing services | Lack of availability of services results in long wait times for service. | | |
| Linguistic diversity | A number of our staff are able to deliver service in multiple languages, including French.<br>We also have access to translation services when needed. | | |
| Consent and privacy | | Verbal consent sought for intake. | Use a common consent form for disclosure of information |
| Success factors for CPA | Develop formal relationships with other Access Hubs to make it easier for applicants and families to move across sectors when needed. | | |
| Information that CPA could gather to help you | | | |

| Topics | Intake Workers Network | Children's Treatment Network of Simcoe-York | CITYKIDS |
|---|---|---|---|
| Description of service provided | *Informal network of intake workers in 30-40 children's mental health agencies, including some hospital programs.<br>*Share information at quarterly meetings (e.g. agency programs, waitlists, new tools, groups running, staffing changes). | *Children's Treatment Network (CTN) is a network of agencies working together to provide single point access, coordinated intake, service navigation, service coordination and rehabilitation service delivery to children and youth birth to 21 yr. with multiple special needs living in Simcoe County and York Region.<br>*CTN also functions as a Health Information Network Provider by providing a "backbone" shared electronic record.<br>*Provides coordinated access to multiple sectors including children's mental health, rehabilitation, early intervention, respite and inclusive recreation, autism services and special education | *CITYKIDS is a network of agencies working together to provide single point access, coordinated intake, service navigation and service delivery to children birth to age 6 and children 6 to 12 yr. attending child care who have extra support/special needs living in the City of Toronto.<br>*Service Navigators provide service system navigation for families using family-centred care approach. Access to services is streamlined through brokering/triaging of referrals to specialized services using warm transfers.<br>*Provides coordinated access to early childhood care and support services, infant mental health, rehabilitation, early intervention, respite, autism services, special needs and mental health |
| Service functions | Intake in member agencies. Most places that have walk-ins use that service as the screening. | *Service Navigators provide service system navigation for families using a family-centred care approach.<br>*Navigators complete the intake for services funded by CTN and delivered by network partners and/or broker referrals to many other services provided by network partners not funded by CTN using a warm transfer process.<br>*Common intake interview and administration of CANS to assist with building an initial service plan, direct referral and follow-up. Centralized intake for CTN's rehab services.<br>*Common consent for sharing of information and opening of a shared electronic record with unique I.D.<br>*Monitor wait times in the system flagged after 60 days<br>*Provide informed service/referral options to professionals<br>*Identify service and system gaps to inform community planning tables. | *Phone service system navigation<br>*Collect common intake info, basic screening, service navigation requests, direct referral and follow-up<br>*Broker referrals to appropriate services and professionals<br>*Provide informed service/referral options to professionals working with children and families<br>*Provide centralized intake to OT consultation services to children in child care<br>*Provide outreach and training opportunities to community<br>*Identify service and system gaps to inform planning tables; offer innovative, responsive participation to initiatives within special needs/mental health community<br>*Coordinate interagency team meetings, Planning and Evaluation Committee and Steering Committee |
| | | | |

| Topics | Intake Workers Network | Children's Treatment Network of Simcoe-York | CITYKIDS |
|---|---|---|---|
| Staffing and training | | *Service Navigators are clinicians with varied backgrounds: Registered ECEs with specialties in special needs resourcing; nursing; occupational therapy; social work; developmental services; infant and child mental health with thorough knowledge of child development.<br>*On the job training plus regular intake meetings to connect staff.<br>*5 Service Navigators and 3 clerks | *Service Navigators are registered Early Childhood Educators with specialties in special needs resourcing, infant and child mental health and thorough knowledge of child development.<br>*2.5 Service Navigators |
| Call volumes | | *Approximately 250 referrals/month; 50% requiring Service Navigation/CFI/CANS | *In 2015, received 765 referrals in 10 month period |
| Budget | | No information | $221,000 annually from Toronto Children's Services, Special Needs Services |
| Service flow | | 1. Referral received by clerk<br>2. Family contacted for consent/opening of record and to book Child and Family Interview (CFI)<br>3. Service Navigator contacts family to conduct CFI and populate the CANS - info captured in record (approx. 90 minutes)<br>4. Service Navigator contacts agencies to broker referral<br>5. Clerks complete transfer of information if outside record | |
| Intake community | | Families, service providers, professionals | Families, service providers, professionals |
| Use of technology, data system and maintenance | *SIR system needs updating | *CTN uses a shared electronic record (Goldcare) to collect and gather child/family demographics, CFI information and referrals. Record feeds into a database which can generate reports for the system.<br>*Agencies are provided with a list of outstanding referrals (over 60 days) on a monthly basis.<br>*CTN has a SharePoint intranet where info such as agency contact info and wait times is housed.<br>*CTN website - Partners Forum - provides a hub of info | *CITYKIDS forms are PDF writable for community professionals and doctors<br>*Phone system - use Devon to Speak to SUE<br>*Investigating options for transferring referrals through a secure cloud.<br>*Service Navigator uses CYSIS to collect and gather child/family demographics and developmental information that mirrors the data elements within the Common Intake Referral Form and Common Intake Navigation |
| | | | |

| Topics | Intake Workers Network | Children's Treatment Network of Simcoe-York | CITYKIDS |
|---|---|---|---|
| | | on community/agency programs specific to extra/special needs<br>*Agency that picks up referral maintains the client record.<br>*Approx. 500 current users<br>*0.5 FTE of help desk support for electronic record and SharePoint. Most calls are for password issues. | Form. Reports can be generated.<br>*The family's service plans are also entered into the database which records the referrals made for the family and the supports when children are re-referred to CITYKIDS. (See interview notes for more info on CYSIS.)<br>*CITYKIDS website offers community partners a hub of info on programs for extra/special needs |
| Intake interview, tools | BCFPI not especially helpful. Different processes for MOHLTC and MCYS. | *CTN uses CFI and CANS (Child and Adolescent Needs and Strengths) - modified ASD/Preschool | *CITYKIDS uses a Common Intake Referral Form and Common Intake Navigation Form |
| Linkage with agencies | | *Referrals in and out, shared electronic record, partnerships within the Network | *Referrals in and out, partnerships within the Network |
| Waitlist | | *System flags all wait times over 60 days; agencies advised monthly of outstanding referrals | *Ensure child is not on duplicated lists |
| Service navigation and warm transfers | | *CTN has 30 partners with signed MOUs that offer child and family in-person visits, service planning, service coordination, specialized services and training<br>*Service navigation recognizes child and family needs on a continuum of social supports, parental supports and specialized services<br>Warm transfer process<br>1. Family and CTN develop service plan, family provides consent for referral<br>2. CTN contacts rep at agency to which referral is being made, discusses referral and agency confirms referral is appropriate<br>3. CTN transfers by email/record or fax to agency and agency confirms receipt<br>4. CTN, if direct referral, sends service plan letter to family and referral source outlining referrals for child/ family<br>5. Agency contacts family to arrange visit or complete further intake | *CITYKIDS has a network of agencies with MOUs with partners who offer child/family in-person visits, service planning, specialized services and training.<br>*Service navigation recognizes child and family needs on a continuum of social supports, parental supports and specialized support.<br>*Send service plan letters to referral sources to inform them of the outcome of their referral.<br>Warm transfer process<br>Same as CTN |
| | | | |

| Topics | Intake Workers Network | Children's Treatment Network of Simcoe-York | CITYKIDS |
|---|---|---|---|
| Decision trees e urgency/priority | *Different programs use different tools (e.g. outpatient vs. residential)<br>*Youthdale has a regional assessment tool<br>*For those using walk-ins as part of intake, this is done in session.<br>*Etobicoke Children's Centre has a Priority Rating Tool. | *If client has already come through CTN intake and has open record, referrals are warmly transferred | *No current priority selection process is used |
| Barriers to accessing service | | *Limitations: Uptake of use of service coordination tools: CANS, shared electronic record for services NOT funded by CTN. Main issue is duplicate data entry. | |
| Linguistic diversity | | *CTN has French Service Navigator and CFI information is inputted in French for French service providers<br>*Three-way phone language translation is used for all other languages. | *CITYKIDS Service Navigator uses Access Alliance to support interpretation<br>*French-speaking families are referred to Centre de Francophone through a warm transfer |
| Consent and privacy | | *Common consent for sharing information and using a shared electronic record | |
| Success factors for CPA | *Envision CPA as a screening function, brief & intended to provide a reliable indication of need. Must have capacity to screen for urgency and seriousness. Must be staffed with clinicians. Screening process if focused might take only 10-15 minutes.<br>*Create a form that can be transferred with referral to minimize repetition for clients.<br>*Include infants and very young children.<br>*Don't be too intrusive.<br>*Need staff person who is capable of doing a safety plan with a family/youth when needed.<br>*Educate other service providers (e.g. family doctors, school personnel) on how to | *Common electronic database to track referrals, wait times, wait lists, length of service, discharges | *Comprehensive service navigation across a range of services for children, youth and families<br>*Language specific service<br>*Electronic service planning record<br>*A comprehensive service navigation app. |
| | | | |

# Appendix 4

## Report on Key Informant Consultations and Documentation – Page 16

| Topics | Intake Workers Network | Children's Treatment Network of Simcoe-York | CITYKIDS |
|---|---|---|---|
| | better gauge crisis and where to send youth.<br>*Some places have a crisis letter with a list of resources to send family as a F/U measure<br>*Compatibility of databases<br>*Maintaining choice for clients<br>*Ensure that connection to clients is quick.<br>Set response time guidelines.<br>*Linkages which allow access to other services & sectors<br>*Private practitioners?<br>*Navigation? Ability to follow-up and reconnect?<br>*Know the restrictions of each agency (e.g. catchment, diagnoses not accepted)<br>*Incorporate a data system with search and match capacity (i.e. as clinician types in client info, system finds agency matches based on key words, geographic location, diagnosis, age, etc.)<br>* CPA will need to differentiate itself from other similar access points in Toronto.<br>*Service should be more robust than 211; provide more than just information.<br>*Keep families in the loop re the status of their referral.<br>*Clearly define roles and expectations of the Intake workers at the receiving MCYS agencies | | |
| Information that CPA could gather to help you | *"Up to the minute" information concerning appropriate services, availability and location, including walk-ins | No information (CTN is not in Toronto) | |

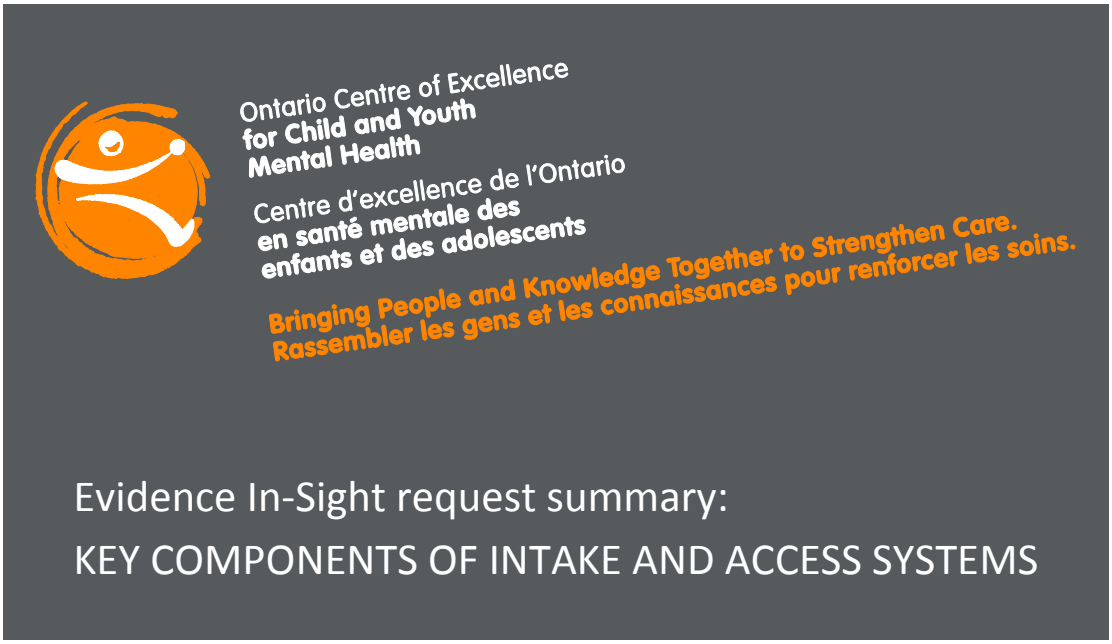
# Appendix 4

## Report on Key Informant Consultations and Documentation – Page 17

| Topics | | Children's Treatment Network of Simcoe-York | CITYKIDS |
|---|---|---|---|
| | *Reliable and efficient system for gathering and maintaining accurate information (will require agencies to keep their information up to date)<br>*Knowledge of waitlists but not waitlist management<br>*Information and processes that don't require families to repeat themselves (some database systems can help, e.g. CYSIS, but not everyone is using the same software)<br>*Ease of transferring consents - needs to be recorded electronically as some places won't take verbal consents<br>*Capacity to deal with complex families that require services from multiple sectors | | |

# Appendix 5

## Ontario Centre for Excellence for Child and Youth Mental Health
## Literature Review Report – Page 1

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# Appendix 5

## Ontario Centre for Excellence for Child and Youth Mental Health
## Literature Review Report – Page 2



### Contents

# Appendix 5

## Ontario Centre for Excellence for Child and Youth Mental Health
## Literature Review Report – Page 3



### How are intake, screening and assessment defined in the literature?

In the context of community based child and youth mental health services, **intake** is defined as the process that takes place between the client's first point of contact and the decision to admit or not admit the client to a program or service. The intake process includes screening, assessment and referral, and may or may not result in admission (U.S. Department of Housing and Urban Development).

Core components of an intake system include (U.S. Department of Housing and Urban Development):

- publicly available information on where and how to access intake
- a mechanism to access intake services, such as by telephone or through a walk-in session
- a screening and assessment process, and tools to gather information for service matching and prioritization
- information about available programs and service-providing agencies
- a process and tools for making referrals
- if needed, a process and tools for making decisions about program admission

**Screening** and **assessment** are part of a staged process to identify and measure mental health and substance use related needs and behaviours of children and adolescents. It can be challenging to determine exactly where screening ends and assessment begins. According to Grisso and colleagues (2005), screening provides "economical identification" and is done universally, whereas follow-up assessment is more selective involves a more extensive and individualized identification of mental health needs.

According to Rush and Castel (2011), mental health screening uses evidence-based processes and tools to identify individuals with mental health issues, or those who are at risk of developing mental health issues. It is meant to be an efficient way to identify the possible presence of a particular disorder and subsequently lead to a detailed assessment, treatment plan and delivery of services. Rush et al. (2013) conceptualize screening as three distinct stages:

**Stage 1:**
A primary screening tool is used to raise a red flag to the possible presence of an issue or group of issues or disorders.

**Stage 2:**
A more comprehensive/longer screening tool is used to probe further into one or more specific issues or disorders.

The brief assessment is a thorough, individualized identification of mental health and substance use strengths and needs for people whose initial screening results indicate the need for further investigation. Although brief, it needs to be thorough enough to sufficiently scan one or more issues.

**Stage 3:**
Assessment involves gathering information through the use of a tool that captures details that are used to provide brief intervention or a targeted referral and placement. Assessment also involves diagnosis and treatment planning. The purpose is to identify and implement evidence-informed treatment for specific disorders or problem areas. Information needs to be adequate for diagnosis and treatment planning and as such, requires clinical competence.

### Key components of intake and access systems

Mental health **triage** is defined as a clinical process conducted by a mental health clinician who prioritizes service type, need and urgency based on assessed and identified risk, need, disability and dysfunction (NSW Ministry of Health, 2012).

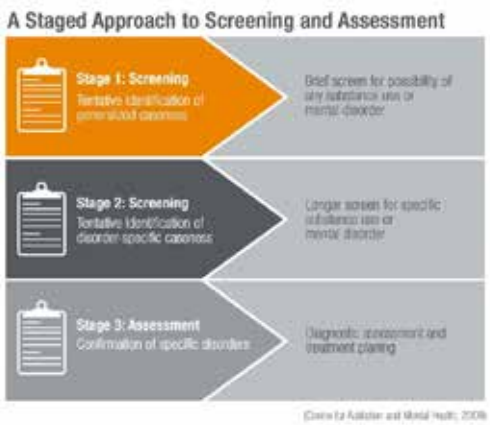


Figure 1: A Staged Approach to Screening and Assessment

## What are effective intake, screening and triage practices?

**Screening and assessment process considerations** (Rush, Rotondi, Furlong, Chau & Ehtesham, 2013)

- The specific characteristics of service users and the screening objectives vary, and these are used to determine the appropriate point of access to services.
- Appropriate screening and assessment practices and processes should be locally and contextually informed and relevant.
- If a youth presents to a specialized mental health service, a screening tool for substance use is usually recommended; if a youth presents to a specialized substance abuse service a screening tool to identify mental health issues is usually recommended.
- Particular characteristics of the service user population guide decisions about which screening tool is used (e.g. age) (Rush, Rotondi, Furlong, Chau & Ehtesham, 2013). The characteristics of the service user population, in particular their age range, will be critical to the selection of screening tools.

**Benefits to implementing a standard screening and assessment process** (Grisso et al., 2005; Rush et al., 2013)

- *Improved staff decision-making*: the three-stage screening and assessment process supports staff decision-making and helps to improve individualized support planning and treatment for clients.
- *Client engagement, motivation and the therapeutic alliance* are enhanced by good tools and a non-threatening and engaging interview approach.
- *Fulfilling regulatory requirements and professional standards*: services may be required to screen for concerns such as suicide risk. Services that screen for several health and social problems will likely opt for brief screening tools for substance use and mental health problems.
- *Managing resources*: a standard screening process helps to ensure consistency across clinicians, as well as comprehensive and coordinated access.
- *Outcome monitoring*: screening and assessment tools should provide information linked to the services that clients receive. It should be possible to link screening to outcome assessment.

The New South Wales Ministry of Health has a mental health triage policy that provides a number of recommendations for triage best practices (NSW Ministry of Health, 2012):

- As an entry point to mental health support and treatment, mental health triage services should take responsibility for the management of a client until transfer to the appropriate agency or person for follow-up.
- Mental health triage services are responsible for the delivery of appropriate and consistent services for all individuals seeking help for a mental illness.
- Mental health triage services are also responsible for facilitating a client's access to information on other services where a public mental health service intervention is not required.
- If a referral is made, every attempt should be made to speak to the referred service in order to complete the triage assessment process.

The triage clinician must (NSW Ministry of Health, 2012):

- identify symptoms of acute psychosis.
- identify possible suicidal behavior or thoughts.
- determine the level of risk of harm to self or others.
- determine whether there is a need for immediate follow up or whether a referral to another service should be considered.
- ensure that the client has a clear understanding of the triage process and subsequent follow-up actions.

### How effective is brief screening in matching clients to the right services?

A brief (or primary) screening tool serves the purpose of raising a red flag to the possible presence of an issue or group of issues or disorders (Rush & Castel, 2011). According to Rush et al. (2013), a three staged screening and assessment process is necessary for effective matching of a client to an appropriate service. Other literature suggests that brief screening tools are effective in identifying appropriate diagnoses and functioning, making it easier to match a client to the appropriate service (Boyle, et al., 2009; Cook et al., 2013).

The Children's Mental Health Priority Criteria Score (PCS) is a 17-item measure used for priority setting and waitlist management of children and adolescents referred for mental health services. A study by Cawthorpe and colleagues (2007) found that the PCS score was meaningfully related to clinician-perceived urgency, clinician perceptions of maximum acceptable wait times and triage to clinical settings that can address increaced urgency. Using this tool, mean differences for those accepted to community, day, or inpatient settings were significant. These findings demonstrate that the PCS appears to be an effective tool in clinical decision-making in matching more urgent cases to appropriate services and for use in priority-setting for children waiting for mental health services.

### What are effective screening, assessment and triage tools?

There have been a number of recent scans for screening instruments and tools. A working group in Toronto composed of agency directors and evaluators has been researching screening and assessment tools, using a rigorous methodology drawing on the literature and stakeholder input.

Members of this group are on Toronto's Knowledge/Information/Data System working and are available to collaborate with the Centralized Intake working group. Their research is very relevant to this report, but it is not included because it is in progress and should be presented in the context of methods, considerations and research goals.

*The Northern California Training Academy*

We found a review of the literature for The Northern California Training Academy (Williams, 2008) for measures used to screen and/or assess both mental health and/or social and emotional functioning across a wide range of children and adolescents. The intended age group was for children and adolescents ranging from less than 1 year to 18 years old. The review was within child welfare but findings are relevant to child and youth mental health since there was a focus on screening tools designed to identify children or adolescents at risk for mental health problems or those requiring further assessment, as well as tools to provide a complete mental and emotional assessment. The author included tools if 1) they could be applied to a range of ages, 2) measure clinically-relevant aspects of mental health, and 3) are appropriate for use in a social work or clinical practice setting. All tools needed to have acceptable reliability and validity psychometrics and have the option for multiple respondents (e.g. youth themselves, parents, teachers, and mental health professionals).

Tools were divided into three categories: screening and/or assessment, screening only and assessment only. After reviewing 95 measures, Williams (2008 suggests that tools that best fit these criteria are:

Screening:

- Behavioral and Emotional Screening System (BESS; ages 3-18)
- Ages and Stages Questionnaire – Social Emotional (ASQ-SE)

Assessment:

- Child and Adolescent Psychiatric Assessment (CAPA)/Preschool Age Psychiatric Assessment (PAPA),
- Behavior Assessment System for Children-2nd edition (BASC-2)

The author also suggests that the Child and Adolescent Needs and Strengths Assessment-Mental Health (CANS-MH) can be used with both a child and their caregiver to assess needs and strengths emerging from the mental health assessment and to guide treatment planning. As no single tool alone has been found to be sufficient, the review suggests possible combinations of measures to form the most comprehensive screening or assessment. (Williams 2008) also notes that no suitable assessment tools have been found for children under the age of two and instead recommends a referral to a clinician for a full assessment.

*Centre for Addiction and Mental Health*

As part of a review of the tools used for addiction service programs, the Ontario Ministry of Health and Long-Term Care commissioned a report to review measures for screening and assessment of concurrent substance abuse and mental health issues (Rush, Rotondi, Furlong, Chau & Ehtesham, 2013). After conducting a literature review, consulting with stakeholders and piloting tools at five Ontario agencies, the working group recommended that the Global Appraisal of Individual Needs (GAIN) be used to replace the existing tools used in publically-funded addiction service programs. A Centre for Addiction and Mental Health Modified version of the GAIN was selected for use as an initial screening tool and the GAIN-Q3-MI was selected as the accompanying assessment tool.

*Western Canada Wait List Project: Child Mental Health Priority Rating Tool*
An emerging tool that did not appear in any of the reviews is the Child Mental Health Priority Rating Tool, developed in Alberta. The tool has been adapted by an agency in Toronto and tested for triaging clients.

The Western Canada Wait List Project led the development of this tool in an effort to provide standardization and fairness in the face of long wait lists for child and adolescent mental health services in Canada. The tool was developed by a panel of mental health professionals including psychiatrists, psychologists, social workers, mental health administrators and a health services researcher. The tool consists of 18 items and was designed to be applicable across a broad age range (5-18 years) to prioritize referrals for treatment. The measure itself does not screen for mental health issues. The developers stress that the tool is meant merely to assist in the management of waiting lists and is not meant to replace clinical judgement for serious cases requiring immediate intervention. More information, including the tool itself and the user manual, is on the project's website:
http://www.wcwl.ca/tools/mental_health/

### What are best practices for warm transfers?

*Warm transfer* or *handoff* is an approach to care transitions in which health care providers directly link clients to another health care provider or specialist using face-to-face or phone transfer mechanisms (Richter et al., 2012).

Face-to-face transers: Tregunno (2009) investigated ways of improving client care transfer between healthcare professionals and facilities. Based on qualitative interviews with clients and healthcare professionals authors provided a list of key guiding principles:

- The transfer of accountability between healthcare professionals is an ongoing process.
- The involvement of the client and her/his family in decisions-making and processes of client care transfer is essential.
- The knowledge and skills required for successful transfer of accountability are consistent across all sectors and health care providers.
- There is a sense of ownership and sustainability when transfer processes are developed at the local level with staff input.
- While knowledge and skills are important in transfers of client care, the use of good clinical judgment in the context of each client situation is a key to successful outcomes for clients and their families.

The *Safe Clinical Handover* report is a resource that provides recommendations for the safe transfer of client care between hospitals and general practice settings. It discusses why safe handover is important, essential elements for how to do it and when to do it (NSW Agency for Clinical Innovation, 2013).

Recommended practices include:

- The client and her/his family should be involved as partners in the transfer of care decision-making process.
- An infrastructure to support healthcare professionals to have access to electronic patient data in the hospital should be developed.
- Clear communication is essential for safe transfers of care. Clinical judgement will be

required to determine the appropriate method.
- Medication reconciliation should occur at every transition of care to ensure a complete and accurate list of medications is available in the patient record.
- A client, her/his family and other care givers should leave the hospital with a copy of their discharge communications, which should include an ongoing management plan.

**Telephone transfers**: This type of warm transfer takes place when a client is moved from one crisis line to another or from the crisis line to a service provider.

We asked two people with years of experience working at telephone intake and referral programs and they provided these recommendations:

> *"From a first-hand perspective I know that warm transfer procedures should not be a 'set in stone action' but are best when described in the ideal, then working within the actual transaction or scenario as it occurs. For example, you will have people that won't want to be transferred for numerous reasons - not ready, display independence, etc. On the other extreme you will have people who only want to be warmed transferred. For most callers, a warm transfer is a nice option but all that is really necessary is what we call a blind transfer – where the call is transferred (no need to redial) but there is no introduction of the caller or situation." (Jacky Roddy, partnership coordinator at Good2Talk: Ontario's postsecondary helpline)*

> *"…warm transfers might be the ideal, but [they are] not always possible or needed. I think the key is the messaging given to the caller, i.e. around the service they are being transferred to, whether they may end up in a queue and need to wait, etc. And giving them the information they would need to contact directly if for whatever reason the transfer doesn't go through, they get cut off, etc. Where possible, if the caller wishes it, the best service would be to warm transfer, i.e. keep caller on the line, contact the other service, make sure the two are connected before hanging up, but in reality, unless you get through the first time, it is unrealistic to have staff holding in a queue with a caller…" (Anne Counter, Director of Information and Referral Services at ConnexOntario)*

According to the Canadian Information and Referral Standards, the following are best practices for connecting clients to mental health services after a client has made contact (including through the telephone):

- Make initial contact with a service provider to verify eligibility or service availability. Notify the service provider that the client will be contacting them or schedule an appointment on behalf of the client.
- Initiate a warm transfer using 3-way calling technology to contact an agency and introduce the client and his or her situation before ending one's own participation in the call.
- With the client's and organization's permission, listen in on a call or sit in on an interview while the client

explains the situation. Provide assistance only when necessary.
- Represent the client when s/he is unable to explain her or his own situation. For example, when a child or family faces barriers to accessing services (e.g. because of language, age, physical or developmental disabilities, communication impairments, mental health issues, poverty, etc.), support and representation may be helpful.
- Negotiate on behalf of clients when a request for service has been denied if the receiving agency did not receive accurate or complete information about the client or his/her situation. Negotiating is also recommended if an agency acts in violation of its own policies or the law (Inform Canada, 2013).

### What are the best ways of building links across sectors to enable efficient and effective referrals outside the child and youth mental health sector?

A report on developing mental health pathways and partnerships in Toronto for children and youth presents the following best practices for facilitating relationships with community partners (CAMH, 2013).

- *Ensure trust between partners*, is fundemental to successful partnerships. It might take time to develop relationships with a foundation of trust, but these are critical to the success of partnerships.
- *Develop an open system of communication*. Determine how conversations will be facilitated with partners. Will they be face-to-face meetings, emails or through teleconference?
- *Work toward the community's vision*. Know what the mental health vision is for your community and work to contribute to this vision. For example, if your community is focusing their resources around suicide prevention, examine how you can be a resource. You want your organization to be known as a partner and contributor.
- *Develop a positive view of each other's role*. Show a genuine interest in the work of other community partners and the different role(s) of the staff.
- *Acknowledge*. When presenting to an audience, acknowledge the importance of the community partners when warranted.
- *Respect the unique culture of each of the partners*. Every organization has a history of what they offer and why. Respect this history and the work that they do. Always look for opportunities to partner in order to streamline services.
- *Invite people to partner*. When planning, think of how your community partners may want to be involved and invite them to be part of the planning committee.
- *Challenge each other*. As the relationship grows, think about what things could be changed to address different issues, implementing integrated service delivery takes time and continuous modification (CAMH, 2013).

There are several models of cross-sector coordination of mental health services and referrals. Coordinated Access, System of Care, and the Choice and Partnership Approach are some examples of models currently being used or piloted in Ontario.

### Key components of intake and access systems

**Coordinated Access** (Ottawa Children's Coordinated Access & Referral to Services):

Coordinated Access and Referral is a case management system designed to provide recommendations and referrals for families, children and youth who have complex needs and are experiencing difficulties gaining access to services and support in the community.

The *Coordinated Access* model, informed and shaped by the system of care philosophy, is a good example of how to build links across sectors to ensure appropriate and meaningful referrals to services for children and youth with complex mental health and/or developmental needs. (Coordinated access, 2015; see http://coordinatedaccess.ca/referral-process/mental-health-sector/application-form/ or http://coordinatedaccess.ca/wp-content/uploads/2015/11/Application-Form-Mental-Health-2015-20161.pdf for more information).

Coordinated Access uses the guiding principles of the System of Care model, including inter-agency and cross-sectoral collaboration, family-centered care and youth engagement to improve services, access to services and supports for children, adolescents and their families.

**The process of coordinated access** (Ottawa Children's Coordinated Access & Referral to Services):

Professionals submit an application to *Coordinated Access* on behalf of children/adolescents and their families to receive referrals and recommendations for a number of services and supports (e.g. in-home services, day treatment, residential services, addiction services, respite, etc.). Any professional from the mental health sector, youth justice services, school boards, child protection services or the developmental service sector may apply for services when past and/or current attempts to receive community-based treatment have been unsuccessful.

**System of Care Philosophy** (Technical Assistance Partnership for Child and Family Mental Health):

A system of care is a coordinated network of community-based services and supports that are prepared to meet the challenges of children and youth with serious mental health needs and their families. System of Care has been most commonly developed and implemented in the U.S., although there are examples elsewhere. Ottawa's coordinated access model, for instance, has used the System of Care Practice Review as a method to evaluate service coordination (see http://coordinatedaccess.ca/community-projects-and-involvement/system-of-care/).
In a system of care, families and youth work as partners with organizations to design mental health services and supports that are effective, that build on strengths of individuals, are client-centered, and that address each person's cultural and linguistic needs. Evaluations and research conducted on System of Care have found that the approach is effective in producing positive outcomes for children and youth with complex mental health needs (Manteuffel, Stephens, Brashears, Kriveloyava, & Fisher, 2008).
For more information on the system of care, and to learn about its core values and guiding principles, you can visit the "Technical Assistance Partnership for Child and Family Mental Health" website by clicking here.

**The Choice and Partnership Approach (CAPA)** (Child and Adolescent Mental Health Services Network, 2013):

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### Key components of intake and access systems

CAPA is a service transformation model that combines collaborative and participatory practice with service users to enhance effectiveness, leadership, skills modeling and demand and capacity management. CAPA was developed in the United Kingdom and is spreading internationally. For instance, the Children's Hospital of Eastern Ontario is piloting CAPA in its mental health outpatient program.

CAPA brings together:

- the active involvement of clients
- demand and capacity ideas
- lean planning and implementation methods

Services can then:

- have a clear working goal with the service user.
- involve clinicians with the appropriate clinical skills.
- be provided without any external or internal wait times.

CAPA:

- is flexible and can be tailored to fit individual services.
- focuses on engagement, therapeutic alliance, choice, strengths, goals and care planning.
- improves access by ensuring timely appointments that are fully booked.
- ensures service users are seen by a clinician with the appropriate skills.
- uses outcome measures.

CAPA does not suggest what specific services or interventions to provide, but helps the organization develop a client-centered/client-led service that is accessible and outcome-focused.

CAPA uses The 5 Big Ideas that are different from more traditional clinical systems.

The 5 Big Ideas are:

- choice
- core and specific partnership work
- selecting core partnership clinician
- job planning
- peer group discussion

Choice is about the philosophy of collaborative practice and being client-centered. The middle three focus on finding the right person to work with the client in partnership, which means knowing the skills and personalities in the team, leading to job planning. Peer group discussion focuses on the goals of the service user and how they are progressing.

To learn more about The Choice and Partnership Approach (CAPA) click here.

### How can technology be used in intake? Are there apps or web-based programs that allow young people to connect with centralized point of access?

E-mental health is considered a promising approach for maximizing the efficiency and cost-effectiveness of mental health services (Lal & Adair, 2012; Taylor, 2015). Young people find technology-based mental health supports to be enjoyable, desirable and sometimes even more engaging than traditional modes of communication (Larion, 2014).

Most of the literature on e-mental health is on interventions for specific disorders or difficulties (i.e. web-based programs or apps which are primarily client-initiated and focus on the self-management of symptoms [Forchuk et al., 2015]; see this resource

for a recent list of mobile applications to support mental health and addictions issues). We focused our search on digital technologies designed to enable communications and connections between young people, families and practitioners (i.e. integrated technologies; Taylor, 2015), but found very little research or grey literature on digital technologies used for intake purposes, including centralized intake. There is, however, a small body of information on integrated technology for service delivery that might be applicable to intake.

**E-counseling**. Headspace (a youth mental health service platform in Australia) offers an e-counselling service (online or via telephone) for young people with mental health concerns. The service is open between 9:00am and 1:00am, seven days a week, where youth can connect with a counsellor for 30-60 minutes on average and chat with them about their concerns. The service aims to reach those who may not be able to easily access a Headspace facility because of geographical reasons, or those who do not feel ready or comfortable to speak to a mental health professional in person.

Increased accessibility and convenience, anonymity and comfort for clients are commonly cited advantages to e-counseling (Harris & Birnbaum, 2014; Shiller, 2009). Research highlights the potential of online counselling to address some of the key practical barriers to in-person support services, including distance from services and transportation costs (Harris & Birnbaum, 2014; Shiller, 2009). E-counseling may also offer a 'safer' space for youth to discuss personal challenges (Harris & Birnbaum, 2014; Shiller, 2009). Research has found that youth sometimes prefer making a first contact with the service system online because it is less anxiety-provoking than in-person appointments or even phone calls (Havas, Nooijer, Crutzen & Feron, 2011; Larion, 2014), although they do remain open to making a follow-up, face-to-face appointment after this initial online contact (Havas et al., 2011). Challenges of e-counseling include difficulty meeting a client's immediate or crisis needs (e.g. suicide risk, abuse) and technological issues (Harris & Birnbaum, 2014). Implementation should be informed by a careful consideration of ethical and practical barriers. Refer to a paper by Shiller (2009) from East Metro Youth Services for practice guidelines.

**Internet-based screening**. We found one article (Diamond et al., 2010) describing an internet-based brief screening tool (Brief Health Assessment; BHS) for youth with mental and behavioural health needs, originally developed for use in primary care. The questionnaire can be completed by youth online (in under 13 minutes on average), and its results can be printed and brought to the youth's first appointment with a service provider, helping them maximize the time spent during this first contact. The program automatically scores the data, generates a report and populates forms for appropriate documentation. The developers of the BHS say internet-based screening tools help to standardize assessments, solve common problems with administration, interpretation and data integration, and increase overall staff efficiency and case identification rates (Diamond et al., 2010).

The BHS has not been independently tested. Diamond and colleagues (2010) evaluated the BHS with 24 young people (aged 14.9 years on average) and found that youth liked the software (75%), understood the questions (96%), answered questions honestly (92%), thought it should be used for future appointments (92%) and found it helpful during the appointment (94%). The researchers also recruited 415 adolescents (aged 12 to 21 years) to test the instrument's psychometric properties (i.e. internal consistency, convergent and divergent validity,

sensitivity and specificity), all of which were reported as adequate to strong (Diamond et al., 2010).

### Are there any advantages for psychoeducation information attached to website or another form of technology?

Poor mental health literacy is a recognized barrier to help-seeking among youth (Gulliver, Griffiths & Christensen, 2010) and research has found that web-based psychoeducation on mental health can increase rates of help-seeking. In a randomized controlled trial of 67 youth aged 18-25 years, a brief, online psychoeducational intervention on mental health increased youth's literacy on anxiety disorders, decreased depression stigma, and instilled more positive attitudes towards help-seeking and intentions to seek help (Taylor-Rodgers & Batterham, 2014). Research also supports an association between psychoeducational information and young people's readiness for services. In a review of 89 engagement interventions from 40 randomized controlled trials in children's mental health services, psychoeducation was the technique most frequently used in interventions that showed success in helping youth cognitively prepare for services. Interventions that are most successful in promoting youth's attendance in services also frequently use psychoeducation as a primary engagement technique (Becker et al., 2015).

Providing psychoeducational information online may thus be an effective low-cost, low-intensity intervention to foster better knowledge of mental health in young people and encourage their use of and readiness for services. Researchers recommend that online mental health information and materials be included in multiple media (e.g. links to resources, animated videos, videotaped presentations, social media and blog integration, etc.) with a careful attention around language, tone and word selection in order to appeal to a diverse range of young people and families (Carew, Kutcher, Wei, & McLuckie, 2014).

### Would it be helpful to post information in the form of bibliotherapy (on website or other forum) for clients?

While research supports the utility of psychoeducation as a tool to help modify certain attitudes and behaviours around mental health, as outlined above (Bonsack, Rexhaj & Favrod, 2015), bibliotherapy goes beyond that and refers to the more intensive use of written instruction materials as a therapeutic tool (Pehrsson and McMillen, 2007). More specifically, bibliotherapy exists in the forms of self-help programs or self-directed therapies (i.e. self-guided cognitive behavioural therapy for specific disorders), provided in purchasable books and carried out with or without the guidance of a mental health professional (Gregory et al., 2014; Montgomery & Maunders, 2015; O'Brien & Daley, 2011). Most of the information we found in this search pertained to the latter, which falls outside the scope of the type of information that would be provided on a centralized intake website.
Self-help approaches, more broadly speaking, have been shown to be well accepted by youth (aged 12 years and up) and their families and can help them manage mild to moderate symptoms of mood, anxiety, and other disorders (Gregory, Canning, Lee & Wise, 2004; O'Brien & Daley, 2011; Pennant et al., 2015). In addition, youth are increasingly inclined to seek information and support around mental health problems online (Carew et al., 2014; Lal & Adair, 2014) and are likely to try the latter first before seeking professional help (Radhu, Daskalakis, Arpin-Cribbie et al., 2012).

# Appendix 5

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### What are some examples of evaluation frameworks for centralized points of access?

See Appendix A.

### Report context

The following Evidence In-Sight report involved a non-systematic search and summary of the research and grey literature. These findings are intended to inform the requesting organization, in a timely fashion, rather than providing an exhaustive search or systematic review. This report reflects the literature and evidence available at the time of writing. As new evidence emerges, knowledge on evidence-informed practices can evolve. It may be useful to re-examine and update the evidence over time and/or as new findings emerge.

Evidence In-Sight primarily presents research findings, along with consultations with experts where feasible and constructive. Since scientific research represents only one type of evidence, we encourage you to combine these findings with the expertise of practitioners and the experiences of children, youth and families to develop the best evidence-informed practices for your setting.

While this report may describe best practices or models of evidence-informed programs, Evidence In-Sight does not include direct recommendations or endorsement of a particular practice or program.

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We appreciate your responding to a brief satisfaction survey that the Centre will e-mail to you within two weeks. We would also like to schedule a brief phone call to assess your satisfaction with the information provided in the report and to discuss possible next steps. Please let us know when you would be available to schedule a 15-minute phone conversation.

Thank you for contacting Evidence In-Sight for consultation on your question. Please do not hesitate to follow up with the lead author or to contact us at 613-737-2297.

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### Search terms

We used the following terms or combination of terms to find literature pertaining to each of the following questions:

***How are intake, screening and assessment defined in the literature?***

intake, screening, assessment, triage, definition of mental health intake, definition of mental health screening, definition of mental health assessment, definition of mental health triage

***What are effective intake, screening and triage practices?***

intake, centralized intake, assessment, screening, triage, best practice, child and youth mental health, practices

***How effective is brief screening in matching clients to the right services?***

effectiveness of brief mental health screening, best practice brief screening, best practice mental health brief screening, effective mental health screening practices, effective brief screening tools

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### Key components of intake and access systems

***What are effective screening, assessment and triage tools?***
screening tools, child and youth mental health, developmental screeners, intake, assessment, mental health measures

***What are best practices for warm transfers?***
warm transfers, client care transfer, hand-off, hand-offs, mental health, crisis line, clinical handover, best practice(s)

***What are the best ways of building links across sectors to enable efficient and effective referrals outside the child and youth mental health sector?***
building partnerships across sectors, referring across sectors, best practices for linking referrals across sectors, cross-sector referral coordination, cross-sectoral coordination of services, centralized intake referral coordination, coordinated referral

***How can technology be used in intake? Are there apps or web-based programs that allow young people to connect with centralized point of access?***
technology, web-based, internet, internet-based, digital, apps, e-mental health, e-counseling, online, intake, screening, mental health

***Are there any advantages for psychoeducation information attached to website or another form of technology?***
psychoeducation, literacy, mental health, information

***Would it be helpful to post information (on website or other forum) for clients?***
bibliotherapy, self-help, web-based support, mental health, children, youth, adolescents

***What are some examples of evaluation frameworks for centralized points of access?***
evaluation framework, centralized intake, key performance indicators, centralized access, single-point access, effectiveness

## Appendix A

**Sample frameworks for evaluating intake services**

Below are four examples of evaluation frameworks of centralized intake services. Two are from existing child and youth mental health centralized intake providers. Two are from fields outside of mental health, but they provide clear examples of the process of developing elements of the evaluation or performance measurement framework of the service.

**Contact Brant for Children's and Developmental Services - Evaluating the Provision Single Point Access Mechanism to Children's Services in Brant** (Shaw, Chmiel, Ruman & Angus, 2013)

Contact Brant developed a logic model (see appendix) and evaluation matrix to help guide the development of a data collection tool to be used for ongoing evaluation of the service. Contact Brant is a single-point service for children and youth ages 0-18 with mental health concerns or intellectual disabilities whose primary objective is coordinated information, intake and referral, and service coordination in the City of Brantford and the County of Brant. Contact Brant does not provide any therapy or programs of its own and the goal of its intake and referral service is to ensure that children and their families access the most appropriate community services at the right time. Contact Brant refers to a number of agencies, including: St. Leonard's Community Services, Woodview Mental Health and Autism Services, Six Nations Child and Family Services, Ontario Early Years Centre Brant, CPRI, and many others. Based on the logic model, key evaluation questions were:

| Evaluation questions | |
|---|---|
| Process | Were clients clear on what services that Contact Brant provides? |
| | Were clients satisfied with services received? |
| | Are Contact Brant services provided in a professional manner? |
| Outcome | Do clients experience greater awareness of community resources? |
| | Do clients experience decreased frustration? |
| | Do clients experience feelings of increased support? |
| | Do clients experience feelings of greater personal empowerment? |

Data on these questions were collected via a client satisfaction survey, developed specifically to provide insight to these questions. The survey was administered either following the interview with the client or by telephone at a later date. Although the BCFPI is used at intake, scores from this measure were not used as part of the evaluation.

**Evaluating the efficiency and effectiveness of the Durham Central Intake System in meeting the needs of clients, service providers, and the community.** (Mulvihill, 2008)

Kinark Child and Family Services developed a logic model and evaluation framework to help guide the evaluation of Centralized Intake in Durham. The evaluation framework specified:

### Key components of intake and access systems

- What the Central Intake aims to achieve
- How services are delivered, and how well
- Measures
- Users of Durham Centralized Intake (including clients, partner agencies, referrals sources, etc.)
- Impact/Outcome of Service
- Currently provided services and service activities

Using the evaluation framework, the purpose of the evaluation was to:

1. Support the coalition to better understand the evaluation process and make use of existing data
2. Support partner agencies in their work
3. Meet issues of quality assurance and evaluation
4. Bring frontline expertise to the evaluation process
5. Increase the capacity of the evaluation and research for partnering agencies
6. Develop an evaluation process for this initiative.

The evaluation framework focused on objectives of Durham Region's centralized intake at four levels: client level, staff level, program level and partner level. Specific indicators are as follows:

| Level | Objective | Indicator |
|---|---|---|
| client | high satisfaction with intake services | high ratings on items related to satisfaction with services (timeliness, ease of access, responsiveness) |
| | Increased awareness of & connection to of community services | high ratings on items related to awareness and ability to access community services |
| | perceived to be referred to *right* service | high ratings on items related to *fit* of services based on need and desired |
| staff | experience of effective and efficient services | high ratings on items related to satisfaction with services |
| | high satisfaction with services | high ratings on items related to satisfaction with services |
| program | rapid response to voice mail (within 24 hours) | average length of response to voice mail message less than 24 hours |
| | short call back times 2nd appointment (> 8 days) | average number of days for second phone appointment less than 8 days |
| | high level of calls with live response | more than 60% of calls answered live |
| | acceptable level dropped calls | less than 10% of calls dropped |
| | streamlined process (clear, minimal steps to services) | low number of call backs and re-referrals |
| | referrals matched to client needs and capacities | high percentage of clients matched to appropriate services based on BCFPI and KIDS referral data |
| partner | high satisfaction with service | high ratings on questionnaire items related to |

| | | |
|---|---|---|
| | | satisfaction with services (access, care, communication, overall assessment) |
| | delivery of intake processes (BCFPI) facilitated | high ratings on questionnaire items related to BCFPI facilitation |
| | increased understanding of client profiles (BCFPI) | profiles and analyses of BCFPI data |
| | referrals appropriate to services provided | high degree of correspondence between partners services and BCFPI and referral data |
| | timely feedback on status of referrals | high ratings on items related to satisfaction with services |
| | increased direct service to clients | number of hours of services provided directly to clients in place intake and BCFPI interviews |
| | increase integration of community services | number of community partnerships, events, funding opportunities |

**Development of key performance indicators to evaluate centralized intake for patients with osteoarthritis and rheumatoid arthritis** (Barber et. al, 2015)

This study describes the process followed to develop a set of key performance indicators to evaluate centralized intake systems for arthritis care in Alberta. Based on the existing provincial quality framework, five dimensions were used to guide the development of key performance indicators:

| | |
|---|---|
| Appropriateness | Whether services are delivered according to best practices and relevant to user needs |
| Accessibility | Whether services are delivered in a timely manner |
| Acceptability | Whether services are responsive to user expectations and preferences |
| Effectiveness | Whether services are based on knowledge to achieve the best outcomes |
| Efficiency | Whether services are optimally used |

Key performance indicators were developed over a three phase process:

1. Establishing measurement priorities: meetings held with various stakeholders such as healthcare providers, managers, researchers, patients and patient engagement researchers. Attendees were asked to define priorities around the perceived impact of the indicator, the provider's influence over performance on the indicator, and the feasibility of measurement.
2. Review of the literature to support development of potential key performance indicators: drew from various sources including two existing sets of measures, the grey literature and the European Musculoskeletal Conditions Surveillance and Information Network.
3. Finalization of indicators via online panel: 3 round process to finalize key performance indicators
    a. Rating based on: scientific validity, face validity, feasibility, importance and likelihood of use on a 9 point Likert scale
    b. Review results from round one and conduct online and in person meeting to review key performance indicators.

c. Final voting with same criteria as round one. Included key performance indicator if it scored seven or higher for validity and importance

When determining the scope of the key performance indicators to be selected, the following three strategic decisions were made:

1. All major steps along the patient flow process, from referral submission, to screening and triage, and to diagnosis and treatment would be captured. Existing guidelines and high quality evidence was sought for established key performance indicators for each step. Professional consensus was deemed an acceptable level of evidence for development and inclusion of a key performance indicator in the absence of established guidelines or existing high quality evidence.
2. Long term patient outcomes as a result of treatment were determined to be outside of the scope of the evaluation on access and intake.
3. Safety indicators (e.g. drug monitoring) were not included as the role of centralized intake is to facilitate access to the most appropriate provider in a timely fashion, but it does not necessarily include treatment of patients and subsequent safety monitoring.

| Key performance indicators | |
|---|---|
| **Rheumatoid arthritis–specific** | Time from RA referral receipt to referral completion for initially incomplete referrals |
| | Percentage of RA referrals received with complete information |
| | Waiting times for rheumatologist consultation for patients with new-onset rheumatoid arthritis |
| | Time to disease-modifying antirheumatic drug therapy for patients with new-onset RA |
| | Percentage of patients with new-onset RA with at least one visit to a rheumatologist in the first year of diagnosis |
| | Rheumatologists per 100,000 population |
| | Waiting times for patients with established RA |
| | Percentage of rheumatoid arthritis patients treated with a disease-modifying antirheumatic drug during the measurement year |
| | Ratio of patient flow to clinic capacity of RA teams participating in centralized intake |
| | Agreement of centralized intake suspected diagnosis versus confirmed diagnosis of RA |
| **Osteoarthritis-specific** | Time from OA referral receipt to referral completion for initially incomplete referrals |
| | Percentage of OA referrals received with complete information |
| | Time from receipt of complete OA referral to musculoskeletal appointment |
| | Percentage of OA referrals scored using Western Canada Waiting List priority referral criteria |
| | Distribution of OA referrals in each urgency category (as scored using the Western Canada Waiting List referral tool) |
| | Percentage of OA referrals triaged as highest urgency based on high Western Canada Waiting List priority criteria scores seen within Wait Time Alliance benchmarks |
| | Ratio of patient flow to estimated clinic capacity of OA teams participating in centralized |

| | |
|---|---|
| | intake |
| | Operating room time for arthroplasty surgeons in Alberta |
| | Agreement of centralized intake suspected diagnosis of severe OA cases (e.g., patients who are candidates for hip or knee joint replacements) versus confirmed diagnosis of severe OA |
| **Applicable to both** | Percentage of patients who receive information regarding resources and tools available for management while waiting for first musculoskeletal specialty contact |
| | Percentage of referrals rejected or redirected when received at centralized intake |
| | Percentage of musculoskeletal appointments completed as scheduled |
| | Percentage of specialist providers participating in centralized intake |
| | Number of referrals received through centralized intake |
| | Patient experience with centralized intake |
| | Referring clinician's experience with centralized intake |
| | Musculoskeletal specialty care provider experience with centralized intake |
| | Administrative staff and allied health professional experience with centralized intake |

# Appendix 5

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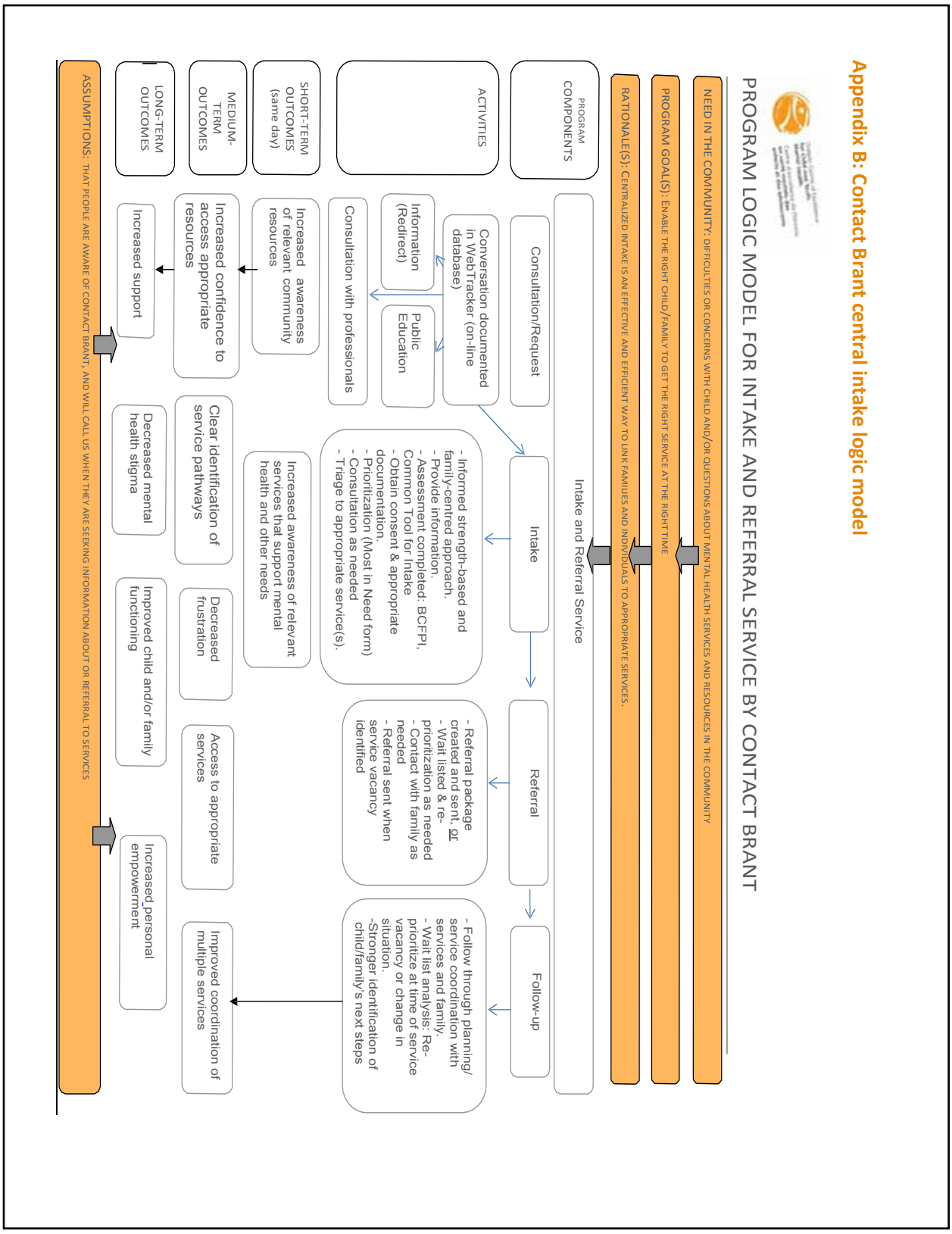
**Appendix B: Contact Brant central intake logic model**



# Appendix 5

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## Literature Review Report – Page 22

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# Appendix 6

## Reports Reviewed by the CPA Working Group

1. *Report on Key informant Consultations and Documentation*, Centralized Point of Access Working Group, Nov 2015
2. *Recommendations on the access and service coordination model for the MCYS-funded service system in Toronto region*, Report to Toronto Region Ministry of Children and Youth Services from the Central Table, June 2012
3. *Access to child and youth mental health services*, Ontario Centre of Excellence for Child and Youth Mental Health, Aug 2015
4. *Self-help resources and bibliotherapy*, Ontario Centre of Excellence for Child and Youth Mental Health, May 2012
5. *Best practices in mental health intake and referral*, Ontario Centre of Excellence for Child and Youth Mental Health, July 2011
6. *Building a child and youth mental health service system of excellence in Toronto*, Report by the Toronto Implementation Panel, Sept 2013
7. *MCYS Access and Service Coordination Report*, KPMG, August 2011
8. *System of Care Practice Review*, Ottawa Children's Coordinated Access and Referral to Services, 2009

# Appendix 7

## Report to Toronto Region Ministry of Children and Youth Services From the Central Table – Page 1

**RECOMMENDATIONS ON THE ACCESS & SERVICE COORDINATION MODEL FOR THE MCYS-FUNDED SERVICE SYSTEM IN TORONTO REGION**

**Report to Toronto Region**
**Ministry of Children and Youth Services (MCYS)**
**From the Central Table**

**June 2012**

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# Appendix 7

## Report to Toronto Region Ministry of Children and Youth Services From the Central Table – Page 3

**Members of the Central Table**

| | |
|---|---|
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| David Rivard<br>Chief Executive Officer<br>Children's Aid Society of Toronto | Karen Engel<br>Executive Director<br>Yorktown Child and Family Centre |
| Karen Turner (Chair)<br>Community Programs Manager, Children's Services<br>Toronto Region- MCYS | Lynne Lucas<br>Program Supervisor<br>Toronto Region-MCYS |

### BACKGROUND

In 2008, Toronto Region-MCYS (Toronto Region) commissioned an evaluation of the Service Coordination Protocol that was established in 2000 as part of Making Services Work for People (MSWFP). The evaluation was undertaken by the former Children's Services Network. The final report identified changes to the model over time and a number of challenges with the current multi-agency access model and service coordination protocol from the perspective of service providers[1]. Subsequent to the introduction of this protocol several services and features have been added to the service delivery system, which also perform access and service coordination functions, in response to the limitations and complexities of the system in Toronto[2].

More broadly, improving access, coordination, and responsiveness have been consistently identified as priority areas for reform in human service systems across Ministries. As such, Toronto Region prioritized the development of an effective model of Access and Service Coordination for the MCYS service system in Toronto[3], and it was included in the Central Table's Work Plan as a principal project. In addition to improving the experience of children, youth and families with the system, a key aspect of this project is the development a model that could be complementary and supportive to other sectors such as health and education.

This report reflects work that has occurred since the Fall 2010.

### PURPOSE AND SCOPE

The purpose of the project was to develop a coherent and equitable process for children, youth and families to access the services they need, as quickly as possible, in a systematic manner, from the first point of contact and throughout their ongoing involvement in the service system. For the purpose of this project, the scope of application for the new model is the Toronto Region MCYS-funded service system (see Appendix A).

The conceptual model outlined in this report reflects a shared vision for a more collaborative and integrated approach to meeting the needs of children, youth and families in Toronto. It necessitates considerable change and re-alignment across the system and will require a thoughtful implementation approach.

### THE PROCESS

This project commenced in the Fall 2010 and the approach included:

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[1] Jarmain, Janice. (2008). *To Serve the Children* Service Coordination Protocol Review and Evaluation Report. Toronto, Ontario.

[2] Examples of system features include Whatever It Takes and the Children's Services Consultation and Review Committee (former Service Resolution Toronto).

[3] Toronto Region is part of the Service Delivery Division of the Ministry of Children and Youth Services (MCYS). The Toronto Region mandate does not include the programs, services and mechanisms funded through Central Region of MCYS-Youth Justice Division.

- a project steering committee (a subgroup of the Central Table - see Appendix B);
- consultations and key informant interviews (see Appendix C)
- a current state assessment;
- jurisdictional review;
- compilation of an inventory of current access and service coordination mechanisms in the Toronto Region related to children and youth services (see Appendix D);
- identification of key components and functions of access and service coordination;
- analysis of model options;
- consultation with and input from the Aboriginal Working Group (see Appendix E);
- development of a conceptual model;
- key implementation considerations.

In the Spring 2011 KPMG was engaged to complete the related project work, examine conceptual options and recommend a model.

**ROLE OF THE CENTRAL TABLE**

The defined role for the Central Table was to provide advice on the project plan, identify key stakeholders, provide input to key deliverables, and to work from the KPMG proposed conceptual model and recommend key considerations during detailed design and implementation. This included: establishing principles for the new model, identifying potential barriers to specific populations, clarifying and refining key functions and corresponding roles and responsibilities, identifying implications for existing system features as well as additional processes that may be required to augment the model for the Toronto context. The Central Table's role did not include the costing analysis, human resources, resource allocation, setting new expectations and requirements for service providers, or the alignment of existing system features.

## THE KPMG REPORT

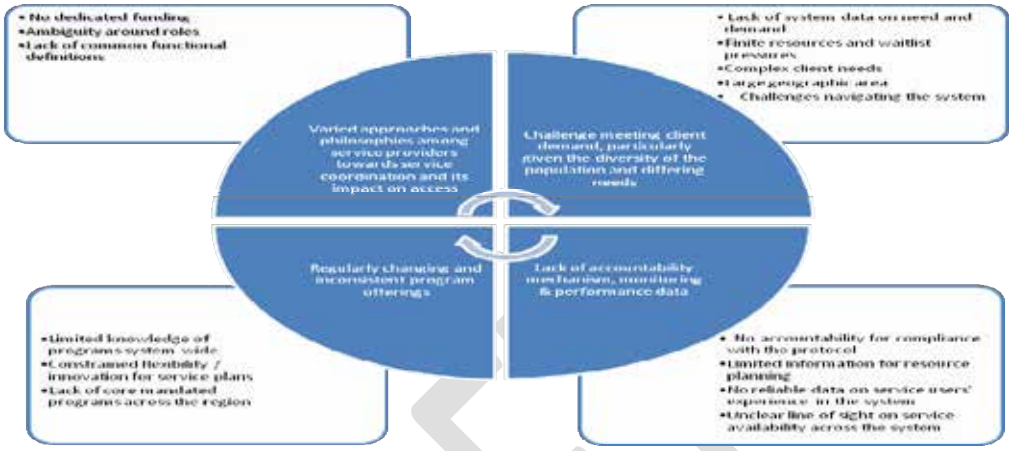
**CURRENT STATE AND THE CASE FOR CHANGE**

Through stakeholder interviews and the review of reports on the current protocol and other related system features, KPMG affirmed a number of issues and challenges with the Toronto model and the need for a new approach.

Figure 1 below summarizes the persistent issues and limitations[4].

[4] KPMG. (2011). MCYS Toronto Region Access and Service Coordination Final Report.

Figure 1




**KEY FINDINGS FROM THE JURISDICTIONAL SCAN AND LITERATURE REVIEW**

KPMG selected jurisdictions that have employed example models along the access and service coordination continuum. Table 1 provides a summary of jurisdictions and the attributes of their respective models[5].

Table 1

| Location | Name of Organization/ Program | Sector | Unique Features Relevant to Toronto Region | Model Type |
|---|---|---|---|---|
| United Kingdom | National Early Support Program (Key Service Worker) | Developmentally Disabled Children and Youth | Similar to current Protocol in the Toronto Region | Disaggregated Service Coordination |
| Ontario | Contact Hamilton | Children's and Youth Mental Health | Ontario-based | Centralized Access |
| Ontario | Whatever It Takes (WIT) | Children's and Youth Mental Health | Toronto-based collaborative model | Centralized Service Coordination |
| Victoria State, Australia | Child FIRST | Child Welfare | Aboriginal communities, high risk populations | Centralized Access and Service Coordination |

The following considerations emerged in the jurisdictional and literature scan:

[5] KPMG. (2011). MCYS Toronto Region Access and Service Coordination Final Report.

1. Advancing integration is a priority across jurisdictions, but there is not yet a path to achieve successful service integration that can be generalized.
2. There are appreciable benefits to families if a centralized access model is well designed.
   - Centralized information databases have provided useful data for planning programs and directing investments in the system
   - Centralized Access and Service Coordination can streamline processes across organizations to clarify roles and responsibilities.
3. Studies indicate that a single point of contact for service coordination eases the burden on families.
   - Evidence suggests that service coordination specifically betters relationships with service providers and access to services, as well as decreases levels of stress.
4. Even centralized systems must cope with waitlists and struggle to reach the most vulnerable communities.
5. Significant investment is required to develop working relationships, protocols, and procedures across agencies and sectors.
6. A formalized Access and Service Coordination system must remain community-focused and adaptable to engage harder-to-reach populations, such as Aboriginal, francophone, and equity-seeking communities.

**RECOMMENDED MODEL IN THE KPMG REPORT**

KPMG recommended a centralized access and service coordination service for children, youth and their families, service providers, relevant professionals and stakeholders, which facilitates integrated, equitable client access to the right services as quickly and directly as possible, in a coordinated and systematic manner. Integral to the recommended model is a new entity to fulfill the functions of access and service coordination as well as the creation of a centralized database.

**Functional Components of the KPMG Proposed Model**
The model proposes a centralized entity dedicated to perform the following functions:

- Providing Information/resources
- Intake, Assessment of needs and Triage
- Develops service plan
- System Navigation
- Service System Coordination
- Partner Liaising
- Information Management (i.e. centralized database)
- Operations and Performance Management

In this model the entity identifies and connects the child/youth/family to a primary service provider to deliver the service or treatment plan. Descriptions of each function are outlined in Table 2 and 3 below.

Table 2 Client-facing Functions (KPMG Model)

| | Client-Facing Function | Description | Channel of Delivery |
|---|---|---|---|
| Conducted by the Integrated Access and Service Coordination Organization | Information | • Supplying children, youth, their families, teachers, medical professionals, probation officers, Youth Outreach Workers and other relevant individuals with data on available programming, basic eligibility, waitlists, etc. | • Telephone<br>• Internet<br>• In person |
| | Intake | • Collecting basic, relevant personal data and information regarding requests from potential clients and interested parties to properly direct inquiries | • Telephone<br>• In person |
| | Identify Needs | • Appraising the client's condition, needs and eligibility to recommend a service and/or service plan, as well as specific and pertinent providers to satisfy client needs<br>• Engaging the expertise of service system partners in an integrated approach to service plan development, including when specialized assessments are required<br>• Transfer service plan to appropriate service provider or relevant professional for day-to-day management | • Telephone<br>• In person |
| | System Navigation | • Leading problem solving discussions with local service providers regarding access to services<br>• Facilitating connections to appropriate services/resources, including supporting the coordination of individualized service plan across sectors and service providers | • Telephone<br>• Internet<br>• In person |
| | Service System Coordination | • Holding responsibility for children and youths' access to services<br>• Confirming the client receives required services and troubleshooting as necessary<br>• Monitoring service plan through active collaboration with families and service providers<br>• Identifying broader system services and supports that may be helpful | • Telephone<br>• Internet<br>• In person |
| Conducted by Service Providers | Treatment/ Support | • Helping to continually identify client needs<br>• Ensuring adequate, day-to-day treatment is provided<br>• Connecting to the Service Coordinator as a resource on an as-needed basis<br>• Informing the Service Coordinator of clients' progress on a regular basis<br>• Collaborating across sectors as needed to sufficiently address client need(s) | • Telephone<br>• In person |

Table 3 Supporting Functions (KPMG Model)

| Supporting Function | Description |
|---|---|
| **Partner Liaising** | • Reaching out to communities around Toronto to collect and share information on available services<br>• Building relationships with service providers, relevant professionals and stakeholders across sectors and geographies to collect information on eligibility and waitlists, etc. |
| **Access and Service Coordination Model Performance Measurement** | • Assessing outcomes of the Centralized Access and Service Coordination entity (capturing information on the number of children accessing the service, average days clients spend on centralized waitlist, number of service providers using the services, accuracy of database information and qualitative data on clients' satisfaction, etc.)<br>• Tracking and reporting on performance data to determine whether children and youth are obtaining the right services in a timely manner<br>• Providing information to support the identification of areas of improvement to better meet clients needs |
| **Information Management** | • Organizing knowledge and analysis in an accessible and useful manner, for both internal and public use |
| **Operational Management** | • Managing the Centralized Access and Service Coordination entity and incorporating continuous service improvements |

The model was designed to embed active collaboration between the entity, parents/caregivers, and service providers, and facilitate as much choice as possible for those seeking service.

### REFINING THE CONCEPTUAL MODEL FOR TORONTO

The Central Table received the final report from KPMG in September 2011 and began the process to recommend refinements to the conceptual model and key implementation considerations.

**A set of principles was affirmed to guide the development of the new conceptual model for Toronto.** The access and service coordination model will:

- ❑ Prioritize the needs of children, youth, and families and not the agenda of providers or administrators
- ❑ Ease the burden on families' lives
- ❑ Leverage local and community knowledge and capacity
- ❑ Employ a framework of cultural competency and understanding of community needs
- ❑ Meet legislative requirements for French Language Services
- ❑ Recognize the uniqueness of Aboriginal communities' needs in design, planning, and service provision
- ❑ Activate a system approach wherein children, youth and families are linked to appropriate services expeditiously
- ❑ Formalize roles and accountability to demonstrate system-wide shared responsibility
- ❑ Enable transparent and timely information about available programming, waitlists, etc.
- ❑ Foster monitoring and data collection to provide information for system planning
- ❑ Provide a simple, efficient, and reliable intake process
- ❑ Strive to overcome structural barriers to achieve equitable services for all

The Central Table recommends changes to the assigned responsibilities for specific "client-facing functions", and additional process components to enhance the responsiveness of the model proposed by KPMG.

The Central Table recommends:

- the clinical assessment function be performed by service providers and not the entity;
- protocols and expectations are established to ensure a timely response to immediate service needs;
- the ongoing service coordination function is provided by the primary service provider, with the support of the entity.

Table 4 summarizes these recommended changes to the KPMG model[6].

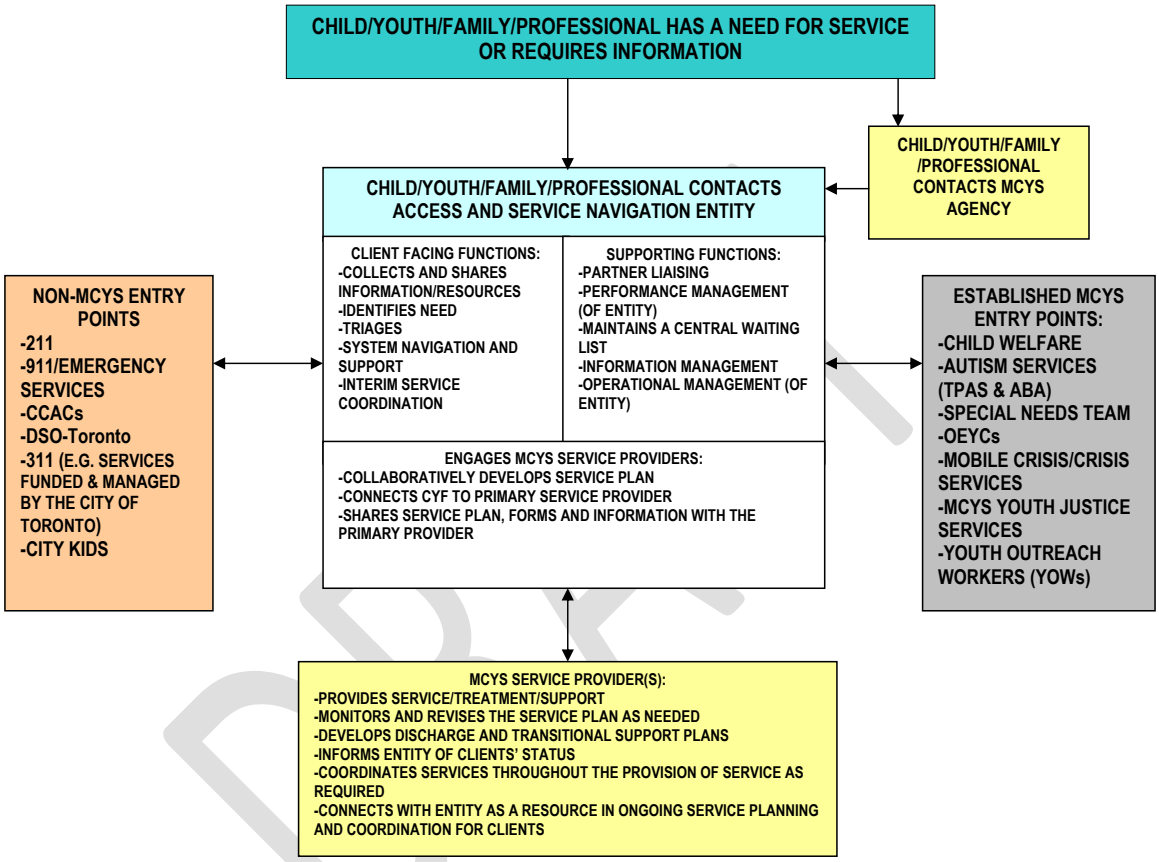
[6] The current MCYS definition and descriptions of Service Coordination were the basis for the descriptions of the access and service coordination functions in Table 4. See Appendix F for more information on current MCYS definitions.

Table 4 Central Table Recommended Changes to Client-facing Functions

| Responsibility for Function | Client Facing Function | Description | Channel of Delivery |
|---|---|---|---|
| Access and Service System Navigation Entity | **Information Gathering/ Information Sharing** | • Supplying children, youth, their families, teachers, medical professionals, probation officers, Youth Outreach Workers, and other relevant individuals with data on available programming, basic eligibility, waitlists etc.<br>• Collecting basic relevant personal data and information regarding requests from potential clients and interested parties to properly direct inquiries | Telephone<br>Internet<br>In person |
| | **Identify Needs**<br><br>**System Navigation/ Support** | • Appraising the client's condition, needs and eligibility to recommend a service and/or (preliminary) service plan (PSP), as well as specific and pertinent providers to satisfy client needs<br>• Engaging the expertise of service system partners in an integrated approach to service plan development including when specialized assessments are needed<br>• Utilizing "Urgent Response" protocols to ensure the immediate/crisis needs are met and to seamlessly connect children, youth, their families existing access points<br>• Transfer service plan to appropriate service provider or relevant professional for service provision and case management<br>• Leading problem solving discussions with local service providers regarding access to services<br>• Facilitating connections to appropriate services/ resources including supporting the coordination of individual service plans (ISP) across sectors and service providers, where necessary | Telephone<br>In person<br><br>Telephone<br>Internet<br>In person |
| | **Service System Coordination** | • Facilitating access to MCYS-funded services<br>• Confirming the client receives required services and troubleshooting, as necessary<br>• Facilitating initial service plan development through active collaboration with families and service providers where necessary<br>• Identifying broader system services and supports that may be helpful, where necessary | Telephone<br>Internet<br>In person |
| **Service Provider** | **Service/ Treatment/ Support/ Coordination** | • Continually identifying and addressing client needs (e.g. clinical assessment, if required)<br>• Ensuring appropriate and adequate services and/or treatment is provided<br>• Connecting to the entity as a resource on an as-needed basis<br>• Informing the entity of clients' status on a regular basis<br>• Informing the entity of program offerings and availability on a regular basis<br>• Ongoing service coordination and collaboration across providers and sectors as needed to sufficiently address client need(s) | Telephone<br>In person |

Figure 2 below provides a diagram of the processes and related responsibilities in the new model.

**Figure 2 Process Map**




As part of the process of refining the conceptual model, Toronto Region consulted with and sought input from the Aboriginal Working Group. The Group supports the concept of a centralized access and service navigation model and further recommended a distinct model, controlled by the Aboriginal community, for Aboriginal children, youth and families. It would perform parallel functions, share a common database and interface with the entity for the broader system.

**IDENTIFIED BENEFITS**

Through the process of refining the conceptual model the Central Table identified

specific benefits for the system. The model has the potential to add value to the system by providing:

- A clear and visible point of access
- Clarity and consistency for children, youth and families
- An added "safety net" for children, youth and families
- A more systemic approach to service delivery
- Greater capacity to monitor effectiveness and contribute to planning and continuous quality improvement through more reliable information and data
- A new resource to service providers
- A stronger commitment to do service coordination
- Increased knowledge about the system
- An entity that is responsible for facilitating and maintaining protocols
- Dedicated support for navigating the system
- More opportunities for inter-sectoral training and partnerships
- A system of triage
- More equitable access and system responsiveness
- New supports for system development
- A central access point to a range of MCYS-funded services

## IMPLEMENTATION CONSIDERATIONS

A centralized model in Toronto will mark a significant shift in roles and processes and will require thoughtful and detailed implementation planning. The following are key considerations for detailed design and implementation:

**1. Approach to Implementation**

1.1 Engage stakeholders (e.g. clients, parents/caregivers, inter-sectoral partners and service providers) in the process in order to foster collaboration and commitment.

1.2 Keep the community and all system partners involved and informed throughout the implementation process.

1.3 Develop a phased implementation plan and establish the priorities for the model and entity for each phase, leading to broader alignment with other service systems.

1.4 Establish a common "basket of services" so that families know what they can expect when they enter the system and ensure that unique or less common services are maintained and accessible.

1.5 Conduct a "process mapping"[7] exercise for clients, from simple to complex needs, to ensure the new process(es) will be less complicated for clients.
1.6 Identify and align all outreach, "drop-in" and "walk-in" services, as well as services that do not require registration or intake, with the new model.
1.7 Explore an approach to waiting list management, including options to support clients who are waiting for MCYS-funded services.
1.8 Further refine and clarify the roles of service providers in coordinating services and examine strategies to incorporate continuous quality improvement into the service coordination function.
1.9 Clarify roles and responsibilities in program areas where MCYS-Toronto Region and the City of Toronto both have service system management roles to ensure effective coordination of services.

**2. Equity**

2.1 Specific orientation/training for staff of the new broader access model on issues effecting Aboriginal children, youth and families, Aboriginal cultures, and service approaches is necessary.
2.2 Develop memorandums of understanding between "mainstream" agencies and Aboriginal service providers to ensure Aboriginal children, youth and families are aware of and can reach an Aboriginal service provider.
2.3 Recruit and train staff of the entity to embed cultural competency and to ensure a holistic and broader system approach to supporting children, youth and families (i.e. knowledge of the broader human service system).
2.4 Review and align outreach initiatives with the aim of actively removing barriers to service for marginalized communities.
2.5 Develop a policy for the triage function and prioritizing based on need.

**3. Protocols**

3.1 Establish information-sharing protocols and expectations to maintain the integrity of the database (e.g. a "cue" for providers to update their information).
3.2 Establish client transfer protocols amongst service providers and between the entity and service providers to ensure continuity of service and the appropriate exchange of information.
3.3 Establish crisis protocols to ensure a timely response to immediate client need.

**4. Performance and Operational Management**

4.1 Conduct a demand analysis[8] to inform next steps in the design.

[7] Process mapping is used to better understand an existing process and identify opportunities to improve effectiveness. It includes a step by step analysis of process flow, including, key functions, activities, roles, decision points, intersections, information flow, etc.
[8] The purpose of a demand analysis is to estimate regional service utilization volumes to inform costing and design of the model. A demand analysis could include analysis of demographics, socio-economic statistics, prevalence rates, etc.

4.2 Develop metrics and quality assurance standards for the system in relation to service coordination to ensure compliance and to support ongoing monitoring and the evaluation of the model.
4.3 Include a complaint process for the entity in the design.
4.4 Establish clear communication and reporting requirements for service providers and the entity to support an atmosphere of trust, mutual accountability and collaboration.

**5. Information Management**

5.1 Develop a comprehensive, web-based database to enable agencies to update information on their services and individual services plans with ease.
5.2 Develop common templates and forms to support the new processes in the model.
5.3 Employ a systematic approach to obtain the necessary information on agencies and their services to support the development of the database.

**APPENDIX A: Overview of the MCYS-Toronto Region Service System**

The scope of the Toronto Region- MCYS service system includes programs and services in the following funding streams.

Early Learning and Child Development*
*Examples of Programs and services include:*

- Infant Development Programs
- Student Nutrition
- Ontario Early Years Centres

Children and Youth At-Risk
*Examples of Programs and services include:*

- Child and Family Intervention – Non-residential & Residential
- Child Treatment
- Mobile Crisis
- Mental Health and Addictions Workers
- Child Abuse Programs
- Section 23 Classrooms
- Intensive Child and Family Services

Youth Opportunities Strategy
*Examples of Programs and services include:*

- Youth Outreach Worker Program

Specialized Services
*Examples of Programs and services include:*

- Out of Home Respite
- Child Treatment Autism Intervention Program
- Applied Behaviour Analysis (ABA)-based Services and Supports for Children and Youth with Autism Spectrum Disorders (ASDs)

Child Protection Services**

* In this program area both MCYS and the City of Toronto have service system management roles. The two governments will work together to clarify roles and ensure effective service coordination and delivery.
**These services are not in scope for the purpose of this project.

***Applicable programs and system features will be determined by MCYS-Toronto Region.***

**APPENDIX B:**

A sub-group of the Central Table served as the project Steering Committee. The committee was comprised of:

| |
|---|
| John Flannery, Surrey Place Centre (Central Table member) |
| Lydia Sai-Chew, Griffin Centre (Central Table member) |
| Lorraine McLeod, City of Toronto, Children's Services |
| Heather Sproule, Central Toronto Youth Services (Central Table member) |
| Dave Johnston, Toronto District School Board (Central Table member) |
| Nancy Andrews, Children's Aid Society of Toronto |

**APPENDIX C: Key Informant Interview Participants**

| | |
|---|---|
| Christine Bartha, Administrative Director, Addictions, Child Psychiatry, Mood and Anxiety Programs, Centre for Addiction and Mental Health (CAMH) | Susan Morris, Chair, Toronto Network for Specialized Care |
| Anna Cooper Client Services Manager, Child and Family Program, Toronto Central Community Care Access Centre | Alan Nickell, Executive Director, Rosalie Hall (Young Parent Resource Centre) |
| Tony Diniz Executive Director, Child Development Institute | Brian O'Hara, Program Director, Centralized Access to Residential Services (CARS) |
| Loraine Duff Director, Community Resources, United Way Toronto | Shirley Shedletsky, Program Coordinator, Centralized Access to Residential Services (CARS) |
| Karen Engel Executive Director, Yorktown Family Services | Camille Orridge, CEO, Toronto Central Local Health Integration Network |
| Suzette Arruda-Santos, Director of Service, Yorktown Family Services | Lorna Power, Supervisor Respite Services |
| Claire Fainer Executive Director, East Metro Youth Services | Kenn Richard, Executive Director, Native Child and Family Services of Toronto |
| Myra Levy, Supervisor East Metro Youth Services (WIT) | Trudy Angeconeb Native Child and Family Services of Toronto |
| Chris Brown, Director (WIT) East Metro Youth Services | Lydia Sai-Chew, Director Griffin Centre (WIT) |
| Wendy Gage, Social Worker Hospital for Sick Children | Barbara Hanssmann, Supervisor (WIT) Griffin Centre |
| Colleen Hua, Program Supervisor, Adult Developmental Services, Ministry of Community and Social Services (DSO- Toronto Lead) | John Wilhelm, Chief Social Worker, Toronto Catholic District School Board (TCDSB) |
| Patricia Manzo Program Supervisor Ministry of Children and Youth Services | Jane Kenny Children's Service System Review and Consultation Committee |
| Paul McCormack, Program Director Special Needs Team | |

**APPENDIX D: Inventory of Access and Service Coordination Efforts in Toronto**

| Initiative | Description | Scope of Mandate |
|---|---|---|
| Centralized Access to Residential Services *(CARS)* **MCYS-Toronto Region** | A centralized mechanism that coordinates access to designated residential services | Mental Health: Children and Youth |
| Children's Service System Review and Consultation Committee *(CSSRC)* (formerly Service Resolution Toronto) **MCYS-Toronto Region** | A city-wide multi-sectoral table that reviews the most complex and high-needs children and youth cases, and develops individual service plans. Funds are available to support individual plans of care. | Highest risk: Children and Youth |
| Toronto Autism *ABA* Services **MCYS-Toronto Region** | Surrey Place Centre (SPC) is the central point of access to Applied Behavioural Analysis services for children with autism. SPC completes a registration for all applicants and maintains a centralized wait list. | Children with autism who are not receiving IBI through the TPAS program |
| Toronto Ontario Early Years Centres *(OEYCs)* **MCYS-Toronto Region** | Provide a common set of early learning and child development programming and parent education and support. OEYCS refer and connect families to other community services. | Children, 0 - 6 (universal) |
| Special Needs Team (*SNT*) **MCYS- Toronto Region** | A centralized team that works with children and youth with developmental disabilities and a mental health diagnosis and/or medically fragile, as well as their families, who have exhausted all available community resources to develop and co-ordinate an interim plan of care. All individual plans of care are approved by Toronto Region. | Children and Youth with special needs (children and youth with developmental disabilities and a mental health diagnosis and/or medically fragile) as well as their families, who have exhausted all available community resources |
| Toronto Partnership for Autism Services (*TPAS)* **MCYS-Toronto Region** | Access is centralized, coordinated and eligibility is determined through Surrey Place Centre for IBI treatment and related services. Service delivery occurs in the five partner agencies. | Children with moderate to severe autism |
| Provincial Youth Outreach Workers (*YOW*) **MCYS-Toronto Region** | Youth Outreach Workers will engage youth in their assigned communities and connect them with needed services, as well as collaborate with other community resources to coordinate youth | Marginalized youth (aged 12 to 21) who have not successfully connected with school or other community organizations |

| | | |
|---|---|---|
| | activities within identified neighbourhoods. | |
| Whatever It Takes (*WIT*)<br><br>**MCYS-Toronto Region** | A centralized program that supports the whole system through two teams providing service coordination and case management for children and youth with complex situations whose needs require multi- sector/agency involvement. Funds are available to support individual plans of care | Mental Health, Children and Youth |
| Respiteservices.com<br><br>**MCYS/MCSS-Toronto Region** | A centralized team that works with families to assess needs, develop individual respite plans, and to act as an information resource to agencies supporting families. Centralized Access Facilitators assist families with forms, contacting agencies and connecting families to respite workers. | Children, Youth and adults with special needs |
| Toronto Region Developmental Services Ontario (*DST-O*)<br><br>**MCSS-Toronto Region** | A regional access point for adult developmental services in Toronto. Developmental Services Ontario (DSO) organizations are the primary contact for information about developmental services and supports and the single point of access to apply for Ministry-funded adult developmental services and supports. | Individuals aged 16+ with developmental concerns |
| Healthy Babies Healthy Children (HBHC)<br><br>**MCYS/City/Toronto Public Health** | 18 month well-baby visit and screening is conducted by TPH nurse. If a developmental concern is identified, family is referred to City Kids (see below) or TPSLS, and from there can be referred to other services, such as Healthy Babies, Healthy Children | Babies 0-18 months<br><br>Children 0-6 years |
| CITYKIDS<br><br>**City of Toronto** | A single point access and coordinated intake to a network of agencies for children that have identified developmental concerns or special needs, and their families. CITYKIDS Service Navigators are based at Mothercraft and are responsible for intake coordination and ensuring integrated service delivery between all agencies involved. | Early Childhood (0-6 years) and children aged 7-12 in child care |
| Toronto Community Care Access Centres *(CCAC)* | Two CCACs across the Toronto Region are established to assess patient needs, determine | Health services |

| | | |
|---|---|---|
| **MOHLTC/LHIN** | requirements for care, answer questions and develop a customized care plan that meets individual health needs. They conduct case coordination and service brokering for community services. | |

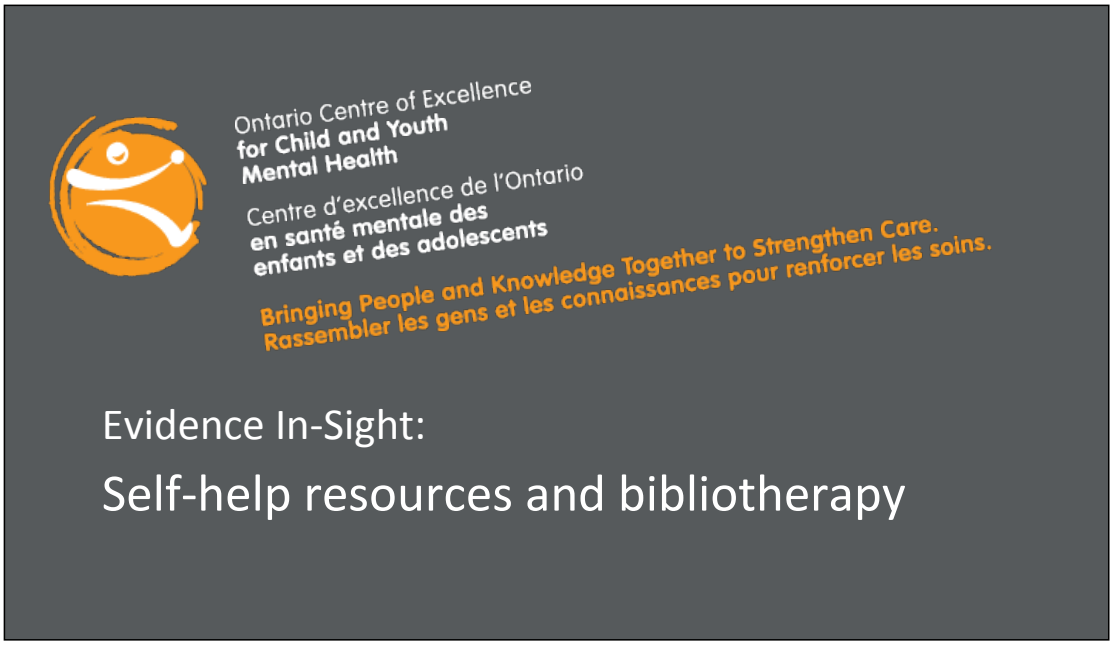
**APPENDIX E: Aboriginal Working Group Member Participants**

| |
|---|
| Andrea Crisjohn<br>Council Fire Native Cultural Centre |
| Kenn Richard<br>Native Child and Family Services of Toronto |
| Jane Harris<br>Anishnawbe Health Toronto |
| Geraldine Standup (Elder) |
| Cathy Pawis<br>Aboriginal Office<br>Toronto District School Board |
| Jonathan Rudin<br>Aboriginal Legal Services of Toronto |
| Crystal Melin<br>Native Women's Resource Centre |

**APPENDIX F: CURRENT MCYS DEFINITIONS AND DESCRIPTIONS FOR ACCESS AND SERVICE COORDINATION FUNCTIONS**

**Excerpts from *To Serve the Children: A Handbook for Children's Services in Toronto***

| Current Model/Service Coordination Protocol | |
|---|---|
| **Description** | **Role/Responsibility *see protocol for exceptions** |
| Receives initial inquiry from CYF or professional | Any/All service providers |
| Gathers information, clarifies request and completes Service Inquiry Report (SIR) | Any/All service providers |
| Conducts needs identification and determines eligibility<br>▪ Determine if client is in crisis and initiate crisis response<br>▪ Determine if there are multiple needs<br>▪ Identify and determine appropriate range of service(s) options for CYF<br>▪ Facilitate linkage to Aboriginal Service Provider(s) as needed<br>▪ Assumes interim service coordination until a lead agency for service provision is secured | Any/All service providers |
| Primary contact for CYF while waiting for service | Any/All service providers |
| Facilitates an initial meeting with CYF | Any/All service providers |
| Facilitates meetings with service providers and CYF as required to develop an initial plan of service<br>▪ Facilitates connections to appropriate services/resources within the broader service system, including inter-sectoral (Service System Navigation) as required | Any/All service providers |
| Monitors and revises the service plan as needed<br><br>Discharge planning and or transitional support planning | Any/All service providers |
| Service Resolution | Children's Service System Review and Consultation Committee (formerly Service Resolution Toronto) |




Date: **May, 2012**

Self-help resources and bibliotherapy

The following Evidence In-Sight report involved a non-systematic search and summary of the research and grey literature. These findings are intended to inform the requesting organization, in a timely fashion, rather than providing an exhaustive search or systematic review. This report reflects the literature and evidence available at the time of writing. As new evidence emerges, knowledge on evidence-informed practices can evolve. It may be useful to re-examine and update the evidence over time and/or as new findings emerge.

Evidence In-Sight primarily presents research findings, along with consultations with experts where feasible and constructive. Since scientific research represents only one type of evidence, we encourage you to combine these findings with the expertise of practitioners and the experiences of children, youth and families to develop the best evidence-informed practices for your setting.

While this report may describe best practices or models of evidence-informed programs, Evidence In-Sight does not include direct recommendations or endorsement of a particular practice or program.

This report was researched and written to address the question:

- *According to the literature, what are evidence-informed self-help resources for common presenting problems in children and youth?*
- *What is the level of evidence for bibliotherapy in child and youth mental health?*

We prepared the report given the contextual information provided in our first communications (see Overview of inquiry). We are available at any time to discuss potential next steps.

We appreciate your responding to a brief satisfaction survey that the Centre will e-mail to you within two weeks. We would also like to schedule a brief phone call to assess your satisfaction with the information provided in the report. Please let us know when you would be available to schedule a 15-minute phone conversation.

Thank you for contacting Evidence In-Sight. Please do not hesitate to follow up or contact us at evidenceinsight@cheo.on.ca or by phone at 613-737-2297.

Self-help resources and bibliotherapy

**1. Overview of inquiry**

A child and youth mental health agency contacted Evidence In-Sight with an inquiry about evidence-based self-help resources for children and youth. The organization wanted to know if the Centre was aware of an existing list of resources for common topics such as anxiety, parenting strategies to reinforce positive mental health development, anger management, ADHD, Tourette Syndrome, obsessive-compulsive disorder, depression, trauma, social skills, emotion regulation and self-harm.

Evidence In-Sight will build from previous work done in this area to prepare a full report. Specifically, the report will address the question: What are evidence-informed, self-help resources for common presenting problems in children and youth. What is the evidence for bibliotherapy in child and youth mental health?

**2. Summary of findings**

- The terms self-help and bibliotherapy are often used interchangeably. "Self-help" tends to refer to interventions using various forms of multimedia not limited to books, and can be an adjunct to or be guided by a practitioner, or be unguided. For the purposes of this report, self-help does not include self-help groups. Bibliotherapy has traditionally been known as using reading materials for help in solving personal problems.
- Various individual studies and meta-analyses suggest self-help and bibliotherapy can be effective. We prepared a list of interventions that have various levels of evidence to support their use. It is important to note that oftentimes analyses of the effect of bibliotherapy do not include specific books used, which limits the books that can be included in this list.
- Much of the research conducted on self-help and bibliotherapy has involved adult populations. More research on self-help/bibliotherapy for children and adolescents is needed in order to assess the impact of these interventions on their mental health.
- A limited number of books and self-help resources have been evaluated for effectiveness with a child/adolescent population. Most often, these pertain to depression and anxiety disorders. Trends indicate that recent research favours computer based or internet based self-help methods for the younger population. Young people tend to be comfortable using such technology and seem to respond favourably to the anonymity provided by such methods.

**3. Answer search strategy**

- Search Tools: EBSCO HOST (Medline, PsycInfo, Psychology and Behavioural Science Collection, Biomedical Reference Collection), Google Scholar
- Search Terms: Self-help, bibliotherapy, children, adolescents, anxiety, depression, effectiveness

**4. Findings**

**4.1 Definitions**

The terms bibliotherapy and self-help are often used interchangeably, and consistent definitions are lacking. Intuitively, we would assume bibliotherapy describes the use of books for therapeutic reasons. It is defined in the Merriam-Webster dictionary as "the use of reading materials for help in solving personal problems or for psychiatric therapy." In a meta-analysis of bibliotherapy, the definition was extended to include the use of audio files or computer programs, as well as books (Marrs, 1995). Specifically, the author defined bibliotherapy as "the use of written materials or computer programs or the listening/viewing of audio/videotapes for the purpose of gaining understanding or solving problems relevant to a person's developmental or therapeutic needs" (Marrs, pp. 846, 1995). The latter conceptualization resembles the term self-help.

Self-help also lacks a consistent definition, but has been defined in one study as "a psychological treatment in which the client takes home a standardized psychological treatment protocol and works through it more or less independently" (Nordgreen et al., pp.13, 2012). Self-help ranges from being completely independent with no therapist involvement (unguided self-help) to an extension of a treatment program, resembling 'homework' assigned by a clinician (guided self-help).

**4.2 Evidence for self-help and bibliotherapy**

Self-help books are not new forms of psychological treatment; they were popular even in the 1950s and remain one of the best-selling types of books (Redding et al., 2008). Despite their popularity, research evaluating the use of self-help books as a form of evidence-based treatment is still needed (Lewis et al., 2012). Evidence is especially lacking for children, youth and young adults (Rickwood & Bradford, 2012). While more research has been called for, there is some existing evidence to indicate that self-help (books and other sources) is effective in treating various types of anxiety, depression, obsessive-compulsive disorder (OCD) and other mental health difficulties.

For example, Floyd et al. (2006) looked at the use of self-help books for depression in older adults, and found self-help was comparable to individual psychotherapy, even after a two-year follow-up. A meta-analysis of bibliotherapy revealed an overall effect size of .56, indicating that bibliotherapy had a moderate, positive effect (Marrs, 1995). In particular, the results showed that anxiety-related problems seemed to be the most amenable to change with bibliotherapy. Sexual dysfunction and depression were also studied, and compared to anxiety these conditions showed a smaller, yet still positive effect sizes. Another meta-analysis of self-help that looked specifically at anxiety and depression showed that self-help produced significant positive effects compared to wait list conditions (Den Boer, 2004).

Lewis and colleagues (2012) conducted a systematic review of randomized controlled trials that evaluated self-help for various types of anxiety disorders in adults. Overall, self-help was superior to waiting list conditions, but was not as effective as therapist administered treatment (Lewis et al., 2012). However, therapist administered treatment did not show any significant benefit over guided self-help. Even minimal guidance has been shown to greatly improve motivation and treatment adherence compared to unguided or 'pure' self-help, which may explain this finding. This study included a variety of self-help modalities such as books, CD-ROMs, and internet-based interventions.

In addition to examining the effect of self-help compared to other forms of treatment or a wait list, research has also tested the amount of therapist involvement. Overall, evidence suggests that guided self-help produces more favourable responses than unguided self-help, in terms of adherence to treatment and overall outcome (Nordgreen et al., 2012; Rickwood & Bradford, 2012). However, Nordgreen et al. (2012) suggested that unguided clients who perceive the self-help intervention to be highly credible may not differ from clients completing a program with guidance from a therapist. Thus, while there are moderating factors that warrant further examination (i.e., to understand the conditions under which self-help is most effective) current research tends to favour some form of therapist involvement.

The majority of research evaluating self-help resources has been conducted with adult populations, and the need for more research specifically focusing on children and youth has been identified (Rickwood & Bradford, 2012). Self-help may be particularly well-suited to younger populations given their typical tendency to want to cope alone, issues related to stigma and low mental health literacy, etc. (Rickwood and Bradford, 2012). Self-help mediates some of these challenges as it is a modality that allows younger people to maintain their independence and anonymity.

In sum, there is evidence indicating that self-help strategies and bibliotherapy can be effective, but more research focusing on children and youth is needed. Another important note is that while studies use the term 'bibliotherapy,' in most cases, specific books used in interventions are not described. Many researchers advocate for more studies on

specific books or other multimedia formats, which would ensure that individual self-help interventions are actually effective. A limited number of interventions and/or books have been tested for effectiveness with a population of children, youth or adolescents.

**4.3 Evidence-informed books or self-help interventions that have been subject to rigorous research**

The following books or resources pertaining to depression or anxiety have some level of evidence to support their use. We placed a particular focus on studies that have used a population of children or adolescents, but in some cases, results involving adult populations were reported if the book or resource had a strong evidence base.

**4.3.1 Depression**

*Feeling Good: The New Mood Therapy* (Burns, 1980)

This book is rooted in Beck's (1970) cognitive theory of depression, and in fact has been described as a "self-administered version of cognitive therapy" (Ackerson et al., pp. 685, 1998). Feeling Good has been chosen as the self-help resource in a number of randomized controlled trials (RCTs) because of its theoretical foundation. Typically, such studies have looked at adult populations and have found the bibliotherapy condition to be superior to the waitlist condition (e.g., Jamieson et al., 1995; Smith et al., 1998). Feeling Good has been used in one known study with adolescents, where youth were randomized into bibliotherapy or a waitlist condition (Ackerson et al., 1998). In both groups, adolescents participated in weekly phone calls for assessment. While therapy was not a component of each phone call, it is important to note this aspect of the study, because even minimal contact with self-help has been shown to improve treatment adherence rates over pure self-help (Nordgreen et al., 2012). Results showed that depressive symptoms in the bibliotherapy condition improved significantly more than those on the waitlist condition. The authors also noted that since adolescents are particularly reluctant to seek professional treatment, bibliotherapy is a promising intervention (Ackerson et al., 1998).

*Control Your Depression* (Lewinsohn et al., 1986)

Researchers describe this book as 'behavioural' bibliotherapy because the contents focus on behavioural strategies such as relaxation, pleasant activities and self-instructional techniques. It has been evaluated in one study which compared Control Your Depression to Burn's Feeling Good (1980) (the latter is considered 'cognitive therapy'). Results showed that both books produced results that were superior to the waitlist condition, but neither book was superior compared to the other. Participants in this study were moderately depressed older adults, and so while these results are positive, Control Your Depression has not been evaluated for effectiveness with a younger population.

**4.3.2 Anxiety**

*Helping Your Anxious Child: A Step-by-Step Guide* (Rapee et al., 2000).

This book has been studied in one known randomized controlled trial. As suggested by the title, it is written for parents to guide their child through various cognitive-behavioural based stages for dealing with anxiety. One study randomly assigned children aged 6-12 to group cognitive-behavioural therapy (CBT), bibliotherapy administered by parents, or a waitlist (Rapee et al., 2006). Results showed that children taking part in group CBT improved more than those in bibliotherapy, but those in bibliotherapy demonstrated improvements over the waitlist. Therefore, researchers suggested that while bibliotherapy may not replace well-researched treatment methods like CBT, given the high cost, limited resources for such programs, and long waiting lists, bibliotherapy may be valuable in certain situations.

*MoodGym*

This intervention was developed in Australia, and is available online at no cost. It has five CBT-based modules that can be completed at one's own pace. It has been studied in one RCT with university students aged 18-23 with a diagnosis of mild to moderate depression or anxiety (Sethi et al., 2010). Students were assigned to one of four conditions: face-to-face CBT, MoodGym combined with face-to-face CBT, MoodGym without any therapist interaction and a waitlist. The most significant improvements were shown in the face-to-face CBT group and the MoodGym plus some face-to-face contact group. This is consistent with other research that indicates even a small amount of face-to-face contact can improve treatment outcomes (Rickwood & Bradford, 2012).

*CoolTeens CD-ROM*

CoolTeens is a twelve week cognitive-behavioural based computer program. An RCT with 43 adolescents aged 14-16 randomly assigned to either the computer program treatment condition or to a waitlist condition was conducted (Wuthrich et al., 2012). CoolTeens participants showed significant reductions in anxiety disorders, total symptoms and severity of symptoms. The authors noted that the use of a computer may be particularly effective for younger people who tend to be familiar with technology and hard to engage in traditional treatment methods.

*Online Anxiety Prevention Program*

This cognitive-behavioural based online prevention program includes six sessions focusing on education, relaxation training and cognitive restructuring. It was developed at the University of Queensland in Australia, and has been subject to one RCT (Kenardy et al, 2003). In this study, 83 university aged students were randomly assigned to the intervention or a waitlist control group. The intervention group showed some improvements, but overall, there was a lack of significant findings in this study. At a six month follow up, decreases in anxiety sensitivity were evident for the intervention group and the control group (Kendardy et al., 2006), but the decrease in the intervention group could not be proven associated with the program.

A number of other self-help books for anxiety have been reported in the literature (Fullana & Marks, 2008). These include:

- Coping with Panic: A Drug Free Approach to dealing with Anxiety Attacks, by George Clum (1999)
- Mastery of your Anxiety and Panic, by Michelle G. Craske and David H. Barlow (2007)
- Living with Fear by Issac M. Marks (2001)

Each of these books has been included as a self-help tool in one or more RCTs with varying amounts of therapist contact. However, none of these studies have included youth or adolescent populations (see Ghosh et al., 1988, Hecker et al., 2004, Febraro, 2005 for more details on these books).

In addition, the following computer-assisted self-help interventions have been empirically examined:

- FearFighter (www.fearfighter.com)
    - FearFighter is an online self-exposure therapy for panic and or phobia. It has been recommended by the National Institute for Clinical Excellence (NICE) and has a strong evidence base. It was assigned a minimum reading age of 11, but has not actually been studied in a population of adolescents.

FearFighter has been evaluated in multiple clinical randomized trials (e.g., Marks et al., 2004; Schneider et al., 2005). The lead author and developer is Dr. Issac Marks.

- Beating the Blues (www.beatingtheblues.co.uk)
    - Beating the Blues is an online CBT intervention for depression that is also recommended by the NICE guidelines. Similar to FearFighter, it has not been tested in younger populations, but has been evaluated in a number of randomized trials and effectiveness studies (e.g. Proudfood et al., 2003; Cavanagh et al., 2006).

**4.4 Evidence-informed self-help books that have been discussed in the literature**

One study listed the top 50 best-selling self-help books for anxiety, depression and trauma related disorders (Redding et al., 2008). Researchers developed a scale informed by the bibliotherapy literature and had psychologists with expertise in each area rate books in terms of usefulness, grounding in psychological science, the extent to which expectations of treatment were outlined for the reader, the specificity of guidance for implementing and evaluating the self-help techniques, and whether any harmful advice was included. The five books receiving the highest score on the developed scale are listed below. The highest score that could be received was 95. Scores received by each book are provided in brackets.

- The OCD Workbook (94), written by B.M. Hyman, 1999
- Dying of Embarrassment (92), written by B. Markway, 1992
- The Shyness & Social Anxiety Workbook (92) written by M.M. Antony, 2000
- Overcoming Compulsive Hoarding (90), written by F. Neziroglu, 2004
- Stop Obsessing (90), written by E.B. Foa, 2001

In addition to ranking the top 50 books according to highest scores, the authors offered the following important key findings:

- The overall scale used to generate each book's total score had various sub-scales. There were strong correlations between sub-scales, indicating that books that scored high on one area of the scale tended to score high on all.
- High scoring books tended to have a cognitive behavioural orientation, were written by a mental health professional and/or someone with a doctoral degree, and focused on specific problems
- Similarly, books with low scores tended to be written by authors who were not mental health professionals and had a broad focus rather than a specific focus.

**4.5 Other self-help books with some level of expert review**

The Family Resource Centre at McMaster University has developed booklists and resources for children and youth on a variety of mental health topics. The lists were developed by having a pediatrician and child psychologist rate each resource, and then parent reviews were incorporated to come up with a final list. The lists can be accessed via the webpage, http://www.communityed.ca/booklists.cfm, and have been prepared for the following topics:

- Attention Problems
- Attention Problems for Children
- Anger

- Anxiety
- Anxiety for Children and Youth
- Aspergers Syndrome
- Autism
- Dating and Sexuality
- Discipline
- Divorce
- Divorce for Children and Youth
- Emotions and Feelings
- Grief and Bereavement
- Learning Problems
- Living with Disability
- Mood and Depression
- Obsessive Compulsive Disorder
- Parenting
- Teasing and Bullying
- Social Skills
- Stress Management and Relaxation

Carolyn Houlding works with the Children's Centre Thunder Bay, and has compiled a list of books, therapist manuals and other resources related to mental health in children and adolescents. To be included in this list, authors had to have published efficacy or effectiveness research in the topic area of their book or manual. For access to this list, simply request it from Stacie at the Centre, scarey@cheo.on.ca.

Iris the Dragon is a series of children's books on a variety of topics related to mental health and healthy development. The mission of the series is to provide educational material for adults and young readers that can facilitate a conversation among parents, teachers and children about issues relating to mental health and wellness in a non-threatening manner. Dr. Simon Davidson, the Chief Strategic Planning Executive at the Centre of Excellence and the Chair of the Child and Youth Advisory Committee at the Mental Health Commission of Canada, has endorsed this book series. The list of books is available at the following website: http://www.iristhedragon.com/index.html.

The University of Pittsburgh's school-based behavioural health project has generated a list of books according to mental health topic. Each list is accompanied by a short paper providing background on each topic. The books included in the list are described in terms of the evidence available to support their use, the author and the content of the book. Bibliotherapy book lists can be accessed at the website, http://www.sbbh.pitt.edu/Bibliotherapy-Lists/245/Default.aspx, and are provided on the following topics:

- Anxiety
- Bereavement and grief
- Bullying
- Chronic disease

- Conduct disorder
- Deployed military
- Drugs and alcohol
- Obsessive compulsive disorder
- Homelessness
- School transition
- Shy children

The American Psychological Association (APA) owns a company that publishes books for children on variety of topics, called Magination Press. Topics range from starting school, normal childhood fears, and shyness to more serious issues such as divorce, depression and chronic illness. The books are written by mental health professionals to teach children about the issue and suggest various coping strategies. A full list of Magination Press books can be found here: http://search.apa.org/publications?query=&facet=&pubtype=magination&section=subject&sort=title_asc.

**For a complete listing of the resources covered in this report, see Appendix A for titles and authors according to mental health concern and level of evidence.**

**5. Next steps and other resources**

Knowing what works and receiving training on an evidence-informed practice or program is not sufficient to actually achieve the outcomes that previous evaluations indicate are possible. A program that has been shown to improve mental health outcomes for children and youth but that is poorly implemented will not achieve successful outcomes (Fixsen et al, 2005). In order for a program to be evidence-informed, it needs to be applied with fidelity to the design and it needs to be implemented using supportive "drivers" related to staff competency, organizational leadership and organizational capacity. These drivers include assessing and monitoring the outcomes of your practice using evaluation or performance measurement frameworks, which are particularly important when there is insufficient evidence in the literature to guide clinical decisions. Choosing a practice is an initial step toward implementation, but the implementation drivers are essential to ensure that the program reaches appropriate clients, that outcomes are successful and that clinical staff members are successful in their work.

The Ontario Centre of Excellence for Child and Youth Mental Health has a number of resources and services available to support agencies with implementation, evaluation, knowledge mobilization, youth engagement and family engagement. For more information, visit:

http://www.excellenceforchildandyouth.ca/what-we-do or check out the Centre's resource hub at http://www.excellenceforchildandyouth.ca/resource-hub.
For general mental health information, including links to resources for families:
http://www.ementalhealth.ca

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**Appendix A – Evidence informed self-help resources for child and youth mental health**

| Resource | Description | Author/ Developer | Topic | Studied population(s) | Description of research evidence |
|---|---|---|---|---|---|
| FearFighter | Online Program | www.fearfighter.com | Panic | Adults | Recommended by NICE guidelines |
| Beating the Blues | Online Program | www.beatingtheblues.co.uk | Depression | Adults | Recommended by NICE guidelines |
| Helping Your Anxious Child: A Step-by-Step Guide | Book | Rapee et al., 2000 | Anxiety | Youth aged 6-12 | Studied in a RCT |
| MoodGym | Online Program | Researchers at the Australian National University | Anxiety | University students aged 18-23 | Studied in a RCT |
| CoolTeens | CD-ROM | Macquarie University in Australia | Anxiety | Adolescents 14-17 | Studied in a RCT |
| Online Anxiety Prevention Program | Online Program | University of Queensland in Australia | Anxiety | University aged students | Studied in RCT |
| Coping with Panic: A Drug Free Approach to Dealing with Anxiety | Book | Clum, 1999 | Panic | Adults | Studied in multiple RCTs |
| Mastery of your Anxiety and Panic | Book | Craske & Barlow, 2007 | Panic | Adults | Studied in RCT |
| Living with Fear | Book | Marks, 2001 | Panic | Adults | Studied in RCT |
| Ranking of top 50 best selling self-help books | Book list | Redding et al., 2008 | Multiple | Adults | Books were rated on scale by expert psychologists |
| Self-help booklist | Book list | Family Resource Centre www.communityed.ca/booklists.cfm | Multiple | Children and youth | Books were reviewed by pediatricians, psychologists and parents |
| Self-help booklist | Book list | Carolyn Houlding & Children's Centre Thunder Bay | Multiple | Children and youth | Books were included if |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | authors published research in topic area |
| Bibliotherapy list of books | Book list | University of Pittsburgh | Multiple | Children and youth | Books are included based on topic relevance; evidence is reviewed if exists |
| Iris the Dragon Series | Children's Book Series | www.iristhedragon.com | Multiple | Children and youth | Recommended by expert in CYMH sector |
| Magination Press | Children's Book Series | American Psychological Association (APA) | Multiple | Children and youth | Published by APA |

**Centralized Point of Access**
**Working Group Report**
**Implementation Strategy Details**

There are many examples of multi-dimensional access systems which incorporate telephone, web-based and other technologies to draw from. Key elements in the design and implementation is capacity of the system to build/adapt a model, identify priorities in the services provided (including intersectoral referrals) and to develop a model which can adapt and grow to meet demand and priorities dictate. Below are the key components to consider when developing the full implementation strategy.

**Finalize the model design**

1. Obtain approval in principle from the Lead Agency to proceed to next steps in implementing the proposed model. Part of this process may involve a more in-depth consultation with the core service agencies, especially about requirements that will impact them.

2. It is important that children, youth and families have meaningful influence on the design of the CPA as we have stated that their needs must be prioritized. The Lead Agency should incorporate into its family and youth engagement, a consultation process for input and feedback on the proposed design of the CPA.

3. Hold discussions with the walk-in network and core service providers to discuss the creation of an integrated access system, including the best ways to ensure that clients contacting the CPA are not referred to waitlists.

4. Conduct a survey of intake practices of the core service providers to better understand how referrals would be made to each agency's programs and whether there is longer term potential to harmonize and simplify these intake practices as part of an integrated access system.

**Operating the CPA**

5. Explore opportunities to leverage infrastructure, access (hours of service), clinical and linguistic competencies through potential partnerships with organizations like Kids Help Phone, ACCESS Point (MOHLTC) and others.

6. Develop a method to assess potential client volume for the CPA.

7. Develop a budget for the first year of operation of the CPA, taking into account start-up costs, projected client volume in year 1, staffing and operational costs. Obtain necessary funding.

8. Determine staff qualifications, then recruit and train staff. Establish HR policies.

**Develop policies and protocols, tools, infrastructure and partnerships**

9. Develop a performance measurement and evaluation framework for the CPA.

10. Hold meetings to share information on the model with community partners, including other access mechanisms.

11. Develop and leverage existing capacity to screen in multiple languages. Develop partnerships with organizations that can help the CPA with interpretation.

12. Select an appropriate screening tool.

13. Identify the required functionality for the CPA's data system. If a common solution for the sector will not be in place when the CPA begins operation, choose a data system for the CPA that would be compatible with a larger solution in the future.

14. Develop a privacy and consent policy that complies with all relevant legislation, regulations and policy directives.

15. Develop a website containing information about all core service agencies and their services, to be launched when the CPA begins operation. Collect psychoeducational resources that can be added to the website.

16. Establish protocols for screening, referrals and the collection and maintenance of client and agency data.

17. Research availability of online tools and apps for online chat, booking appointments at core service agencies and screening in different languages.

**Communications and Marketing**
18. Develop and implement a communications and marketing strategy for the CPA.

| **Administrative/leadership Activities** | **Timeline** | **Considerations** |
|---|---|---|
| Establish expert advisory panel and create terms of reference | Q1 | |
| Establish a budget for year one | Q1 | Identify "core" items and ability to "ramp-up" as further funding and support is identified |
| Hire project manager | | Depending on the budget and other capacity considerations, consideration might be given to hiring a project manager to lead the development of the implementation plan |
| **Planning activities** | | |
| Develop a phased implementation plan and establish priorities for each phase and timetable | Q1 | |
| Develop evaluation strategy | | Includes key performance indicators for each phase and implement strategy for continuous quality improvement, benchmarks and scheduled review timeline |
| Develop an engagement strategy for relevant stakeholders to foster collaboration and commitment.<br>- Leverage expertise, capacity and competencies<br>- Identify existing strategies for engaging harder to reach and traditionally | Preliminary discussions have already started | In addition to core service agencies, organizations such as Kids Help Phone may provide opportunity to collaborate and provide an opportunity to leverage existing expertise and infrastructure through partnerships and agreements<br><br>Additional engagement strategy for the core |

| Administrative/leadership Activities | Timeline | Considerations |
|---|---|---|
| underserved populations | | service agencies to be developed<br>- Verify priorities<br>- Identify and verify agency and service programming information available<br>- Build system-wide "buy-in" on the development and implementation plan |
| Create strategy to estimate regional service utilization (demand) | | |
| **Model design activities** | | |
| Identify scope of basket of services | | Prioritize the services to ensure "core" services are identified. Additional services to be ready for inclusion as capacity and funding is available |
| Determine structure and location of service. | | Will be influenced by the discussions with relevant stakeholders and possible partners |
| Determine required technology including data base and social media. Ensure data base is compatible with agency specific systems. Establish information sharing protocols between the access system and service providers. | | Work with expert panel , review KIDS working group recommendations |
| Identify all area requiring policy and additional protocols (Privacy and Consents, warm transfers, triage and crisis management etc ) | | |
| Identify the processes necessary to ensure wait list information flows expeditiously to access system | | |
| Recruitment and training of staff for cultural competency, (and) suicide prevention, screening for client risk, triage competency, and safety planning | | Identify training needs |
| Develop and create a website | | Can be a "Quick win" and be developed simultaneously as telephone access component is being developed, and if possible, implemented as the first stage of the CPA providing valuable resources (including psychoeducational material) and information about local walk-in services and service agencies (using service mapping information and other resources) |
| **Full implementation** | | |
| Develop a communication/outreach strategy, including to marginalized populations | | Work with recommendations from the Communications Working Group as well as core service providers to ensure alignment of messaging and accurate, up to date information |
| Promote walk ins as phase one of new access system | | |