Evaluation of the Ottawa-Carleton Transitional Youth Program:

Transitional Program Based on a Shared Care Management Model

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Faculty/Presenter Disclosure

- **Faculty: Katharine Gillis**

- **Relationships with commercial interests:**
  - **Speakers Bureau/Honoraria:** nil
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Disclosure of Commercial Support

- **This program has received financial support from** no commercial entity
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- **Potential for conflict(s) of interest:**
  - Katharine Gillis has received no payment/funding, etc. from any commercial entity supporting this program AND/OR organization whose product (s) are being discussed in this program.
  - No commercial entity developed/licenses/distributes/benefits from the sale of a product that will be discussed in this program.

Mitigating Potential Bias

- N/A

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- Partner Organizations:
  - Youth Services Bureau, Canadian Mental Health Association, Dave Smith Centre, Royal Ottawa Mental Health Centre, Queensway-Carleton Hospital, Montfort Hospital, Children's Hospital of Eastern Ontario, Ottawa Hospital
- Funding Support:
  - Champlain LHIN, Ontario Centre of Excellence for Child and Youth Mental Health, CHEO RI, CIHR

Learning Objectives

1) To learn of existing models used to transition youth from child/youth mental health services to adult services

2) To learn how the Ottawa-Carelton Shared Care Management model has bridged two complex systems, Child and Adolescent Mental health Care Services and Adult mental Health Care Services, to better serve the needs of transitional youth.

3) To discuss the evaluation results for the youth who have transitioned

The Starting Point

- 70% of **mental health problems begin in childhood or adolescence** (Statistics Canada, 2002)
- 15 – 21% of children and youth at least one diagnosable mental health disorder (Ministry of Child and Youth Services, 2006)
- Only 1/6 with a mental health disorder (in Ontario) have received a mental health service for their condition in the past 6-months
- **Untreated** children and adolescents with mental health concerns become "**more vulnerable and less resilient**" with time (Wattie, 2003)

The Problem

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

(McGorry, 2007, p. s53)

Definitions

Transition

- "the purposeful **planned movement of adolescents** which chronic physical and mental conditions **from child-centered to adult-oriented health care systems**…to provide health care that is uninterrupted, coordinated, developmentally appropriate, psychosocially sound, and comprehensive" (Blum 1993, p. 570)
- "A way to enable and support a young person to move towards and onto a **new life stage**" (Beresford, 2004, p. 584)
- "A dynamic process with a **beginning, middle and end**" (McDonagh, 2006, p. 3)

Transfer

Transition Age

Definitions

Transition

Transfer

- Formal transfer: synonymous to transition
- Informal transfer: “termination of care by a children’s health provider which is re-established with an adult provider” (Burke et al., 2008) – **absence of coordinated movement**

Transition Age

Definitions

Transition

Transfer

Transition Age

- Typically 16-25 years
- Flexibility related to **chronological age** and **developmental age** is important

Importance of Optimal Transition

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

Facilitators to Effective Transition

- Empirically informed practice guidelines
  1. An **active**, future-focused process
  2. Y**oung-person-centered**
  3. I**nclusive** of parents/care-givers
  4. Starts **early**
  5. Resilience framework
  6. Multidisciplinary, inter-agency
  7. Involves **pediatric** and **adult** services, in addition to **primary care**

Facilitators… Cont.

8. Provision of **coordinated**, uninterrupted health care
   - Age and developmentally appropriate
   - Culturally appropriate
   - Comprehensive, flexible, responsive
   - Holistic – medical, psychosocial and educational/vocational aspects
9. **Skills training** for the young person in communication, decision-making, assertiveness, self-care, and self-management.
10. Enhance **sense of control** and interdependence in healthcare
11. To maximize life-long functioning and potential

Barriers to Effective Transition

1. Time
2. Different Care Philosophies
3. Training
4. Financial – insurance resources for service provision
5. Difference perceptions of young person, parents, providers
6. Attitudinal
7. Discomfort of professionals involved
8. Difficulty accessing resources
9. Poor intra-agency coordination
10. Poor inter-agency coordination
11. Difficulties addressing parental issues
12. Adolescent resistance
13. Family resistance
14. Lack of institutional support/lack of local protocols and procedures to guide transitions
15. Lack of planning
16. Lack of appropriate adult specialists
17. Arbitrary age restrictions

Action or Inaction

- Grass roots approach
- Broad interest that was maintained over time
  - Youth Services Bureau, Canadian Mental Health Association, Dave Smith Centre, Royal Ottawa Mental Health Centre, Queensway-Carleton Hospital, Montfort Hospital, Children's Hospital of Eastern Ontario, Ottawa Hospital

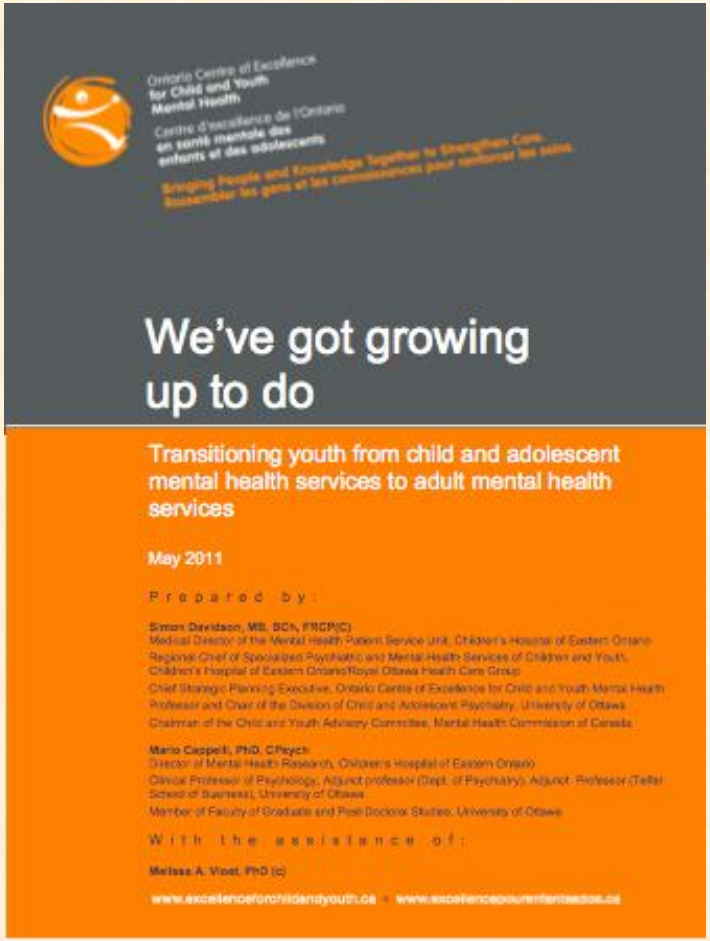
Funding Support:

- Champlain LHIN, Ontario Centre of Excellence for Child and Youth Mental Health, CHEO RI, CIHR

Policy Maker Meeting: Practice level considerations

1. **Developmental considerations** should play a major role in helping to direct transitional process for youth
2. Transitional **planning needs to be initiated earlier** in the process, and transitional care plans need to be **flexible** to adapt to difference service environments and the needs of the youth involved
3. Transitional planning needs to be viewed as a **shared responsibility** rather than risk transfer
4. **AMHS (adult mental health services) perspectives** need to be engaged at both the **policy and service levels** in order to support a successful model of transition for youth
5. **Families are important stakeholders** and need to be engaged in the transition process while still respecting the burgeoning autonomy of youth in transition

Ontario Policy Paper



http://www.excellenceforchildandyouth.ca/sites/default/files/policy_growing_up_to_do.pdf

Transitional Models

Reciprocal Service Agreements (BRIDGE & TRACK Studies, UK)

- Having agreements to direct the transition helps clarify roles and responsibilities
- Protocols must be realistic given the context of the service and they must be used to be effective
- Often relies on chronological age

Standalone Transition Service Providers (e.g., "Orygen" & "Headspace" in Melbourne,Australia, "Youthspace" in UK)

- Prioritizes the transition for youth
- Targets youth from 12-25
- Considers developmental age
- Costly and contingent upon stakeholder buy-in at multiple government and community levels.
- Youth encounter two transitions: at entry and exit.

Transition Teams

- Better coordination of care
- Shared Management Model
- Assists in the management of responsibility concerns.
- CAMHS-AMHS Team Collaboration
- Costs associated
- Requires buy-in by service providers.
- Untried in mental health

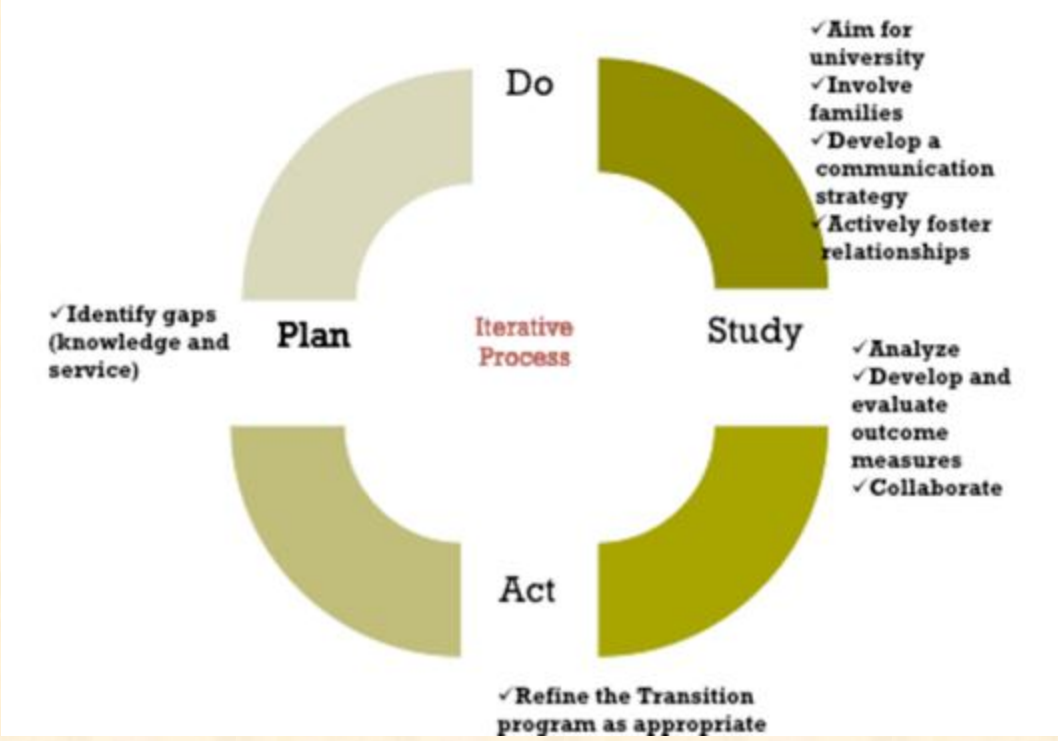
Model selection

Shared Management Model

- A **transition team** is created to support youth transitioning between child and adult health service organizations. Typically, clinics operate out of both locations and employ a **transitions coordinator**
- Identified as a **leading process** in healthcare (LIFEspan model; Accreditation Canada, 2008)
- Aligns with SCMHA of Ontario (2008) recommendations advocating for **system navigators** for youth and families moving through the CAMHS/AMHS transition
- Supports the use of "**tools**" that are intended to act as treatment plans and protocols for individual service users

Model selection

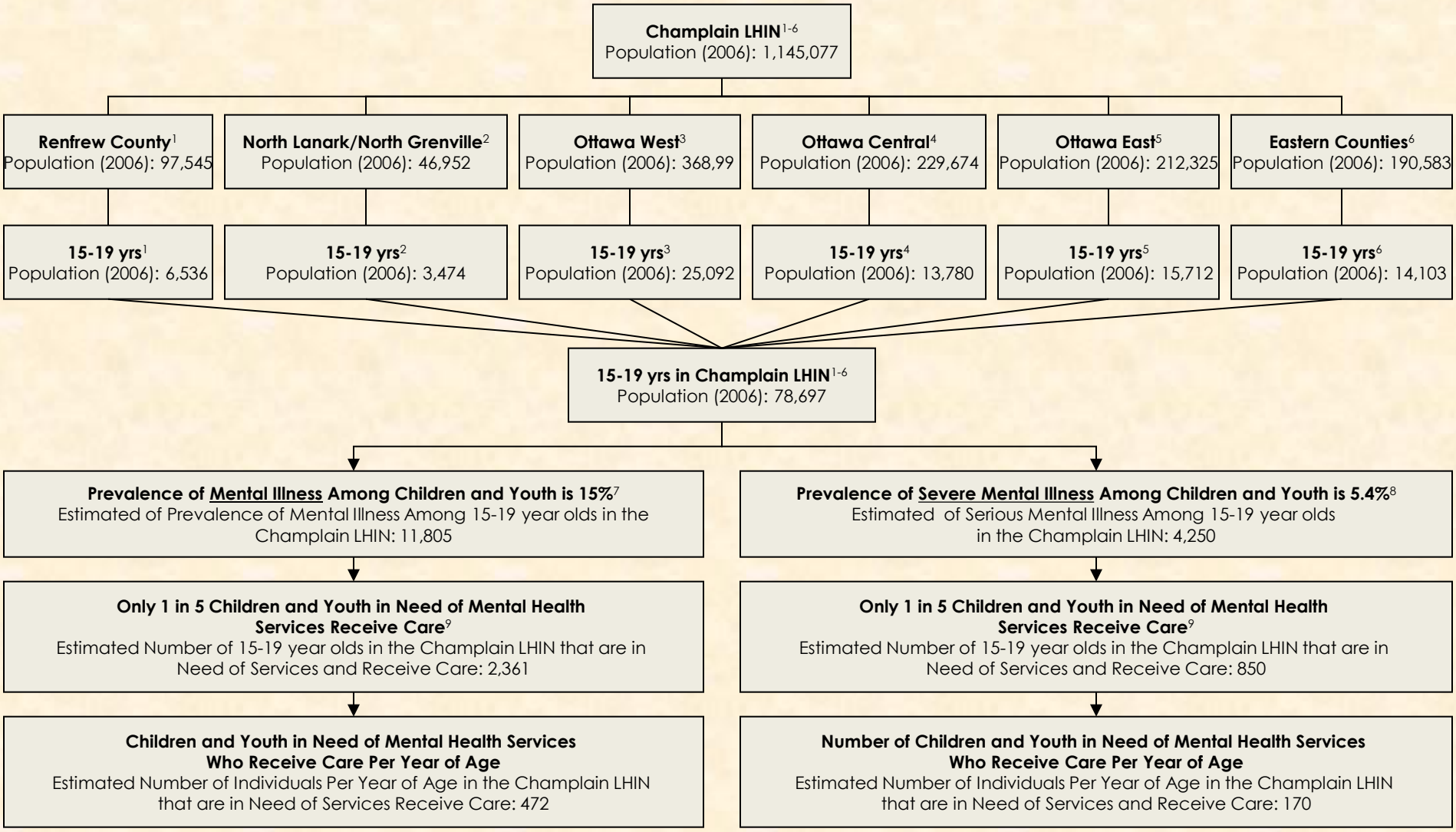
- **Transitions Coordinators** can help direct the "**development** of a transition program while also assisting with **training**, **evaluation**, and even **management** of a transition clinic, among other tasks." (PCMCH, 2009, p.14).
- This team approach facilitates the transition between programs and reflects a **planned** and **coordinated** methodology.



Ottawa Mental Health Transitional Youth Program

Activities
1. Define Scope of Problem
2. Identify Partners and Contributions
3. Identify Referral Criteria
4. Developing Standard Case Review Process
5. Hiring of Transitions Coordinator
6. Develop and Implement an Evaluation Platform

Scope of Problem



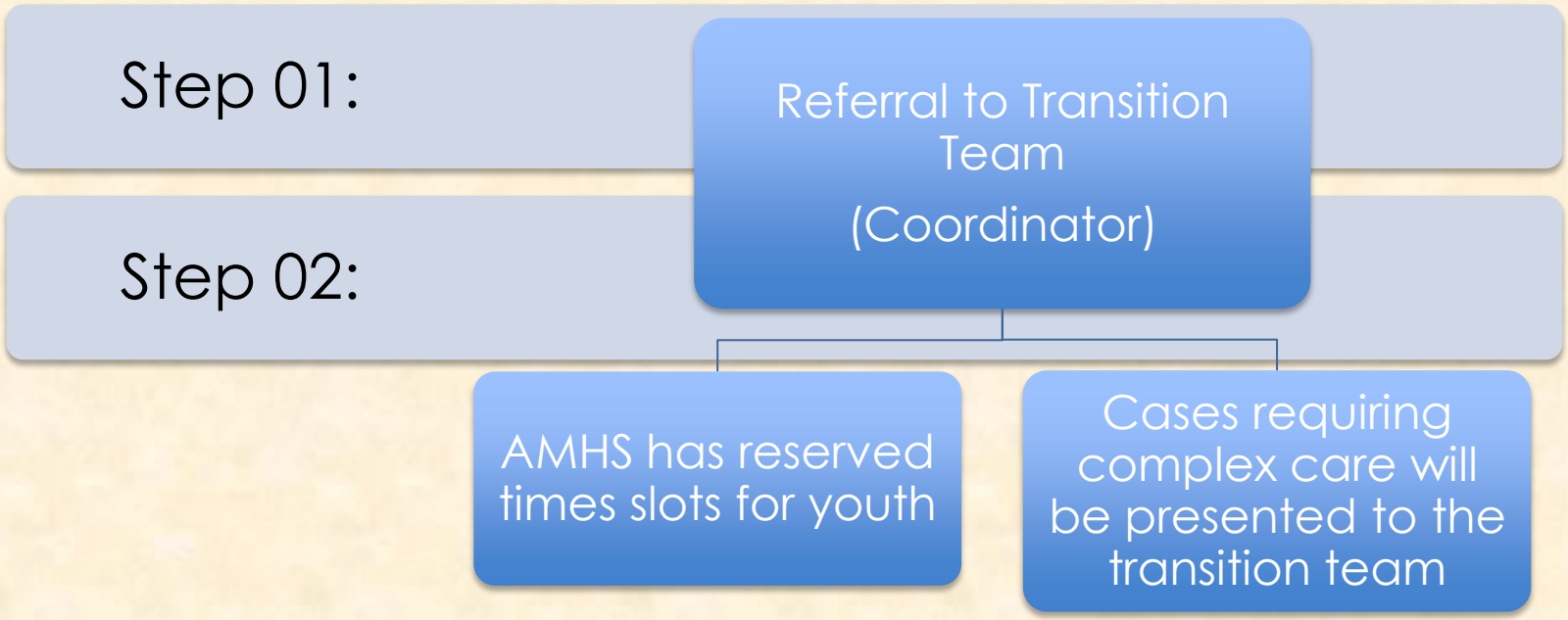
Partner Contributions

Partner	Contribution
Royal Ottawa Health Care Group	Recovery Service Unit Program Urgent Care Consultation Service (prioritized within 2 weeks for medication consult and/or diagnostic clarification) Telehealth Clinical Bridging Service to Schizophrenia Team Phone Consultation
Canadian Mental Health Association	Outreach Services DBT Concurrent Disorders Service Intensive Case Management Dual Diagnosis Team
Youth Services Bureau	Walk-in Clinic Intensive Case Management Wraparound Services Counseling Family Therapy
Queensway-Carleton Hospital	Commitment to accept up to 10% of patients enrolled in the transitions program Psychiatric consultations and some allied health involvement
The Ottawa Hospital	ON Track Program Eating Disorder Program
Dave Smith Treatment Centre	Residential and Community-Based Substance Abuse Treatment Comprehensive Substance Use Assessment (including the GAIN Q, the GAIN I and other tools to do an assessment – specifically for problematic use & abuse or dependence) Priority Referrals
Montfort	Psychiatric Consultation Day Treatment Program Short-term Psychiatric Involvement
Children's Hospital of Eastern Ontario	Continued involvement of CAHMS providers during period of parallel care Research Contributions

Referral Criteria/Guidelines

- Youth 16 to 24 years of age, living in Ottawa (may also be receiving services from Ottawa provider)
- In active care of project partner
- Complex mental health problems such as bipolar, psychosis, co-occurring substance use and mental illness, as well as comorbidity/possible personality disorder
- May be in need of specialized assessment to facilitate transition to AMHS
- Current provider agrees to be involved in developing transitional plan of care and participating actively in transition team
- In need of services that are available from partners
- In need of integrated multiple services (more than one)

Standard Case Review Process



Shared Management Model

ADVISORY COMMITTEE

Committee Member	Partner Organization
Glen Barnes	Dave Smith Centre
Jean-Claude Bisserbe	Royal Ottawa Mental Health Centre
Clare Gray	Children's Hospital of Ottawa Ontario
Elaine Medline, Louise Grenier, Nicole Lafreniere-Davis	Champlain LHIN
Wendy Cole	Queensway-Carleton Hospital
Elizabeth Druss	The Ottawa Hospital
Alison Freeland	Royal Ottawa Mental Health Centre
Katharine Gillis	The Ottawa Hospital
Francine Gravelle	Youth Services Bureau
Hazen Gandy	Children's Hospital of Ottawa Ontario
Joanne Lowe	Youth Services Bureau
John Lyons	University of Ottawa
Simon Davidson	Children's Hospital of Ottawa Ontario
Karen Tataryn	Children's Hospital of Ottawa Ontario
Bruce Kennedy	The Ottawa Hospital
Diane Lavallee	Monfort
Anne MacDonald	Queensway-Carleton Hospital
Colleen MacPhee	The Ottawa Hospital
Alison Middlebro	Royal Ottawa Mental Health Centre
Christine Slepanki	Royal Ottawa Mental Health Centre
Robert Swenson	The Ottawa Hospital
Audrey Tedford	Canadian Mental Health Association
Smita Thatte	Royal Ottawa Mental Health Centre

IN-KIND CONTRIBUTIONS

PARTNER	CONTRIBUTION
Royal Ottawa Health Care Group	Recovery Service Unit Program Urgent Care Consultation Service (prioritized within 2 weeks for medication consult and/or diagnostic clarification) Telehealth Clinical Bridging Service to Schizophrenia Team Phone Consultation
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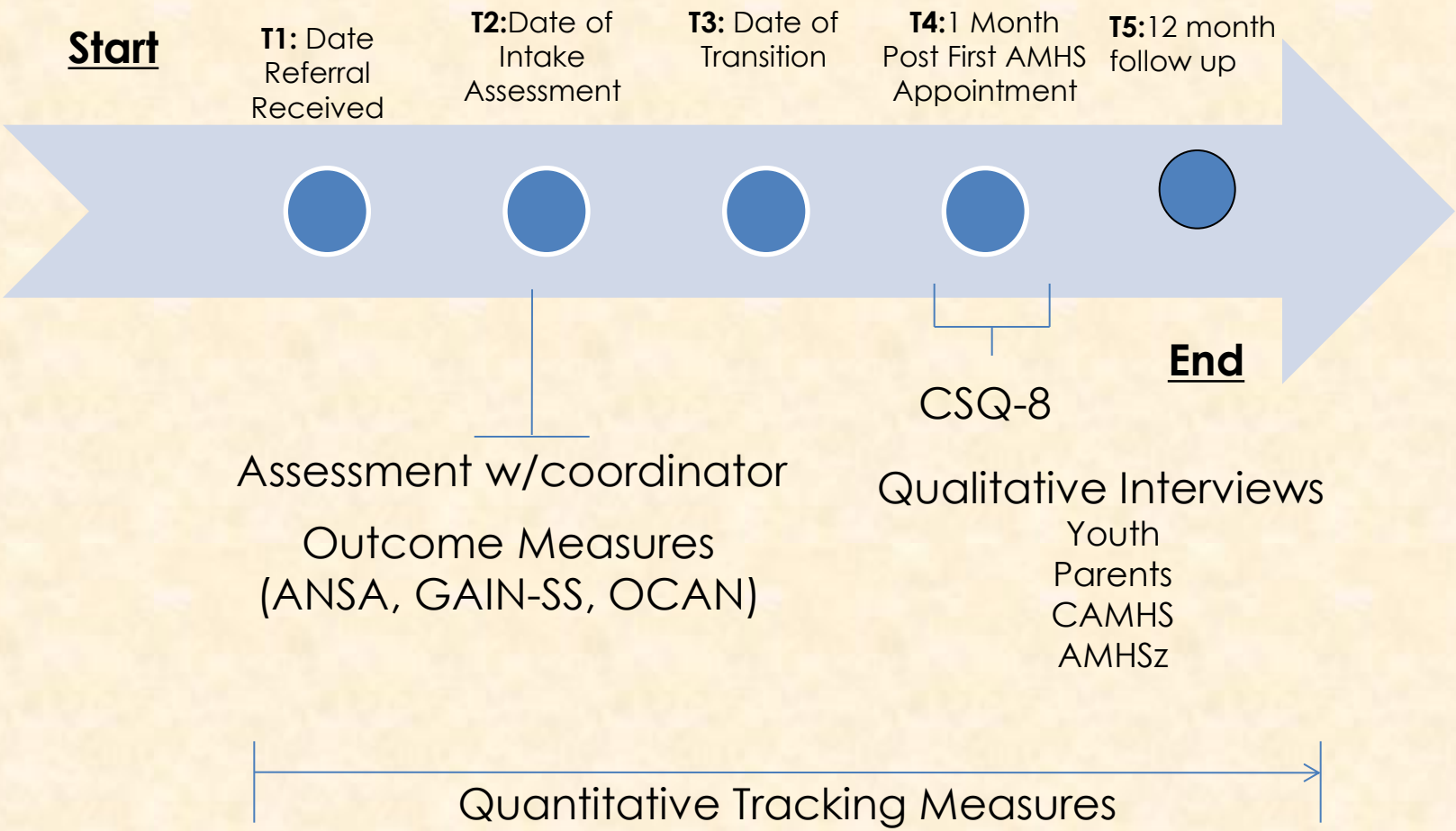
CAMHS

COORDINATOR

Evaluation Platform

Construct	Measure	Data Source
Transition Process	Tracking Tools (Cappelli, 2010) Qualitative Interviews	Transition Coordinator Chart Reviews CAMHS Provider AMHS Provider
Mental Health	Ontario Common Assessment of Need Intake Interview	Transition Coordinator Youth Caregiver
Substance Use	Global Appraisal of Individual Needs Short Screener (GAIN-SS) Intake Interview	Youth
Needs, Strengths and Service Planning	Adult Needs and Strengths Assessment Intake Interview	Transition Coordinator CAMHS Provider AMHS Provider Youth Caregiver
Client Satisfaction	Client Satisfaction Questionnaire Qualitative Interviews	Youth Caregiver
Organizational and Provider Response	Tracking Tools Qualitative Interviews	Clinical Case Review Committee CAMHS Provider AMHS Provider

Schedule of Measures



Results - Demographics

- As of February 2013 (approximately 20 months) 156 referrals.
- 137 accepted services (88%)
- 1 suicide death

- 63.5% of youth are female and 36.5% are male

- The mean age at time of referral was 17.66 (SD = 0.82)

- 18.8% of youth had CAS (Children's Aid Society) involvement

- 76.9% of youth live with their parents, 7.7% live on their own, 3.9% live with a relative or friend, 7.7% live at a shelter/home, and 3.8% live in a group home

- 80% of youth had a family history of mental illness (88.9% mother, 70.8% father, 51.7% sibling)

Our Results: Diagnosis

Diagnoses	DX at time of referral to transitions program (%)
Anxiety Disorders	66.4
Mood Disorders	57.5
Disorders usually first diagnosed in infancy, childhood, or adolescence	38
Substance-Related Disorders	20.9
Schizophrenia and other Psychotic Disorders	9
Personality Disorders	9
Eating Disorders	3.7
Somatoform Disorders	1.5
Additional (Academic problems, relational problems)	17.9

Results: Comorbidity

Number of diagnoses	DX at time of referral to transitions program (%)
1	9.6
2	24
3	26
4	23.1
5+	17.3

Results – GAIN-SS Highlights

Internalizing Disorders: 96% of youth in the transition program reported scores falling in the moderate to high range.

Externalizing Disorders: Analyses of the sample revealed that 86% of youth scored in the moderate to high range in this domain, with 62% of these endorsing a level of need that falls in the high range.

Substance Disorders: Over half the youth, 54%, enrolled in the transition program indicated a need for clinical intervention to address substance-related problems.

Crime/Violence: Over half the youth (52%) enrolled in the transition program reported moderate to high levels of need to address problems in this domain.

Results – Linkages to Services

Overall Links to Services

- **From first referral to program (Time 1) to assessment by coordinator (Time 2): N=137**
  - M = 61 days (SD=53.1)
- **From assessment by coordinator (Time 2) to first appointment at AMHS (Time 3): N=56**
  - M = 100 Days (SD=66.7)
- **Still on the Wait list for adult services: N=81 (59%)**
  - M = 243 Days (SD=179.3)

Results – Linkages to Services

Links to Services Over Time

Timeframe	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
Time 1-Time 2 (N = 137)	68 days (n = 33)	79 days* (n = 35)	59 days (n = 33)	37 days* (n = 36)
Time 2-Time 3 (N = 56)	106 days (n = 21)	113 days (n = 14)	92 days (n = 16)	66 days (n = 5)

Note: * = significantly different wait times

Comparison between transitioned and wait-listed youth

- We cannot find differences:
  - Acuity
  - Diagnosis
  - Reason for referral
  - Source of referral
  - Adult service destination
  - Gender

Follow Up: Transitioning

What has your transition experience been like?	
Theme 01: Enjoyed working with the coordinator	It was very good. Coordinator was very personable, easy to talk to I enjoyed the sessions through the coordinator's assessment
	The jump to moving to adult services was initially very scary to me, so seeing someone who would help me through this process was reassuring
Theme 03: Involvement in Care Plan	Its more like me having to volunteer on my part than being forced into it like in the past
Theme 04: Easier to access AMHS	It makes it easier to access AMHS It assists in the process without [people] being forgotten or having to sit on a long wait list before being seen
Theme 05: Supportive Team	Everyone seemed to be 'on my team' wanting me to get better I felt very supported
On a scale of 1 to 10 with 1 being not satisfied at all and 10 being very satisfied, how satisfied were you with your transition experience?	
Theme 01: High Level of Satisfaction	"8" the experience was very good "10" I didn't see any negative component "10" everything went very smoothly "10," everything is good. I was given all the tools to work it through and given all the necessary info "10" a lot faster than my usual experiences "10" it was very smooth "7" It could have been a 10 if the services could have been immediate

Local Implications:

- Positive:
  - Engaged hospital and community services
  - Increased awareness of transition issues
  - Recognition of the wait times
  - Commitment to ongoing evaluation
- Limitations:
  - Sustainability of in-kind contributions
  - Role of the coordinator (overextended)
  - Minimal primary care engagement

Ontario Centre of Excellence for Child and Youth Mental Health

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CIHR Meeting

An International Perspective on Youth Transitions

Thank you!

Questions??