Ten years of research in collaborative youth mental health (YMH) care in multiethnic and socioeconomically diverse neighbourhoods: lessons learned

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**PRESENTER DISCLOSURE**

- **Presenters:** Lucie Nadeau, Janique Johnson-Lafleuer, Cécile Rousseau
- The presenters have not received any commercial support and have no conflicts to declare
- This work was supported by the *Fonds de la recherche en santé du Québec* (FRSQ), the Quebec Ministries of Health and Social Services (MSSS) and Education, Recreation and Sports (MELS), the *Centre de liaison sur l’intervention et la prévention psychosociales* (CLIPP), and the Canadian Institutes of Health Research (CIHR)
Thank you to all participants and the research team

Researchers and research assistant
(in alphabetical order)

LEARNING OBJECTIVES

• **Learning Objective 1**
  Gain knowledge related to challenges and facilitators of collaborative YMH care in multiethnic and socioeconomically diverse neighbourhood

• **Learning Objective 2**
  Reflect on the influence of reforms and institutional environments on collaborative YMH care services

• **Learning Objective 3**
  Appreciate the benefit of mixed-method and multi informant (youth, parents, clinicians) complementary perspectives in research in collaborative YMH care
Research program in collaborative youth mental health (YMH) care

**2007-2011 (CIHR, MSSS)**
Research projects: “Implementation of shared care in YMH”
“Shared care in YMH in multiethnic neighborhoods”

**2012-2017 (FRSQ, MSSS, MELS, CIHR)**
Research projects on collaborative care in YMH

- Research projects on clinical outcomes
- Research projects on training initiatives

**2014 (+CLIPP)**
Implementation of a Community of Practice

Methods
QL: Qualitative
QT: Quantitative
2007-2011: Main research results (QL + QT)

Importance of clinical interprofessional **discussions**, modulated modes of **communication** and **harmonizing administrative and clinical priorities**

Importance of **continuity of care** and a **welcoming environment**

Importance of addressing **cultural differences** between families and professionals

Importance of integrating **family interventions**


Objectives of the CoP are:
• To facilitate the exchange of expertise and knowledge
• To encourage a culture of interprofessional and interorganizational collaboration

Activities

Lunchtime thematic discussions
(Average of 20 participants)

Interorganizational half-day meetings
(Average of 40 participants)

Newsletter to CoP members
To vitalize exchanges and inform (research info, KT activities, etc.)

Web platform
(communaute-smj.sherpa-recherche.com)

- Resources (articles, podcasts, tools, links)
  - Thematic fact sheets
  - Members’ directory
  - Discussion forum
Reviewed after its implementation
Community of Practice: evaluation (N=46)

**Satisfaction**
- I’m satisfied with my experience (76%)
- The themes interest me (81%)
- I have an interest in participating to activities (65%)

**Impacts**
- The CoP is useful for my practice (71%)
- My participation allows me to reflect on my practice (79%)
- To be a member allows me to feel less isolated (65%)

**Liveliness**
- I want to share experiences (59%) and resources (64%)
- I feel comfortable to speak during activities (37%)
- I have the impression that I have things to bring to the group (52%)

“An enrichment and a pause necessary to reflect on our clinical practice.”

“Pooling of experiences, professional stimulation, important hindsight on our practices.”

“Resourcing.”
2012-2017: Research program

Research projects on clinical outcomes
- “Partnership and youth clinical outcomes”
- “Characteristics of interventions and quality of services”

Research projects on training initiatives
- “Continuing education and interinstitutional concertation”
2012-2017: Research program

Research projects on clinical outcomes

- “Partnership and youth clinical outcomes”
- “Characteristics of interventions and quality of services”
2012-2017: Research program

TYPE OF INTERVENTION
- Individual (psychotherapy or medication)
- Systemic (including family intervention / therapy)
- Multimodal (mixed)

SOCIAL FACTORS (psychosocial adversity)
- Socioeconomic status
- Migratory status and duration of migration (if relevant)

FAMILY FACTORS
- Household size / Single parent or Two parent
- Parents’ level of education / Proficiency of an official language
- Family cohesion and conflict (FES)

INDIVIDUAL FACTORS
- Age / Gender / Clinical presentation at T0 (Dx et SDQ)

QUALITY OF SERVICES
- Outcome (SDQ)
  (associated symptoms and dysfunction)
  T0 - T1 (6 months) - T2 (1 year)

QUALITY OF PARTNERSHIP
- Perception of Interprofessional collaboration (PINCOM.Q)
- Shared decision-making comfort (ECD-p)

INSTITUTIONAL CHARACTERISTICS
- Duration of the «Guichet d’accès»
  (single window-access mechanism)
- Respondent psychiatrists’ model
Clinical outcomes: Main research results

QT (preliminary results): clinical outcomes

QT (preliminary results): organizational factors

QT: Social and family factors

QT + QL (preliminary results): types of interventions


QT (preliminary results): clinical outcomes

Significant decrease in symptoms

(Emotional and behavioral difficulties score - SDQ)

\[ M_{ET} \]

<table>
<thead>
<tr>
<th></th>
<th>T0</th>
<th>T1</th>
<th>T2</th>
</tr>
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<tbody>
<tr>
<td>ET</td>
<td>15.77 (6.37)</td>
<td>14.86 (6.45)</td>
<td>12.50 (6.65)</td>
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</table>

\[ F(2,87) = 18.09, p < .001 \]

Significant decrease in impairment

(Impact scores - SDQ)

\[ M_{ET} \]

<table>
<thead>
<tr>
<th></th>
<th>T0</th>
<th>T1</th>
<th>T2</th>
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</thead>
<tbody>
<tr>
<td>ET</td>
<td>3.46 (2.66)</td>
<td>2.94 (2.68)</td>
<td>2.32 (2.67)</td>
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</tbody>
</table>

\[ F(2,87) = 15.66, p < .001 \]

Decrease in levels of family conflicts

(FES scores)
A better **perception of interprofessional collaboration** is associated with a decrease in emotional and behavioral difficulties, and a decrease in level of family conflicts, between T0 (baseline) and T1 (6 months).

A greater **comfort in decision-making processes** leading to choice of intervention is associated with less emotional and behavioral difficulties, and with a lower impact score (T1).
Family conflicts have a significant role in behavioral and emotional problems in youth

Family environment is more central as a contributing factor compared with poverty and immigration

Importance of taking into account the specific characteristics of the immigrant population studied

Interventions aiming at engaging families and transforming family environment are promising in YMH, as well as collaborative models of services supporting primary care settings in addressing family issues
Children who received the systemic therapy had greater symptoms (T0-T1-T2) and greater family conflicts (T0) than those who received the mixed therapy.

Children who received the systemic and mixed therapy had a significant decrease in overall impairment (T0-T2).

Children who received the mixed therapy had a significant decrease of symptoms over time (T0-T1-T2).

Children who received the systemic therapy had a significant decrease in family conflicts over time (T0-T2).

QT (preliminary results): types of intervention

- Individual (14%)
- Systemic (21%)
- Mixed (65%)
QL: Types of interventions (and process of care)

Welcoming process
Explanatory Model
Shared decision-making
Type of therapy
Outcome


Participants (sub-sample of immigrant families)

- Narratives from triads of youth (or child), parents, primary clinician

N=22 triads
(99 individual interviews)
- At T1 (post 6 months)
- and T2 (post 1 year)
• Engagement in therapy closely linked to comfort with the welcoming process.

• Importance of the care setting (rooms, waiting room, welcoming process)

• Importance for the institutions to welcome different languages (and use interpreters)
• No clear divergence in models, contrary to expected, but divergence in terms of attitude towards treatment

• Rather a multi-factorial model often with family adhering to part or whole.

• Narratives around culture rarely expressed, more so about context
• Active (we) vs passive (they) position towards decision regarding therapy, but not necessarily indicative of type of engagement / outcome.

  ▪ Active position usually associated with positive outcome / some passive position indicative of poor alliance / Some passive position while confidence in services and therapist and engaging well in therapeutic process (Particularly in cases of trauma)

• Determined in part by (cultural) values (politeness, tendency towards more paternalist representation of clinician-patient rapport, importance of performance) and family characteristics and clinician’s attitude.

• Lack of knowledge of the system, unclear what can be offered, and what each profession does.
• Individual therapy rarely a definite plan.
  ▫ Individual work may be a first step if the parent(s) is too fragile, or because of major conflict, or of absence of parent

• Much family intervention / therapy: not a classic family therapy

• Much need to adapt to the family context, challenges
• Some examples of outcome being negatively influence by incapacity to develop a shared decision-making

• Family therapy / intervention without individual can mean less influence on one prominent symptom as per parent, yet much influence on family dynamics. (converging with QT results)
2012-2017
Research program on collaborative care in YMH

Research projects on training initiatives

• “Continuing education and interinstitutional concertation”
Continuing education in transcultural (youth) mental health for professionals and trainees

Monthly 3-hour meetings bringing together professionals from health and social service institutions (primary care), youth protection and schools

In depth clinical case discussions around a situation brought by a team (alternating each month between institutions)

What are Interdisciplinary Case Discussion (ICD) Seminars?

Research objectives of the evaluative study (2013-2015)

➢ To study the impact of ICD Seminars in terms of:
  • The transfer of clinical knowledge and clinical know-how
  • The quality of partnerships
  • The subjective experience of participants
Research results

ICD seminars: improve interventions

- Improve the evaluative capacities of professionals (information collection)
- Encourage taking into account and integrating biological, family, social and cultural factors
- Support the elaboration of a multimodal intervention

Research results

ICD seminars: facilitate partnership

- Help to overcome interdisciplinary barriers and to work in complementarity
- Help to deconstruct prejudices and build bridges between the institutions
- Facilitate referrals and joint working

Lessons learned

• Collaborative care in YMH requires **time and spaces for dialogue**
  ▫ For actors to engage in the process
  ▫ To self-reflect
  ▫ To empower clinicians as actors in YMH (agency)
  ▫ To empower patients and families
  ▫ To built confidence on the process of collaboration
• Continuity of care and organizational culture influence outcomes
• Need for an equilibrium between individual and family interventions
• Usefulness of research: a voice for all actors
Thank you

18th Canadian Collaborative Mental Health Care Conference (2017)

Connecting People in Need with Care

June 2 and 3, 2017 | Delta City Centre, Ottawa, Ontario
EXTRA SLIDES
Case illustration 1

F 12, 2nd generation migrant from South Asia
Anxiety dx, family hx of organized violence

Welcoming process
- Friendly and bilingual clinician
- Confidential room at school
- Mother knows of care institution since adolescence

Explanatory model
- Parent: anxiety transmitted during pregnancy / reinforced by book from India // clinician: fright experiences

Shared decision-making
- Active stance of parents
- Good alliance

Type of therapy
- Mostly individual
- CBT classic
- Healing as well through spirituality

Culture
- Mother recall of an identity of immigrant as adolescent
  “Now culture, ethnic, not much important”

Outcome
- Good outcome
Case illustration 2

M 10, 1st generation recent migrant, Syria
Aggressivity and depression

Welcoming process
Both parent and youth confident in CLSC
Rapid access to care
CLSC “is choosing the right persons”

Explanatory model
Both parent and clinician explain difficulties from bullying (discrimination) and adjustment to immigration

Shared decision-making
Active stance of parents
Good alliance

Type of therapy
Mixed (individual and familial)

Culture
“Bring me back to Syria!”
Both youth and parent in close contact with community

Outcome
Victim of physical abuse by peer during follow-up
Still fragile at T2
Family moving = discontinuity
Case illustration 3

F 14, 1st generation migrant from Jordan
Anxiety dx, perfectionist, major family conflicts

Welcoming process
- Comfortable at CLSC
- Fast access to care
- Feels respected

Explanatory model
- Parent T1: anxiety from youth / T2: contribution of family conflicts / clinician: fright experiences
- Passive stance of parents and youth
  T1: Mother wanted psychologist / T2 agree with SW
  But respected in wish not to repeat art therapy

Shared decision-making
- Mostly familial
  Addresses family conflicts

Type of therapy
- Value of autonomy promoted by clinician / mother felt unrespected by negative comment of child about country of origin / “we are really modern and Canadian, not like real Arab”

Culture

Outcome
- Partial ↓ of Σ
  Improved family dynamics

"It was as if... little by little, the home was becoming less and less stressed." - youth
Research projects
“Partnership and youth clinical outcomes” (QUAN)
“Characteristics of interventions and quality of services” (QUAL)

### Participants (QUAN)

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<thead>
<tr>
<th></th>
<th>DLM</th>
<th>BCS</th>
<th>SOV</th>
<th>CVD</th>
<th>ODI</th>
<th>DLL</th>
<th>PSC</th>
<th>TOTAL</th>
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<td>5</td>
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### Participants (QUAL)

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<tr>
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<td>6</td>
<td>5</td>
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## Participant characteristics (n = 125)

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<td>Participating parent</td>
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<td>Mother</td>
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<tr>
<td>Father</td>
<td>22</td>
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<td>Child gender</td>
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<td>Boys</td>
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<td>Girls</td>
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<tr>
<td>Parent born in Canada</td>
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<tr>
<td>If no, number of years in Canada (M = 10 years, SD = 7.13, range 1-49)</td>
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<tr>
<td>Child born in Canada</td>
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Research projects
“Partnership and youth clinical outcomes”
“Characteristics of interventions and quality of services”

Quantitative analyses (preliminary results): organizational factors

Structure, models of services and partnership

- A better perception of interprofessional collaboration is associated with a decrease in emotional and behavioral difficulties, and a decrease in level of family conflicts, between T0 (baseline) and T1 (6 months).

<table>
<thead>
<tr>
<th>Variables</th>
<th>Change in difficulty score between T0-T1 (parent)</th>
<th>Change in family conflict score between T0-T1 (parent)</th>
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<td>-.39</td>
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<tr>
<td>R²</td>
<td>.08</td>
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<td>F</td>
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</table>

*p < .05, † < .08
Research projects
“Partnership and youth clinical outcomes”
“Characteristics of interventions and quality of services”

Quantitative analyses (preliminary results): organizational factors

Structure, models of services and partnership

- A greater comfort in decision-making processes leading to choice of intervention is associated with less emotional and behavioral difficulties, and with a lower impact score.

<table>
<thead>
<tr>
<th>Variables</th>
<th>Difficulty score T1 (parent)</th>
<th>Impact score T1 (parent)</th>
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<td>β</td>
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<td>Decision-making process leading to choice of intervention</td>
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<td>R²</td>
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<tr>
<td>F</td>
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<td>6,39*</td>
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*p < .05