The Hamilton Family Health Team

Program Evaluation

The Primary Care Child & Youth Mental Health Initiative

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Executive Summary:

As part of recent primary health care reform by the Ministry of Health and Long Term Care (MOHLTC), in 2005 the Ontario government approved the formation of 150 Family Health Teams (FHT’s) across the province. Family Health Teams are larger-scale associations of Family Physician’s (FPs) offices, designed to provide new opportunities to develop collaborative inter-disciplinary teams, thereby providing more comprehensive health care across client life-spans.

The Hamilton Family Health Team (HFHT) is the largest FHT in Ontario, consisting of approximately 150 FPs, partnered with nurses, nurse practitioners, dietitians, mental health counsellors (MHCs), psychiatrists and pharmacists to provide comprehensive and collaborative primary care to over 375,000 people in greater Hamilton.

During the formation of the HFHT, the MOHLTC funded a 2 year pilot project, known as the Child & Youth Mental Health Initiative (C&YMHI), to develop and implement child and youth mental health services within the primary care setting.

The C&Y MHI has been in operation for three years and is a “stepped model” of care providing direct clinical services in “pilot site” FP practices, as well as a broad range of services across the HFHT.

As the HFHT makes plans for future development and sustainability of child and youth mental health in the primary care setting, it is critical to review the findings to ensure the effectiveness and successful uptake of such a model of care.
The objectives of the evaluation were to assess the effectiveness of the capacity building “stepped approach” model employed by the HFHT C&Y MHI, and to develop and implement a “toolkit” of clinical resources to assist other FP practices interested in implementing this program.

Information gathered in this evaluation will be used to inform improvements and expansion of the C&Y MHI.

The program evaluation invited all healthcare providers working within the C&Y “pilot site” practice teams, as well as, children, youth and families who were referred for Child and youth mental health services at the pilot sites to participate in one or more of the evaluation activities.

Many sources of information and evaluation methods were used including questionnaires, one-on-one interviews, focus groups, administrative data abstraction, and referral tracking.

The evaluation methodology was approved by the Research Ethics Board (REB) of St. Joseph’s Healthcare Hamilton; and Hamilton Health Sciences/McMaster University of Health Sciences; and their affiliated institutions.

The key findings of the evaluation were as follows:

**Objective 1:** To evaluate the effectiveness of the capacity building “stepped approach” model employed by the HFHT Child & Youth Mental Health Initiative
In 2007, the Child & Youth Mental Health Counsellors (C&YMHCs) provided service for 18% of the overall Child and youth referrals to the Mental Health Program (MHP). In 2008 there was a significant increase, with 29% of overall MHP referrals for Children & Youth seen by C&YMHCs. Across all the family practices in 2008, there were a total of 47 telephone, email and fax consultation requests between the general MHCs and C&YMHCs. The consultations were requested by 19% of the general MHCs. In 2009 there were 90 consultations, an increase of 87%, with 49% of the general MHCs seeking consultations. Consultations between the C&YMHCs and the FPs went from 0 in 2008 to 9 in 2009.

There were a total of 88 Child and youth consultations via telephone, email or fax with the Child and youth psychiatrist for a period of 11 months from Sept 08 to July 09 throughout the organization. FPs represented 35% of the consultations, 9% were made by MHCs, and 56% were sought by the C&YMHCs. Non pilot site FPs represented 34% of the consultations, with 66% at pilot site practices. Comorbid conditions were reported in 73% of the child and youth referrals seeking consultation with the child psychiatrist. The most common presenting concerns for psychiatric consultation were ADHD, Anxiety, Depression and Oppositional Defiant Disorder.

In 2007 (Apr 07 to Mar 08) there were 196 patient requests (to Contact Hamilton, the single point of access for Child and youth mental health services in Hamilton) for Child & Youth Mental Health services, versus 385 in 2008/2009 (Apr 08 to Mar 09). This indicates a 96% increase in request volume. For both years, 80% of the requests came from patients at non pilot site family practices.
From Apr 07 to Mar 08 there were 38 requests for child and youth services made to Contact Hamilton by a HFHT family practice on behalf of a patient. There were 43 requests or a 13% increase for the period of 2008 to 2009.

Patient satisfaction questionnaires, as well as Child and youth surveys, indicated a high degree of satisfaction with the C&Y MHI services - 91% rated the counseling session to be helpful or very helpful and 94% stated that they are very likely to follow-up if they needed to see a MHC for their child in the future. On-site access made it convenient to use services, and ready availability of the C&Y MHCs was greatly appreciated. Having services and information in one location with health care professionals who have established relationships with the patient enriches the quality and continuity of care. Trust and a positive relationship between the patient and the FP had a positive impact on trust building with the counsellor.

**Objective 2:** To develop and implement a “toolkit” of resources to assist primary care practices within the HFHT and other Family Health Teams in Ontario interested in implementing this program.

A self-administered early identification questionnaire - The C&Y Detection Questionnaire (used to assist primary care teams in identifying risk-factors and symptoms consistent with mental health problems), and the C&Y Community Service Tool (child and youth mental health system navigation tool) were developed and presented to MHCs, FP teams and Practice Administrators. Pre, post and follow-up questionnaires were administered regarding knowledge transfer, increased awareness and comfort of accessing community child and youth mental health services as a result of these new tools.
Surveys of healthcare professionals indicate a high degree of satisfaction with the C&YMHI. MHCs report increased awareness, knowledge and comfort related to child and youth mental health. FPs reported feeling better educated, aware and sensitive to child and youth mental health problems. Accessibility to consultation with a C&YMHCs, and a child and youth psychiatrist, has increased the practice team’s confidence in dealing with children and youth. There is a higher degree of awareness, comfort and knowledge in relation to navigation of children’s mental health services and community resources. Family doctors, in general, receive minimal training in child and youth mental health, and therefore lack confidence, knowledge and unique skills required to work with children and youth. Participating in sessions with the C&YMHCs was useful for the family and the FPs, thereby increasing capacity and interdisciplinary team functioning.

Since the implementation of the C&YMHI, there has been a steady increase in the number of children and youth referred for mental health issues. In the first year, the number of child and youth referrals increased by 230%, largely influenced by the influx of new resources (C&YMHCs, MHCs, nurses, psychiatrists) during the formation of the HFHT. Referrals have continued to increase as the awareness of the C&YMHI grows at “pilot sites”. C&YMHC referrals increased in the past year by 52%, while the general MHC referral rate decreased by 1%. Awareness of the variety of services offered by the C&YMI to support practice teams has increased the demand for services. Consequently, non-pilot site practices have come forward asking for the addition of C&YMHC resources. This is an enormous drain on limited resources and cannot be sustained over the long term. An additional challenge is to ensure that the best practice clinical approaches employed by the pilot practice sites be sustained while the program evolves throughout the HFHT.
Lack of technology in practices (e.g. Electronic Medical Records or EMRs, access to Internet resources) and training to optimize the use of EMR creates barriers to accessing and implementing clinical tools and resources.

Increasing capacity of the practice teams is important to sustaining and expanding the C&YMHI. Increased funding to support child and youth mental health in primary care is also important over the long-term as primary care is seen as the “medical home” for patients. Building community collaboration and good leadership, increasing awareness of child and youth mental health issues, and continued evaluation are also key aspects to ensuring quality care and sustainability.

Improved partnerships and formal links between primary care, children’s mental health and adult mental health are required for optimal and continual care. Clearly defining primary care’s role and scope of practice on the continuum of care is important. Working collaboratively at a community level to develop a community service delivery model will prevent duplication of services and optimize internal and external resources.

Support for computer training and orientation to the EMR is necessary for all primary care team members in order to optimize time and increase competency given the diversity of the patient population and fast paced environment of primary care.

The kinds of changes to FP practice teams as a result of the C&YMHI take time and patience to implement. Other lessons learned through this pilot project include identifying practice/provider-specific needs prior to implementation, know your community partners and communicate with them often, and remember that work with children and youth is different than, and takes more time than, work with adults.
Given the needs of child and youth mental health in the general population, it is not surprising that primary care is becoming a key access point for prevention, early identification, and monitoring of child and youth mental health conditions. Consideration needs to be given to adapting the program to best fit each practice’s unique needs, while maintaining the overall goals and objectives of the program. At a family practice team level, it is important to “start small”, trying not to do too much all at once, but to be realistic about developing services that are sustainable. Taking the time to assess practice and patient needs beforehand will positively influence final outcomes, and increase satisfaction for patients and the practice team. Adopting a philosophy of building in the evaluation from the beginning will support small changes during system redesign by using a “PDSA” cycle (Plan Do Study Act) of evaluation.

In looking at future development of the C&YMHI, there needs to be an emphasis on practice team system redesign rather than simply looking to an increase in staff specializing in child and youth mental health. This requires that practice teams maximize the potential of existing resources with the support of the C&YMHI. New approaches to care can be explored, in addition to strengthening linkages with community partners.
1. Introduction

Primary care is highly accessible and a universal point of contact for children and youth at risk for mental health problems. Most children and youth have a family physician (FP) who they see periodically and mental health concerns are among the most common reasons children see a family physician - approximately 10% attend primary care with a primary complaint related to mental health (Kramer & Garralda, 2000).

The incidence of mental health problems in North America is roughly 18.6% in the general population of children and youth, however, current detection rate of children in primary care with mental health issues is 2% of the population (Kramer & Garralda, 2000). There is a unique opportunity to offer increased prevention, early detection and intervention at a primary care level.

The overall number of children with mental health problems who are served in specialty mental health programs is small, meaning that a large number of children go untreated (Cockburn & Bernard, 2004; Garralda, 2001). Consumers prefer the family practice as it is seen as less stigmatizing (Kramer & Garralda, 2000). Poor mental health among adolescents has been linked with behaviours that can damage physical health over the short and long-term as well as with mental health problems in adulthood (Walker & Townsend, 1998).

The family physician is the “medical home” and as such provides a mechanism for the ongoing monitoring of children and youth experiencing mental health concerns. This connection continues throughout periods when other more specialized mental health services are being utilized. The primary care practitioner often has knowledge of the family and its circumstances over time (Kramer & Garralda, 2000). Additionally, the family doctor’s office is where children
and youth resume and maintain their care following periods of specialized mental health care. Building the capacity for primary care to be one of the effective front doors for child and youth mental health is essential for overall health and wellness throughout the life span.

The continuity of care will improve the flow throughout the service spectrum, potentially be more cost effective, provide better clinical outcomes, and reduce the chances of children and youth “falling through the cracks”.

Mental health is one aspect of overall health and for these reasons, it seems logical that services would be accessible through the family practice in primary care. However, approximately 70% of family physicians indicate a lack of preparedness to see mental health problems (Steinhauer, 1999) and many family physicians (FP) and nurses report time constraints, lack of knowledge regarding community resources, and comfort level and skills in addressing mental health concerns particularly in young children.

Additionally, child and youth mental health services have often been developed as an “add-on” to adult services without consideration of the unique needs and developmental/familial issues for this population.

With this understanding and identified need, the Hamilton Family Health Team commenced with the Child & Youth Mental Health Initiative (CYMHI).

1.1 Program Overview:

The Child and Youth (C&Y) Mental Health Initiative is a part of the Mental Health Program and targets C&Y (0 to 18 yrs) and their families with emotional, behavioural and psychosocial issues.
The Hamilton Family Health Team (HFHT) includes approximately 150 family physicians (FPs) partnered with nurses, nurse practitioners, dietitians, mental health counsellors (MHCs), psychiatrists and pharmacists to provide comprehensive and collaborative primary care to over 375,000 people in greater Hamilton. The HFHT Mental Health Program provides a broad range of mental health (MH) services to patients across the life span. MHCs and psychiatrists work collaboratively in the practices to provide comprehensive care to patients with mental health issues.

1.2 Reviewing the Literature

An extensive literature review was completed and models of care for C&Y mental health were examined. The work of The Canadian Collaborative Mental Health Initiative (CCMHI), funded through Health Canada’s Primary Health Care Transition Fund assisted in guiding the planning process for the Child and Youth Mental Health Initiative. The goal of the CCMHI is to improve the mental health and well being of Canadians by increasing collaboration among primary health services and mental health. A “toolkit” to guide and offer practical advice on different aspects of planning, implementing and evaluating a collaborative child and youth mental health care initiative was developed with an inter-professional expert panel and guided by a working group representing a number of key stakeholder groups.

In 2006, Children’s Mental Health Ontario (CMHO) and the Ministry of Children and Youth Services (MCYS) established a framework – “A Shared Responsibility: Ontario’s Policy Framework for Child & Youth Mental Health”. This frame aims to foster collaboration amongst everyone who shares responsibility for the healthy development of Ontario’s children and youth: communities, including families/caregivers and all child and youth serving providers and sectors (for example, health, education, child protection and well-being youth justice, social services, recreation, heritage and culture), the adult mental health sector and all levels of government.
The framework outlines a continuum of care which encompasses a wide range of services and supports to meet the needs of child and youth mental health. This document served as a guide during the design and development stages of the C&YMHI in determining the scope and function of primary care services within a community service delivery model.

A review of the literature revealed that most C&Y are seen by their primary care physician at least once a year (Kramer & Garralda, 2000) and prefer to seek mental health care at the family practice since it is viewed as less stigmatizing than specialized services. Approximately 10% of children attend primary care with a primary complaint related to mental health (Garralda, 1998). Early intervention is important as it may prevent deterioration leading to the necessity of a referral to specialists (Lacey, I, 1999). The majority of mental illness in young people goes unrecognized and untreated, leaving them vulnerable to emotional, social and academic impairments during a critical phase of their lives (Friedman R.A., 2006). Therefore, the primary care setting has a unique opportunity to offer mental health prevention, early intervention and monitoring of C&Y and families.

1.3 Planning Stage of the Child & Youth Mental Health Initiative

During the planning stage of the C&YMHI a child and youth mental health advisory committee met for a period of approximately six months (Jan 06 to June 06) to identify the scope and develop a framework for the project. This group consisted of a community child psychiatrist, an experienced MHC working with children and youth in a primary care setting (the former HSO Program), the Mental Health Manager and the Director of Mental Health. Based on the research findings and the advisory groups input, the following goals were established for the C&YMHI:
1.4 Goals of the Child & Youth Mental Health Initiative:

- To increase access to C&Y mental health services through the family physicians office.
- To increase capacity in C&Y mental health amongst the practice teams.
- To increase early detection and intervention of C&Y mental health problems.

1.5 Implementation Stage of the Child & Youth Mental Health Initiative: A “Stepped Approach”

An experienced clinician in child and youth mental health services was hired as the Coordinator in June 06 to oversee the planning, development and implementation of the Child & Youth Mental Health Initiative.

It was decided that a “stepped approach” exploring a variety of services would facilitate the broadest learning of opportunities and challenges of implementing and adapting best practice models of child and youth mental health clinical services into a primary care setting. It would also serve as an exercise in the sustainability of the services.

The first step was to identify six “pilot site” practices that would serve as a “hands on” experience. While developing the services, resources and tools and identifying needs at the “pilot sites” – this would offer the prospect of how to increase capacity throughout the organization thereby gradually rolling out additional services to all family practice teams within the HFHT.

Phase I – Pilot Site Selection:

The selection of “pilot sites” began with the following criteria in mind:

- The FP identified child and youth mental health as a priority area on a survey that was conducted by the HFHT.
• The family practice team members were open to learning about child and youth mental health issues and expanding their professional scope of practice.

• The “pilot sites” chosen would represent a cross section of family practices that reflected the diversity of the Hamilton community e.g. cultural, economic and social needs; geographically spread throughout the community e.g. north end Hamilton, suburban locations, Hamilton Mountain; and a variety of family practice settings e.g. group practices (two or more FPs), sole FP practices, sole practitioners co-located in the same building.

• Statistics obtained from Contact Hamilton (the single point of access for child and youth mental health services in Hamilton) revealed areas of Hamilton with a high number of referrals for mental health services. This was a consideration when determining pilot site locations.

Phase II – Child and Youth Mental Health Direct Clinical Services

Child & Youth Mental Health Counsellors (C&Y MHCs) (2 FTE) with specialized training in child and youth mental health were gradually co-located into six practice “pilot site” locations from Dec 06 to Nov 07. C&Y MHCs provide direct clinical services at pilot sites which include education, assessment and brief intervention for children, youth and families. Another function of the C&Y MHC at the “pilot sites” is to increase inter-professional capacity building within the family practice teams which consisted of FPs, nurses, nurse practitioners, office staff, dietitians, pharmacists, MHCs and at one practice a lab technician. The C&Y MHCs also provide informal (the “hall-way chat”) and formal consultation to the inter-professional team, conduct educational in-services, develop and supply the practice with clinical resources and tools related to child and youth mental health.

Phase III – Child and Youth Mental Health Consultation Services:

In addition to the pilot sites, C&Y MHCs offer telephone, fax and email consultations for the general MHCs and FPs across the HFHT. C&Y MHC are also available to provide “on-site” patient consultation in collaboration with the general MHCs at the family practice. A brief consultation form was developed (Appendix A) to gather critical information related to clinical questions and to be used for data gathering purposes.
A child and adolescent psychiatrist (.2FTE) provides telephone and fax consultation throughout the HFHT for FPs and MHCs. The psychiatrist is accessible by telephone one day per week and responds to any email or fax consults that he receives throughout the week. The psychiatrist meets with the C&Y MHCs on a weekly basis to discuss and consult on cases and program development.

Phase IV – Training and Professional Development/Support

C&Y MHCs and the child psychiatrist work collaboratively to conduct professional development training for MHCs on a variety of topics related to child and youth mental health (ADHD diagnosis & treatment, Anxiety Disorders in Children & Youth, Suicide risk for depressed teens, child protection reporting, system navigation, etc.)

Monthly MHC peer support /case consultation groups are offered by the C&Y MHC to provide support, education and input on a broad range of case presentations and community resource navigation issues.

Weekly bulletins and notifications (Thursday Links) are sent out to MHCs on a variety of mental health topics – included in these weekly bulletins are up-to-date information on child and youth related seminars, community forums, clinical rounds, journal articles, etc. The Mental Health Program distributes a monthly newsletter which features C&Y related topics and information pertaining to community service partners.

Lunch & Learns are offered at both pilot site and non pilot site family practices whereby the C&Y MHCs and/or the child psychiatrist meet with the practice team. The informal presentations pertain to the identified need of the practice and can be case discussions or topic specific.
Discipline specific monthly meetings take place centrally at the HFHT for office administrators, dietitians and nurses. With the aim of increasing awareness and knowledge related to child and youth mental health, the coordinator of the C&YMHI has taken the opportunity at these meetings to provide education, information and share resources as it relates to child and youth mental health.

**Phase V – Clinical Resources and Tools**

Patient education resources (ADHD toolkit, etc), system navigation tools and information on accessing community child and youth mental health resources have been developed and distributed throughout the HFHT to facilitate capacity building (awareness, comfort, knowledge), and early detection (knowledge exchange, skills) related to child and youth mental health problems. A self-administered early identification questionnaire (C&Y Detection Questionnaire) was developed to assist primary care teams in identifying risk factors and symptoms consistent with mental health problems.

**2. Program Evaluation**

**Purpose and Rationale:**

The C&YMHI is the only formalized child and youth mental health programming being implemented in primary care in Canada. Because of this, there is great interest in the evaluation results from those internal and external to the HFHT. As the HFHT makes plans for future development and sustainability of child and youth mental health in the primary care setting, it is critical to review the findings to ensure the effectiveness and successful uptake of such a model of care. This initiative provides the opportunity for stronger collaboration along the service continuum with the potential for new innovations in C&YMH care to emerge and for primary care to participate in community planning for C&YMH services. As the HFHT C&YMHI
explores ongoing development and expansion into more practices, the opportunity to further evaluate this “stepped approach” capacity building model will provide direction for other primary care settings, as well as inform further model development.

**HFHT Evaluation Practices**

The main approach currently being used by the HFHT to evaluate the C&YMHI is the Improvement Model and, specifically, the Plan-Do-Study-Act (PDSA) cycle. The Improvement Model is a proven methodology for making changes in real-life settings. It has been successfully used in a variety of settings, including primary care. The idea behind the PDSA approach is to plan a small change, make the change, assess the impact of the change, and act on the learnings. The cycle is repeated multiple times. Organizations can track the changes made and the impacts (processes and outcomes) associated with these changes. To support these activities (as well as program planning and monitoring), a number of data collection systems have been established within the HFHT.

### 2.1 Evaluation Objective(s)

The identified objectives of the evaluation were:

i) To evaluate the effectiveness of the capacity building “stepped approach” model employed by the HFHT Child & Youth Mental Health Initiative

- Does having MHCs with specialized training in C&YMH increase comfort, knowledge and skills for the general MHCs, FPs and practice team members at the “pilot sites”?

- Does having a C&YMHC co-located at a family practice with a general MHC increase the comfort of the general MHC to see children and youth?

- Is there an increase in the number of children and youth seen by general MHCs and C&YMHCs?

- Are there differences in the ages of children seen by MHCs and C&YMHCs?

- Does having a C&YMHC at the family practice increase patient satisfaction?
• Has there been an increase in children and youth identified with mental health concerns by the FP and/or MHC?

• Has there been an increase in referrals to external specialized mental health services for children and youth by the FP and/or the MHC?

• Has there been an increase in MHCs seeking telephone and/or faxed/email consultation with a C&YMHC?

• Have MHCs and FPs utilized indirect telephone consultation with the child & adolescent psychiatrist?

• Are practice teams feeling supported and feel that the C&YMHI has added value to the services that the patients receive?

ii) Does a “toolkit” of clinical tools and resources assist other primary care practices within the HFHT and other Family Health Teams in Ontario interested in implementing this program?

• Does the use of a screening tool in primary care increase comfort, knowledge and awareness of child and youth mental health issues?

• Does the use of a screening tool increase the detection rate of children and youth with mental health issues?

• Does the development of a community resource tool to navigate child and youth mental health services increase health care provider knowledge, comfort and awareness and thereby increase access to services for children and youth?

• Does the community resource tool increase the number referrals and recommendations to community services by the health care professional?

3. Methodology

3.1 Evaluation Design: Methods:

A mixed methods design was used with quantitative (questionnaires and administrative data extraction) and qualitative (interviews and focus group discussions) methodologies. Process (questionnaires, administrative data extraction, interviews and focus groups with healthcare providers) and outcome (surveys and interviews with patients and parents of child and youth patients referred to the program) measurements were used to help interpret administrative data.
re: uptake and use of the model and to identify facilitators and barriers to implementation of the model and lessons learned.

Outcome measures enabled us to determine the impact the program is having on children, youth and their families and facilitated an assessment of the “stepped approach” in achieving the intended outcome with health professionals and practice teams (increasing awareness, knowledge and comfort).

Process and implementation measures assisted us in two ways: 1) information gathered examined the delivery of program components as planned and the challenges faced during implementation. 2) identified the facilitators and barriers to implementation, and lessons learned; this information will be valuable to other primary care practices within the HFHT and other FHTs that are interested in implementing this program.

All healthcare providers working within the C&Y pilot site practices (34 FPs, 17 MHCs, 8 NPs, 18 RNs, 1 RPN, 8 RDs, and 5 Pharmacists) were invited to participate in one or more of the evaluation activities. There are 77 mental health counsellors working for the HFHT Mental Health Program and practice administrators working at all the practice sites. They were asked to take part in the evaluation. As well, all children and youth (ages 0 to 18) referred to the program were included in this evaluation project. Contact Hamilton, the central point of intake for all families seeking mental health and developmental services for children and youth in Hamilton, developed a database to facilitate tracking requests and intakes for HFHT patients.
3.2 **Sources of Information:**

An evaluation framework for the C&YMHI was developed based on the program logic model for this initiative. The evaluation framework is presented in Appendix B.

3.3 **Outcome Measurements**

3.3.1 **Referral tracking - Program referrals**

Process data is routinely collected centrally at HFHT that includes the number of children and youth referred to and seen at the HFHT family practices by the mental health counsellors (MHCs) and the child and youth MHCs (C&YMHC). The total number of referrals for each year (Jan 07 - Dec 07 and Jan 08 - Dec 08) were compared in order to identify changes in referral rate.

Internal data was compiled by the Coordinator of the C&YMHI tracking the number of referrals (Sept 07-08 and Sept 08 - Aug 09) for child and youth consultations via telephone, fax, email, and onsite consultations between a C&YMHC and general MHC and a C&YMHC and family physicians. Indirect telephone, email and fax consultations between the child and adolescent psychiatrist and various health care professionals (FP, MHC and C&YMHC) were tracked (Sept 08 - July 09).

A protocol was established between Contact Hamilton and the HFHT (Addendum 1) with the following objectives:

- Facilitate timely access to appropriate services
- Strengthen primary health care’s relationship with children/youth and their families
- Ensure that least intrusive and most appropriate services are used first
- Build strong communication protocols; ensure coordinated actions are taken; avoid duplication of effort and services
- Strengthen the community’s collective ability to support children and youth; plan effectively within the existing service system

A referral can be made in one of two ways; by calling Contact Hamilton or by completing a referral form that was developed (Appendix C). The data was collected at Contact Hamilton identifying HFHT patients who requested service or completed a referral for community and specialized children’s services (Apr 07 - Mar 08 and Apr 08 – Mar 09) to monitor changes in the number of patients requesting information or seeking services for child and youth mental health. Patients were asked to identify their HFHT FP when calling and this data was used to look at increases in the overall number of HFHT FPs who had patients making requests.

### 3.3.2 Child & Youth Mental Health Knowledge/Comfort/Awareness and Resources

Changes in knowledge and comfort amongst MHCs, FP and practice administrators were assessed using questionnaires (Appendix D). Validated questionnaires addressing these issues could not be found, therefore the C&YMHI developed questionnaires that were designed to explore knowledge, comfort (re: C&Y MH issues) and awareness and use of C&Y MH services. Questionnaires were administered pre, post and at three-month follow-up. MHCs were asked to complete a questionnaire before and after C&YMHI in-service/education sessions. In-service presentations were focused on three areas: 1) an overview of the C&YMHI (the population, rationale, goals, internal (HFHT) resource availability and future directions; 2) early identification of children and youth who are “at risk” for mental health problems, and 3) child and youth system navigation and community resources. Clinical tools were introduced to support knowledge transfer, awareness, comfort and skill development.
3.3.3 Clinical Tools and Resources

i) **C&Y Detection Questionnaire and Guide to Service** was developed to help identify patient risk factors, concerns and symptoms consistent with mental health problems in children and youth. The self-administered questionnaire (a few screening questions + the validated brief version BCFPI questionnaire) is scored by the health care professional and shared with the patient to identify a range of services and next steps. A listing of child and youth resources and services are connected to the questionnaire to guide service options for the patient (Addendum 2). An in-service was presented to the MHCs to introduce the C&Y questionnaire and its use. The in-service consisted of one 90-minute session during a lunch hour. An overview of the questionnaire was presented (rationale, history and design method) and participants were given case study examples to practice using and scoring the questionnaire. Pre, post and follow-up data collected would help determine the facilitators and barriers to implementing and using a tool for screening in a busy primary care setting (Appendix E).

ii) **C&Y Community Resource Tool** – A systems navigation tool for HFHT healthcare providers was developed to facilitate increased knowledge and awareness of community child and youth mental health services (Appendix F). This tool is divided into a list of key community services/resources; specialized services accessed through Contact Hamilton and healthcare provider services for children, youth and families. Services and questionnaires are hyperlinked for convenience and access. The Community Resource Tool has been introduced to family practice teams, MHC, practice administrators and shared electronically, on the Intranet and in hard copy format (Addendum 3).
3.3.4 Patient/Family Satisfaction

**Questionnaires:**

The HFHT currently has processes in place for collecting information on patient/family satisfaction. For the C&Y initiative, this survey has been slightly modified, with some additional questions added that address specific aspect of the C&Y Mental Health initiative. (Appendix G). Patients were given the questionnaire to complete at the end of their session with the C&YMHC. Questionnaires were given out over a period of two months (Apr, May 09).

3.3.5 Child & Youth Survey (9-18yrs):

A sample (n=50) of C&Y patients (ages 9-18 years old) were invited via a letter from the C&Y Initiative Coordinator to participate in an online survey. A list of all patients seen by the C&Y MHCs was generated and reviewed so as to remove any patient for whom participation in an evaluation might be detrimental. A random sample of patients was drawn from the shorter list. For patients aged 12 and under, the letter of invitation was sent to the patients’ caregiver/parent. For patients over age 12, the letter was sent directly to them. The survey was administered through Survey Monkey and was used to gather information regarding the patient’s experience with the C&Y Initiative. The survey was developed based on feedback from the investigation team, pilot tested with convenience sample of children 9-18 years of age, and modified based on the feedback received regarding clarity of the questions, question wording, etc. Time to complete the survey is approximately 10 minutes. (Appendix H). A total of 23 surveys were completed (46% response rate).

3.3.6 One to One Telephone Caregiver/Parent Interviews:

To gather further satisfaction feedback regarding the C&YMHI, parents of C&Y referred to the program were invited to participate in one-to-one interviews with a random sample (N=8-10). Interviews with nine caregivers (100% response rate) took place over the telephone at a time
that was convenient for the participants and were approximately 30 minutes in length.

Participants were invited via a letter from the C&Y Initiative Coordinator (Appendix I).

A trained interviewer led the interviews using a semi-structured interview guide (Appendix J). Interview participants provided written consent prior to participation (Appendix K). Interview and survey participants will each be given a gift card ($25 for interview and $10 for survey - Wal-Mart or Blockbuster) in appreciation of their time taken to participate in the study.

3.4 Process Measurements:

3.4.1 Health Professional Focus Groups

C&YMHI pilot-site primary care practice teams were invited to participate in one of six focus group discussions to gather information regarding process issues, including barriers and facilitators to program referrals, information transfer and receipt, and follow-up. Self-perceived changes in knowledge and comfort level were also explored. Practices were randomly selected and focus groups were held at the practices at a time most convenient to participants (i.e. during a team meeting) and lasted approximately 45-60 minutes in length. The practice team members who participated in the focus group consisted of FPs (7), Nurse Practitioners (2), RNs (6), office staff (8), MHCs (4), adult psychiatrist (1) (Appendix L). Participants were invited via a letter from the C&Y Initiative Coordinator (Appendix M).

There were two focus groups (N=15) conducted for MHCs practicing at one of the HFHT family practice pilot sites. Questions explored facilitators and barriers to program implementation and comfort level (re: C&Y issues), and changes in knowledge (re: C&Y issues) were asked to participate in one of two focus group discussions separate from the rest of the practice (Appendix N). Participants were invited via a letter from the C&Y Initiative Coordinator (Appendix O).
3.4.2 Interviews with C&YMHI Leads

One-to-one interviews took place with all C&Y Initiative MHCs and administrative leads to explore facilitators and barriers to program implementation and lessons learned. Additionally, a random sample of FPs (n=3) were asked to participate in an interview to explore facilitators and barriers to program implementation, comfort level (re: C&Y issues), and changes in knowledge (re: C&Y issues). FP participants were invited via a letter from the C&YMH Initiative Coordinator.

A semi-structured interview guide was used for the 1:1 interviews and focus group discussions were digitally recorded and transcribed verbatim. A full report of interview discussions are found in (Appendix P). Interviews and focus group participants provided written consent prior to participation (Appendix Q). C&Y Initiative MHCs and leads did not provide written consent as this is an internal evaluation and their participation/consent is implied. Two researchers independently reviewed the transcripts to identify themes arising from the data and develop operational codebooks to guide the analysis process. The responses were then collated according to the categories derived. Data from the focus groups and interviews will be summarized using the categories from the interview guides.

4. Results

The following is a summary of the highlights and main themes that have emerged from the evaluation surveys, questionnaires, interviews and focus groups. Detailed summaries of the results of the Health Care Professional survey outcomes on the Community Resource Tool and Child & Youth Detection Questionnaire are presented in Appendix R. Interviews with patient caregiver/parents can be found in Appendix S.
4.1 **Objective 1.** To evaluate the effectiveness of the capacity building “stepped approach” model employed by the HFHT Child & Youth Mental Health Initiative.

4.1.1 **Direct Service Referrals for Children & Youth:**
MHCs (77 MHC/46FTE) representing 119 family practices saw a total of 887 children and youth in 2007 (Jan-Dec) and 879 in 2008 (Jan-Dec). C&YMHCs (3 C&YMHC/2.1FTE) representing 21 family practices saw 190 children and youth in 2007 and 360 children and youth in 2008. Overall there was an increase in referrals for children and youth by 15%, however this increase is representative of a 53% increase in the number of children seen by a C&YMHC.

![Figure 1: Illustrates the number of children and youth seen in 2008 by a general MHC at non-pilot and pilot sites and C&YMHCs. Overall, there is no difference between the number of children and youth seen by general MHCs at sites where there is a C&YMHC co-located. There are a larger proportion of children and youth seen at pilot-sites but this is reflective of the additional resource of the C&YMHC. The graph also depicts the number of children and youth seen according to their age. This indicates that general MHCs see a larger proportion of youth (>13yrs) than children (<12yrs).](image-url)
4.1.2 Consultation Service Referrals for Children & Youth

Figure 3: From 2007/2008 to 2008/2009 – there was an increase of 87% in consultations between a C&YMHC and a general MHC. Consultations were requested by 27% of the general MHCs in 2007/2008 which increased to 49% of overall MHC seeking consultation. Telephone consultation is the preferred method of consultation; however requests for on-site consultation
increased 100% in 2009. Consultations also increased by 100% for 2009 between the C&YMHC and the family physician.

Figure 4: There were a total of 88 child and youth consultations via telephone, email or fax with the child and youth psychiatrist for a period of 11 months from Sept.08 to July 09. FPs represented 35% of the consultations, 9% by the general MHC and 56% of consultations sought by the C&YMHC.

Figure 5: Non pilot site family physicians represented 34% of the psychiatric consultations with 66% of consultations at pilot site practices.
4.1.3 Indirect Psychiatric Consultation – Diagnosis

Figure 6: Comorbid conditions were reported in 73% of the child and youth referrals seeking consultation with the child psychiatrist. The most common presenting concerns for psychiatric consultation were ADHD, Anxiety, Depression and Oppositional Defiant Disorder.

4.1.4 Contact Hamilton – Patient Requests (see explanation for figure 7 on next pg)
Figure 7: HFHT patient requests were tracked by Contact Hamilton (the single point of access for child and youth mental health services in Hamilton). Patient requests indicate that a telephone call has been made by the patient to inquire about service provisions for a child, youth or family. In 2007/2008 (Apr 1/07 to Mar 31/08) there were 196 patient requests and in 2008/2009 (Apr 1/08 to Mar 31/09) there were 385 patient requests. This indicates a 96% increase in requests by HFHT patients. HFHT FPs were identified by name when patients made a request. There were a total of 74 FPs who were identified 2007/2008 – this, however increased to 128 in 2008/2009.

Figure 8: FPs at non-pilot sites made up 80% of the requests

4.1.5 Patient Related Impacts

Surveyed child and youth patients (N=23) reported the most common reasons for meeting with a C&YMHC was school problems, family, feeling sad or down, and eating or body image.

<table>
<thead>
<tr>
<th>Question</th>
<th>Not at all Helpful</th>
<th>Helpful</th>
<th>Very Helpful</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>1. How helpful was it to talk to the counsellor?</td>
<td>4% (1)</td>
<td>17% (4)</td>
<td>13% (3)</td>
</tr>
<tr>
<td>2. How helpful did you find the suggestions?</td>
<td>9% (2)</td>
<td>17% (4)</td>
<td>22% (5)</td>
</tr>
</tbody>
</table>
3. What the child/youth found to be most helpful about speaking with the counsellor – (see Figure 9 below)

What the Youth Found Most Helpful About Meeting with a C&Y MHC

Additional Comments made by the children and youth

“Just the idea of letting of some tension built up in a creative way”

“Learning that anxiety and depression is quite common in my age group”

Overall, most of the children and youth (78%) reported feeling comfortable, listened to, and understood by the C&YMHC. After meeting with the C&YMHC, 87% of respondents stated that they felt prepared to handle the problem.
Figure 10

Therapeutic Factors

Figure 11

Plan of Action

Figures 10 and 11 represent parents’ and caregivers’ overall ratings of satisfaction with the C&YMHC. All of the patients found it either “helpful” (11%) of “very helpful” (89%).
4.1.7  **Interviewed Parent/Caregivers** (N=8) were asked to provide input on their experiences of having C&YMH services accessible at their family doctors office. All parents were very appreciative of the mental health services (one to one sessions) available to them at their family physician's office. The parents felt the counsellors were very approachable and highly qualified. Being able to see the counsellor in the family physician office was convenient. Until the physician mentioned the services most parents were not aware of their availability. One parent also noted that her trust in her family physician impacted her trust in the counsellor (as she was recommended by the physician). A couple of parents felt the opportunity to discuss their problems with other parents going through similar situations would be helpful (via support groups).

“…I found it quite easy to get the child and youth worker counsellor because they are right there with the doctor’s office, and the doctor had recommended it and I trusted the doctor - that they would provide somebody that would be of assistance to my children at that time.” (P1)

“As a patient I like to know my options. So, if the doctor or staff at the clinic are very clear about the options and sort of the pros and cons of each one then very helpful.” (P2)

While counselling was the service most often discussed, parents did find the other services useful, specifically books, online activities, and Internet-based information (especially about medication options). Parents appreciated that there were no costs associated with using the services.

“The internet, there was a virtual type of activity for the children to do, and it’s right on their level, and they like going onto the computer so that was something easy for them.” (P1)

Most parents felt that increasing awareness of the services available was important as many parents are likely unaware of their availability. Parents also wanted updates on the services available. As many mental health and behavioural issues are first identified at school a couple of parents felt it would be important to better educate school staff on identifying and dealing with
these issues. The availability of the child and youth mental health services should be increased (i.e. more counsellors in more practices and increased hours – beyond 9-5). Parents also noted that it was important that both they and their child felt supported by the family physician and practice staff. Discussing mental health issues is difficult; therefore, having a supportive environment to do this is important.

“And then there’s the embarrassment, you don’t want to be thought of as a bad parent and you’re kind of at your wit’s end and what do you…it’s I think that just being, approachable and open to hearing whatever somebody has to say.” (P2)

Two primary barriers were identified: 1) As with many primary care and specialist services, waiting times was a significant barrier to accessing these services. While parents appreciated that the service was part of the family practice they found that they still had to wait two-four weeks for an appointment with a counsellor. Given that some of the mental health problems their children are dealing with need immediate attention it is difficult to address the issue in a timely fashion when you have to wait several weeks to discuss it. 2) Scheduling appointments during a standard 9-5 work day is also difficult as this often necessitates the parent taking time off work and the child missing school (which can be a problem if child is already missing a lot of school because of mental health issues).

“I think if they made it more available in evenings as well, cause part of my son’s problem with depression is that he does miss a lot of school for him to then have to miss school because of the appointment and then I’m a single parent so I’m having to leave work early or not pick up a shift for that day so it makes it very difficult.” (P8)

Other barriers include lack of time with the physician, ability to discuss issues privately with the physician or counsellor (without child present – if child too young to leave alone in waiting room), and youth may find it difficult to talk openly with an adult (generation issues – ‘they don’t understand’).
Parents didn’t have many suggestions as most of them felt their family physician’s office was already family friendly. A couple of parents mentioned having more children’s books and toys available. A full report of patient responses can be found in (Appendix S)

4.1.8  **Interviewed C&YMHI Staff and Program Leads** were asked to discuss the desired outcomes for the initiative and identify barriers and challenges to implementation. Review of the model was explored and the facilitators and barriers to the sustainability of the initiative were discussed.

*Facilitators to implementation include:*

- A skilled leader to coordinate the initiative.
- Choosing practices that were motivated and had a high demand for this service was also important.
- Increasing the knowledge and capacity of the existing primary care team (especially if it included a MHC). This not only facilitated the success of the service but also improved the sustainability of the service.
- Individualizing the program to the practice.
- Increasing awareness and knowledge of mental health issues and the service among all members of the practice.
- Easy access/opportunity for consultation between the MHC and the physician.
- A family friendly space to conduct family meetings.

“I have been encouraged by people, MHCs embracing those opportunities and really being very keen and somewhat excited to start seeing C&Y which I think is a very successful indicator of the kind of support that [the Program Coordinator and C&Y MHC leads] have provided to the program to shift and that has been a huge shift.” (P2)

“In the implementation stage having something that is flexible and not having some sort of hard, fast way of approaching this, but really using our stakeholders, our consumers, the physicians, as a way to help us build the program. So they were really our advisors to this throughout the process.” (P1)

“Apart from everything else that we’ve put in place the trust and the relationship that we’re establishing at a practice level has given us the opportunity to do what we have done and has extended our services to the patients.” (P1)
Barriers to Implementation:

- A significant barrier to change noted by program staff was the difficulty introducing a new service/model to an already busy practice.
- This was also compounded by the fact that most of the practices were also struggling with incorporating the new FHT model at the same time.
- Other barriers included lack of appropriate space.
- Inappropriate referrals.
- Diversity of practices (trying to fit one model into different practices).
- Technology (didn’t systems used in practices = no consistent means of communication/documentation).
- Lack of C&YMHC resources to meet the high demands for the service.

Space Challenges:

“…practical things (like) having the proper space, and particularly for the work we’re doing with children and youth and families, the understanding that you need a child and youth friendly environment that enables the individual and family to be able to talk about some pretty difficult things. And so, space has not always been available to see a whole family.” (P1)

“Primary care is a natural setting for C&Y MH services. Need to think about how to expand existing resources and add new resources at the primary care level”. (P3)

“I think we need to be thinking about, at a whole different level, within our social work schools, within nursing, of how to provide some training and education around the role of a mental health counsellor in a family health team, working in primary care.” (P1)

4.1.9 Focus Group Interview Summary (primary care team members, MHCs and FP)  
Results of the focus groups and FP interviews were based on questions pertaining to their experiences, challenges, barriers, lessons learned and recommendations for future directions as it relates to the C&YMHI. Interviews in full can be found in (Appendix T). 
Practice teams found the program very rewarding and felt it valuable to both them and their patients. The program was particularly helpful in alleviating the general MHCs workload,
providing patients and physicians with the needed expertise, addressing MH problems earlier, and further strengthening the collaborative/multidisciplinary practice.

Providers found that communication was a key to the success of the program. C&Y MHCs consulted regularly with physicians and general MHC to strengthen the value of their recommendations and follow-up with patients. For patients, adherence was improved if the physician was involved in part of the interview. Offering the program on-site/at the practice was also seen to improve the validity of the service for the patients (i.e. C&Y MHC part of a trusted team). Pre-appointment questionnaires and activities allowed C&Y MHC to maximize and focus the appointments.

Primary barriers or challenges included lack of family-friendly environment and space for family meetings, restricted hours and availability of the C&Y MHC (9-5 model not conducive to working parents and children in school), and lack of technology to facilitate transfer of information and communication among providers.

Overall, most providers did not have any suggested changes to the model and felt it worked well as it was. Some suggestions were, expanding hours of service beyond 9-5, highlight importance of collaboration, flexibility of model to fit different practices, and how to more effectively deal with crisis situations.

Everyone agreed that the program positively impacted both knowledge of C&Y MH issues and resources for dealing with these issues. For some providers existing knowledge was reinforced, for others the new knowledge allowed them to better meet their patients’ needs and improved their confidence level when dealing with MH issues. Some providers also felt they were now more sensitive to C&Y issues surrounding growth and development.
Providing tools and resources in the waiting room for parents increased their knowledge and facilitated parents identifying MH problems and seeking help.

Some key lessons learned included the importance of working as a team, communication, in-service education sessions lead by C&Y MHCs for the team, using a reminder phone call system to improve patients’ adherence to appointments, increasing awareness of service among patients, educating patients about the collaborative care approach (to increase comfort level and trust of non-physician providers), and value of pre-appointment activities to maximize time with C&Y MHC.

4.2 Objective 2: Does a “toolkit” of clinical tools and resources assist other primary care practices within the HFHT and other Family Health Teams in Ontario interested in implementing this program?

4.2.1 C&Y Community Resource Tool

The Coordinator of the C&YMHI provided a 30-minute in-service on child and youth mental health community resources at a regular monthly meeting of practice administrators who work at the family practices across the organization. Prior to and following the presentation, pre and post questionnaires were administered on their awareness, knowledge and comfort of community resources for children and youth. Overall, the awareness, comfort and knowledge increased and at three-month follow-up.
4.2.1a Practice Administrators Questionnaires (Awareness, Comfort, Knowledge)

C&YMH - Services
Awareness, Knowledge, Comfort - Practice Administrators

4.2.1b Mental Health Counsellors:

A presentation took place at a monthly MHCs meeting to introduce the protocol between Contact Hamilton and HFHT. During this presentation there was an overview of child and youth community services and a system navigation tool was presented (C&Y Community Resource Tool). Awareness, knowledge and comfort in community services increased significantly. MHCs (93%) reported the session to be helpful and that it increased the likelihood that they would refer patients to these services (see Table 1).

<table>
<thead>
<tr>
<th>Question: Awareness of services and community resources available for children, youth and families?</th>
<th>NOT AWARE</th>
<th>SOMEWHAT AWARE</th>
<th>VERY AWARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre session N=47</td>
<td>4% (2)</td>
<td>79% (37)</td>
<td>15% (7)</td>
</tr>
<tr>
<td>Post session N=28</td>
<td>18% (5)</td>
<td>32% (9)</td>
<td>50% (14)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question: Knowledge of the services and resources available for children and youth in the community?</th>
<th>NEED TO KNOW MORE</th>
<th>SOMEWHAT KNOWLEDGEABLE</th>
<th>VERY KNOWLEDGEABLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre session N=47</td>
<td>26% (12)</td>
<td>68% (32)</td>
<td>4% (2)</td>
</tr>
<tr>
<td>Post session N=28</td>
<td>11% (3)</td>
<td>54% (15)</td>
<td>36% (10)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question: Comfort level in knowledge and accessing services and resources</th>
<th>NOT COMFORTABLE</th>
<th>SOMEWHAT COMFORTABLE</th>
<th>VERY COMFORTABLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre session N=47</td>
<td>34% (16)</td>
<td>62% (29)</td>
<td>4% (2)</td>
</tr>
<tr>
<td>Post session N=28</td>
<td>4% (1)</td>
<td>46% (13)</td>
<td>50% (14)</td>
</tr>
</tbody>
</table>
A three-month follow-up was conducted and the MHCs (N=27) – 74% reported increased knowledge (somewhat often) and 97% reported that the community resource tool had likely resulted in an increase of referrals to community services (somewhat often). However, 44% of the respondents (not at all) stated that the tool did not increase comfort in accessing community services (see Table 2).

<table>
<thead>
<tr>
<th>Question: In relation to the Community Resource Tool…</th>
<th>Percent (number) of MHCs who responded</th>
<th>Percent (number) of MHCs who responded</th>
<th>Percent (number) of MHCs who responded</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) How often have you used it to increase your knowledge of child and youth services</td>
<td>NOT AT ALL 26% (7)</td>
<td>SOMETHAW OFTEN 67% (18)</td>
<td>VERY OFTEN 7% (2)</td>
</tr>
<tr>
<td>b) Has it increased your comfort level in accessing the services and resources</td>
<td>NOT AT ALL 44% (12)</td>
<td>SOMETHAW OFTEN 52% (14)</td>
<td>VERY OFTEN 3% (1)</td>
</tr>
<tr>
<td>c) Has it made it easier for you to identify appropriate services and resources for the families that you serve?</td>
<td>NOT AT ALL 22% (6)</td>
<td>SOMETHAW OFTEN 59% (16)</td>
<td>VERY OFTEN 11% (3)</td>
</tr>
<tr>
<td>d) Have you increased your referrals to community services for C&amp;Y as a result of having the tool?</td>
<td>NOT AT ALL 0% (0)</td>
<td>SOMETHAW OFTEN 56% (15)</td>
<td>VERY OFTEN 41% (11)</td>
</tr>
</tbody>
</table>

* Not at all, Somewhat Often, Very Often – Somewhat Often and Very Often = Somewhat often

4.2.2 C&Y Detection Questionnaire and Guide to Service

MHCs (18) attended a professional development in-service introducing a child and youth “detection” questionnaire. Survey data collected pre (n=11) revealed that over 90% of the MHCs in attendance were not using any formal screening questionnaire for child and youth mental health. However, 73% reported having “somewhat knowledge” in identifying children “at risk” or a with a specific problem area (3 on a 5 point scale). When asked how helpful it would be to have a “tool” that would assist in identifying C&Y “at risk” or with problems – 82% stated it would be very helpful.
Do you currently use an intake/assessment questionnaire for C&Y?  

| Yes (1) | No (10) |

Table 3:

<table>
<thead>
<tr>
<th>How knowledgeable are you in:</th>
<th>1 = Not at all knowledgeable</th>
<th>2 = Not knowledgeable</th>
<th>3 = Somewhat knowledgeable</th>
<th>4 = Knowledgeable</th>
<th>5 = Very knowledgeable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identifying children “at risk”</td>
<td>0</td>
<td>1</td>
<td>8</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Identifying a specific “problem area” among children and/or youth</td>
<td>0</td>
<td>1</td>
<td>8</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Discussing an identified “problem area” with children and/or youth</td>
<td>0</td>
<td>2</td>
<td>5</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

1 = Not at all helpful  
2 = Not helpful  
3 = Somewhat helpful  
4 = Helpful  
5 = Very helpful

A three-month follow-up questionnaire was administered to determine the facilitators and barriers to implementing the tool into their clinical practice. The respondents (n=6) (83%) indicated that they had not shared the tool widely with the practice team and that having the tool electronically and on the electronic medial records system would increase use of the tool. Half (50%) of the MHC have been using the tool and the other half (50%) are not.

5. Conclusion

5.1 Discussion and Interpretation of Findings

The stepped approach to capacity building has proven to be successful on many levels. Greater numbers of children and youth are receiving services at sites where C&YMHC are co-located. The support given to FPs and practice teams by an experienced child and youth clinician, increases comfort, knowledge and awareness of current and emerging trends with children and youth. The addition of a C&YMHC specializing in child and youth mental health
has increased confidence levels in the practice team to see children and youth. Overall, there has been an increase in the number of children and youth receiving services, and MHCs report a higher degree of awareness, knowledge and comfort in working with children, youth and families. However, referrals to general MHCs declined by 1% in the past year. Further investigation into the barriers to access for children and youth to see a general MHC is needed.

The evaluation process has helped to identify some important features about the child and youth patient population accessing mental health services in primary care. The data clearly reports that general MHC see youth more frequently than children (0 to 13yrs). Prevention and early identification strategies require a plan to strengthen comfort and skill in working with all ages of children. As was illustrated in the data for psychiatric consultations, approximately 50% of the consultations took place with patients who have comorbid chronic conditions. Developing a strategy and seamless service with community partners to share responsibility for the care of complex patients and chronic conditions while waiting for specialized mental health services is important to the sustainability of the existing C&YMH resources.

Consultation services have demonstrated the greatest increase in request for services from the practice teams, FPs and MHCs. Children and youth with complex mental health needs are receiving services in primary care with the support of the C&YMHCs and the child psychiatrist. Increased awareness of community specialized services are reflected in the increase of requests and intakes at Contact Hamilton. Patients express appreciation and satisfaction at the convenience of seeing a C&YMHC at the family practice. Parents found other services useful, specifically books, online activities, and Internet-based information (especially about medication options).

The development of clinical tools and resources expanded the health professional’s comfort, awareness and knowledge in accessing services for children and youth. The child and youth
detection questionnaire provides guidance in asking questions but it has not been widely used by the general MHC. FPs have been using the questionnaire but they were not included in this aspect of the evaluation due to time constraints.

5.2 Recommendations

The evaluation was timely in the evolution of the program. The demand for child and youth mental health services has increased over the duration of the program. The result being that the current model of service is no longer sustainable with the limited existing C&YMH resources. Increasing the capacity of the practice team that maximizes the resources of the interdisciplinary team is important to sustaining and expanding the program. Sustaining child and youth mental health services in primary care is not simply about adding resources that specialize in this population. It requires the family practice team to identify the needs of the population and to establish a plan that will optimize on the potential of the resources within the team. This approach in capacity building is far more sustainable and can be supported by the C&YMI team by offering ongoing support to practices as needed. As one of the MHCs remarked about the importance of capacity building through collaborative care:

“I think at times we are at risk of having divided care, divided up care, you do your piece, I’ll do mine. And, I feel very strongly that divided care is not our goal and it’s not shared care in the way we’ve talked about proximity, cross-over, interchange” (MHC)

The C&YMH is uniquely positioned in the community to offer prevention, detection and early intervention services. The findings from this evaluation should be used for community service delivery planning with special attention to linkages between agencies and organizations as well as support requests for additional funding to expand the initiative. Sharing the outcomes of the program evaluation with the Ministries as it relates to Ontario’s Policy Framework for Child & Youth Mental Health has the potential to influence interagency collaboration. Services for youth
and young adults can be improved by strong partnerships and formal links. Children and youth with complex and/or chronic needs often require services through multiple sectors. The family physician is often the consistent caregiver over the development of the individual. The consistency, trust and familiarity with the family doctor is an important aspect of the continuity of care for the patient. “Transitional Youth” or young adults moving from child services to adult services often “fall through the cracks” and the FP is required to provide care with little or no support during a period of “waiting” for adult services. Knowledge and awareness by community partners of primary care’s role and need for ongoing support by specialized services following episodes of care needs to be understood. For these reasons, improved partnerships and formal links between primary care, children’s mental health and adult mental health is required.

“...the need to work at a community level with your community partners, because that’s the only way that you are going to better inform them of what our services are, what our capacity is to provide services, and also what the needs are and being really clear about what it is that we can do in primary care, and what it is that we can’t do in primary care.” (P1)

Additionally, youth commonly report that they are not interested or motivated to seek specialized mental health services outside of the family practice and therefore consideration needs to be given to how youth mental health issues can be treated and managed effectively within the primary care setting.

A coordinated and integrated IT system and supports are essential for high quality health care. Currently, the HFHT has nine different electronic medical records (EMR) all requiring different software and processes for information gathering and medical record keeping. This makes it extremely challenging to develop resources and tools that are useful and compatible across the
organization. The development of resources in hard copy is time consuming and not efficient as hard copies need to be replenished and accessible in order to be useful.

Support for computer training and orientation to the EMR is necessary for all primary care team members in order to optimize time and increase competency given the diversity of patient population and fast pace of environment of primary care.

A website that is user friendly and maximizes both professionals and patients access to information is an essential for the sustainability of services. The HFHT Intranet is not well organized for professionals and therefore is under-utilized. Allowing patient access on the HFHT internet to on-line questionnaires, educational resources, and self-management tools has the potential to increase efficiency and consumer knowledge.

It's important to provide opportunities for ongoing professional development in child and youth mental health. According to the Ontario Chairs of Family Medicine and the Council of Ontario University Programs in Nursing, interdisciplinary education should be mandatory for all professional education programs before practice. The only way to truly engender integration and interdisciplinary primary care teams is if the educational models for teaching and clinical practice are integrated so that each professional becomes aware of the knowledge, skills, and attributes that colleagues of different disciplines bring with them. This level of awareness ensures that each team member values and respects the work of the others (Pringle, Levitt, Horsburgh et al. 2000). Ongoing training and education in child and youth mental health is necessary at all levels of medical and professional training.
There is the opportunity for the evaluation to offer guidance to other community organizations and Family Health Teams interested in establishing a similar initiative. Building community collaboration, increasing awareness of C&Y MH issues and continued evaluation are also key aspects to ensuring quality care and sustainability.

5.3 Lessons Learned

From the outset of the application of the implementation grant, fundamentally, you must have the support of the organization to undertake an evaluation project. Information about key aspects of the evaluation were shared (scope, design, purpose, how the results would be disseminated and acted upon) with the central program. Within the HFHT, there is a research advisory committee led by a lead researcher, clinical program director, managers of various programs and health care providers who have experience, interest and value research and evaluation. All research ideas and projects are presented to this committee to ensure that research conducted is in keeping with the goals of the HFHT organization and is value added for patients and practice teams. This team provided feedback and suggestions related to a communication strategy and process for sharing the project with all levels of the organization. Involving patients in the evaluation was a key to understanding the successes and barriers of the C&YMHI and therefore required consent and an application was made for ethics approval.

It was essential to have the support internally for the implementation of the evaluation prior to introducing the evaluation components to the practice teams, health professionals and patients. Given the unique structure of our organization, the input and participation of the stakeholders are essential to undertake such a project with a spirit of willingness and cooperation. Since this was the first large scale program evaluation since the development of the HFHT, it was imperative to have a clear plan of how the evaluation would unfold taking into consideration the time-line and needs of the project as well as the burden on family practices and patients.
Involving all members of the family practice including patients was deemed a valuable and positive experience by those who participated.

There was reluctance initially by some of the practice teams to participate, as they felt it was time consuming and required great organization to bring team members together. However, once engaged in the focus group discussions, the opportunity to reflect, review and provide feedback was appreciated.

Enhancing team communication was an unexpected outcome of conducting the focus groups. Many of the family practice teams are in the early stages of team development, and therefore had not experienced nor appreciated the value in taking time to share as a team. All practice team members were invited to provide input which was an opportunity to highlight issues of importance and common concern. Participants were surprised by the increased awareness and knowledge they had acquired during the short period of time that the C&YMHI had been in place. Sharing the results of this program evaluation throughout the organization validates the hard work and positive changes family practice teams have incorporated into their practices during a time of broader organizational development.

With respect to evaluation and quality improvement methodologies, having family physicians, inter-professional teams in the primary care practices, and other staff within the central office engage in evaluation activities has increased knowledge and the importance of integrating evaluation into everyday practice. We will continue to promote and plan to build knowledge and skills in this area.

The support and guidance provided by the Center of Excellence has enhanced the learning and fostered a curiosity regarding the role and value of evaluation. The support was given in a spirit
of inquisitiveness with importance placed on the learner and the goals of the evaluation being achieved through the experience.

Collaboration is a key component to the evolution and success of the program development, implementation and evaluation. Linkages and strong working relationships were established internally and externally. Many community partners informed the planning and ongoing development and implementation of the C&YMHI. MHCs and FPs had reported confusion, lack of understanding and poor communication as barriers to services for child and youth mental health. A protocol for making referrals and regular communication was developed with Contact Hamilton in an effort to improve access. Ongoing dialogue between our two organizations and using a PDSA evaluative approach has proven to be effective in identifying barriers to service for patients. As well, a data system was established to track HFHT referrals at Contact to identify referral patterns and trends. This relationship has also increased awareness about the primary care system with the staff at Contact Hamilton. Key partners have actively participated in the development and provided ongoing support for the development and implementation of the C&Y Detection Tool (Dr. Charles E. Cunningham, Donna Bohychuk and Peter Pettingill). Collaboration will continue as the C&Y detection tool undergoes more rigorous evaluation.

5.4 Sustainability and Continuing Evaluation Practices

Understanding what data to collect and how to use the data to assist the development of the program is a key factor in evaluation. Start small with an evaluation framework that is manageable for both the stakeholders and individual(s) conducting the evaluation. Consumer input is required to effectively evaluate the program. It is challenging to engage and recruit children and youth in providing feedback about services. A strategy of offering blockbuster gift cards to children and youth yielded a 50% response rate. An on-line survey was designed in keeping with today’s technology, in hopes that this approach would attract and
interest young people to participate. However, the survey was completed by 25% of the respondents with the other 25% participating following a mail out of the survey. Telephone interviews proved to be an effective strategy in seeking feedback from parents as the scheduling of interviews took place in the evening and after work hours.

6. Next Steps

- Reviewing the current model of C&YMH services to make sure we are using the program resources effectively across all practices.

- Create equity and spread while ensuring the program is sustainable over the long-term.

- Work with family practice teams to come up with solutions for optimal use of interprofessional resources.

- Primary care is a natural setting for C&Y MH services therefore we need to think about how to expand existing resources through developing collaborative practices internally and externally.

- Ongoing evaluation of the C&YMHI consultation model is necessary with emphasis on meeting the goals of capacity building at a practice team level. As we look for efficiencies and innovative approaches in providing support to family practice teams, it’s important to monitor any changes in the current model of service delivery.

- Currently, a new initiative is underway to reduce barriers and support families with complex needs who have not been able to follow-through with a recommendation to seek specialized services through Contact Hamilton for a variety of reasons (no telephone access, English as a second language, trust, disorganization).

- Rigorous evaluation of the C&Y Detection Tool is necessary to determine the feasibility and validity of the questionnaire. The exploration and future development of a computerized version of the scale would increase the utility of the tool. The tool has the potential to be used as a brief, convenient measure of progress for patients starting various forms of treatment, identify commonly referred problems, and triage tool to determine level of service e.g.( phone consultation, further screening, referral to specialized services, brief primary care intervention.
7. Knowledge Exchange

7.1 Knowledge Exchange Activities

The C&YMHI evaluation process has raised the profile of the program evaluation through discussions and information sharing within the organization and at a community level.

The following is a list of knowledge exchange activities:

- Advancing the Vision and Voices of Collaboration – the 10th National Conference on Collaborative Mental Health Care – presentation May 09
- The Trillium Primary Care Research Forum – poster June 09
- Poster submission to the North American Primary Care Research Group (NAPCRG) Conference has been accepted for November 09
- Presentation at the Children’s Services System’s Meeting (October 09) - Membership on this committee is comprised of the HFHT, Children’s Mental Health, representatives from the Ministry of Health and Long-Term Care (MOHLTC), Ministry of Children and Youth Services and Ministry of Community and Social Services (MCSS), MCSS-funded agencies, Youth Justice, Child Welfare, Education, and Children’s developmental sector organizations
- The Community Resource Tool – Child & Youth Systems Navigation: This tool has been shared with numerous community partners to support design of similar resources for their individual settings (education, child welfare)
- Quality Improvement & Innovation Partnership Website (QIIP) – Evaluation findings and resources/tools will be shared on this website. QIIP assists Ontario’s Family Health Teams with the work they are doing, and provides a forum for FHTs to learn about each other’s achievements, activities, and exchange of ideas
- A full report on the evaluation will be accessible through the HFHT Intranet
- The evaluation will be presented at a various HFHT meetings (MHC meeting and the Clinical Program Managers meeting)
- A summary of the evaluation will be available for HFHT Board of Directors
- Information regarding the evaluation will be shared in the HFHT Newsletter
- Regional CHEO conference poster presentation (January 10)
- The evaluation report will be made available for other FHT’s to review
I would like to thank the following individuals and organizations for their support during the development, implementation and evaluation of the C&YMHI.

- **Carrie McAiney** – Evaluation FHT
- **Pat Carter** – Research Assistant
- **Child & Youth Mental Health Counsellors (Ted Ridley and Kate Jasper)**
- **The Provincial Centre of Excellence for Child & Youth Mental Health at CHEO** – Evangeline Danesco
- **Dr. Nick Kates & HFHT Mental Health Program**
- **Don Buchanan** – Offord Centre for Child Studies & McMaster Children’s Hospital
- **Chuck Cunningham PhD** – Professor – McMaster University, McMaster Children’s Hospital
- **Dr. Ken Burgess, Lead Physician, HFHT**
- **CCMHI Toolkit development team**
- **Annette Sloetjes** – student
- **Elka Persin** – Program Assistant
References and Related Readings


6) Friedman, RA, New England Journal of Medicine, December 2006


17) Spenser, Helen, MSW, MD, CCFP, FRCP(C) (Lead), Harold Lipton, MA, C. Psych. Assistant Lead), Margaret Steele, HB.Sc., MD, FRCP(C), M.Ed., Neal Stretch, MD, CCFP, Patrick McGrath, OC, Ph.D., FRSC, Anne Gillies, MD, FRCP(C) (2005) Establishing collaborative initiatives between mental health and primary care services for children and adolescents - A companion to the CCMHI planning and implementation toolkit for health care providers and planners (Canadian Collaborative Mental Health Initiative).


1.0 Scope of the Protocol

The scope of this protocol will address:

Access to the children’s services system by Hamilton Family Health Team clinicians on behalf of:
- Children between the ages of birth and their birthday presenting with social, emotional, behavioural and/or psychiatric needs (“mental health”)
- Children between the ages of birth and their birthday presenting with developmental concerns

Access to children’s mental health services offered through Hamilton Family Health Teams by Contact Hamilton.

Exclusions:
Access to adult developmental services through Contact Hamilton and access to adult mental health services through the Hamilton Family Health Team are not dealt with under the scope of this protocol.

2.0 Parties to the Protocol

Hamilton Family Health Team

Children’s Services Sector

Contact Hamilton for Children’s and Developmental Services

3.0 Objectives

This protocol will assist Hamilton Family Health Teams (HFHT) and Contact Hamilton to:
- Facilitate timely access to appropriate services
- Strengthen primary health care’s relationship with children/youth and their families
- Ensure that least intrusive and most appropriate services are used first
- Build strong communication protocols; ensure coordinated actions are taken; avoid duplication of effort and services
- Strengthen the community’s collective ability to support children and youth; plan effectively within the existing service system

4.0 Overview of Hamilton Family Health Teams

The Hamilton Family Health Team (HFFHT) is made up of approximately 113 family doctors partnered with nurses and nurse practitioners, dieticians, mental health counsellors, psychiatrists and pharmacists to provide comprehensive and collaborative primary care to over 250,000 people in greater Hamilton.

The HFHT Mental Health Program provides a broad range of mental health services to the patients, largely at the physician’s office, thereby increasing access and facilitating a shared, comprehensive health care model that builds the mental health knowledge and skills of the practice team.

Central to the Program are the mental health counsellors who spend varying amounts of time in each practice depending on the patient roster size and clinical needs. Experienced mental health clinicians, most commonly with degrees in social work or mental health nursing, provide education, assessment, treatment/management and follow-up for a broad range of mental health concerns across the lifespan. The Mental Health Program has initiatives underway in the areas of Child & Youth Mental Health, Substance Use and Depression Care to build the capacity of the inter-professional teams for these identified high needs populations within primary care. Counsellors also provide consultation and resources to the physician and other practice team members.

A central Group Program provides access for all HFHT patients to psycho-educational groups such as stress management, generalized anxiety disorder, parenting and cognitive behaviour therapy for depression and insomnia.
Although not fully realized, it is the goal of the HFHT to provide psychiatric consultation to each practice on a regular basis. Medication issues, clarification of diagnosis and patients requiring stabilization are the most common reasons for consultation. The counsellor and/or family physician discuss the specific reasons for the consultation before the person is seen and review the proposed management plan after the consultation. Child psychiatrists and geriatric psychiatrists are available in a limited number of practices for telephone advice and periodic meetings to discuss cases.

5.0 Overview of Contact Hamilton

Contact Hamilton is the single access point for services for children/youth presenting with social, emotional, behavioural and/or developmental concerns funded by the MCYS as well as services for children and adults with developmental disabilities funded by the MCSS.

Specific to this protocol, Contact Hamilton’s primary functions include:
- Information and consultation about community services for children presenting with social, emotional, behavioural and/or developmental concerns and their families
- Eligibility determination
- Intake / information gathering
- Resource / service planning
- Facilitation of individual planning meetings
- Recommendations regarding the most appropriate service options
- Prioritization of needs
- Making and tracking referrals
- Centralized waitlist management

6.0 Access to Children’s Services Through Contact Hamilton as Requested by the Hamilton Family Health Team Practice

6.1 Determining the Need for a Referral to Contact Hamilton

A referral to Contact Hamilton can be made directly by the youth/guardian or can be facilitated by the HFHT clinician. This protocol is specific to situations where the HFHT clinician is facilitating the referral.

6.1.1 Children’s Mental Health

All requests for children’s mental health services will first be vetted through the mental health counsellor at the HFHT practice. The mental health clinician considers the following before endorsing the referral to Contact Hamilton:
- The level of acuity of the child/youth’s presentation (is it beyond the scope of the HFHT mental health clinician?)
- The child/youth’s history or previous involvement with the children’s services system
- The wishes of the youth/family regarding where they wish their services to be provided (i.e. within the HFHT or outside of it)
- The service that is required does not exist within the HFHT practice.

6.1.2 Children’s Developmental

Any HFHT clinician can make a referral to Contact Hamilton, with consent, seeking children’s developmental services. The child/youth does not have to have a confirmed developmental disability.

6.2 Making a Referral to Contact Hamilton

The HFHT ‘referent’ will make the referral. The referent is the key contact person at the HFHT regarding the child/youth/person and could be the Mental Health Clinician, Nurse, Nurse Practitioner, Dietician, Physician or other member of the HFHT practice.

The referral can be made in one of two ways:
- By calling Contact Hamilton or
- By completing in full the referral form (preferred)
Addendum 1

With both options, the referent must have the consent of the youth/guardian before making the referral. Consent will be documented at Contact Hamilton as per the organization’s policies and procedures.

The referent will call Contact Hamilton at 905-570-8888 and provide the receptionist with the name of the child/youth OR the referent will complete the referral form in full, and fax it to Contact Hamilton at 905-522-5998. In both scenarios, the referent will forward, with consent, any applicable clinical tools that may have been administered (SNAP 4, Marsh Anxiety Scale for Children – MASC and the Child Depression Index – CDI).

With respect to these clinical tools, it is important to note here that the mental health worker would have reviewed the findings with the child/youth and guardian prior to sharing these with Contact Hamilton. In addition, Contact Hamilton Intake and Resource Coordinators are not in a position to interpret or review the findings with the child/youth and guardian; any questions will be redirected back to the mental health counsellor.

Upon receipt of the call or referral form and related clinical tools at Contact Hamilton, the Receptionist will check Contact Hamilton’s database to determine if the child/youth is already registered with Contact Hamilton.

Where the child/youth is already registered with Contact Hamilton, the referent will be connected with the person’s Resource Coordinator.

Where the child/youth is not already registered with Contact Hamilton, the referent will be connected with an Intake Coordinator. The Intake Coordinator will determine the nature of the request / presenting issue. The Intake Coordinator will confirm the child’s/youth’s eligibility for access to the children’s services system:

• The child/youth is presenting with a social, emotional, behavioural and/or developmental concern AND
• Is aged between birth and their birthday AND
• Lives in Hamilton AND
• Appropriate consent is in place.

Once eligibility has been confirmed, the child/youth is assigned a Resource Coordinator.

6.3 The Intake Phase

The Resource Coordinator reviews the information provided in the referral form or verbally by the referent and proceeds by calling the youth/guardian.

Once (re)connected with a Resource Coordinator, the Resource Coordinator completes or updates the child’s/youth’s intake information.

With respect to children presenting with a mental health need: intakes are typically conducted over the telephone with the guardian/youth and takes approximately 1 to 1 ½ hours to complete. In-office appointments are accommodated as required/requested.

With respect to children presenting with developmental needs: intakes are typically conducted in person, either in the person’s home or at the office and takes approximately 1 ½ hours to complete.

During the intake meeting, the Resource Coordinator completes the Common Intake with the youth/guardian and others (e.g. HFHT key contact person) where required. The Resource Coordinator also administers the Brief Child and Family Phone Interview (BCFPI) with the youth/guardian in the following situations:

• The child/youth is presenting with social, emotional and/or behavioural issues between the ages of 3 and 18 AND
• The child/youth is NEW to Contact Hamilton OR
• The child’s/youth’s situation has changed significantly since the completion of the original intake/BCFPI OR 12 or more months have passed since the completion of the BCFPI AND
• Interpretation services are not required.

It is standard practice for the Resource Coordinator to collect information about the child’s/youth’s family doctor (i.e. name, address, telephone number). At this time, the Resource Coordinator will determine if the child’s/youth’s physician is part of a HFHT by checking the roster of HFHT practices (updated regularly and provided by the HFHT). Where the child/youth does not have a family physician, the Resource Coordinator will advise the family of the following websites identifying physicians accepting new patients:

- Hamilton Family Health Team website: www.hamiltonfht.ca
- College of Physicians and Surgeons of Ontario website: \[www.cpsco.on.ca/Doctor_Search/dr_srch_hm\]. A link to this website can also be found on Contact Hamilton’s resource database, available through the Contact Hamilton website: contacthamilton.
Once the information has been gathered, the Resource Coordinator identifies and prioritizes the child’s/youth’s needs using the “Needs Profile”.

Youth/guardians advise the Resource Coordinator of changes in their situation and /or changes in their contact information as it occurs (e.g. address, telephone number). The Resource Coordinator re-prioritizes the needs as required and takes appropriate next steps.

6.4 The Recommendation Phase

Once the intake process is complete, the Resource Coordinator makes and documents all the recommendations made to the youth/guardian and their outcomes. Resource Coordinators are guided by the “least intrusive” principle as appropriate. Recommendations may include referrals for MCYS/MCSS funded programs; referrals for non-MCYS/MCSS funded programs or a combination.

The youth/guardian considers the recommendations made by the Resource Coordinator.

The Resource Coordinator documents the youth’s/guardian’s response (i.e. agreement or rejection) for each recommendation made. The following actions are taken depending on the response to the recommendation:

- Where the recommendation is declined, the Resource Coordinator reviews the rationale, addresses any outstanding issues and makes alternative recommendations, where appropriate.
- Where the consent is provided regarding a service for which Contact Hamilton is not the single access point, the youth/guardian follows up with that referral independently. Resource Coordinators assist as required.
- Where the consent is provided regarding a service for which Contact Hamilton is the single access point, the Resource Coordinator follows the “Referral Process” identified in Section 6.5.

The Resource Coordinator will obtain and document consent from the youth/guardian to forward the HFHT clinical tools to the agency/agencies referred to. If consent is not provided, the tools cannot be forwarded.

The Resource Coordinator mails the youth/guardian a letter outlining the recommendations made and the resulting action plans. With respect to children’s mental health referrals, the Resource Coordinator will, with consent, also advise the child’s/youth’s physician and the HFHT referent by letter (one letter is addressed to both the physician and the referent) of the child’s/youth’s needs, resulting service recommendations and where known, projected waiting time. The letter will recommend that the physician see their patient if they deem it necessary and will identify that the child/youth remains their responsibility. The letter will indicate that the specialized service will be time limited.

6.5 The Referral Phase

The referral package to MCYS/MCSS funded service providers include:
- Referral Form
- Common Intake
- BCFPI (where applicable)
- Clinical tools administered by the HFHT (if any)
- Needs Profile
- Verbal or written consent

Agencies receive the referrals and have specific time frames within which they must respond to Contact Hamilton about the appropriateness of the referral.

Resource Coordinators track all referrals made to MCYS/MCSS funded services and record all relevant dates (e.g. referral date, wait list date, cancelled date, start date and discharge date) in Contact Hamilton’s website.

6.6 Participation in Children’s Integrated Planning Meetings

From time to time, Children’s Integrated Planning meetings may be required to assist in:
- Determining the most appropriate service option
Addendum 1
- Identifying a service provider
- Coordinating various supports and / or
- Accessing a service that is urgently required

The intent of the Children’s Integrated Planning Meeting is to engage in collective and collaborative service planning with the child / youth and their family in a proactive way (pre-crisis). The goal is to avert crisis situations from occurring or should they occur, to be able to respond in a meaningful and timely way. Please refer to the Children’s Integrated Planning Meeting Procedure for details (Appendix).

Where the child is already a patient of a HFHT and receiving mental health service from them or where a referral to the HFHT mental health service has been made, the mental health clinician will be invited to participate in the Children’s Integrated Planning Meeting. Where there is current involvement with the mental health clinician, the clinician can speak to their involvement and any recommendations they may have. Where the child/youth has recently been referred to the mental health service but not in service, the HFHT clinician can speak to the mental health service and what support they may be able to provide the child/youth and family.

7.0 Access to Mental Health Services Available at the Hamilton Family Health Team

Contact Hamilton and other community services (e.g. children’s mental health services providers) can request access to the mental health services offered through the HFHT on behalf of a child/youth already registered as a patient with the specific HFHT provider.

The physician of the HFHT determines whether or not the mental health service is required / appropriate for the child/youth.

7.1 Referral Indicators

It may be appropriate for the referent (i.e. Contact Hamilton Resource Coordinator, children’s mental health provider) to direct a child/youth and their family to the Hamilton Family Health Team for the provision of mental health service in the following situations:

- The child/youth is a patient of a HFTH practice AND
- The presenting concerns are of a psycho-social or medical nature as school problems, ADHD, parent/child conflict, behaviour adjustment to separation and divorce AND
- An early intervention (first level) service is appropriate due to the lesser degree of acuity and/or lack of co-morbidity AND
- Other community or Employee Assistance Programs (EAP) services are not available or appropriate to meet the needs OR
- Specialized children’s mental health services have been successfully provided and there is a need for primary level follow up care OR
- The concerns would benefit from health teaching, early detection and intervention in keeping with a primary care environment OR
- The issues presented are primarily related to family issues and functionality (not child/youth specific).

7.2 Initiating a Request for Service

Where the referent believes that a referral to the HFHT is appropriate, she/he will complete a Consideration for Referral to the Hamilton Family Health Team Mental Health Program Form and fax it to the appropriate physician’s office. In the case of Contact Hamilton, the Common Intake and BCFP are not sent.

The HFHT practice will connect with the referent within 14 days regarding the outcome of the referral.

8.0 Communication Between the Family Health Team and the Children’s Mental Health Provider

When a child/youth is referred to a children’s mental health service, it is important that the HFHT be kept abreast of the child’s/youth’s status. Solid communication between the children’s mental health service and the HFHT will reinforce the collaborative relationship between the two, thus providing a seamless service to the child/youth and their family.

With consent, while the child/youth is in the care of a children’s mental health outpatient service, the service provider will provide the HFHT with regular updates about the child’s/youth’s status (e.g. every three months and/or at naturally occurring transition points like movement from one service to another within the agency, new plans of care). The frequency and
method by which the updates are provided are negotiated between the service provider and the HFHT clinician. In addition, the service provider will alert the HFHT practice when the person has terminated service and the outcome of their intervention. Where consent is not provided, updates to the HFHT cannot be provided.

9.0 Contact Hamilton’s Resource Database

In partnership with Community Information Service (CIS), Contact Hamilton has created a resource database that enables Resource Coordinators to access up-to-date information about community-based services and supports for children. In addition, a “public view” of this resource database is also available to the general public through Contact Hamilton’s website: \[www.contacthamilton\].

The HFHT will keep their records updated with CIS. This will ensure that information about the HFHT is kept current for use by Contact Hamilton Resource Coordinators and by the general public.

HFHT staff are encouraged to use the public view of this resource database at any time. Orientation to this resource database by Contact Hamilton staff can be made available upon request.

10.0 Children’s Services System Meetings

The CSSC is a regular forum for Children’s service providers funded by MCYS/MCSS to conduct sector specific business. A single senior representative from the HFHT is represented on this committee.

The CSSC meets nine times per year on the Wednesday of the month from 9 am to 12 pm. Meetings do not take place in July, August and December.

11.0 Liaison Meetings

The purposes of the liaison meeting include: protocol review; issues identification and resolution and relationship building / maintenance.

Frequency: Twice yearly (spring and fall) and as required

Membership: HFHT Children’s Mental Health Representative and Contact Hamilton liaison person and representation from the children’s services sector.

Time sensitive referral/access related process issues are dealt with directly between the specific HFHT mental health representative and the Contact Hamilton liaison person. Other time sensitive process issues are dealt with directly between the specific HFHT mental health representative and the appropriate party.

Time sensitive client-related matters are dealt with directly between the specific HFHT mental health clinician and the appropriate party.

12.0 Privacy of Information / Confidentiality

HFHT, Contact Hamilton and children’s services sector agree to comply with the following privacy related procedures:

12.1 Where the HFHT or children’s services provider discloses personal information to Contact Hamilton, the HFHT ensures that:

A. All personal information disclosed to Contact Hamilton has been done in accordance with all applicable laws pertaining to the personal information in question, and specifically, where applicable, consent by the individual(s) whose personal information is provided has been obtained and;

B. The HFHT or children’s services provider will promptly respond to Contact Hamilton enquiries concerning the personal information provided to Contact Hamilton.
12.2 Where the HFHT or children’s services provider receives personal information from Contact Hamilton and with respect to such personal information, the HFHT ensures that:

A. All personal information disclosed by Contact Hamilton to the HFHT or children’s services provider will be used only in the manner and for the purposes that Contact Hamilton has agreed upon;

B. The HFHT or children’s services provider will not disclose personal information provided by Contact Hamilton without the consent of Contact Hamilton or the person whose personal information is in question;

C. The HFHT or children’s services provider has implemented appropriate security measures to protect the personal information provided by Contact Hamilton;

D. The HFHT or children’s services provider will promptly provide notice to Contact Hamilton about:
   - Any request for the disclosure of personal information, including requests by law enforcement authorities, without responding to the request unless required by law or judicial order;
   - Any accidental or unauthorized access of personal information.

E. The HFHT or children’s services provider will comply with any reasonable recommendations made by governmental privacy authorities with respect to the protection of personal information provided by Contact Hamilton.
Referral Form to Contact Hamilton from the HFHT

Consideration for Referral to the HFHT Mental Health Program Form
### CHILD & YOUTH COMMUNITY RESOURCE TOOL (Revised - September 2009)

<table>
<thead>
<tr>
<th>Open Access – Patient Can Call</th>
<th>Must Call or Fax CONTACT Hamilton 905-570-8888 [Referral Form]</th>
<th>Healthcare Provider Referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Shelters for Youth &amp; Families</strong></td>
<td><strong>Youth Housing/Residential</strong></td>
<td>McMaster Child &amp; Youth Inpatient Service, Day Hospital &amp; Urgent Access (6-18yrs)</td>
</tr>
<tr>
<td>Notre Dame Youth Shelter</td>
<td>Brennan House (16-20 years)</td>
<td>Eating Disorders Program (up to 17)</td>
</tr>
<tr>
<td>Wesley Urban Ministries Youth Housing</td>
<td>Canada House (males 12-18)</td>
<td>McMaster Children’s Exercise &amp; Nutrition (4-18yrs)</td>
</tr>
<tr>
<td><strong>Teen Pregnancy &amp; Parenting</strong></td>
<td>Charlton Hall (girls 12-18)</td>
<td>Anxiety Disorders Clinic (16+)</td>
</tr>
<tr>
<td>Angela’s Place (young moms 16-20)</td>
<td>Lynwood Hall Child &amp; Family Centre Residential Treatment Program (6-18)</td>
<td>First Episode Psychosis (16+)</td>
</tr>
<tr>
<td>Grace Haven (pregnant up to age 21)</td>
<td>Children With Complex Needs (ICFS) Intensive Child and Family Services - In Home</td>
<td>St. Joseph’s Health Care</td>
</tr>
<tr>
<td>St Martin’s Manor (pregnant up to 21)</td>
<td></td>
<td><strong>Day Treatment/School Programs/Alternative Education</strong></td>
</tr>
<tr>
<td><strong>Day Treatment/School Programs/Alternative Education</strong></td>
<td></td>
<td>Adolescent Special School Program (6-18)</td>
</tr>
<tr>
<td>Charlton Hall Day Treatment (12-17yrs)</td>
<td>McMaster CYMHP Outpatient Service</td>
<td>McMaster Developmental Pediatric Services Infant Parent Program (0-3yrs)</td>
</tr>
<tr>
<td>COMPASS Day Treatment Program</td>
<td>McMaster CYMHP Outpatient Service (6-18)</td>
<td></td>
</tr>
<tr>
<td>Lynwood Hall Day Treatment (11-14yrs)</td>
<td>Assessment / Individual / Family / Group Therapy</td>
<td>McMaster Children’s Outpatient Services (6-18)</td>
</tr>
<tr>
<td>Wilma’s Place (16-19yrs)</td>
<td>Hamilton Child and Adolescent Services (5-10)</td>
<td>McMaster Children’s Inpatient Services (6-18)</td>
</tr>
<tr>
<td>James St. School (16-20yrs)</td>
<td>Quick Access Service</td>
<td>McMaster Children’s Day Hospital &amp; Urgent Access (6-18)</td>
</tr>
<tr>
<td><strong>Children with Disabilities</strong></td>
<td>Assessment / Individual / Family / Group Therapy</td>
<td>Eating Disorders Program (up to 17)</td>
</tr>
<tr>
<td>Extend-A-Family</td>
<td>Trauma Treatment Program</td>
<td>McMaster Children’s Exercise &amp; Nutrition (4-18yrs)</td>
</tr>
<tr>
<td>Special Services at Home</td>
<td>Assessment / Treatment for Sexually Offending Youth</td>
<td>Anxiety Disorders Clinic (16+)</td>
</tr>
<tr>
<td>Community Living Hamilton</td>
<td>Assessment / Treatment for Sibling Sexual Abuse</td>
<td>First Episode Psychosis (16+)</td>
</tr>
<tr>
<td></td>
<td>Forensics Fire Setting Risk Assessments</td>
<td>St. Joseph’s Health Care</td>
</tr>
<tr>
<td><strong>Child &amp; Family Supports</strong></td>
<td>Community Child Abuse Council</td>
<td></td>
</tr>
<tr>
<td><strong>Youth Substance Use</strong></td>
<td></td>
<td>Adolescent Special School Program (6-18)</td>
</tr>
<tr>
<td>AY - Alternatives for Youth (13-22 yrs)</td>
<td>905-527-4469</td>
<td></td>
</tr>
<tr>
<td><strong>List of Resources Related to Substance use</strong></td>
<td></td>
<td>McMaster Children’s Outpatient Services (6-18)</td>
</tr>
<tr>
<td><strong>Family/Couple Therapy</strong></td>
<td></td>
<td>McMaster Children’s Inpatient Services (6-18)</td>
</tr>
<tr>
<td>Catholic Family Services - Walk in</td>
<td>905-527-3823</td>
<td>Eating Disorders Program (up to 17)</td>
</tr>
<tr>
<td><strong>Child Abuse</strong></td>
<td></td>
<td>McMaster Children’s Exercise &amp; Nutrition (4-18yrs)</td>
</tr>
<tr>
<td>Community Child Abuse Council</td>
<td>905-523-1020</td>
<td>Anxiety Disorders Clinic (16+)</td>
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<tr>
<td>(Prevention/Education/Treatment)</td>
<td></td>
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</tr>
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<td><strong>Community Group Programs</strong></td>
<td></td>
<td>St. Joseph’s Health Care</td>
</tr>
<tr>
<td>Group Programs (Parents, Teens, Children)</td>
<td>905-545-0133</td>
<td></td>
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<td>Banyan Community Services</td>
<td></td>
<td></td>
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<td>Community Education Flyer</td>
<td>905-524-9884</td>
<td>McMaster Children’s Outpatient Services (6-18)</td>
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<td>Hamilton Ontario Early Years Information (6-6yrs)</td>
<td>905-524-2100, x77406</td>
<td>McMaster Children’s Inpatient Services (6-18)</td>
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<tr>
<td>McMaster Infant Parent Program (IPP) (6-3yrs)</td>
<td></td>
<td>Eating Disorders Program (up to 17)</td>
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<tr>
<td>Community Separation/Divorce Resources (HFHT)</td>
<td></td>
<td>McMaster Children’s Exercise &amp; Nutrition (4-18yrs)</td>
</tr>
<tr>
<td><strong>Child &amp; Youth Patient Education (Books, websites, etc.)</strong></td>
<td></td>
<td>Anxiety Disorders Clinic (16+)</td>
</tr>
<tr>
<td>ADHD, Anxiety, Mood, Parent &amp; Youth Resources</td>
<td></td>
<td>First Episode Psychosis (16+)</td>
</tr>
</tbody>
</table>

### Child & Youth Telephonic Services
- HFHT Child & Youth Telephone Consult - 905-667-XXXX
- ADHD SNAP IV Questionnaires
- Anxiety Scale - SCARED Questionnaire
- Depression/Teen PHQ-9 Questionnaire

### Child & Youth Urgent/Crisis Services
- COAST Crisis Outreach And Support Team: 905-972-8338 (24 hours)
- McMaster 1 Session Psychiatric Consult: 905-521-2100, ext. 77406
- McMaster Consult 1 Session Psychiatric Consult (referral form below)

### Community Living Hamilton
- 905-528-0281
- Assessment / Individual / Family / Group Therapy

### McMaster Consult 1 Session Psychiatric Consult
- 905-521-2100, ext. 77406
- McMaster Consult 1 Session Psychiatric Consult (Referral Form)

### McMaster Child & Youth Inpatient Service, Day Hospital & Urgent Access (6-18yrs)
- Eating Disorders Program (up to 17)
- Anxiety Disorders Clinic (16+)
- First Episode Psychosis (16+)

### McMaster Children’s Exercise & Nutrition (4-18yrs)
- Anxiety Disorders Clinic (16+)
- First Episode Psychosis (16+)

### McMaster Children’s Inpatient Services (6-18)
- Anxiety Disorders Clinic (16+)
- First Episode Psychosis (16+)

### McMaster Children’s Outpatient Services (6-18)
- Anxiety Disorders Clinic (16+)
- First Episode Psychosis (16+)

### McMaster Children’s Day Hospital & Urgent Access (6-18)
- Anxiety Disorders Clinic (16+)
- First Episode Psychosis (16+)

### St. Joseph’s Health Care
- 905-522-7336
- 905-525-6640
- 905-549-4276
- 905-540-6586
- 905-577-8451
- 905-575-7500
- 905-527-2129
- 905-527-3823
- 905-577-1020
- 905-521-2100 x. 77967
- 905-522-1155 x.36236
- 905-572-6787
- 905-521-2100 x. 77406
- 905-521-2100, ext. 77885
- 905-521-2100, ext. 77326
- 905-521-2100, ext. 77211
- 905-577-8451
- 905-545-0133 (905) 521-2100, ext. 77211
- 905-577-8451
- 905-545-0133 (905) 521-2100, ext. 77211
Introduction
The C & Y MH Community Resource Tool was developed to facilitate easy access to resources for children, youth and families.

Instructions for using the C & Y MH Community Resource Tool
There are 3 means of accessing the C & Y MH Community Resource Tool

1. Hard copy version that can be posted at the family practice

2. Electronic version that can be downloaded onto your desktop computer
   ▶ To open a link to services, hover over the resource and press Ctrl and right click the mouse

3. Intranet version is accessible through the HFHT website
   To access via Intranet:
   • First go to the HFHT Website www.hamiltonfht.ca
   • In right hand corner enter your “log-in”
   • On the right side under “Quick Links” click on C&YMH Community Resource Tool

The C & Y MH Community Resource Tool has been divided vertically into 3 areas of service/concerns:
• Yellow - Open Access Patient can call
• Orange - Services accessed through Contact Hamilton
• Red – Healthcare Provider Referrals

Arrow on left side of page indicates service level from least intensive to most intensive services

Important Information at the bottom of the chart
A. Commonly used referral forms and questionnaires
B. Urgent Services telephone numbers

ACKNOWLEDGEMENTS: This C&YMH Community Resource Tool (draft) has been developed by the Hamilton Family Health Team, C&Y Mental Health Initiative and the Evaluation Project is funded by the Children’s Hospital of Eastern Ontario (CHEO).

For copies or for more information on this project, please contact Brenda Mills at brenda.mills@hamiltonfht.ca or call (905) 667-4854
This information will assist your family practice team in providing the best possible care for you and your family. Your answers will be kept strictly confidential as part of your child’s, teen’s and/or your medical record. Completing the questionnaire is voluntary and will not affect the health care you receive from your family practice team.

If you have questions or want help filling this out - please ask a member of your family practice team.

Name of Family Doctor: ______________________ Date: ________ Child’s Name: ______________________

Name of person completing this form: ______________________________________________

Who currently lives in the family home? (List name(s) and relationship; i.e. mother, brother, etc.)
____________________________________________________________________________________________
____________________________________________________________________________________________

Are you currently attending school? Yes / No Name of School: ______________________
Grade ______

1. What is your main concern?
__________________________________________________________________________________________
__________________________________________________________________________________________

2. How long has this been a problem (circle one)

   - Less than 3 months
   - 3 to 6 months
   - 6 to 12 months
   - 1 to 2yrs

3. Please circle any of the following that apply to you or your family:
   - Financial stressors
   - Death of loved one
   - Family Violence
   - History of abuse (parent)
   - History of abuse (child)
   - Alcohol or Drug Use (parent)
   - Alcohol or Drug Use (child/teen)
   - Moved homes
   - Separation / Divorce
   - Custody / Access Dispute
   - Major physical illness (parent)
   - Major physical illness (child)

4. What steps have you taken to deal with the problem at home, school, etc.?
__________________________________________________________________________________________
__________________________________________________________________________________________

5. Have you received help in the past or currently for this problem? Yes / No (please check all that apply)
   Family Doctor □  Contact Hamilton □  CAS/CCAS □  School Support □
   Parenting Group □  Other □ (Explain) ____________________________
   Did you find it helpful? Yes / No (Explain) ____________________________

6. Do you have any specific questions you would like answered?
__________________________________________________________________________________________

7. Is there anything else that would be helpful to share?
__________________________________________________________________________________________

ACKNOWLEDGEMENTS: This Child &Youth questionnaire (draft) has been developed by the Hamilton Family Health Team, Child &Youth Mental Health Initiative and the Evaluation Project is funded by The Provincial Centre of Excellence for Child & Youth Mental Health at CHEO.
Child's Name: Male___ Female___
Age: Day____ Month_____ Year_____
Today's date: Day____ Month _____ Year _____

Below are examples of problems which children sometimes have. Please circle whether each is NEVER true, SOMETIMES true, or OFTEN true of this child.

<table>
<thead>
<tr>
<th></th>
<th>never</th>
<th>sometimes</th>
<th>often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. distractible, has trouble sticking to an activity</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>fails to finish things he/she starts</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>difficulty following directions or instructions</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>impulsive, acts without stopping to think</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>jumps from one activity to another</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>fidgets</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total 1.</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. cranky</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>defiant, talks back to adults</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>blames others for his/her own mistakes</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>easily annoyed by others</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>argues a lot with adults</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>angry and resentful</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total 2.</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. steals things at home</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>destroys things belonging to others</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>engages in vandalism</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>broken into a house, building or car</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>physically attacks people</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>uses weapons when fighting</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total 3.</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOTALS 1 through 6</strong></td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

(Note: For Office use, completed by clinician, transfer totals to BCFPI DT Scoring Sheet top of Page 3)

<table>
<thead>
<tr>
<th></th>
<th>never</th>
<th>sometimes</th>
<th>often</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. worries about being separated from loved ones</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>worries bad things will happen to loved ones</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>scared to sleep without parents nearby</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>overly upset when leaving loved ones</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>overly upset while away from loved ones</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>complains of feeling sick before separating</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total 4.</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. worries about doing better at things</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>worries about past behaviour</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>worries about doing the wrong thing</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>worries about things in the future</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>afraid of making mistakes</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>overly anxious to please people</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total 5.</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. no interest in usual activities</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>gets no pleasure from usual activities</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>trouble enjoying him/her self</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>not as happy as other children</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>feels hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>seems unhappy, sad, or depressed</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total 6.</strong></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
The BCFPI is not a diagnostic tool. Although it supports the identification of common mental health problems, it may miss some problems or over-estimate others. It facilitates the communication of clinical information when consulting with, or referring to a mental health specialist. It should be interpreted by a qualified mental health provider or physician with training in psychometric interpretation.

The BCFPI self-administered Detection Tool is a version of the BCFPI and is not a diagnostic tool. Although it supports the identification of common mental health problems, it may miss some problems or over-estimate others. It facilitates the communication of clinical information when consulting with, or referring to a mental health specialist. It should be interpreted by a qualified mental health provider or physician with training in psychometric interpretation.


### Instructions for Scoring BCFPI Detection Tool

1. On page 2 of the BCFPI Self-Administered Detection Tool add responses for each 6 item scale
   - Never = 0, Sometimes = 1, Often = 2 (Maximum = 12)
   - All items must be answered - if there is missing data for a scale, do not score that scale
   - Include only 1 response for each of the 6 items
     i.e. if both 'sometimes' and 'often' are circled for the same item, use only the '2' for often

2. Insert totals from Page 2 in the box on the bottom of Page 2 Questionnaire.

3. Transfer totals from boxes on page 2 to the corresponding numbers at the top of this page with symbols 😊
   - Match for age and sex i.e., boys 6-12, 13-18 or girls 6-12, 13-18. Circle the number in the shaded column
     - if equal to the middle number, the child scores higher than 93% of the population
     - if equal or greater than the highest number, the child scores higher than 97% of the population.

4. Transfer totals from this page to the reverse on Page 4 Detection Tool Recommendations

---

**BCFPI Detection Tool Scoring Sheet – C&Y Mental Health Scale**

<table>
<thead>
<tr>
<th>Child’s Name</th>
<th>Sex</th>
<th>M_____</th>
<th>F_____</th>
<th>Child’s Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person Who Filled Out Form</td>
<td>Date of Pre-Screen</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Insert Totals from Page 2</th>
<th>1. RAIA 😊</th>
<th>2. COOP 😊</th>
<th>3. COND 😊</th>
<th>4. SEP 😊</th>
<th>5. M. ANX 😊</th>
<th>6. MOOD 😊</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boys</td>
<td>Girls</td>
<td>Boys</td>
<td>Girls</td>
<td>Boys</td>
<td>Girls</td>
<td>Boys</td>
</tr>
<tr>
<td>6-12</td>
<td>13-18</td>
<td>6-12</td>
<td>13-18</td>
<td>6-12</td>
<td>13-18</td>
<td>6-12</td>
</tr>
<tr>
<td>&gt;97%</td>
<td>&gt;=10</td>
<td>&gt;9</td>
<td>&gt;=8</td>
<td>&gt;8</td>
<td>&gt;=9</td>
<td>&gt;9</td>
</tr>
<tr>
<td>&gt;93%</td>
<td>9</td>
<td>8</td>
<td>7</td>
<td>7</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>&lt;=8</td>
<td>&lt;=7</td>
<td>&lt;=6</td>
<td>&lt;=6</td>
<td>&lt;=7</td>
<td>&lt;=7</td>
<td>&lt;=2</td>
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</table>
### SCORING:
Transfer total scores from
BCFPI Detection Tool Screen/Scoring Sheet below

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<th>Age 6-12</th>
<th>&gt;=10</th>
<th>&gt;=9</th>
<th>&gt;=3</th>
<th>&gt;=7</th>
<th>&gt;=8</th>
<th>&gt;=5</th>
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<tbody>
<tr>
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<td>13-18</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Girls</td>
<td>Age 6-12</td>
<td>&gt;=8</td>
<td>8</td>
<td>&gt;=2</td>
<td>&gt;=7</td>
<td>&gt;=8</td>
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<tr>
<td></td>
<td>13-18</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Boys</th>
<th>Age 6-12</th>
<th>9</th>
<th>8</th>
<th>6</th>
<th>7</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>13-18</td>
<td>8</td>
<td>8</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Girls</td>
<td>Age 6-12</td>
<td>7</td>
<td>7</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>13-18</td>
<td>7</td>
<td>8</td>
<td>5</td>
<td>7</td>
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</table>

<table>
<thead>
<tr>
<th>Boys</th>
<th>Age 6-12</th>
<th>&lt;=8</th>
<th>&lt;=7</th>
<th>&lt;=2</th>
<th>&lt;=5</th>
<th>&lt;=6</th>
<th>&lt;=4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>13-18</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Girls</td>
<td>Age 6-12</td>
<td>&lt;=6</td>
<td>&gt;=6</td>
<td>&lt;=1</td>
<td>&lt;=5</td>
<td>&lt;=6</td>
<td>&lt;=3</td>
</tr>
<tr>
<td></td>
<td>13-18</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

### RECOMMENDATIONS:
Please check (✓) below the recommendations you have identified

- Referral to Contact Hamilton (referral form)
- McMaster C&Y Psychiatric One Time Consultation (referral form)
- McMaster C&Y Telephone Consultation (905-521-2100 x74400)
- Catholic Family Services, 447 Main St., E., Unit 201 (905-527-3823)
- Psychological/psycho-education testing: private/school (support letter given to family)
- Other: ____________________________________
- Practice MHC & C&YMHC Co-session
- Referral to practice Mental Health Counsellor
- Child & Youth HFHT Consult - Telephone or Fax
- Child & Youth MHC or Child Psychiatrist
- EAP Service
- SNAP IV Questionnaires to be completed
- Call Contact Hamilton for consultation (905-570-8888)
- Community Program:
- Parenting skills group: (905-521-2100 Ext.77312)
- Community Flyer Group:
- Educational materials provided
- Monitor – 1 month/ 2month/3month/6 month
- Follow-up appt. needed______________________

The BCFPI is not a diagnostic tool. Although it supports the identification of common mental health problems, it may miss some or over-estimate others. It facilitates the communication of clinical information when consulting with, or referring to a mental health specialist. It should be interpreted by a qualified mental health provider or physician with training in psychometric interpretation.
# Appendix A

## Child & Youth Mental Health Information Request

**Child & Youth Psychiatrist – Dr. Peter Kondra**

(Count 905-546-6356  (Fax) 905-667-4873

Attention: Dr. Kondra

**Child & Youth Mental Health Counsellor – Brenda Mills**

(Tel) 905-667-4854  (Fax) 905-667-4873

### Form

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>DOB:</th>
<th>Date of Consultation:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of Practice:</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient HIN #</th>
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<table>
<thead>
<tr>
<th>Backline Line #</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

### Person Requesting the Consultation:

<table>
<thead>
<tr>
<th>Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>______</td>
</tr>
</tbody>
</table>

#### Who have you discussed this patient with? (check box)

- [ ] Physician
- [ ] MHC
- [ ] Psychiatrist
- [ ] Other: ___________

- [ ] Physician
- [ ] MHC
- [ ] Psychiatrist
- [ ] C&Y MHC
- [ ] Other: ___________

### Patient Summary

#### Presenting Concern/s:

1. ___________________________________________________
2. ___________________________________________________

#### Where is the problem occurring?

- [ ] Home
- [ ] School
- [ ] Community
- [ ] Peers
- [ ] Other: _______________________

### Brief Family History

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

### Trauma:

- [ ] Abuse
- [ ] Violence
- [ ] Neglect
- [ ] Death of Loved One
- [ ] Other: _______________________

#### Past 6 months

- [ ]

#### Past

- [ ]

### Prior Assessments (Please fax)

- [ ] Screening Questionnaire
  - [ ] Yes
  - [ ] No
- [ ] Completed:
  - [ ] Yes
  - [ ] No
- [ ] Other Assessment Tools
  - [ ] Yes
  - [ ] No

### Medications

<table>
<thead>
<tr>
<th>List current medications</th>
<th>Type &amp; Dosage:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Reason for Request

- [ ] Medication
- [ ] Diagnosis
- [ ] Case Support
- [ ] Medication Management
- [ ] Treatment Recommendations

9/30/2009

- 1 -

App A_Consultation Form
### This Section to be Completed by Consultant

**Person Providing Consultation**

| Name: ___________________________ | ☐ C&Y Psychiatrist | ☐ C&Y MHC | ☐ General Psychiatrist | ☐ MHC | ☐ Other: ___________________________ |

**Recommendations**

- ☐ Educational Materials
- ☐ Psychoeducational Counselling
- ☐ Referral to Community Agency/Groups
- ☐ School Interventions
- ☐ Single Session Consultation @ CYMHP – Chedoke Site/McMaster
- ☐ MHC to assess further
- ☐ MHC to provide treatment
- ☐ Psychological Testing
- ☐ Referral to Contact Hamilton
- ☐ Other: ___________________________

**Diagnostic Impressions and Discussion**

- __________________________________
- __________________________________
- __________________________________
- __________________________________
- __________________________________
- __________________________________
- __________________________________
- __________________________________
- __________________________________

**Follow Up**

- __________________________________
- __________________________________
- __________________________________
- __________________________________
- __________________________________
- __________________________________
- __________________________________
- __________________________________

**Date of Follow Up with Consultant**

9/30/2009

- **DD / MM / YY**
## Appendix B

### Child & Youth Mental Health Initiative: Program Logic Model

#### Hamilton Family Health Team

<table>
<thead>
<tr>
<th>Components</th>
<th>Direct Consultation</th>
<th>Indirect Consultation</th>
<th>Capacity Building</th>
<th>Knowledge Translation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Activities</strong></td>
<td>Assessment and management of mental health issues among C&amp;Y (age 0-18yrs) and their families. Provision of educational materials for C&amp;Y and their families. Linkage of C&amp;Y and their families to community and specialized resources.</td>
<td>Provision of indirect consultation (telephone &amp; in-office), and professional development activities, with MHCs within the HFHT re: C&amp;Y mental health issues.</td>
<td>Provision of educational materials and indirect consultation to family physicians and other members of the primary care team re: C&amp;Y mental health issues.</td>
<td>Sharing of information on the implementation of the C&amp;Y mental health program and its impacts, within the HFHT, and with other FHTs, mental health organizations, and local planning bodies.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Process Indicators/ Outputs</th>
<th># of C&amp;Y seen within the primary care practices of the HFHT</th>
<th># (and type) of consultations provided to MHCs by the C&amp;Y MHC</th>
<th># (and type) of consultations provided to family physicians by the C&amp;Y MHC</th>
<th># of presentations conducted (to each stakeholder group) # of reports disseminated (to each stakeholder group)</th>
</tr>
</thead>
</table>

| Short-term Objectives | To increase the number of C&Y assessed for mental health issues within the HFHT. To increase the detection of C&Y mental health issues in the HFHT. To increase the percent of referrals to specialized mental health services from primary care offices supported by the C&Y MHCs. To have high ratings of satisfaction with the program & the support provided by the C&Y MHCs among C&Y and their families. | To increase knowledge of, and comfort with, the assessment and management of C&Y mental health issues among MHCs within the HFHT. To increase awareness of community supports and resources for C&Y. | To increase knowledge of, and comfort with, the assessment, treatment, and management of C&Y mental health issues among family physicians and other team members within the HFHT. To increase awareness of community supports and resources for C&Y. | To share information internally and externally about the C&Y program’s implementation, facilitators and barriers to implementation, lessons learned, and outcomes. |

| Long-Term Objective | To improve the provision of mental health services to children and youth in primary care. |

C&Y = Child/Children and Youth; MHCs = Mental Health Counsellors; HFHT=Hamilton Family Health Team
# Child & Youth Mental Health Initiative: Indicators and Measures – Measurement Strategy

## Hamilton Family Health Team

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Indicator(s)</th>
<th>Source of Data (records, clients, caregivers, etc.)</th>
<th>Method to Collect Data</th>
<th>Who Collects Data</th>
<th>When Data are Collected</th>
</tr>
</thead>
<tbody>
<tr>
<td>To increase the number of C&amp;Y assessed for mental health issues within the HFHT.</td>
<td>Increase in number of C&amp;Y seen by a MHC/C&amp;Y MHC.</td>
<td>Referral data collected centrally by the HFHT (practices with a C&amp;Y MHC and those that have had indirect consultation with a C&amp;Y MHC)</td>
<td>Referral forms submitted by MHCs</td>
<td>MHCs and C&amp;Y MHCs</td>
<td>Collected on an ongoing basis. Submitted to central office quarterly.</td>
</tr>
<tr>
<td>To increase the detection of C&amp;Y mental health issues in the HFHT.</td>
<td>Increase in number of mental health issues detected among C&amp;Y.</td>
<td>Referral data collected centrally by the HFHT (practices with a C&amp;Y MHC and those that have had indirect consultation with a C&amp;Y MHC)</td>
<td>Referral forms submitted by MHCs</td>
<td>MHCs and C&amp;Y MHCs</td>
<td>Collected on an ongoing basis. Submitted to central office quarterly.</td>
</tr>
<tr>
<td>To increase the percent of referrals to specialized mental health services from primary care offices supported by the C&amp;Y MHCs.</td>
<td>Increase in the percent of referrals made to specialized mental health services in Hamilton.</td>
<td>Data from CONTACT Hamilton (an organization that centrally coordinates access to specialized mental health services for C&amp;Y)</td>
<td>Reports provided by CONTACT Hamilton on referrals made from HFHT practices</td>
<td>CONTACT Hamilton</td>
<td>Collected on an ongoing basis. Will request reports quarterly.</td>
</tr>
<tr>
<td>To have high ratings of satisfaction with the program and the support provided by the C&amp;Y MHCs among C&amp;Y and their families.</td>
<td>High ratings of satisfaction (i.e., &gt; 80% report being “satisfied” or “very satisfied”) among C&amp;Y and their families on patient and family surveys. Reported impact of the program.</td>
<td>C&amp;Y and family surveys Focus groups with C&amp;Y and family members.</td>
<td>Surveys administered Focus groups</td>
<td>HFHT Evaluator / Research Assistant</td>
<td>Collected after the first visit and upon completion of treatment. Focus groups conducted at end of project.</td>
</tr>
<tr>
<td>To increase knowledge of, and comfort with, the assessment and management of C&amp;Y mental health issues among MHCs within the HFHT.</td>
<td>Increase in scores on a questionnaire that assesses knowledge and comfort related to the assessment and management of C&amp;Y mental health issues</td>
<td>MHCs within the HFHT</td>
<td>Pre and post administered questionnaire</td>
<td>HFHT Evaluator / Research Assistant</td>
<td>Baseline &amp; end of the project</td>
</tr>
</tbody>
</table>

**C&Y = Child/Children and Youth; MHCs = Mental Health Counsellors; HFHT=Hamilton Family Health Team**
## Child & Youth Mental Health Initiative: Indicators and Measures – Measurement Strategy

### Hamilton Family Health Team

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Indicator(s)</th>
<th>Source of Data (records, clients, caregivers, etc.)</th>
<th>Method to Collect Data</th>
<th>Who Collects Data</th>
<th>When Data are Collected</th>
</tr>
</thead>
<tbody>
<tr>
<td>To increase awareness of community supports and resources for C&amp;Y among MHCs within the HFHT.</td>
<td>Increase in scores on a questionnaire that assesses knowledge and comfort related to the assessment and management of C&amp;Y mental health issues</td>
<td>MHCs within the HFHT</td>
<td>Pre and post administered questionnaire</td>
<td>HFHT Evaluator / Research Assistant</td>
<td>Baseline &amp; end of the project</td>
</tr>
<tr>
<td>To increase knowledge of, and comfort with, the assessment, treatment, and management of C&amp;Y mental health issues among family physicians within the HFHT.</td>
<td>Increase in scores on a questionnaire</td>
<td>Family physicians within the HFHT</td>
<td>Pre and post administered questionnaire</td>
<td>HFHT Evaluator / Research Assistant</td>
<td>Baseline &amp; end of the project</td>
</tr>
<tr>
<td>To increase awareness of community supports and resources for C&amp;Y among family physicians within the HFHT.</td>
<td>Increase in scores on a questionnaire</td>
<td>Family physicians within the HFHT</td>
<td>Pre and post administered questionnaire</td>
<td>HFHT Evaluator / Research Assistant</td>
<td>Baseline &amp; end of the project</td>
</tr>
<tr>
<td>To examine: 1) the implementation of the C&amp;Y mental health initiative in primary care and 2) participation in the evaluation of the C&amp;Y mental health initiative.</td>
<td>Re: Program implementation: facilitators, barriers &amp; lessons learned. Re: Participation in evaluation: benefits, drawbacks &amp; lessons learned.</td>
<td>C&amp;Y mental health initiative lead, C&amp;Y MHCs, MHCs, family physicians, primary care team</td>
<td>Individual interviews and focus groups</td>
<td>HFHT Evaluator / Research Assistant</td>
<td>End of the project</td>
</tr>
<tr>
<td>To share information internally and externally about: 1) the program’s implementation, facilitators and barriers to implementation, lessons learned, and outcomes and 2) benefits, drawbacks &amp; lessons learned related to participating in the evaluation of the program</td>
<td>Number of presentations and reports on the C&amp;Y mental health program disseminated</td>
<td>Data kept by the C&amp;Y MHCs</td>
<td>Summary of information collected by the C&amp;Y MHCs</td>
<td>C&amp;Y MHCs</td>
<td>Throughout the project</td>
</tr>
</tbody>
</table>

C&Y = Child/Children and Youth; MHCs = Mental Health Counsellors; HFHT=Hamilton Family Health Team
Appendix C     Referral Form to Contact Hamilton from the HFHT Practice
Fax:  905 – 522-5998

Request is for:
☐  Children’s Developmental Services
☐  Children’s Mental Health Services (endorsed by HFHT mental health clinician)

<table>
<thead>
<tr>
<th>Child/Youth Information:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child’s/Youth’s Name:</td>
</tr>
<tr>
<td>Date of Birth:</td>
</tr>
<tr>
<td>Address:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Guardian Information:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guardian’s Name:</td>
</tr>
<tr>
<td>Guardian’s Address:</td>
</tr>
<tr>
<td>Phone:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physician Information:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician’s Name:</td>
</tr>
<tr>
<td>Address:</td>
</tr>
<tr>
<td>Phone Number:</td>
</tr>
<tr>
<td>Fax Number:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HFHT Referent Information:</th>
</tr>
</thead>
<tbody>
<tr>
<td>HFHT Contact Person:</td>
</tr>
<tr>
<td>Position:</td>
</tr>
<tr>
<td>Address:</td>
</tr>
<tr>
<td>Phone Number:</td>
</tr>
<tr>
<td>Fax Number:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Consent Information:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obtained from:</td>
</tr>
<tr>
<td>Type of consent:</td>
</tr>
<tr>
<td>☐ Verbal ☐ Written (attach copy)</td>
</tr>
<tr>
<td>Purpose of consent:</td>
</tr>
<tr>
<td>☐ Referral to Contact Hamilton to access children’s services</td>
</tr>
<tr>
<td>Date obtained:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Attachments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ SNAP 4 ☐ MASC ☐ CDI ☐ Other:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reason for Referral / Presenting Situation:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>HFHT Service History:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service</td>
</tr>
<tr>
<td>---------</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medication History:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication</td>
</tr>
<tr>
<td>------------</td>
</tr>
</tbody>
</table>

Name and position of person completing this form:

Signature:        Date:
### 3 month follow-up Evaluation

1. How often have you used the **Community Resource Tool** in the past 3 months to increase your knowledge of C & Y Services?

   - Not at all □
   - Somewhat □
   - Very Much □

2. How often have you used the **Community Resource Tool** in the past 3 months to increase your patient’s knowledge of C & Y Services?

   - Not at all □
   - Somewhat □
   - Very Much □

3. Has the Community Resource Tool increased your **comfort level accessing** the services/resources?

   - Not at all □
   - Somewhat □
   - Very Much □

4. Has the **Community Resource Tool** made it easier for you to identify appropriate services/resources for the families you serve?

   - Not at all □
   - Somewhat □
   - Very Much □

5. Have you increased your referrals to community services for C & Y as a result of having the **Community Resource Tool**?

   - Not at all □
   - Somewhat □
   - Very Much □

6. What are the barriers to using the Community Resource Tool (language, convenience, etc)?

   - ________________________________________________________________
   - ________________________________________________________________
   - ________________________________________________________________

7. Please share your feedback on what we can do to improve the Community Resource Tool.

   - ________________________________________________________________
   - ________________________________________________________________
   - ________________________________________________________________

---

If you would like additional copies of the Community Resource Tool – please indicate the number needed beside your name.

Name: ____________________________  Phone: ____________________

---

Office Admin – Pre & Post-Q, Resource Tool
A primary goal of the Hamilton Family Health Team’s Child & Youth Mental Health (C&YMH) Initiative is to increase access to child and youth mental health services in our community. The Child & Youth MH Community Resource Tool will be presented at today’s meeting. This tool was developed to facilitate easy access to resources for children youth and families.

Your feedback will provide us with the information we need to assess and promote awareness, knowledge and skills. Ultimately, we aim to increase early detection and intervention of child & youth mental health problems within the family doctor’s office and ensure that all mental health care providers and families are both aware and knowledgeable about the services and resources available in our community.

This Evaluation Project is made possible and funded by The Provincial Centre of Excellence for Child & Youth Mental Health. Thank you for your valuable and essential input.

### Pre Session Evaluation

1. How would you rate your current **awareness** of services and community resources available for children, youth and families?
   - Very aware □
   - Somewhat aware □
   - Not aware □

2. How often do you manage calls or requests from a parent asking for mental health resources?
   - Very often □
   - Somewhat often □
   - Not at all □

3. How would you rate your **awareness** of child & youth mental health issues?
   - Very aware □
   - Somewhat aware □
   - Not aware □

4. How often are you requested by one of the practice team to make a referral for a child/youth mental health problem?
   - Very often □
   - Somewhat often □
   - Not at all □

5. How would you rate your current **knowledge** of the services and resources available to C&Y in our community?
   - Very knowledgeable □
   - Somewhat knowledgeable □
   - Need to know more □

6. How **comfortable** are you with your current knowledge of services/resources?
   - Very comfortable □
   - Somewhat comfortable □
   - Not comfortable □

7. What resources/services do you currently use when securing or providing information to the families you serve? (multiple answers possible)
   - Community Education calendar □
   - Pamphlets □
   - Personal list I’ve created □
   - Contact Hamilton Website □
   - The internet □
   - Other □

   **Comments:** __________________________________________________________

6. What do you hope to gain from today’s session?
   **Comments:** __________________________________________________________

---

**Name:** ________________________________  **Phone:** ___________________
# Child & Youth Mental Health Initiative

## C&Y Community Resource Tool

### Post Session Evaluation

1. As a result of today’s presentation, how would you now rate your current **awareness** of services and community resources available for children, youth and families?
   - Very aware □
   - Somewhat aware □
   - Not Aware □

2. After today’s presentation how would you rate your current **knowledge** of the services and resources available to C&Y in our community?
   - Very knowledgeable □
   - Somewhat knowledgeable □
   - Need to know more □

3. Has today’s presentation increased the **comfort level** that you will access the services/resources?
   - Very comfortable □
   - Somewhat comfortable □
   - Not comfortable □

4. Will today’s presentation make it **easier** for you to identify appropriate services/resources for the families you serve?
   - Yes □
   - No □
   - If no, why: __________________________________________________

5. Will the information provided at this session **increase** the likelihood that you will recommend or refer these services to the families you work with?
   - Yes □
   - No □
   - If no, is it because you already recommend these services?
   - Comment: ___________________________________________________________

6. Did you find this information session helpful?
   - Yes □
   - No □
   - If no, why: _____________________________________________________

7. Is there anything else from today’s information session that could have been added or improved upon?
   - Yes □
   - No □
   - If yes, please comment: __________________________________________
   - ____________________________________________________________
   - ____________________________________________________________
   - ____________________________________________________________

---

Name: ____________________________ Phone: ____________________
### Post Session Evaluation

1. **After today’s presentation – how would you rate your awareness of services and resources available for children & youth (C&Y)?**
   - Very Aware □
   - Somewhat Aware □
   - Not Aware □

2. **After today’s presentation - how would you rate your knowledge about services/resources related to C&Y?**
   - Very knowledgeable □
   - Somewhat knowledgeable □
   - Not knowledgeable □

3. **Has today’s presentation increased the comfort level that you will access the services/resources?**
   - Very comfortable □
   - Somewhat comfortable □
   - Not comfortable □

4. **Will today’s session make it easier for you to identify appropriate services/resources for the families you serve?** Yes □ No □
   - If “no”, why: __________________________________________________________

5. **Will the information provided at this session increase the likelihood that you will recommend or refer these services to the families you work with?** Yes □ No □
   - If “no”, is it because you already recommend these services? Yes □ Other □
   - Comments: __________________________________________________________

6. **Did you find this information session helpful?** Yes □ No □
   - If “no” why: __________________________________________________________
   - __________________________________________________________

7. **Is there anything else from today’s information session that could have been added or improved upon?** Yes □ No □
   - If “yes: please comment: __________________________________________________________
   - __________________________________________________________

Other Comments: ___________________________________________________________________
_____________________________________________________________________________

**Thank You**

Name (Optional) ______________________________________________________________

Can we contact you for more information? Yes □ No □ Telephone: _____________________
Appendix E  Child & Youth Detection Questionnaire Survey  Date:

1. Do you currently use an intake/assessment questionnaire for children and youth?
   Yes  No
   If you answered yes, please identify the tool/questionnaire

2. Which age group of children/youth are generally referred to you at the FP office?
   0 to 6yrs.  Yes/No
   7 to 11yrs. Yes/No
   12 to 18yrs. Yes/No
   Parents/caregivers only Yes/No
   None of the above Yes

5. How knowledgeable are you in:
   • Identifying children “at risk”?
     Not at all  1  Somewhat  2  Very  3
   • Identifying a specific “problem area” among children and/or youth?
     Not at all  1  Somewhat  2  Very  3
   • Discussing an identified “problem area(s)” with children and/or youth?
     Not at all  1  Somewhat  2  Very  3
   • Discussing an identified “problem area(s)” with parent/caregiver?
     Not at all  1  Somewhat  2  Very  3

6. How would you rate your current knowledge about C&Y community resources?
   Not at all  1  Somewhat  2  Very  3

7. How helpful would it be to have a “tool” that would assist you in identifying children and youth “at risk”?
   Not Helpful  1  Somewhat Helpful  2  Very Helpful  3

9. How helpful would it be to have a “tool” to monitor the progress of a child or youth?
   Not Helpful  1  Somewhat Helpful  2  Very Helpful  3

Thank You!
The secondary goal of the Hamilton Family Health Team’s Child & Youth Mental Health (C&Y MH) Initiative is to increase access to child and youth mental health services in our community. Today, Contact Hamilton’s Presentation will provide more information about their organization and the community services and resources in the field of C&Y MH.

Your feedback will provide us with the information we need to assess and promote awareness, knowledge and skills. Ultimately, we aim to increase early detection and intervention of child & youth mental health problems within the family doctor’s office and ensure that all mental health care providers and families are both aware and knowledgeable about the services and resources available in our community.

This Evaluation Project is made possible and funded by The Provincial Centre of Excellence for Child & Youth Mental Health.

Thank you for your valuable and essential input.

### Pre Session Evaluation

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.</strong></td>
<td>I currently work with the following age range of clients (multiple answers possible): Infants (0 - 6 yrs) □ Children (7-12 yrs) □ Teens (13 – 18 yrs) □ Caregivers/Parents □</td>
</tr>
<tr>
<td><strong>2.</strong></td>
<td>How would you rate your current awareness of services and community resources available for children, youth and families? Very aware □ Somewhat aware □ Not Aware □</td>
</tr>
<tr>
<td><strong>3.</strong></td>
<td>How would you rate your current knowledge of the services and resources available to C&amp;Y in our community? Very knowledgeable □ Somewhat knowledgeable □ Need to know more □</td>
</tr>
<tr>
<td><strong>4.</strong></td>
<td>How comfortable are you with your current knowledge of services/resources? Very comfortable □ Somewhat comfortable □ Not comfortable □</td>
</tr>
<tr>
<td><strong>5.</strong></td>
<td>What resources/services do you currently use when securing or providing information to the families you serve? (multiple answers possible) Community Education calendar □ Pamphlets □ Personal list I’ve created □ Contact Hamilton website □ The internet □ Other □ Comments: __________________________________________________________</td>
</tr>
<tr>
<td><strong>6.</strong></td>
<td>What do you hope to gain from today’s session? Comments: _______________________________________________________________</td>
</tr>
</tbody>
</table>
Appendix G  PATIENT SATISFACTION QUESTIONNAIRE  
Child & Youth Mental Health Initiative (C&YMH) in Primary Care Evaluation Project

Your family practice team is dedicated to providing the best possible care for you and your family. Please take a few minutes to answer the following questions. Your answers will be kept strictly confidential. Filling out the questionnaire is completely voluntary and will not affect the health care you receive from your family practice team.

This Child & Youth Mental Health Evaluation Project is currently conducting a patient satisfaction survey and **we greatly appreciate your feedback regarding your experience.** Your feedback will be used to improve the quality of service offered through your family physician’s office. Your answers will be kept confidential and no personal identifying information will be disclosed. This Evaluation Project is made possible and funded by The Provincial Centre of Excellence for Child & Youth Mental Health.

If you have any questions or concerns, please contact: Pat Carter, Research Assistant, Hamilton Family Health Team, C&Y Mental Health Initiative, CHEO Evaluation Project at: 905-667-4848 Ext 148.

**Evaluation of Mental Health Services**

<table>
<thead>
<tr>
<th></th>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>What main concern prompted</strong> you to make the appointment regarding your child/youth’s mental health?</td>
<td>_____________________________________________</td>
</tr>
</tbody>
</table>
| 2 | Who did you meet with today from the family practice team?                                    | 1. Family Physician Yes □  No □   
|    | 2. Mental Health Counsellor (MHC) and/or Yes □  No □   
|    | 3. Child & Youth Mental Health Counsellors (MHC)? Yes □  No □   
|    | 4. other ____________________                                                                    |
| 3 | Were you **comfortable** talking with the family practice team member(s)? Yes □  No □       |
|    | If no, why:                                                                                   | _____________________________________________                         |
| 4 | Did you feel **understood and listened** to? Yes □  No □                                     |
|    | If no, explain                                                                               | _____________________________________________                         |
| 5 | Were the practice team member(s) **friendly, polite and respectful**? Yes □  No □             |
| 6 | Did today’s session help you to develop a plan to address the problem? Yes □  No □             |
| 7 | What **recommendations** were given to you today?                                             | Follow-up appt. □  Educational Materials □  Referral to a Parenting Group □   
|    | Referral to a community group □  Call Contact Hamilton □                                       |
|    | Other □                                                                                       | _____________________________________________                         |
| 8 | How likely are you to follow-up with the recommendations that were given to you today?       | Very Much □  Mostly □  Somewhat □  a little □  not at all □             |
| 9 | How likely are you to return for future appointments related to emotional/behavioural problems? | Very Much □  Mostly □  Somewhat □  a little □  not at all □             |
| 10| Did you feel the session was helpful today?                                                    | Very Much □  Mostly □  Somewhat □  a little □  not at all □             |
| 11| Is there anything else that you would like to comment on that has not been covered in this questionnaire? | _____________________________________________                         |
Appendix H    Child and Youth Survey
To be posted on Survey Monkey

1. What were the main reasons you saw the Counsellor? (Check off all that apply)
   - school problems
   - friendships
   - family
   - bullying or teasing
   - feeling down or sad
   - feeling worried or stressed
   - temper
   - alcohol, drugs or gambling
   - sleeping problems
   - eating or body image
   - other (please explain) ______________________________________________

2. How comfortable were you in talking with the Counsellor?
   
<table>
<thead>
<tr>
<th>Not at all Comfortable</th>
<th>Comfortable</th>
<th>Very Comfortable</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

3. How well do you feel the Counsellor listened to you?
   
<table>
<thead>
<tr>
<th>Not at All</th>
<th>Well</th>
<th>Very Well</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

4. How well do you feel the Counsellor understood the things you talked about?
   
<table>
<thead>
<tr>
<th>Not at All</th>
<th>Well</th>
<th>Very Well</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

5. What things did the Counsellor suggest you do? (Check all that apply)
   - Come to a follow-up appointment
   - Read some information
   - Visit a website
   - Try something different or try practicing a new skill or tool
   - Call Contact Hamilton
   - Attend a program or group in the community
   - Other (please explain) ______________________________________________
How helpful did you find these suggestions?

<table>
<thead>
<tr>
<th>Not at All</th>
<th>1</th>
<th>Helpful</th>
<th>2</th>
<th>3</th>
<th>Very Helpful</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
</table>

Was there anything that got in the way of you doing the things that the Counsellor suggested?

☐ no
☐ yes → If yes, what were they? (Check all that apply)
☒ time
☒ friends
☒ family
☒ not having a computer
☒ not having a way to go somewhere (no transportation)
☒ I don’t think the things suggested will help me
☒ other (please explain) ____________________________

6. How helpful was it to talk to the Counsellor?

<table>
<thead>
<tr>
<th>Not at All</th>
<th>1</th>
<th>Helpful</th>
<th>2</th>
<th>3</th>
<th>Very Helpful</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
</table>

What did you find most helpful? (Check all that apply)

☒ being able to talk to someone
☒ the things the Counsellor suggested I try
☒ feeling like they understood
☒ having someone listen to me
☒ meeting the Counsellor in a place that was easy to get to
☒ meeting in a place that was confidential (no one knew why I was there)
☒ meeting in a place that I was used to
☒ I didn’t find anything helpful
☒ other (please explain) ____________________________

7. Did you see the Counsellor on your own or with someone else?

☒ on my own (skip pattern insert to Q8)
☒ with someone else

If you saw the Counsellor with someone else:

Who were you with?

☒ parent/guardian
☒ another family member
☒ a friend

How helpful was it to have someone there with you?
8. After meeting with the Counsellor, how prepared were you to handle the things that were bothering you?

Not at All 1 2 Prepared 3 4 Very Prepared 5

9. If you were having trouble again, how likely would you be to see a Counsellor again?

Not at All 1 2 Likely 3 4 Very Likely 5

10. If someone close to you needed some help, how likely would you be to suggest they go and see someone at their family doctor’s office?

Not at All 1 2 Likely 3 4 Very Likely 5

11. Is there anything we could do to make it easier for you to talk about things that are bothering you?

☐ No
☐ Yes

If yes, please explain
____________________________________________________________________________________

Thank you very much for your help. We would like to know something about the kids that answered the questions. Can you please tell us a little about yourself?

Are you a male or a female?
☐ male
☐ female

How old are you? _____ years old

As a small thank you for answering these questions, we would like to send you a $10 Blockbuster gift card. Please give your name and address below and we will mail a gift card to you in the next few weeks.
Dear (Name of Patient’s Family Member for patient 12 and under):

Sometimes kids and parents need someone to talk to about things that are happening at home, school, with friends, etc. A Child & Youth Counsellor works at your child’s family doctors office as part of a special project for children, youth and families (0 to 18yrs.). The counsellor meets with children, youth and families to talk, or to give information about things that can be helpful.

Since your child has met with a Child & Youth Counsellor, it’s important to find out how he/she felt about the experience (Was it helpful? etc.) and how it could be improved. Your child has been randomly selected to participate in this process. Together with your child, you can decide to participate or not.

If your child would like to take part (and you are in agreement), all your child needs to do is go to [provide url] or go to the [XX] section of the Hamilton Family Health Team website and click on [YY]. This will bring you to a website called “Survey Monkey” where your child will be asked to answer some questions. Your child will not be asked to provide his/her name and all of his/her answers will be confidential (private). Your child’s answers to the questions will in no way affect the care that he/she receives. In fact, no one (including your child’s family doctor and the Child and Youth Counsellor) will know whether you child completed the questions or not. The questions will you’re your child about 10 minutes to answer.

If you and your child decide to take part, we will give your child a $10 Blockbuster gift care as a small thank for taking the time to help us.

The questions will be available on Survey Monkey until [indicate date]. If you have any questions about this letter, please contact Pat Carter at 905-667-4848 ext. 148 or by email at: @mcmaster. If you have any questions about the evaluation of this program, you can contact Brenda Mills, Coordinator, Child & Youth Mental Health Initiative @ 905-667-4854.

Thanks for considering this.
Sincerely,

Brenda Mills, Coordinator
Child & Youth Mental Health Initiative
Hamilton Family Health Team
Dear (Name of Patient):

Sometimes kids and parents need someone to talk to about things that are happening at home, school, with friends, etc. A Child & Youth Counsellor works at your family doctors office as part of a special project for children, youth and families (0 to 18yrs.). The counsellor meets with children, youth and families to talk, or to give information about things that can be helpful.

Since you have met with a Child & Youth Counsellor, it’s important to find out how you felt about the experience (Was it helpful? etc.) and how it could be improved. You have been randomly selected to take part in this process. You can decide to participate or not. It is up to you.

If you would like to take part, all you need to do is go to [provide url] or go to the [XX] section of the Hamilton Family Health Team website and click on [YY]. This will bring you to a website called “Survey Monkey” where you will be asked to answer some questions. You will not be asked to provide your name and all your answers will be confidential (private). Your answers to the questions will in no way affect the care that you receive. In fact, no one (including your family doctor and the Child and Youth Counsellor) will know whether you answered the questions or not. Answering the questions will take about 10 minutes.

If you decide to take part, we will give you a $10 Blockbuster gift care as a small thank for taking the time to help us.

The questions will be available until [indicate date]. If you have any questions about this letter, please contact Pat Carter at 905-667-4848 ext. 148 or by email at: @mcmaster. If you have any questions about the evaluation of this program, you can contact the Chair of the Hamilton Health Sciences/Faculty of Health Sciences Research Ethics Board at 905-521-2100, ext. 42013.

Thanks for considering this.
Sincerely,

Brenda Mills, Coordinator
Child & Youth Mental Health Initiative
Hamilton Family Health Team
Appendix I

Dear (insert name of parent),

Your family doctor is currently participating in a special project for children, youth and families called the Child and Youth Mental Health Initiative, which is a part of the Mental Health Program at the Hamilton Family Health Team. This purpose of this project is to provide resources and counselling to help support the healthy development of children and youth (ages 0 to 18) and their families.

It’s important to find out from parents what they think about this program and how it could be improved. To do this, we are contacting parents of children that have used the program and are asking them to answer some questions about the program.

You have been randomly selected to take part in a telephone interview. You can decide whether or not you would like to participate. The interview will take about 30 minutes of your time. Your answers to the questions will be kept confidential (private) and will in no way affect the care that your child receives. In fact, no one (including your family doctor and the Child and Youth Counsellor) will know whether or not you took part in the interview.

As a small token of our appreciation for participating, you will be given a $25 gift card from a local retailer (WalMart, Shopper’s Drug Mart).

Our research assistant, Pat Carter, will be contacting you within the next few days to see if you are willing to take part. If you are, a date and time that is convenient for you will be scheduled. If you are not interested in participating, just tell Pat when she calls. We will not contact you about this again.

The questions will be available until [indicate date]. If you have any questions about this letter, please contact Pat Carter at 905-667-4848 ext. 148 or by email at: @mcmaster. If you have any questions about the evaluation of this program, you can contact Brenda Mills, Coordinator @ 905-667-4854.

Thank you for considering this request.
Sincerely,

Brenda Mills, Coordinator
Child & Youth Mental Health Initiative
Hamilton Family Health Team
Appendix J
Interview discussion guide – Parents

Introduction key points to review by facilitator:
- Introduce self/role
- Confidentiality (no names will be used in and report/transcript etc)
- Purpose/use of digital recorder
- Any questions

1. What child & youth mental health services would you find most helpful to access at your family physicians office?
   Prompts: books, parenting DVD’s, websites, information regarding community services, diagnosis, medication, 1:1 counselling, group counselling)

2. How can we support patient involvement (parents, children, and youth) in pursuing and accessing their needs related to child & youth mental health both at the family practice and in the community?

3. How can the practice team help you in accessing child & youth mental health resources/services?

4. What are the barriers to discussing child & youth mental health issues at your Family Physicians office?

5. Does it make it easier to raise questions about mental health because a mental health counsellor is available at the family doctors office? Yes/no and why.

6. What has been most valuable to you in being able to access child & youth mental health services at your family physicians office?

7. What is needed to make your Family Practice office family friendly?

Thank you for taking the time to share your thoughts and ideas – it’s important to have this feedback so we can improve the services we offer.

We would like to let you know about an opportunity that you may be interested in participating in. At the end of May, there is a conference in Hamilton for doctors, nurses, counselors, etc from all over the world to learn about how to improve health care. We are planning to have a group of parents and kids talk about what it was like to see a counselor at the family doctors office – no private information would be shared about the counselling session. It would be a great opportunity for you to teach us. Are you interested in learning more about this?

(If yes…) can I please have your name and address and we’ll send you some additional information. You can review this and decide if you’d like to participate.
(If no…) That’s fine. Thank you again for participating in this interview.
Appendix K

CONSENT STATEMENT

SIGNATURE OF RESEARCH PARTICIPANT

I have read the preceding information thoroughly. I have had the opportunity to ask questions, and all of my questions have been answered to my satisfaction. I agree to participate in this study. I understand that I will receive a signed copy of this form.

______________________________
Name of Participant

__________________________________________________________________________  ______________
Signature of Participant        Date

Consent form administered and explained in person by:

______________________________
Name and title

__________________________________________________________________________  ______________
Signature       Date

Principal Investigator

______________________________
Print Name

__________________________________________________________________________  ______________
Signature        Date
Appendix L
Focus Group Discussion Guide – Primary Care Practice Team

Introduction key points to review by facilitator:
- Introduce self/role
- Confidentiality (no names will be used in and report/transcript etc)
- Purpose/use of digital recorder
- One person speaks at a time (please)
- Any questions re: group format/structure before we begin recording/discussion

1. What has your experience with the Child & Youth (C&Y) Mental Health (MH) pilot been?
   Probe: How have you used / connected with the initiative?

2. What aspects of the program have worked well?

3. What are some of the barriers or challenges faced in implementing the program in primary care?

4. Are there aspects of the model that you think need to be changed or modified? If yes, what and why?

5. Has your connection with the C&Y MH initiative helped to increase your knowledge of C&Y MH issues (e.g., identification, assessment & management)? If so, how?

6. Has your connection with the C&Y MH initiative helped to increase your knowledge of available C&Y MH resources? If so, which resources?

7. In thinking about other primary care practices that are interested in implementing a C&Y MH initiative, what lessons have you learned that would be helpful to share with them?

8. What has it been like to participate in the evaluation of the C&Y MH initiative?
   Probes: What have the benefits been?
   What have some of the challenges been?

9. If you were providing advice to other primary care practices interested in evaluating a similar initiative, what advice would you give them?

10. Do you have any other comments you would like to share about the C&Y MH initiative?
Appendix M

Dear (insert name),

As you are aware, your practice is currently participating as a pilot site in the Child and Youth (C&Y) Mental Health Initiative, which is a part of the HFHT Mental Health Program and targets C&Y (0 to 18 yrs) and their families with emotional, behavioural and psychosocial issues.

As part of the ongoing evaluation of this initiative, we are conducting interview and focus group discussions with providers within the participating practices. The purpose of these discussions is to gain a better understanding of the barriers to the implementation and use of the initiative. We are also hoping to identify some strategies to facilitate and improve the use of the C&Y Initiative in the future (both at your practice and other primary care settings).

You have been randomly selected to participate in an interview. We expect the interview to be approximately 30 minutes in length and will take place at the HFHT office. The interview can be scheduled at a time that is most convenient to you.

Our research coordinator (insert name), will be contacting you within the next few days to see if you are willing to participate in this interview and, if so, set up a date and time for the interview (we’d like the interviews to occur within the next few weeks if possible).

Thank you for considering this request. If you have any questions, please contact us at 905-667-4848 or by email at  mephersondoe@hamiltonfht, or .mills@hamiltonfht.

Sincerely,

Catherine McPherson-Doe, Manager
Mental Health Program
Hamilton Family Health Team

Brenda Mills, Lead
Child & Youth Mental Health Initiative
Hamilton Family Health Team
Appendix N

Focus Group Discussion Guide – MHC

Introduction key points to review by facilitator:
- Introduce self/role
- Confidentiality (no names will be used in and report/transcript etc)
- Purpose/use of digital recorder
- One person speaks at a time (please)
- Any questions re: group format/structure before we begin recording/discussion

1. What has your experience with the Child & Youth (C&Y) Mental Health (MH) pilot been?
   Probe: How have you used / connected with the initiative?

2. What aspects of the program have worked well?

3. What are some of the barriers or challenges faced in implementing the program in primary care?

4. Are there aspects of the model that you think need to be changed or modified? If yes, what and why?

5. Have you accessed the C&Y MH Counsellors for telephone advice?
   If yes, did you find this helpful? Why or why not?

6. Have you conducted a joint visit with a C&Y MH Counsellor?
   If yes, did you find this helpful? Why or why not?

7. Has your connection with the C&Y MH initiative helped to increase your knowledge of C&Y MH issues (e.g., identification, assessment & management)? If so, how?

8. Has your connection with the C&Y MH initiative helped to increase your knowledge of available C&Y MH resources? If so, which resources?

9. In thinking about other primary care practices that are interested in implementing a C&Y MH initiative, what lessons have you learned that would be helpful to share with them?

10. What has it been like to participate in the evaluation of the C&Y MH initiative?
    a. What have the benefits been?
    b. What have some of the challenges been?
    c. If you were providing advice to other primary care practices interested in evaluating a similar initiative, what advice would you give them?

Do you have any other comments you would like to share about the C&Y MH initiative
Appendix O

Dear (insert name of primary care practice),

As you are aware, your practice is currently participating as a pilot site in the Child and Youth (C&Y) Mental Health Initiative, which is a part of the HFHT Mental Health Program and targets C&Y (0 to 18 yrs) and their families with emotional, behavioural and psychosocial issues.

As part of the ongoing evaluation of this initiative, we are conducting interview and focus group discussions with providers within the participating practices. The purpose of these discussions is to gain a better understanding of the barriers to the implementation and use of the initiative. We are also hoping to identify some strategies to facilitate and improve the use of the C&Y Initiative in the future (both at your practice and other primary care settings).

You have been randomly selected to participate in a focus group discussion with other members of your practice. We expect the discussion to be approximately 45-60 minutes in length and will take place at your practice. The discussion will take place on [date] at [time].

Our research coordinator (insert name), will be contacting you within the next few days to see if you are able to participate in this discussion.

Thank you for considering this request. If you have any questions, please contact us at 905-667-4848 or by email at mephersondoe@hamiltonfht or mills@hamiltonfht.

Sincerely,

Catherine McPherson-Doe, Manager Mental Health Program Hamilton Family Health Team

Brenda Mills, Lead Child & Youth Mental Health Initiative Hamilton Family Health Team
Appendix P

Interviews with C&Y MH Initiative Staff & MH Program Leads (N=5)

Summary
Rationale for the development of the pilot program and expected outcomes
A need for increased child and youth mental health services was identified by 2 means: 1) a review of population health data within the HFHT area, and 2) a survey that was administered to physicians after the HFHT was formed asking them to identify areas for improved specialized services. Additionally, a review of the current literature indicated that approximately 20% of children and youth have mental health problems, with mental health problems being indentified in about 2% of this population in the family practice.

The primary objective of the program was to increase identification and early intervention of mental health issues within the child and youth population. Goals of the program also included increasing capacity and access to C&Y MH services.

There is little support within current literature regarding providing this type of service with the primary care setting; therefore, it was difficult to define expected outcomes. The primary outcome was improving mental health of children and youth in Hamilton. Other anticipated outcomes included:

- Ultimate/overreaching goal: improve mental health of C&Y in Hamilton.
- Increasing knowledge/capacity among primary care staff to address C&Y MH needs.
- Decrease C&Y MH services access wait times for patients and families.
- Increase detection rates within practices.
- Improve collaboration with community partners.
- Improve awareness of C&Y MH problems and of resources available (to both families and providers).

Facilitators to the success of this pilot program included the importance of having a skilled coordinator and C&Y MHCS to lead the initiative. Choosing practices that were motivated and had a high demand for this service was also important. Increasing the knowledge and capacity of the existing primary care team (especially if it included a MHC) not only facilitated the success of the service but also improved the sustainability of the service. Other facilitators included individualizing the program to the practice, increasing awareness and knowledge of mental health issues and the service among all members of the practice, easy access/opportunity for consultation between the MHC and the physician, and having an appropriate and family friendly space to conduct family meetings.

Barriers to implementation
A significant barrier to change noted by program staff was the difficulty introducing a new service/model to an already busy practice. This was also compounded by the fact that most of the practices were also struggling with incorporating the new FHT model at the same time. Other barriers included lack of appropriate space, inappropriate referrals, diversity of practices (trying to fit one model into different practices), technology (didn’t systems used in practices = no consistent means of communication/documentation), and lack of resources to meet the high demands for the service.

Suggested changes to the model
Participation in the pilot project helped program leads identify aspects of the model that needed to be addressed prior to continued implementation. Ensuring the model fit the needs and structure of the individual practice was routinely mentioned by program leads and staff. The program model also needed to include resources to help improve the knowledge and capacity of the entire practice team to deal with C&Y MHC concerns (i.e. online workshops, resources etc).

**Sustaining the program**
As previously mentioned, increasing capacity of both the practice team and the program (i.e. more C&Y MHCs) is important to being able to both sustain the program and expand it. Not surprisingly, increased and on-going funding is also important. Good leadership, increasing awareness of C&Y MH issues and continued evaluation were also discussed by program leads and staff regarding ensuring sustainability.

**Lessons learned**
Practices and program staff need to have patience and remember that change takes time! Other lessons learned through this pilot project include identifying practice/provider- specific needs prior to implementation, know your community partners and communicate with them often, and remember that dealing with children and youths takes more time than adults.

**Advice to other practices**
Start small! Don’t try to do too much all at once. It’s important to take the time and assess what your practice and patient needs are, what resources you have, and what resources you need to address these needs.

**Detailed themes and quote examples.**

A. **Goals of the Child & Youth (C&Y) Mental Health (MH) pilot at the HFHT**

Rationale for the development of the program: A need for increased child and youth mental health services was identified by 2 means: 1) a review of population health data within the HFHT area, and 2) a survey that was administered to physicians after the HFHT was formed asking them to identify areas for improved specialized services. Additionally, a review of the current literature indicated that approximately 20% of children and youth have mental health problems, with mental health problems being indentified in about 2% of this population in the family practice.

The primary objective of the program was to increase identification and early intervention of mental health issues within the child and youth population. Goals of the program also included increasing capacity and access to C&Y MH services.

B. **Expected outcomes of the C&Y MH pilot**

While the primary care office is ideal location to offer mental health services to child and youth (consist source of care over patient’s lifetime and considered the gateway to all services), offering this type of specialized service in this setting is relatively new and therefore there is little data regarding outcomes one can expect to achieve.

Due to the lack of support in the literature needed to address the “large gap between the knowledge and understanding of what child and youth mental health is between the primary care sector and the specialized services.” (P1) Therefore, before increasing the mental health services available within primary care the program leads initiated measures to increase knowledge and understanding
of mental health issues among primary care providers (what is it, what does it look like). Program leads then focused increasing the patient’s access to specialized services by identifying what services were available in the community and which of these services could be offered in the family practice and which needed to be offered by referral to specialists.

Specific anticipated outcomes included:
- Ultimate/overreaching goal: improve mental health of C&Y in Hamilton.
- Increasing knowledge/capacity among primary care staff to address C&Y MH needs.
- Decrease C&Y MH services access wait times for patients and families.
- Increase detection rates within practices.
- Improve collaboration with community partners.
- Improve awareness of C&Y MH problems and of resources available (to both families and providers).

C. Facilitators to the implementation of the program

- Having an experienced program coordinator to oversee the implementation and evaluation of the program.
- Skilled C&Y MH counsellors!
- Choosing high need practices to pilot the program.
- Providing support to existing MHC to expand capacity to provide counselling to C&Y:
  “I have been encouraged by people, MHCs embracing those opportunities and really being very keen and somewhat excited to start seeing C&Y which I think is a very successful indicator of the kind of support that [the program coordinator and C&Y MHC leads] have provided to the program to shift and that has been a huge shift.” (P2)

- Piloting the program in a couple of practices to work out some kinks.
- Needed to ensure program was as transferable across multiple practices as possible
  “In the implementation stage having something that is flexible and not having some sort of hard, fast way of approaching this, but really using our stakeholders, our consumers, the physicians, as a way to help us build the program. So they were really our advisors to this throughout the process.” (P1)

- Taking each practices perceived needs into consideration and trying to adapt the program to best fit that practice (while still maintaining overall goals and objectives of program)
- Coordinator of program had direct patient care opportunity and this allowed her to work with the program in ‘real world’ context – this helped better identify barriers and address challenges.
- Being part of the team also allowed coordinator to help the counsellors find their place in this new team environment.
- Counsellors appreciated easy/immediate access to family physicians for quick consults and prescriptions.
- Working with practices that were receptive to the change and appreciated service provided by the C&Y MHC.
- Identify most effective means of communication with each practice team
- Relationship between counsellors-practice-program
“Apart from everything else that we’ve put in place the trust and the relationship that we’re establishing at a practice level has given us the opportunity to do what we have done and has extended our services to the patients.” (P1)

D. Barriers or challenges faced during implementation

- Diversity of practices - Multiple practices needed to be taken into consideration – what works in one practice may not work in another (due to different structure; staff; practice size etc)
- Counsellors not used to working as part of a team = learning curve.
- Implementing a new program/service into an already busy practice and during a pre-existing time of change (i.e. implementation/development of the FHT model).
- Space – need appropriate room to be able to meet with the family; also, environment needs to be comfortable and facilitate open and confidential discussion.

“…practical things (like) having the proper space, and particularly for the work we’re doing with children and youth and families, the understanding that you need a child and youth friendly environment that enables the individual and family to be able to talk about some pretty difficult things. And so, space has not always been available to see a whole family.” (P1)

- Technology – each practice uses different levels and types of technology so “there isn’t one consistent way of communicating or being able to develop resources and tools for the practices that are applicable across the FHT.” (P1)

- How to work with specialty service partners in the community (i.e. defining scope of practice of new service available in family practice and coordinating with community partner services).
- High demand for service – hard to keep up with. Not enough C&Y MH counsellors to meet demand.
- Lack of resources to address needs of the high-demand/complex patient’s and families being seen = challenge.

“Many of these children and families have so much against them you know, it’s difficult for them to achieve positive outcomes and also because of that it’s incredibly labour intense.” (P2)

- Important to keep within focus of primary care.

“Because I think at this point, we know the work is there, and there’s more work that we can handle; but, what we do want to continue to look at is that the quality of our work is within our scope of practice, and that we’re not also going beyond what our expertise is because we need to keep our eye on what the focus is in primary care.” (P1)

E. Suggested changes to the model

- Making sure we are using the program resources in the most effectively across all practices (create equity) and making sure the program is sustainable over the long-term.
- Need to consider overall system and specific practice.
- Increasing capacity (i.e. more C&Y MH counsellors and C&Y training): “what is it we can do that will increase the capacity, at a practice team level that they can provide services in C&Y mental health?”(P1)
- Increasing knowledge and capacity among existing team members to better meet the C&Y MH needs - can’t continue to offer full-time C&Y MHC as has been done in pilot – need to stretch this resource across more practices.
“One of our challenges is to define what provision of child care services ought to be like in the family practice setting and it’s probably somewhat different than what the current C&Y MHCs provide in those settings, which tends to be more intense than we had originally pictured. So perhaps to state it more clearly then would be to umm across the entire FH Team provide ways of increasing capacity and access to the inter-professional teams within those settings.” (P2)

- Increase appropriateness of referrals to the C&Y MHC (through better education of practice staff).
  “The referrals that I’ve gotten have become more, more appropriate, more focused, more uh, zeroed in on what I can do, what can be most effective.” (P5)

- Someone that is part of the practice team full-time is a stronger resource and represents a greater resource for the team (know each other better – comfort - trust).

F. Sustaining the program
- Primary care is a natural setting for C&Y MH services. Need to think about how to expand existing resources and add new resources at the primary care level.
  “I think we need to be thinking about, at a whole different level, within our social work schools, within nursing, of how to provide some training and education around the role of a mental health counsellor in a family health team, working in primary care.” (P1)

- Providing online CME workshops/sessions/resources for physicians and other allied health professionals in primary care focussed on C&Y MH education.
- Improving early identification of MH problems efforts.
- Funding!!
- Good leadership
- Continued evaluation (outcome data to support need for service/on-going funding).
- Increasing awareness of C&Y MH problem/needs.
- Thinking about how the program fits within the healthcare system.

G. Lessons learned – how to improve implementation at future practices
- Patience – change takes time!
- Identifying needs of physicians and practices and individualizing program to meet those needs (improves effectiveness of program).
- It takes more time to deal with children’s MH issues than adults because you need to be more of advocate for the child and work through the system for them.
- Prior to implementation – get to really know the whole practice team, including frontline staff. Will facilitate program and help identify specific needs.
- Know your community partners.
  “…the need to work at a community level with your community partners, because that’s the only way that you are going to better inform them of what our services are, what our capacity is to provide services, and also what the needs are and being really clear about what it is that we can do in primary care, and what it is that we can’t do in primary care.” (P1)
- Evaluation process has helped to identify some important indicators and outcomes.

H. Advice to other interested practices
• Document and track what you are doing (i.e. the changes). Helps identify what works and what doesn’t and why.
• Think about an evaluation plan at the beginning and revisit end goals/outcomes throughout the process to make sure you don’t lose site of those outcomes during the administrative logistical challenges you may face.
• Start out with something small and manageable – don’t get overwhelmed trying to role out a big initiative all at once.
• Take advantage of education opportunities.
• Be pro-active in identifying C&Y MH problems early.

“I mean there are some flags that we know pretty early on in kids, so when you’re doing a file review with a kid who’s like ten or eleven, you look back to their early development ‘caused you’re looking for flags. So, we know what they are, so what if we picked them up earlier and provided more support for families?” (P3)
Appendix P

Interview Guide – C&Y MH Initiative Staff & MH Program Leads

Introduction key points to review by facilitator:
▪ Introduce self/role
▪ Confidentiality (no names will be used in report/transcript etc)
▪ Purpose/use of digital recorder
▪ Any questions before we begin recording/discussion

1. What was the rationale for developing a Child & Youth (C&Y) Mental Health (MH) pilot at the HFHT? What outcomes were you hoping to achieve?

2. During the implementation of the program, what aspects have worked well?

3. What are some of the barriers or challenges faced during implementation?

4. Are there aspects of the model that you think need to be changed or modified? If yes, what and why?

5. As interest in the program increases, what needs to be done to meet the demand?

6. What’s needed to ensure the sustainability of the program?

7. In thinking about other primary care practices that are interested in developing a C&Y MH initiative, what lessons have you learned that would be helpful to share with them?

8. What has it been like to participate in the evaluation of the C&Y MH initiative? What have the benefits been? What have some of the challenges been? If you were providing advice to other primary care practices interested in evaluating a similar initiative, what advice would you give them?

9. Do you have any other comments you would like to share about the C&Y MH initiative?
Appendix Q

CONSENT STATEMENT

SIGNATURE OF RESEARCH PARTICIPANT

I have read the preceding information thoroughly. I have had the opportunity to ask questions, and all of my questions have been answered to my satisfaction. I agree to participate in this study. I understand that I will receive a signed copy of this form.

____________________________________
Name of Participant

____________________________________       ____________
Signature of Participant     Date

Consent form administered and explained in person by:

____________________________________
Name and title

____________________________________       ______________
Signature       Date

Principal Investigator

____________________________________
Print Name

____________________________________       ____________
Signature     Date
Appendix R

Section 1.0 Community Resource Tool survey outcomes as completed by practice administrators

Part A: Preliminary session evaluation

Part B: Post session evaluation

Part C: 3 month follow-up evaluation
**Section 1.0:** Community resource tool survey outcomes from practice administrators in the Hamilton Family Health Team

**Part A:** Baseline evaluation data

### Table 1: Resources and services used by practice administrators when providing information to patients and families; at baseline. N=23

<table>
<thead>
<tr>
<th>Question: What resources/services do you currently use when securing or providing information to the families that you serve? (Multiple answers possible)</th>
<th>Percent (number) of practice administrators who responded yes.</th>
<th>Percent (number) of practice administrators who responded no.</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Community education calendar</td>
<td>22% (5)</td>
<td>78% (18)</td>
</tr>
<tr>
<td>b) Pamphlets</td>
<td>35% (8)</td>
<td>65% (15)</td>
</tr>
<tr>
<td>c) Personally created list</td>
<td>13% (3)</td>
<td>87% (20)</td>
</tr>
<tr>
<td>d) Contact Hamilton website</td>
<td>35% (8)</td>
<td>65% (15)</td>
</tr>
<tr>
<td>e) Internet</td>
<td>13% (3)</td>
<td>87% (20)</td>
</tr>
<tr>
<td>f) Other (see comments)</td>
<td>35% (8)</td>
<td>61% (14)</td>
</tr>
</tbody>
</table>

**Comments:**
- We have a counselor/social worker on site
- Counselors advice
- This is dealt with by our mental health counselor, psychiatrist, nurse, and/or physician
- I am not the one involved
- Via NP, MHC
- Mental health counselor
- Community services handbook
- Our child and youth counselor: Ted Ridley
- Mental health counselor assigned to office

### Table 2: Management of requests by practice administrators for mental health resources and referrals; at baseline. N=23

<table>
<thead>
<tr>
<th>Question: How often do you manage calls or requests from a parent asking for mental health resources?</th>
<th>Percent (number) of practice administrators who responded “not at all”</th>
<th>Percent (number) of practice administrators who responded “somewhat often”</th>
<th>Percent (number) of practice administrators who responded “very often”</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NOT AT ALL</td>
<td>SOMEWHAT OFTEN</td>
<td>VERY OFTEN</td>
</tr>
<tr>
<td>Question: How often do you manage calls or requests from a parent asking for mental health resources?</td>
<td>30% (7)</td>
<td>52% (12)</td>
<td>17% (4)</td>
</tr>
</tbody>
</table>

| Question: How often are you requested by one of the practice team members to make a referral for a child/youth mental health problem? | 52% (12) | 39% (9) | 9% (2) |
### Table 3: Practice administrator’s awareness of child and youth mental health issues; at baseline

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>NOT AWARE</th>
<th>SOMEWHAT AWARE</th>
<th>VERY AWARE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Question:</strong> How would you rate your awareness of child and youth mental health issues?</td>
<td>8.7% (2)</td>
<td>83% (19)</td>
<td>8.7% (2)</td>
</tr>
</tbody>
</table>

### Table 4: Intentions of practice administrators for information session

<table>
<thead>
<tr>
<th>Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availability of the services</td>
</tr>
<tr>
<td>Awareness for my own knowledge</td>
</tr>
<tr>
<td>Good information to help our patients</td>
</tr>
<tr>
<td>More awareness of resources</td>
</tr>
<tr>
<td>More information for our office</td>
</tr>
<tr>
<td>More awareness of what resources are available for families/children</td>
</tr>
<tr>
<td>Information that would enable us to provide the quickest and most appropriate referral or intervention</td>
</tr>
<tr>
<td>Practical knowledge of options</td>
</tr>
<tr>
<td>Better knowledge of what is available in the community for child and youth mental health</td>
</tr>
<tr>
<td>More awareness</td>
</tr>
<tr>
<td>More info, and help to service parents</td>
</tr>
<tr>
<td>More resources</td>
</tr>
<tr>
<td>More information and resources</td>
</tr>
<tr>
<td>More information to bring back to practice team</td>
</tr>
<tr>
<td>Updated information</td>
</tr>
<tr>
<td>Information and resources that can be passed on to parents or referral resources that I can utilize</td>
</tr>
<tr>
<td>More info for doctor</td>
</tr>
<tr>
<td>Knowledge to direct parents</td>
</tr>
<tr>
<td>Share info with staff that deals with it more</td>
</tr>
<tr>
<td>Additional information</td>
</tr>
<tr>
<td>More insight into available services</td>
</tr>
</tbody>
</table>
**Part B: Post-session evaluation data**

<table>
<thead>
<tr>
<th>Table 5: Awareness, knowledge, and comfort of practice administrators in relation to the services and community resources available for children, youth, and families.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>QUESTION:</strong> Awareness of services and community resources available for children, youth and families?</td>
</tr>
<tr>
<td>Pre session N=23</td>
</tr>
<tr>
<td>Post session N=22</td>
</tr>
</tbody>
</table>

**QUESTION:** Knowledge of the services and resources available for children and youth in the community?

**NEED TO KNOW MORE** | **SOMewhat KNOWLEDGEABLE** | **VERY KNOWLEDGEABLE**
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre session N=23</td>
<td>74% (17)</td>
<td>26% (6)</td>
</tr>
<tr>
<td>Post session N=22</td>
<td>5% (1)</td>
<td>45% (10)</td>
</tr>
</tbody>
</table>

**QUESTION:** Comfort level in knowledge and accessing services and resources

**NOT COMFORTABLE** | **SOMewhat COMFORTABLE** | **VERY COMFORTABLE**
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre session N=23</td>
<td>65% (15)</td>
<td>26% (6)</td>
</tr>
<tr>
<td>Post session N=22</td>
<td>0% (0)</td>
<td>41% (9)</td>
</tr>
</tbody>
</table>

*Median: One type of average, found by arranging values in order and selecting the one in the middle.*

<table>
<thead>
<tr>
<th>Table 6: Identification and recommendation by practice administrators of appropriate services and resources for families worked with. N=22</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Question:</strong> As a result of today’s presentation...</td>
</tr>
<tr>
<td><strong>a)</strong> Will it be easier to identify appropriate services and resources for the families that you serve?</td>
</tr>
<tr>
<td><strong>b)</strong> Will there be increased likelihood for recommendation or referral of these services to the families that you work with.</td>
</tr>
<tr>
<td><strong>c)</strong> Did you find this information session helpful?</td>
</tr>
</tbody>
</table>
**PART C:** Follow-up data

**Table 7:** Measuring the effectiveness of implementing the Community Resource Tool with the practice administrators

<table>
<thead>
<tr>
<th>Question: In relation to the Community Resource Tool...</th>
<th>Percent (number) of practice administrators who responded “not at all”</th>
<th>Percent (number) of practice administrators who responded “somewhat often”</th>
<th>Percent (number) of practice administrators who responded “very often”</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) How often have you used it to increase your knowledge of child and youth services</td>
<td>33% (5)</td>
<td>60% (9)</td>
<td>7% (1)</td>
</tr>
<tr>
<td>b) Has it increased your comfort level in accessing the services and resources</td>
<td>13% (2)</td>
<td>40% (6)</td>
<td>47% (7)</td>
</tr>
<tr>
<td>c) Has it made it easier for you to identify appropriate services and resources for the families that you serve?</td>
<td>13% (2)</td>
<td>33% (5)</td>
<td>53% (8)</td>
</tr>
<tr>
<td>d) Have you increased your referrals to community services for child and youth as a result of having it?</td>
<td>47% (7)</td>
<td>53% (8)</td>
<td>0% (0)</td>
</tr>
</tbody>
</table>
Section 2.0 Community Resource Tool survey outcomes as completed by mental health counselors

Part A: Preliminary session evaluation

Part B: Post session evaluation

Part C: 3 month follow-up evaluation
Section 2.0: Community resource tool survey outcomes from mental health counselors in the Hamilton Family Health Team

Part A: Baseline evaluation data

Table 1: Demographics of patient population for mental health counselors

<table>
<thead>
<tr>
<th>Question: I currently work with the following age range of clients (multiple answers possible).</th>
<th>Percent (number) of MHC who responded yes.</th>
<th>Percent (number) of MHC who responded no.</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>a) Infants (0-6 years)</td>
<td>19% (9)</td>
<td>81% (38)</td>
</tr>
<tr>
<td>b) Children (7-12 years)</td>
<td>62% (29)</td>
<td>38% (18)</td>
</tr>
<tr>
<td>c) Teens (13-18 years)</td>
<td>79% (37)</td>
<td>21% (10)</td>
</tr>
<tr>
<td>d) Caregivers/parents</td>
<td>89% (42)</td>
<td>11% (5)</td>
</tr>
</tbody>
</table>

Table 2: Resources and services used by mental health counselors when providing information to patients and families; at baseline.

<table>
<thead>
<tr>
<th>Question: What resources/services do you currently use when securing or providing information to the families that you serve? (Multiple answers possible)</th>
<th>Percent (number) of practice administrators who responded yes.</th>
<th>Percent (number) of practice administrators who responded no.</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>a) Community education calendar</td>
<td>60% (28)</td>
<td>40% (19)</td>
</tr>
<tr>
<td>b) Pamphlets</td>
<td>66% (31)</td>
<td>34% (16)</td>
</tr>
<tr>
<td>c) Personally created list</td>
<td>43% (20)</td>
<td>57% (27)</td>
</tr>
<tr>
<td>d) Contact Hamilton website</td>
<td>11% (5)</td>
<td>89% (42)</td>
</tr>
<tr>
<td>e) Internet</td>
<td>51% (24)</td>
<td>49% (23)</td>
</tr>
<tr>
<td>f) Other (see comments)</td>
<td>36% (17)</td>
<td>64% (30)</td>
</tr>
</tbody>
</table>

Comments:

•
<table>
<thead>
<tr>
<th>Question: What do you hope to gain from today’s session?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Comments:</strong></td>
</tr>
<tr>
<td>• Referral info; Existing programs, process, and waiting times</td>
</tr>
<tr>
<td>• Current info and agencies</td>
</tr>
<tr>
<td>• Current info</td>
</tr>
<tr>
<td>• A roadmap and direction</td>
</tr>
<tr>
<td>• Increased awareness of C&amp;Y services and knowledge (i.e. accessing these services)</td>
</tr>
<tr>
<td>• Better understanding of resources</td>
</tr>
<tr>
<td>• More access to services (quick access)</td>
</tr>
<tr>
<td>• Knowledge about navigating the system</td>
</tr>
<tr>
<td>• Better understanding of what is available in the system</td>
</tr>
<tr>
<td>• Practical knowledge</td>
</tr>
<tr>
<td>• Numbers</td>
</tr>
<tr>
<td>• Names to contact</td>
</tr>
<tr>
<td>• Savvy about using the system and influencing change</td>
</tr>
<tr>
<td>• Knowledge of specific community resources</td>
</tr>
<tr>
<td>• Increase my knowledge of resources</td>
</tr>
<tr>
<td>• Understand why there are so many difficulties getting Contact to access case/referrals</td>
</tr>
<tr>
<td>• Know what else Contact offers other than referrals</td>
</tr>
<tr>
<td>• Awareness and knowledge about services</td>
</tr>
<tr>
<td>• Increased knowledge and awareness for ease of access for child services</td>
</tr>
<tr>
<td>• Increased knowledge of resources and access</td>
</tr>
<tr>
<td>• Referral process</td>
</tr>
<tr>
<td>• Information updates regarding services and any chances in access process</td>
</tr>
<tr>
<td>• Increased awareness and knowledge</td>
</tr>
<tr>
<td>• Additional information RE: resources and process for referral</td>
</tr>
<tr>
<td>• A more complete knowledge of resources</td>
</tr>
<tr>
<td>• Understanding of resource counselor role- why so difficult to access in timely manner</td>
</tr>
<tr>
<td>• How to navigate Contact and inform patients</td>
</tr>
<tr>
<td>• To become more knowledgeable about resources</td>
</tr>
<tr>
<td>• Better understanding of how CONTACT can be helpful to me/clients in my work</td>
</tr>
<tr>
<td>• How to access services</td>
</tr>
<tr>
<td>• How Contact works</td>
</tr>
<tr>
<td>• When to access what service</td>
</tr>
</tbody>
</table>
### Table 4: Awareness, knowledge, and comfort of mental health counselors in relation to the services and community resources available for children, youth, and families.

<table>
<thead>
<tr>
<th>QUESTION: Awareness of services and community resources available for children, youth and families?</th>
<th>NOT AWARE</th>
<th>SOMEWHAT AWARE</th>
<th>VERY AWARE</th>
<th>Median response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre session N=47</td>
<td>4% (2)</td>
<td>79% (37)</td>
<td>15% (7)</td>
<td></td>
</tr>
<tr>
<td>Post session N=28</td>
<td>18% (5)</td>
<td>32% (9)</td>
<td>50% (14)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>QUESTION: Knowledge of the services and resources available for children and youth in the community?</th>
<th>NEED TO KNOW MORE</th>
<th>SOMEWHAT KNOWLEDGEABLE</th>
<th>VERY KNOWLEDGEABLE</th>
<th>Median response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre session N=47</td>
<td>26% (12)</td>
<td>68% (32)</td>
<td>4% (2)</td>
<td></td>
</tr>
<tr>
<td>Post session N=28</td>
<td>11% (3)</td>
<td>54% (15)</td>
<td>36% (10)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>QUESTION: Comfort level in knowledge and accessing services and resources</th>
<th>NOT COMFORTABLE</th>
<th>SOMEWHAT COMFORTABLE</th>
<th>VERY COMFORTABLE</th>
<th>Median response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre session N=47</td>
<td>34% (16)</td>
<td>62% (29)</td>
<td>4% (2)</td>
<td></td>
</tr>
<tr>
<td>Post session N=28</td>
<td>4% (1)</td>
<td>46% (13)</td>
<td>50% (14)</td>
<td></td>
</tr>
</tbody>
</table>

### Table 5: Identification and recommendation by mental health counselors of appropriate services and resources for families worked with.

<table>
<thead>
<tr>
<th>Question: As a result of today’s presentation...</th>
<th>Percent (number) of practice administrators who responded yes.</th>
<th>Percent (number) of practice administrators who responded no.</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Will it be easier to identify appropriate services and resources for the families that you serve?</td>
<td>96% (27)</td>
<td>0% (0)</td>
</tr>
<tr>
<td>b) Will there be increased likelihood for recommendation or referral of these services to the families that you work with?</td>
<td>93% (26)</td>
<td>4% (1)</td>
</tr>
<tr>
<td>c) Did you find this information session helpful?</td>
<td>93% (26)</td>
<td>7% (2)</td>
</tr>
</tbody>
</table>
### PART C: Follow-up data

Table 6: Measuring the effectiveness of implementing the Community Resource Tool with the mental health counselors

<table>
<thead>
<tr>
<th>Question: In relation to the Community Resource Tool...</th>
<th>Percent (number) of practice administrators who responded “not at all”</th>
<th>Percent (number) of practice administrators who responded “somewhat often”</th>
<th>Percent (number) of practice administrators who responded “very often”</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) How often have you used it to increase your knowledge of child and youth services</td>
<td>26% (7)</td>
<td>67% (18)</td>
<td>7% (2)</td>
</tr>
<tr>
<td>b) Has it increased your comfort level in accessing the services and resources</td>
<td>44% (12)</td>
<td>52% (14)</td>
<td>3% (1)</td>
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<td>c) Has it made it easier for you to identify appropriate services and resources for the families that you serve?</td>
<td>22% (6)</td>
<td>59% (16)</td>
<td>11% (3)</td>
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<tr>
<td>d) Have you increased your referrals to community services for child and youth as a result of having it?</td>
<td>0% (0)</td>
<td>56% (15)</td>
<td>41% (11)</td>
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N=27
Appendix S

Interviews with Parents (N=8; however 1 audio lost during download process)

Summary
Overall impression of the child and youth services
All parents were very appreciative of the mental health services available to them and their children at their family physician’s office. One-to-one sessions with counsellors were the service most often discussed. The parents felt the counsellors were very approachable and highly qualified. Being able to see the counsellor in the family physician office was convenient. Until the physician mentioned the services most parents were not aware of their availability. One parent also noted that her trust in her family physician impacted her trust in the counsellor (as she was recommended by the physician). A couple of parents felt the opportunity to discussion their problems with other parents going through similar situations would be helpful (via support groups).

While counselling was the service most often discussed, parents did find the other services useful, specifically books, online activities, and Internet-based information (especially about medication options).

Parents appreciated that there were no costs associated with using the services.

Supporting patient/parent involvement and facilitating use of services at the family physician practice
Most parents felt that increasing awareness of the services available was important as many parents are likely unaware of their availability. Parents also wanted updates on the services available. As many mental health and behavioural issues are first identified at school a couple of parents felt it would be important to better educate school staff on identifying and dealing with these issues. The availability of the child and youth mental health services should be increased (i.e. more counsellors in more practices and increased hours – beyond 9-5). Parents also noted that it was important that both they and their child felt supported by the family physician and practice staff. Discussing mental health issues is difficult; therefore, having a supportive environment to do this is important.

Barriers to accessing mental health services at the family physician practice
Two primary barriers were identified: 1) As with many primary care and specialist services, waiting times was a significant barrier to accessing these services. While parents appreciated that the service was part of the family practice they found that they still had to wait 2-4 weeks for an appointment with a counsellor. Given that some of the mental health problems their children are dealing with need immediate attention it is difficult to address the issue in a timely fashion when you have to wait several weeks to discuss it. 2) Scheduling appointments during a standard 9-5 work day is also difficult as this often necessitates the parent taking time off work and the child missing school (which can be a problem if child is already missing a lot of school because of mental health issues).

Other barriers include lack of time with the physician, ability to discuss issues privately with the physician or counsellor (without child present – if child too young to leave alone in waiting room), and teenagers may find it difficult to talk openly with an adult (generation issues – ‘they don’t understand’).

Making the family practice office more family friendly
Parents didn’t have many suggestions as most of them felt their family physician’s office was already family friendly. A couple of parents mentioned having more children’s books and toys available.
Themes in detail with quote examples
A. Child & youth mental health services at Family Practice

- On-site access made it easy to use services
- Availability of the counsellors was greatly appreciated
- Some people prefer the one-to-one session with a counsellor and perceive that as more valuable than websites or books as it’s individualized to you (other sources present just general information)
  “We found that sites were just too general, and I think having a one-on-one counselor - we felt we were important and we were the focus of being there.” (P3)
- Other’s like being able to read through information on their own (via books, websites etc)
- Would not have been aware of the services had they not been at practice
- Physician recommendation added credibility to and trust of the service

  “…I found it quite easy to get the child and youth worker counsellor because they are right there with the doctor’s office, and the doctor had recommended it and I trusted the doctor - that they would provide somebody that would be of assistance to my children at that time.” (P1)

- Overall, services were quite useful (books, information on websites, online activities for the kids)
  “The internet, there was a virtual type of activity for the children to do, and it’s right on their level, and they like going onto the computer so that was something easy for them.” (P1)

- Support groups would be helpful
  “I would say if more people are involved and they know other families are out there, you know with the same situation, that kind of motivates you, it helps everybody talk and share their stories and whatnot.” (P4)

B. Supporting patient involvement (parents, children, and youth)

- Increasing awareness/advertisement of the services available within the family practices. Also ensuring information is at an appropriate reading level
  “I think there should be pamphlets with numbers and information, and if people don’t understand it, then they should explain it in terms that people will understand.” (P6)

- One parent suggested advertising services through schools as well (i.e. send flyers home with kids) to increase awareness

- One parent also suggested educating school staff more regarding mental health and behavioural issues
  “In the community, I’d think schools need to be better educated on many levels. They need to get a better handle on situations.” (P8)

- Increasing availability of services – more physician offices, more counsellors
- Counsellors are very approachable and know how to communicate with the children at their level
- Shared-decision making – making sure patients/parents are aware of the choices
“As a patient I like to know my options. So, if the doctor or staff at the clinic are very clear about the options and sort of the pros and cons of each one then very helpful.” (P2)

- More time with the physician (important to bring up the problem initially)

C. Facilitating access to child & youth mental health resources/services

- Increase days/times services available (i.e. KIDS peer group program)
- Provide updates regarding any new services
- Increase awareness/knowledge of the services
- Feeling that physician/staff are supporting you is important

“...And then there’s the embarrassment, you don’t want to be thought of as a bad parent and you’re kind of at your wit’s end and what do you…it’s I think that just being, approachable and open to hearing whatever somebody has to say.” (P2)

D. Barriers to child & youth mental health services

- Overcoming stigma of admitting/discussing mental health issues
- Access to services (i.e. appointments with counsellors) at times limited by parent’s work schedule and often necessitates taking time off work and the child missing school (which can be a problem if child is already missing a lot of school because of mental health issues)

“I think if they made it more available in evenings as well, cause part of my son’s problem with depression is that he does miss a lot of school for him to then have to miss school because of the appointment and then I’m a single parent so I’m having to leave work early or not pick up a shift for that day so it makes it very difficult.” (P8)

- One parent mentioned scheduling problem with child participating in the KIDS peer group program as well
- *Problems often need immediate assistance and there is usually a 2-3 week wait time to see counsellor (*availability of services)

“Because sometimes, it just comes up right then and they need to talk about it right then and there. And there’s like a 2 week or 3 week waiting period. So, what xxx had them do is write down concerns but by that time, their other issues and the other concerns aren’t as important then, and it’s just left and it could be revisited if there was more immediate access.” (P1)

“The day we were supposed to go, the lady my daughter was to see, she had to cancel our appointment and rebook us and my daughter felt she was not important and that was very stressful, that was the last thing I needed right then. So I would think, maybe just, even a backup, I would like to see more counselors in there.” (P3)

- Privacy can be an issue if parent wants to discuss issues with physician without child present (i.e. if child too young to leave alone in waiting room)
- Age/generation differences may put-off teenagers (i.e. they feel that adult counsellor doesn’t understand them)

E. Impact of mental health counsellor availability at the family doctors office

- More confidential setting to discuss issues (vs. school setting); stigma associated with mental health issues also not a factor in this setting
- No cost
- Everyone under one roof is helpful
F. Most valuable about access to child & youth mental health services at your family physicians office
   • Problem is being addressed and dealt with – “somebody is there to help”
   • Continuity of care – all your information is in one place
   • Excellent counsellors

G. Making the Family Practice office family friendly
   • Already is
   • More books and toys to occupy kids
   • In one case the patient felt a lack of respect and support from the staff
Appendix T
Primary care team members [includes 3 physicians, staff (4 team interviews), and MHCs (2 FGs)]

Summary
Experience incorporating the program into practice
Practice teams found the program very rewarding and felt it valuable to both them and their patients. The program was particularly helpful in alleviating the general MHCs workload, providing patients and physicians with the needed expertise, addressing MH problems earlier, and further strengthening the collaborative/multidisciplinary practice.

Key features/aspects of the program that lead to its’ success
Providers found that communication was key to the success of the program. C&Y MHCs consulted regularly with physicians and general MHC to strengthen the value of their recommendations and follow-up with patients. For patients, adherence was improved if the physician was involved in part of the interview. Offering the program on-site/at the practice was also seen to improve the validity of the service for the patients (i.e. C&Y MHC part of a trusted team). Pre-appointment questionnaires and activities allowed C&Y MHC to maximize and focus the appointments.

Barriers or challenges faced during implementation
Primary barriers or challenges included lack of family-friendly environment and space for family meetings, restricted hours and availability of the C&Y MHC (9-5 model not conducive to working parents and children in school), and lack of technology to facilitate transfer of information and communication among providers.

Suggested changes to the model
Overall, most providers did not have any suggested changes to the model and felt it worked well as it was. Some suggestions were, expanding hours of service beyond 9-5, highlight importance of collaboration, flexibility of model to fit different practices, and how to more effectively deal with crisis situations.

Impact of the C&Y MH initiative on knowledge of and resources for C&Y MH issues
Everyone agreed that the program positively impacted both knowledge of C&Y MH issues and resources for dealing with these issues. For some providers existing knowledge was reinforced, for others the new knowledge allowed them to better meet their patients’ needs and improved their confidence level when dealing with MH issues. Some providers also felt they were now more sensitive to C&Y issues surrounding growth and development.

Providing tools and resources in the waiting room for parents increased their knowledge and facilitated parents identifying MH problems and seeking help.

Lessons learned – how to improve implementation at future practices and advice for practices
Some key lessons learned included the importance of working as a team, communication, in-service education sessions lead by C&Y MHCs for the team, using a reminder phone call system to improve patients’ adherence to appointments, increasing awareness of service among patients, educating patients about the collaborative care approach (to increase comfort level and trust of non-physician providers), and value of pre-appointment activities to maximize time with C&Y MHC.
Detailed results with quote examples

A. How has the program been used / experience with the program?

- Positive experience for the practice team
- Wonderful addition to practice
- Great feedback from families
- MHCs found support from C&Y MHCs valuable as well as having joint appointments with children/families (i.e. regardless of which counsellor taking lead on appointment)
- Those MHCs that had more contact and involvement with C&Y MHC and his/her appointments found the program and experience more useful
- Helped alleviate workload of general MHC (being able to transfer C&Y referrals to C&Y MHC within practice)
- Helped address the many requests/calls from school boards with concerns about some children
- Informal and formal learning opportunities appreciated
- Particularly helpful for a young practice or one in a high-risk area
- Physician joins appointment between family/child and the MHC at the end and/or follows-up with the family/child afterwards
- Some practices have monthly team peer support meetings – MHCs find this usual to present C&Y MHC problems and ask for advice
- Support provided by program team excellent (i.e. emailing questions and being provided with useful resources)
  “I’ve often emailed if I have questions around certain areas that she’s been able to provide references or practical information I can use with patient care, that’s been wonderful.” (MD1)
- Being able to participate in sessions with the families useful for both the family and physician.
  “Often I would join her with the family for part of the interview as well and that’s helped the patient understand the model of collaborative care and that xxx’s suggestions were something that would be shared with me and we’d all be working towards something, working towards the same end point.” (MD1)

B. Key features/aspects of the program = success

- Program physically taking place in practice
- Patients/family feel secure in familiar setting of primary care practice
- Communication / ability to consult with C&Y MHC on-site (impromptu conversations in the halls)
- Willingness/enthusiasm of patients for the program (no resistance)
- Quicker access
- Practices already using interdisciplinary model to practice so adding a new discipline not a problem
- Pre-appointment materials (i.e. questionnaires) provided by C&Y MHC helpful for the family and allows appointment time to be optimized
- Practices that had MHCs (and C&Y MHC) integrated into EMR system (allowed the counsellors to review each others notes and more effectively communication information)
  “…so I was able to look at your note from the day as well and you can see mine because it’s available so we can, the potential for communication is really quite strong.” (MHC)
• Keeping consultations within practice (as opposed to old model of consults to outside agencies) improves continuity of care and communication
  “...if you compare it to a historical model when there were child specific issues, we would make a referral to a children’s agency out there and out there and waiting lists and not always excellent communication to the family doc and kids would be medicated or not or treated or referred out there in the satellite, it’s more organic.” (MHC)

C. Barriers or challenges faced during implementation
• Lack of full-time C&Y MHC
• Hours of service (typically 9-5) – difficult for working parents and child in school.
• Manpower – stretching workload (already maxed out) of general MHCs to now incorporate C&Y
• Commitment of the patients (i.e. to attend appointments, timing, program follow-up etc)
  “A lot of the parents have difficult lifestyle issues, poverty issues, other children, they have to work, just trying to get them to their appointments on a timely fashion and then to commit to the program has been challenging.” (MD2)
• Space planning – need child play area, room for family interview, space for 1:1 interview with child, etc
• Lack of child-minding to enable parent(s) to meet privately with MHC
• Lack of technology in many practices (i.e. EMRs, access to Internet resources)

D. Suggested changes to the model
• No changes – model worked great, just need full-time
• Extended hours/availability of MHC
• Model needs to be flexible to fit individual practices/teams
• Need to build in how to handle crisis situations/phone calls
• Collaboration among all providers is key aspect to successful model
• Recognition of scope of problem – not just a child problem
  “It’s not just a child problem, it’s a family problem. And I think that we need to understand that so that when they’re dealing with a child mental health issue, they’re going to be dealing with a whole family, they have to be able to deal with the whole family.” (MD2)

E. Impact of the C&Y MH initiative on knowledge of C&Y MH issues
• Yes!
• Now better educated and aware of C&Y problems – more sensitive to the issues
• Also important – increased comfort level dealing with these issues that normally would have been referred to paediatrician
  “I think it has supported myself, I think my partners feel the same way, in managing AD independently of a paediatrician, I think it feel like its a big commitment to apply that label and consider those types of medications and I think having the option from someone that has a lot of experience in that field has helped increase our comfort level with that.” (MD1)
• More aware of evaluation tools available and medications
• MHCs now looking at C&Y problems/meetings differently (was missing some things/signs in the past)
• Positively reinforced existing knowledge

F. Impact of the C&Y MH initiative on knowledge of C&Y MH resources
• Resources now available in waiting room has helped families self-identify problems and seek out the help themselves and practice now has practical tools to offer
• MHC noted knowledge of many of the resources but involvement with C&Y MHC increased knowledge on how best to access and use the resources

G. Lessons learned – how to improve implementation at future practices
• Presentations (by program coordinator) very useful
• In a multidisciplinary practice it is helpful if the physician is able to join in on the appointment with the patient and other provider in the last couple of minutes (to move things forward and show patient that primary provider (physician) is involved).
  “And I think I get a lot better compliance with the patient, not only putting recommendations into play but also the patient attending to the other providers appointments, otherwise they don’t feel as much of an obligation I think to follow through with that, but if they know this is something my doctor is part of and it’s appointments with my doctor as well, they tend to be more reliable in attending.” (MD1)
• Appointment reminder calls increase adherence/attendance
• Increase awareness of service to parents
• Team meetings that incorporate both physician and MHCs are important
• Pre-appointment activities helped make the time with the C&Y MHC more valuable
• Small/isolated practices need to know how best to access C&Y MHCs for consults and support
• Difference between shared-care and divided-care – must be careful.
  “I think at times we are at risk of having divided care, divided up care, you do your piece, I’ll do mine. And, I feel very strongly about that but divided care is not our goal and its not shared care in the way we’ve talked about proximity, cross-over, interchange” (MHC)

H. Benefits of the program
• Great learning resource
• New service for patients
• More sensitive to issues surrounding development, growth, learning
• Particularly valuable to physicians/practices in high-risk areas
• Increases confidence in dealing with C&Y MH problems
• Being able to see kids sooner

I. Challenges faced during the program
• Was supposed to have access to psychiatrist for urgent situations but had difficulty accessing
  “At one point we were given a number that there would be a psychiatrist that could give us telephone advise at McMaster, so I tried once and they told me we don’t know what you are talking about.” (MD1)
• Working in consult notes from other providers into the current EMR system
• Logistics can be challenging in scheduling and providing support to multiple practices
• Maximizing access to C&Y MHC (i.e. not just in-person but phone and email)

J. Advice to other interested practices
• Utilize resources and education provided by C&Y MHC – helped identify severity of C&Y MH problems
• In-services by the C&Y MHC for the physicians are very useful
• Place education materials in waiting room
“I think having those educational materials available for patients in exam rooms and waiting rooms is something we have found very, very useful.” (MD1)

- Need to educate patient about team model – to increase adherence to recommendations made by other providers in practice
- Regular communication with the patients and the MHC is important to understand how well the program is working
### Accounting Summary of Expenditures

<table>
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<th>Eligible Budget Items</th>
<th>Approved Budget ($)</th>
<th>Actual Expenditures ($)</th>
</tr>
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<td>Transcriptionist</td>
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<td><strong>Administrative Costs (detail required; max 10%)</strong></td>
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<td>Photocopies (C &amp; Y Community Resource Tool)</td>
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<td><strong>Knowledge Exchange Activities (max $5,000)</strong></td>
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<td>Refreshments re focus groups</td>
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<table>
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<th></th>
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