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VIGNETTE: A TRANSDISCIPLINARY COMMUNITY MENTAL HEALTH PROGRAM PROVIDING CLINICAL CARE TO STREET-INVOLVED YOUTH IN HAMILTON

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INTRODUCTION

The Good Shepherd Youth Services Community Mental Health Program operates within a framework that prioritizes partnerships while aiming to provide quality care through a transdisciplinary model. The model focuses on triage, assessment and treatment; providing clinical interventions to disenfranchised youth in Hamilton, Ontario. The program has the following key components, which we will describe in this paper: service delivery approach (i.e. referral process), tailored care pathways, inter-professional collaboration (i.e. with consulting psychiatrists), mental health education, ongoing evaluation and knowledge sharing (i.e. information exchanged with community partners), committed clinicians and contribution from the clients. The following case study identifies and describes an approach to clinical care that can be adapted elsewhere.

HISTORY

In 2004, the Street Involved Youth Managers (currently the Street Youth Planning Collaborative, a committee of street-involved-youth-serving agencies in Hamilton) approached the Social Research and Planning Council of Hamilton to develop a community plan funded by the National Crime Prevention Strategy. The development of a community plan was needed to address the growing population of street-involved youth in Hamilton (Vengris, 2005). The project aimed at developing a profile of street-involved youth, establishing 'best practices' (the maintenance of quality methods that have consistently been demonstrated as superior) and to identify existing gaps in service. One of the recommendations from this needs assessment was for the Children's Service System Table of Hamilton (a committee of Ministry of Children and Youth Services-funded agencies) to increase mental health services available to street-involved youth.

In 2007, the Community Mental Health Program began. Initially a liaison nurse, whose primary role was to advocate for youth and form alliances with health care

providers and frontline social services staff, staffed the program. In 2012, the program expanded to its current form and in 2014 provided services to 140 unique individuals. The Community Mental Health Program provides clinical services to Notre Dame House, an emergency shelter for homeless youth; Brennan House, a residential treatment program for youth over 16; Angela's Place, a young parent centre; and Notre Dame Community Resource Centre, a multi service resource centre for street-involved youth.

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MODEL OF CARE

The following seven elements comprise the Community Mental Health Program's model of care.

Service Delivery Approach

From 2012–2014 the Community Mental Health Program received two evaluation grants from the Ontario Centre of Excellence for Child and Youth Mental Health[1]. The purpose of the evaluation was to examine the program's efficacy. This process, which included a logic model and evaluation framework (Appendix A and B) allowed the clinicians to identify and evaluate the different components used within the program. The overall impression of the program aligns with current standards for best practices that emphasize youth-friendly services. Our experience through evaluation has truly allowed the Community Mental Health Program to cultivate an enthusiasm for learning and set a standard for capacity development.

The service delivery approach has a continuum that encompasses the different stages of intervention. They include referral, triage, assessment and treatment. The referral is an internally developed document (Appendix C) designed to capture identifying information and concerns regarding the youth's thoughts, feelings and behaviors. This one-page form is completed with the youth and asks the staff member to rate their concerns (based on the Ministry of Children and Youth Services Rating Scale[2]). The referral form can be completed over several conversations and considers the youth the expert on their own experiences. The referral form informs the program that the youth is interested and in need of services. At the time of referral, the staff member also completes a Child and Adolescent Needs and Strengths Assessment (Praed, 2014) to accompany the referral form. The Child and Adolescent Needs and Strengths Assessment is used to facilitate the design of individual treatment plans.

The triage interview (Appendix D), which is usually the first appointment with a clinician, elaborates on the information collected on the referral form. The clinician has a discussion with the youth, obtains disclosures for collateral information and determines if a mental health assessment is needed. The assessment interview (Appendix E) encourages the youth to expand

1. Evaluation Grant Final Reports can be viewed on the Centre's website, Grants and Awards Index: http://www.excellenceforchildandyouth.ca/resource-hub/grants-and-awards-index
2. Rating Scale:

   Level 1 – All youth and their families.

   Level 2 – Identified as being at risk of experiencing mental health problems.

   Level 3 – Experiencing significant mental health problems or illness (i.e. dual diagnosis, concurrent disorder, taking psychotropic medications) that affects their functioning in some areas.

   Level 4 – Experiencing the most severe, complex, rare or persistent diagnosable mental illness (i.e. hospitalized and/or admitted to an inpatient unit on numerous occasions for a serious mental illness) that significantly impairs functioning.

on mental health history and is a clinician-led process of gathering diagnostic impressions (i.e. evaluative interpretations that shape a diagnosis). The assessment interview includes the completion of a Mental Status Examination (a clinical evaluation tool, completed by a clinician). The assessment may also include standardized assessments completed individually by the youth online: the Children's Depression Inventory 2nd Edition (Kovacs, 2011), the Multidimensional Anxiety Scale for Children 2nd Edition (March, 2013) and the Connors 3rd Edition (Connors, 2013). These standardized assessments identify emotional and behavioral concerns and assist in tracking any changes in these areas throughout treatment.

The Community Mental Health Program offers an individualized approach to treatment, often in consultation with the onsite nurse practitioner, family physician and adolescent psychiatrist. These health care professionals work as a clinical team with the youth to decide the type of therapeutic interventions (including psychotropic medications) that will be used.

Tailored Care Pathways

After the triage appointment youth are assigned to a care pathway that will determine their participation in the program:

Care Pathway One is for youth whose needs are rated a two (a Ministry of Children and Youth Services assigned number categorizing needs for service, refer to endnote two). The clinician meets with the referring staff member and recommends individual Skills for Life education (see Mental Health Education) between a frontline staff member and the youth.

Care Pathway Two is also for the youth whose needs are rated a two. The clinician recommends targeted prevention (skills-based group programming) that takes place at various locations within a 12-week rotation. Group programming is based on the Skills for Life curriculum (for example, the How-To of Sleep – a group designed to assist youth in improving their sleep hygiene). Youth can join the group any time throughout the program.

Care Pathway Three is for the youth whose needs are rated three or four. The clinician conducts an assessment (see Service Delivery Approach) and provides individual treatment that is informed by the youth's point of access (e.g. residential treatment, shelter or transitional housing). Within this care pathway consultation with other health care professionals is common.

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What is notable about the care pathways is that there continues to be an appreciation for the youth's precarious lifestyle and transience. This consideration requires flexibility in treatment times and transitions. For example, if a youth fails to arrive for individual treatment and the file is closed it may be reopened at the request of the youth versus needing to return to the beginning, i.e. referral process, triage interview, etc. Primary means of communication with the youth are in person, via email, by text message and Facebook.

Inter-professional Collaboration

Collaboration is embedded in the culture of the Community Mental Health Program and is crucial in our aim to provide quality care. Interagency consultation is an essential aspect and likely the greatest resource available to the program. In addition to the two-person Good Shepherd Youth Services Clinician Team, a Good Shepherd nurse practitioner and a Hamilton Shelter Health Network family physician are available two days a week for primary care, collaboration and consultation. Three adolescent psychiatrists from children's mental health organizations consult to the program providing five sessions a month. These relationships with other health care providers allow for rich treatment planning, effective transitions and high quality service provision.

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Informal collaboration also occurs with frontline staff members within the Street Youth Planning Collaborative, community allies (e.g. addiction counselors), hospital staff from emergency departments and psychiatric units, and school-based social workers. The Board of Directors of Good Shepherd is also a strong supporter of the program's model of care.

Mental Health Education

The Mental Health Team facilitates a comprehensive education program called Skills for Life© which is comprised of 18 skills emphasizing functioning (e.g. sleeping and eating patterns), emotion regulation and shaping behavior (identifying and practicing preferred behaviors). Skills for Life comes from understanding the importance of global functioning (the adequacy of a youth's sleep and eating patterns, their physical health and participation in the activities of daily living, limited criminal involvement, substance use and high-risk behaviors), practice-based evidence (professional knowledge) and principles of Dialectical Behavior Therapy (a form of talk therapy used to help change behaviors) (Linehan, 2014). McCay and Andria (2013) conducted a study using Dialectical Behavior Therapy with street-involved youth and their findings suggest that these interventions increase the youth's capacity to endure challenging situations, manage emotional instability and improve quality of life. More than half of the youth who receive treatment (up to six months) in the program show an improvement in their global functioning. The program's priority of improving youth's global functioning has proven to be consistent for two years. The Skills for Life program is a curriculum designed to be administered by frontline staff members and is the foundation for the program's targeted prevention. Four times a year the clinicians provide training in the Skills for Life program through a one-day workshop available to frontline staff.

Ongoing Evaluation and Knowledge Sharing

Evaluation of the Good Shepherd Youth Services Community Mental Health Program consists of the collection and aggregation of information to support the development of program outcomes. Information is gathered monthly and quarterly using multiple internally developed Microsoft Excel spreadsheets including: self-reported demographic characteristics of the youth (e.g. age, ethnicity, community of origin), primary issues of concern, crisis services provided by the clinicians (e.g. management of self harming behaviors or suicidal gestures), type of participation in the program, other health care accessed and family involvement. Annual outcomes are reported to the Ministry of Children and Youth Services, our funding agent. The program also has internal program outcomes that promote growth (e.g. increase the number of staff trained in Skills for Life) and to evaluate effectiveness (e.g. the measurement of emotional symptoms before and after participation in the program). As of 2014, 93 Youth Services staff members were trained in the Skills for Life curriculum. For youth who receive treatment (up to six months) in the program for singular or concurrent emotional symptoms, 63% experience a decrease in depressive symptoms and 57% experience a decrease in anxiety symptoms.

Knowledge exchange refers to the dialogue between those who create and use information as it relates to professional development (Ministry of Children and Youth Services, 2006). This exchange serves to facilitate the use of evidence in practice. The program takes pride in being community based and aims to create and participate in mental health promotion with the intention of enhancing awareness, improving practices and strengthening relationships. For example, the clinicians presented the results from the program evaluation at the 2014 Children's Mental Health Ontario Conference.

Committed Clinicians

One full-time and one part-time Master's prepared clinicians staff the Community Mental Health Program. Staff are trained as counselors, psychotherapists and social workers. Despite the differences in their academic and professional experiences, one similarity is the committed approach each takes in their provision of care. The shared vision amongst the program's clinicians is to provide the best care to the youth accessing services and challenge each other to ensure this mission is followed. This level of commitment is such an important part of the model because so many of the youth accessing care regard Youth Services as home.

Contribution from the Clients

What is known from the youth accessing services is that their experience of the program determines their participation. Bhui, Shanahan & Harding (2006) found that homeless young people's views of mental illness is more negative with "homeless participants perceiving mental health services as being for 'crazy people' often leading to a denial of their own mental health problems" (152). With this knowledge it became important for the program to consider how it was being experienced and actively integrate this matter into its administration.

Throughout the 2012–2014 program evaluations conducted in partnership with the Ontario Centre of Excellence for Child and Youth Mental Health, the experiences of those who participated in the Community Mental Health Program were explored. Through satisfaction questionnaires, 80% of youth respondents reported overall satisfaction with mental health services offered by the Good Shepherd Youth Services Community Mental Health Program. The experiences of the Community Mental Health Program address the importance of scheduling flexibility, sensitivity to culture, and choice in service agreements, inclusion in treatment planning and services delivered respectfully. Youth have the option to complete satisfaction surveys as they exit the program; this information is aggregated quarterly and informs annual outcomes and the evolution of care pathways.

CONCLUSION

This case study examined Good Shepherd Youth Services Community Mental Health Program's model of care, a dynamic and transdisciplinary approach to care that relies on essential elements and whose main outcome is the engagement and treatment of a historically hard to reach population (Bhui et al., 2006; Karabanow, 2004; Leeuwen, 2004), disenfranchised youth. This model of care reflects partnership, client centered practices and a shared vision. Under a collaborative lens the program is able to effectively utilize resources, consider service responsiveness and demonstrate a commitment to the support of quality care.

REFERENCES

Bhui, K., Shanahan, L. & Harding, G. (2006). Homelessness and mental illness: A literature review and qualitative study of perceptions of the adequacy of care. *International Journal of Social Psychology, 52* (2), 152–165.

Connors, C.K. (2013). *Connors*. (3rd ed.). Toronto, ON: Multi-Health Systems Inc.

Karabanow, J. (2004). Making organizations work: Exploring characteristics of anti-oppressive organizational structures in street youth shelters. *Journal of Social Work, 4 (*1), 47–60.

Kovacs, M. (2011). *Children's Depression Inventory Technical Manual*. (2nd ed.). Toronto, ON: Multi-Health Systems Inc.

Leeuwen, J Van (2004). Reaching the hard to reach: Innovative housing for homeless youth through strategic partnerships. *Child Welfare League of America, 83*, 453–468.

Linehan, M.M. (2014). *DBT skills training manual* (2nd ed.). New York: Guilford Press.

March, J. S. (2013). *Multidimensional anxiety scale for children*. (2nd ed.). Toronto, ON: Multi-Health Systems Inc.

McCay, E. & Andria, A. (2013) The need for early mental health intervention to strengthen resilience in street involved youth. In S. Gaetz, B. O'Grady, K, Buccieri, J. Karabonow & A. Marsolais (Eds.), *Youth Homelessness in Canada: Implications for Policy and Practice* (pp. 229–243) Toronto: Canadian Homelessness Research Network Press.

Ministry of Children and Youth Services. (2006). A shared responsibility: Ontario's policy framwork for child and youth mental health. Toronto, ON: Queen's Printer for Ontario.

Praed Foundation. (2014). *Child and adolescent needs and strengths assessment form (CANS).* Retrieved from https://canstraining.com/

Vengris, J. (2005). Addressing the needs of street-involved and homeless youth in Hamilton. Social Planning and Research Council of Hamilton.

APPENDIX A: LOGIC MODEL

NEED IN THE COMMUNITY: There are a growing number of street-involved youth struggling with mental illness and mental health problems in the Hamilton community

PROGRAM GOAL(S): To increase the global functioning of street-involved youth ages 16–21 with mental illness and mental health problems

RATIONALE(S): The research shows that the use of evidence-informed practice leads to improved global functioning of youth with mental illness and mental health problems

PROGRAM COMPONENTS	Referral & Triage	Assessment	Treatment
ACTIVITIES	• Referral form completed by frontline workers • Collect relevant documentation (consent for prior assessments, staff observations) • Prioritize needs based on functioning, risk behaviors and family functioning using the Child and Adolescent Needs and Strengths Service Sector Assessment • Triage interview • Exchange of information from mental health clinicians to frontline workers about management of youth's specific mental health problems	• Conduct assessment interview • Complete Personal Health Information Protection Act consent form (if applicable) • Complete clinical impression • Complete referral to family physician (if referral to psychiatry needed) • Youth referred to psychiatry attend psychiatric assessment interview	• Individual Therapy (Cognitive Behavioral Therapy, Dialectical Behavior Therapy, Motivational Interviewing, Short-Term Crisis Support, Advocacy, Liaison) • Group Programming • Appointment to consulting Adolescent Psychiatrist • Refer to Barrett Crisis Centre • Conduct staff coaching • Refer to emergency room at hospital for assessment • Skills from Skills for Life curriculum
SHORT-TERM OUTCOMES	↑ in basic functioning (eating, sleeping, physical health, school or work attendance) ↑ awareness of mental illness/ mental health problems	↑ knowledge of needs and strengths related to mental health problems ↑ knowledge of mental health treatment options ↓ in drug and alcohol use	↓ in high risk behaviors (dangerousness, runaway, crime/ delinquency, sexual aggression) ↑ global functioning ↑ ability to regulate emotions ↑ ability to organize time and possessions ↑ ability to regulate behavior ↑ ability to utilize Skills For Life with limited supports
MEDIUM-TERM OUTCOMES			↑ ability to regulate behavior with limited supports ↑ ability to regulate emotions with limited supports ↑ ability to organize time and possessions with limited supports
LONG-TERM OUTCOMES	↑ ability to regulate emotions independently ↑ ability to organize time and possessions independently	↓ anxiety symptoms ↓ depression symptoms	↑ ability to regulate behavior independently ↑ ability to utilize Skills for Life independently
Assumptions:	Youth are committed to participate within mental health program activities Frontline workers are committed to the mental health program		

APPENDIX B: PROCESS EVALUATION FRAMEWORK

EVALUATION QUESTIONS (What do we want to know about this program?)	**LINK TO ACTIVITIES OR TARGET POPULATION IN LOGIC MODEL**	**INDICATOR(S)** (How will we know we have achieved our goal?)	**DATA COLLECTION METHOD(S)** (What data collection method will be used to measure the indicator? e.g. survey, focus group, interview, document review, etc.)	**DATA COLLECTION TOOL(S)** (What specific tool will be used? Specify the name and whether it is a standardized tool or internally developed)	**RESPONDENT(S)** (Who will provide the information needed? For example, parent, child, clinician, teacher, program staff, etc.)	**PERSON(S) RESPONSIBLE FOR DATA COLLECTION** (Who is responsible for ensuring the data are collected?)	**TIMING OF DATA COLLECTION** (When will the data be collected?)
What are the primary issues of concern that are referred to the community mental health program?	Referral & triage	Referral form Previous assessments from other mental health agencies	Document review To be categorized within categories: emotional symptoms, behavioral symptoms, psychosis, risk behaviors	Mental Health Referral Binder (internally developed) Client files	Clinician Program staff	Mental Health Worker	February 2014 Pre data
What are the demographic characteristics of the youth served?	Triage interview	Age, gender, community of origin	Document review	Triage interview form (internally developed)	Clinician Program staff	Mental Health Worker	February 2014 Pre data
What are the youth's and staff's experiences of the community mental health program?	Program delivery Skills for Life	Rating of satisfaction	Questionnaire	Staff Satisfaction questionnaire Youth Satisfaction questionnaire *Adapted from the Youth Satisfaction Survey (YSS)	Program Staff Youth	Case Manager	July 2014 Post data

Outcome Evaluation Framework

EVALUATION QUESTIONS (What do we want to know about this program?)	**LINK TO OUTCOMES IN LOGIC MODEL** (What outcome from the logic model does the evaluation question relate to? e.g. increased self-esteem)	**INDICATOR(S)** (What is one possible measurable approximation of the outcome?) e.g., Increased score on the Rosenberg Self-Esteem Scale	**DATA COLLECTION METHOD(S)** (What data collection method will be used to measure the indicator? e.g. survey, focus group, interview, document review, etc.)	**DATA COLLECTION TOOL(S)** (What specific tool will be used? Specify the name and whether it is a standardized tool or internally developed)	**RESPONDENT(S)** (Who will provide the information needed? For example, parent, child, clinician, teacher, program staff, etc.)	**PERSON(S) RESPONSIBLE FOR DATA COLLECTION** (Who is responsible for ensuring the data are collected?)	**TIMING OF DATA COLLECTION** (When will the data be collected?)
Does the global functioning improve for the youth who participate in the mental health program?	↑ global functioning	↑ sleep ↑ eating ↑ physical health ↑ activities of daily living limited criminal involvement	Questionnaire	CANS-SC	Youth	Case Manager	February/July 2014 Pre/post data
Does youth participation in the Community Mental Health Program decrease emotional symptoms?	↓ anxiety symptoms ↓ depression symptoms	↑ ability to regulate emotions	Assessments	CDI 2 MASC 2	Youth	Mental Health Worker	February/July 2014 Pre/post data
Does youth participation in the Community Mental Health Program decrease behavioral symptoms?	↑ attention ↓ hyperactivity ↓ opposition ↑ ability to organize time and possessions ↓ difficulties with conduct	↑ ability to regulate their behavior	Assessment	CONNORS 3	Youth	Mental Health Worker	February/July 2014 Pre/post data

APPENDIX C:
COMMUNITY MENTAL HEALTH PROGRAM REFERRAL FORM

An internally developed document used across the various programs served by the Community Mental Health Program. The Referral Form is designed to capture identifying information and concerns regarding the youth's thoughts, feelings and behaviors.

APPENDIX D:
COMMUNITY MENTAL HEALTH PROGRAM TRIAGE FORM

An internally developed document used at the triage interview, typically the first scheduled appointment with a youth. The Triage Form is designed to elaborate on the information collected at referral, prioritize the youth's needs, and specify the type of participation in the program.

APPENDIX E:
COMMUNITY MENTAL HEALTH PROGRAM MENTAL HEALTH ASSESSMENT

An internally developed document used during the clinician led assessment period. The Assessment Form is designed to gather diagnostic impressions and begin to determine treatment approaches.

Download these documents:

http://homelesshub.ca/systemsresponses/27-vignette-transdisciplinary-community-mental-health-program-providing-clinical-care

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Chloe has Bachelor degrees in Psychology and Drama in Education and Community from the University of Windsor. She also has a Master's in Creative Arts Therapies from Concordia University.

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Christine Evans has been the Clinical Leader of the Community Mental Health Program at Good Shepherd Youth Services for the last 6 years. She has spent her career working with disenfranchised children and their families, in the educational and mental health fields in England, Nova Scotia and Ontario.Christine completed her Master's Degree in Counselling at Acadia University and is a qualified special education teacher. She has worked on developing programs for at risk students, children in the care of child welfare agencies, and street involved youth. She was engaged in developing the Comprehensive Guidance Curriculum in Nova Scotia and the Skills for Life Program. Christine has presented on topics concerning child and youth mental health in Nova Scotia, PEI and Ontario.

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