

Summary of Feedback: Moving on Mental Health

Eleven feedback sessions were held in December 2016 and January 2017 to test out some “big ideas” for improving child/youth mental health services in Dufferin Wellington. The feedback from participants is summarized here.

Idea #1: CareTeam Dashboard

The idea, as it was proposed: A digital dashboard that helps workers, parents and youth to be on the same page about goals, challenges, current strategies, case history, preferences, and who’s on the team. It facilitates inclusion, holistic decisions, and gives agency for the family’s voice. It puts all information in one accessible and usable place—helping everyone know who’s on the team and work together across silos to support the complexity of a person/family.

Where this idea came from

Problem(s) this idea is meant to solve: Children, youth and families with mental health issues often need support from multiple organizations with different realms of expertise, however, these organizations also have different mandates, staff, policies, and information management systems. This segmented system of care often puts the parent in the position of de facto case manager, acting as a conduit of information, retelling their story and updating workers. Decisions made by different members of the team may lack key information, and the family and other workers may not understand who is on the team.

Why does addressing this matter? Addressing these issues could relieve some pressure from parents who are already stretched; reduce the time service providers spend providing and tracking down updates; ensure that details don’t get lost in the shuffle; make conversations and decisions concrete and accessible so that they can be referenced by parents and workers (giving parents the ability to reread information, ensure they understand it, and ask follow-up questions as needed).

What we learned from feedback sessions

Positive kernels of this idea:

- A one-stop-shop for information is beneficial for families and workers.
- This is in line with an overall trend toward digitized information and online communication; especially relevant for teens.
- This would reduce the number of phone calls and emails needed to coordinate a plan across agencies.
- Provides an avenue for recording preferences, celebrating strengths and goals, and noticing progress over time.

Concerns and key questions:

- Confidentiality was a major concern: Who has access to what information? In general, the family should decide who gets access to specific information, with the family having the ability to rescind this access at any time. However, some service providers worried that some parents/youth don’t have the capacity to make these decisions in their own best interest.
- Who monitors the dashboard? Is it secure? Who updates it? Could this lead to increased indirect service time?
- Concern that clinical information and strategies should not be made accessible to those without clinical training.
- When should children/youth have access to what information (as some information can be highly sensitive for a child)?
- When working with youth, what information should parents have access to and when?
- A digital tool would not be accessible to those with low technical literacy and limited access to the internet.
- Indigenous communities could see the dashboard as a way of monitoring or reporting on them. This dashboard is seen as misaligned with their worldview, which emphasizes relationships, collaboration, and agency within one’s own health decisions. This tool is an extension of a system not built for these communities.
- How might we ensure that information on the dashboard isn’t used against a worker or a parent (inappropriately)?
- When is a dashboard profile opened? Can someone opt-out?

Conclusions

- There is broad buy-in for making it easier for the appropriate people to have the information they need when they need it in order to support someone.
- Provide appointment reminders via text to reduce the number of missed appointments.
- Explore inter-agency scheduling solutions so that valuable case conferences are easier to arrange.
- Identify, review and potentially adjust barriers that impede workers at different agencies from sharing information (appropriately and securely) via email.
- Make it easier for families and workers to know who’s on the team, what they do, and how to contact them.

- Leverage technology to facilitate efficient information sharing: auto-populate data (as appropriate) from pre-existing tools and databases.
- If the dashboard doesn't move forward, don't lose sight of the potential impact of providing a case management tool for parents.

Idea #2: Check-ins While You Wait

The idea, as it was proposed: A youth or guardian receives a short call, once a month from a Here 24/7 staff member (or someone like that) while they are on a waitlist for service. The staff member would check-in to:

- Review what the person is waiting for and how long the wait might be;
- Understand if anything has changed for the person/family; and
- When appropriate, adjust the care plan to reflect current needs.

Where this idea came from

Problem(s) this idea is meant to solve: We've heard that waiting for services can be scary—lots of overwhelming information to process and often long stretches of sporadic communication from services. This can leave youth and/or families feeling neglected, alone and unsupported during what can be very stressful times. We also know that situations can change rapidly—with the onus to communicate changing behaviours often falling on parents.

Why does addressing this matter? We think proactively reaching out to youth/families would help review and confirm that people are in line for the appropriate service(s), allow service staff to assess changing needs, and provide answers and resources for people while they wait—all in service to improving the experience of waiting, building trust in the system and easing the minds of those in need of service. On a larger scale, we think that the information garnered by these check-ins would positively impact wait times across the system by ensuring people are aligned with services they actually need and, in so doing, reduce incidents of individuals occupying a spot for a service they don't need.

What we learned from feedback sessions

Positive kernels of this idea:

- Amongst other impacts, these calls would help clarify information if there had been any misunderstandings in previous exchanges.
- This could increase trust in services and alleviate anxiety and confusion for youth/families.

Concerns and key questions:

- This idea assumes consistent and predictable access to a phone, which just isn't a reality for some people we serve.
- Check-ins should be built through relationships and trust, as defined by the youth/family.
- Check-in calls are a brief, verbal window into a situation. There is concern about the skill needed to make accurate determinations of need through this format, especially if the caller doesn't know the family well.
- Who has strong enough system navigation knowledge, connections to resources, and clinical training to make informed decisions and recommendations during these calls?
- How might we prepare the caller in such a way that they feel familiar to the youth/family, even if they aren't? How might we change how we document information to help the caller get up to speed quickly and thoroughly?

Conclusions

- There is significant buy-in from service staff and families for a mechanism to help people feel like they haven't been forgotten—that the system cares about them even when services don't have space for them. Consider how we might make families feel cared for without overwhelming staff or setting unreasonable expectations for the family?
- Consider providing monthly check-ins by sending a one-way letter to families, describing what they're waiting for and why, how long it might take, who they can contact if they have questions, while helping them feel cared for.
- Discussion during feedback sessions highlighted a lack of system-level waitlist management—there doesn't seem to be data on the impact of getting someone onto the right waitlist sooner. Consider the potential impact of managing waitlists at a system level and how this might enable problem-solving to find appropriate services for a family sooner.

Idea #3: Team Huddle (Guide)

The idea, as it was proposed: A guide for facilitating inter-agency conversations about what's going on for a child, youth or family, and finding solutions that might help. With empathy at its core, this provides the facilitator with a consistent and effective process that works toward outcomes outlined in the Collaborative Case Conference guide.

Where this idea came from

Problem(s) this idea is meant to solve: We've heard that a team that forms around a child/youth can feel haphazard, leaving the youth or parent to connect dots of who is helping with elements of the care plan. Coordinating times for inter-agency team meetings to discuss a situation together can be challenging. When team meetings do happen, we've heard they aren't always executed with consistency—largely varying depending on the effectiveness of the facilitator—leaving the family feeling frustrated. Current tools (e.g. Collaborative Case Conferencing Guide) seem to be more output focused without giving guidance on how one might get to those outcomes. This leaves a lot of room for interpretation—a potential cause for the lack of consistency.

Why does addressing this matter? We know that it takes the combined effort of skilled professionals to help children and youth in our communities—no one person has all the answers. Running effective meetings is a skill, and we think that supporting people to build that skill would enable improved cohesion amongst team members with different backgrounds and areas of expertise, build on personal strengths to achieve clearly defined outcomes, and lead to better experiences—particularly for families, but also for all team members.

What we learned from feedback sessions

Positive kernels of this idea:

- This builds off of the positive aspects of Collaborative Case Conference (CCC) and Signs of Safety (SOS) models.
- A tool to help guide all team members to contribute effectively and respectfully would be helpful.
- A comfortable meeting format helps relieve anxiety about large meetings.
- This is in service to the child—their voice should carry the most weight and this idea supports that.
- Intentionally wrapping a meeting up with a reflection was well received.
- This is reminiscent of Indigenous circles—a circle approach is very welcoming and respectful.

Concerns and key questions:

- Must ensure that a focus on strengths is not at the expense of recognizing concerns.
- How might we use this with clients who struggle with self-reflection?
- How might we get everyone bought into a consistent process and common language, whatever that may be?
- Who initiates a huddle, and how does that impact accountability and follow-through of action items?
- How might we ensure that a team can quickly share critical updates, concerns and key information, and efficiently move to finding solutions that focus on the child and family?

Conclusions

- Many workers find Collaborative Case Conferences and Signs of Safety very effective, and have invested a lot into training staff in these approaches—build on this.
- There is great interest in having a common language and a common meeting process across services—can we get system-wide buy-in (including non-clinical organizations) around one common approach to inter-agency meetings that builds on the successes of CCC, SOS and other examples?
- Running an effective meeting that leaves everyone feeling good takes a certain skillset—could training dollars be directed toward building workers' facilitation skills, particularly for inter-agency meetings?
- Consider reviewing the CCC guide and other relevant material to provide direction on *how* to run meetings to achieve the outlined goals (include more process guidance).

Summary of Participant Demographics

From November 28th, 2016 to January 12th, 2017 the MOMH Prototyping Team held 11 feedback sessions across Dufferin Wellington:
(Y) = Youth, (F) = Families, (S) = Staff

November 28 – Ensuring School Success group (S)	January 9 – CMHA WW Guelph Pod (S)
November 29 – Family & Children's Services Guelph Wellington (S)	January 9 – CMHA WW Guelph (F)
December 13 – Dufferin Child and Family Services (S)	January 10 – Guelph Service Providers (S, F)
December 13 – Dufferin Child and Family Services (F)	January 12 – CMHA WW Mt. Forest (S, F)
December 14 – GLOWW group of youth (Wellington) (Y, S)	January 12 – CMHA WW Mt. Forest (F)
December 20 – CMHA WW Fergus Rural Pod (S)	

Participant Totals

Youth	3	Youth: Ages 12-18 (x2), ages 19+ (x1), currently accessing service (x3), English speaking (x3) LGBTQ+ (x2), Inuit (x1)
Parents/Caregivers	9	Parents/Caregivers: Parent (x6), friend (x2), French speaking (x1), currently accessing service (x6), First Nations/Métis/Inuit (x2)
Service Staff	69	
Total	81	

Service Organizations Represented

Canadian Mental Health Association Waterloo Wellington	Homewood—Community Addiction Services
CCAC, MHAN team (mental health & addiction nurses)	Kerry's Place Autism Services
Centre for Psychological Services, University of Guelph	Ministry of Child & Youth Services
Community of First Nations, Metis, Inuit	Norfolk Psychological Services
Dufferin Child and Family Services (DCAFS)	Psychologist in private practice
Dufferin-Peel Catholic District School Board	Upper Grand District School Board
Family & Children's Services of Guelph-Wellington	Waterloo Catholic District School Board
Family Counselling and Support Services for Guelph-Wellington	Waterloo-Wellington CCAC
Guelph Community Health Centre	Wellington Catholic District School Board
GLOWW Youth Group	WCDSB, St John Bosco Alternative Learning High School

Reported Populations Served by Organizations In Attendance

Adults (x28)	Newcomer (x17)
Children, 0-11 (x62)	Immigrant (x23)
Youth, 12-18 (x65)	LGBTQ+ (x26)
First Nations (x23)	French Language (x7)
Métis (x21)	Other populations mentioned: parents (x5), caregivers (x2), non-English-speaking families (x1), special education needs (x1), early psychosis 14-35 (x1), schools (x1)
Inuit (x20)	