CHILD AND YOUTH MENTAL HEALTH AND AUTISM SPECTRUM DISORDER THINK TANK

KEY RECOMMENDATIONS

Capacity and Educational Training Needs

1. Understand the current state and identify frontline staff trainings needs, attitudes, and myths.
    a. Provide training and education across all sectors (i.e., mental health, autism, education, health).
2. Build capacity in the delivery of mental health care for children and youth with autism, and vice versa (e.g., assessment, identification, program delivery).
3. Improve access to intersectoral case consultation for assessment and intervention.
4. Review funding model – funding siloes lead to siloed care.
5. Include families as influencers. Provide a forum for families to advocate; organize families around issues of mental health and autism.

Family and Caregiver Support and Engagement

1. Peer mentoring and support. Connecting families to people in similar situations with lived experience is powerful.
2. Parent and youth engagement/collaboration at all levels.
    a. Engagement should not be limited to the "strong" families.
3. Build strong connections between developmental, mental health, and education sectors to improve outcomes and family experience.
4. Standardize services across the province. Consistency of services means families know what to expect.
5. Accessibility. Develop a better understanding of system capacity.
    a. Consider developing a tool to support this.
    b. Develop service hubs, physical or virtual. Human presence is key.
    c. Work with boards of education to integrate access.
6. Communication. Use plain, user-friendly language.
    a. Different modes of communications are needed; enable communicators and consider the different needs of audiences.
    b. Equip families with knowledge and position them as partners.
    c. Communication should be human.

Integration and Co-delivery of Services

1. Develop a joint mental health and autism ECHO.
2. Create regional groups that bring autism and mental health staff together.
3. Pilot projects that include multidisciplinary teams, including autism and mental health.
4. Implement a special needs strategy that brings mental health to the table. The strategy should include care coordinators, wraparound supports, and a family service plan. Care coordinators must understand how autism and mental health connect and they must be included as part of the child/youth and family team.
5. Increase roundtable opportunities.

6. Use Regional Autism Providers of Ontario (RAPON) leadership to promote mental health and autism collaboration/partnership.
7. Lobby mental health and autism stakeholder for primary care/diagnostic hubs – psychoeducational perspective.
8. Use of program adaptations – obtain feedback from authors on how far one can adapt.

CYMH-Autism Pilot Projects

1. Develop a community of practice.
    a. Developing partnerships with autism agencies to support capacity building.
    b. Co-leadership and collaboration between ABA and mental health through supervision and co-facilitation (registered psychotherapist or BCBA).
2. Keep track of adaptations used in the pilot.
    a. Include 2 or 3 agencies in one pilot.
    b. Need buy in from parents – family therapy, parents integrated in group model.
3. Consider sustainability when implementing pilots.
4. For replication, further capacity building. Assess competency/sense of competency among staff prior to and after the pilot has been implemented for some time.
5. Create multidisciplinary community of practice.
    a. Create an ECHO that clinicians can bring cases to
6. Walk-in, single session model co-facilitated by behaviour and mental health consultants.
7. Intensive Secret Agent Society feasibility study in community (training and follow up).
8. Call for data from agencies.
9. Can peers/social skills be adopted/expanded with mental health lens.
10. Pilot different projects at different sites.

Building an Evidence-Base for More Effective Policy and Program Development Through Data Collection and Analysis

1. Leverage existing data collection processes that are currently in place (i.e., CMH Ministry BI approach).
2. Leverage the education system, given that school boards
    a. collect a lot of data;
    b. must report to the Ministry on students with disabilities; and
    c. have mental health leads.
3. Minimize burden on families. Data collection should be quick, simple, and inform clinical decision making.
4. Evaluate pilot projects.
5. Establish partnerships with other providers, given limited resources in the sector.
6. Offer incentives or supports for data collection for smaller service providers who may not have the capacity to participate in data collection initiatives.