TEARING DOWN SILOS:
HOW INTEGRATING CHILD AND YOUTH MENTAL HEALTH WORK IN A MULTI-SERVICE MODEL CAN HELP YOUR ORGANIZATION AND CLIENTS

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GETTING STARTED: A QUICK SCENARIO

Situation:
• A 7 year old boy living with biological parents, with a diagnosis of ADHD.
• Boy is struggling at school, both academically and socially
• A father with explosive anger which leads to domestic violence in the household
• A child protection involvement with the family
• Parents needing help to cope with their son’s challenges

To meet their needs in your service area:
• How many agencies would this family need to interact with?
• How many intake processes would the family need to go through?
• Would the family find its members placed on different waitlists with potentially different response times?
• How many different front-line workers would the family need to work with?
Workshop Learning Objectives:

- Understand the integrated service delivery model developed at Valoris for Children and Adults of Prescott-Russell
- See how integrating services creates efficiencies in the system
- Imagine how clients with multiple needs can benefit from an integrated service delivery
- Consider how integration in your own agency’s service delivery model might improve efficiency and outcomes
TERMS AND DEFINITIONS

- **Single-service organization**: Holder of a single « mandate », for example child and youth mental health (CYMH); child welfare (Children’s Aid Society – CAS); infant development services, etc. Different services can be offered within that single mandate (e.g. brief services, counselling and therapy, crisis services, etc.)

- **Multiservice organization**: Holder of multiple « mandates », often under a same roof, often offered by different teams within the organization. For example an organization that has CYMH services and autism services, with distinct intake processes, waitlists, etc.
**TERMS AND DEFINITIONS**

- **Integrated multiservice organization**: Holder of **multiple mandates**, where the service delivery for the different needs is offered by **one single team**, and in some instances, by one single worker. For example, an organization that offers CAS services, CYMH services, and infant development/infant mental health services through a single point of access, by a single team of workers and supervisors who can meet the range of different needs expressed by the families.
BRIEF HISTORY
AN INTEGRATED SERVICE MODEL WAS BORN

« ...there are both direct client benefits as well as cost savings that will be realized by the adoption of the single-agency integrated service model... »

- KPMG feasibility study, 1997
WHAT ARE THE CLIENTS’ NEEDS?

- Developmental need
- Mental health need
- Community integration need
- Youth protection need
- Gender-based violence need
WHAT CAN INTEGRATION LOOK LIKE?: STAFF

Front-line workers

Expertise

Specific literacy

CAS  CYMH  IMH/CD  GBV  ADS
SPECIFIC LITERACY = MULTIPLIED CAPACITY!
SHARED SERVICES
A SINGLE PLAYER FOR LOCAL AND REGIONAL MEMORANDUMS OF UNDERSTANDING
MULTIPLE SOURCES FOR DIVERSE AND MEANINGFUL YOUTH AND FAMILY ENGAGEMENT
COMMON PHILOSOPHY, TOOLS AND TRAININGS

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interRAI™

A Brief Introduction To Social Role Valorization

A high-order concept for addressing the plight of societally devalued people, and for structuring human services

4th EXPANDED EDITION

Wolf Wolfensberger
SINGLE POINT OF ACCESS

Hello!
Bonjour!

An Integrated Services Experience since 2001
SEAMLESS NAVIGATION ACCROSS SERVICES

• Infant mental health/Infant development to CYMH
• Children’s developmental services to adult developmental services
• Easier service delivery to people whose needs fall under multiple mandates (e.g. autism respite and CYMH)
SIMPLIFIED CLIENT PATHWAY
DIFFERENT CLIENT PATHWAY AND EXPERIENCE

CLIENT EXPERIENCE
Domestic violence situations. Referral has been made to the local children’s aid society by a school board social worker.

1. Intake receives child abuse report.
2. No child protection issue confirmed but...
   A. Mother requires VAW counselling services.
   B. Child requires VAW child witness support.
3. 6 months later. Following an accident that left the child with physical limitations, the child exhibits signs of depression, increased anxiety, and tendencies towards isolation.
4. Several years later. The child (youth) expresses a need for additional supports.

Worker 1 assigned to family and completes evaluation.
Worker 1 offers counselling support to mother and child.
Mother contacts worker 1, who updates child’s file, offers short-term supports, and completes a request for specialized CYMH services.
Community Worker 2 offers CYMH services.
Youth contacts community worker 1 to request assistance.
Worker 1 updates youth’s file, offers short-term support to child and completes a request for specialized CYMH services.
Worker 2 offers CYMH services.

Goals achieved. File closed.
Goals achieved. File closed.
Goals achieved. File closed.
DIFFERENT CLIENT PATHWAY AND EXPERIENCE

Worker 1 completes evaluation.

Worker 1 initiates referral to Counselling and Support Services of CAS for VAW services. Intake and evaluation completed by Worker 2. Worker 3 offers counselling supports to mother and to child.

Mother contacts Worker 3 to advise of concerns and request assistance. Worker 3 assists with referral to Community Youth Mental Health Services. Intake and evaluation completed by CYMHS Worker 4. CYMHS Worker 5 offers services.

Youth contacts CYMH intake services to request assistance. File updated by CYMH (Worker 4 or other). CYMH Worker 5 (or other) offers services.

Goals achieved. File closed.

Goals achieved. File closed.

Goals achieved. File closed.
ADVANTAGES FOR STAFF

- Wider opportunities for professional development
- Encourages “cross-pollinisation” of ideas between fields
- Reduces chances of “professional boredom”
- Better and quicker understanding of client’s strengths and needs
- Better knowledge of what works/what doesn’t within a family; time saved in adapting methods/approaches previously used with client
Things that can hinder integration of services

- The system is not designed with integration in mind
  - Multiple sector-specific legislative requirements
  - Multiple funding ministries
  - Multiple program guidelines
  - Multiple reporting expectations, templates, and deadlines
  - Multiple accreditation and permit standards
  - Multiple laws framing confidentiality
  - Multiple mandated databases mean some clients have multiple files for a single referral
  - Multiple simultaneous ministry initiatives
OTHER CHALLENGES OF INTEGRATION

- Finding the right professionals to do the integrated work (it’s not for everyone!)
- May require a transformation of workplace culture
- Integration is not appropriate for all client needs (e.g. because of implications around confidentiality, dual relationships, etc.)
BEFORE AND AFTER INTEGRATION

- **Before integration:**
  - 3 agencies (CYMH, Gender-based violence, Children’s Aid)
  - 3 different intakes with 3 different workers
  - 2 uncoordinated waitlists and service timelines
  - At least 3 different intervention workers in addition to the 3 intake workers
  - 3 interventions plans, independent of each other
  - 3 service philosophies, not always aligned

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**BEFORE AND AFTER INTEGRATION**

- **Since integration:**
  - 1 integrated agency meets all needs
  - A single intake call
  - A single integrated plan that follows the family’s pace
  - A single professional oversees the plan
  - If there are wait times (for example before a Partner Assault Response – PAR - group starts), they are known and taken into account in the service planning
  - A single point of contact for coordination with the school

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QUESTIONS AND COMMENTS?

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