

Establishing Child and Youth Health Indicators Workshop
“Part Deux”

November 10, 2004 from 2:30 – 8:30pm
The Grand Salon at the Fairmont Queen Elizabeth Hotel, Montreal, Quebec

Expert Panel Presentation of Recommendations

1. Name of the Expert Panel: *Mental Health Expert Panel*

2. We would like to thank the following Expert Panel members for their time and support:

Melanie Barwick (co-chair)	The Hospital for Sick Children,
Eric Fombonne	McGill University
Cynthia Koning	Glenrose Rehabilitation Hospital
Stan Kutcher	Dalhousie University
Ian Manion (co-chair)	Children’s Hospital of Eastern Ontario
Marlene Moretti	Simon Fraser University
Debra Pepler	York University
Diane Sacks	Canadian Pediatric Society
Richard Tremblay	University of Montreal
Jean Wittenberg	The Hospital for Sick Children

PROCESS:

- Collective agreement to orient partners outside of the field of infant, child and youth mental health of the different lens required when considering these issues
- Development of a joint statement to be used as a preamble to our panel’s report

Preamble:

”Mental health conditions in infants, children and youth are determined by the complex interactions between biological, interpersonal and environmental influences. These interactions effect child mental health in different ways at each developmental period and certain factors have stronger impacts at one age than at others. Only through adopting a holistic and dynamic view of children's mental health and its determinants can we hope to understand the etiologies, trajectories and potential interventions for various mental health conditions. Embracing a holistic perspective is at least equally, if not more, critical in mental health relative to physical health concerns.”

- Identification of key sources of information on infant, child and youth indicators in Mental Health
- Agreement on a framework/template
 - adaptation of the CIHI framework for use in identifying indicators in infant, child and youth Mental Health
- Identification of a focus for the panel
 - mental health conditions (including behaviours such as suicide)
- Identification of key questions
 - what do we know about mental health conditions?
 - as a function of developmental level
 - as a function of geographical area
 - as a function of country of origin and culture
 - are there trends in conditions over time (historical)
 - are we providing the right services to the right individuals in the right time frame (developmentally, practical wait times)?
 - what is the true value of a psychiatric diagnosis?
 - real sequelae of a disorder (short and longer term)
 - implications for practice for the mental health as well as the physical health service provider
 - relevant co-morbid conditions that affect burden of disease and resource intensity for its intervention
 - do current diagnostic categories capture the complexity of etiology, clinical symptoms, & developmental trajectory in infant, child and youth mental health
 - what are the true costs of the conditions identified?
 - short and longer term
 - real and projected (including lost opportunity and productivity)
 - cost to the individual and their family as well as the cost to the health care and other related systems, and to society as a whole
 - how do costs differ across conditions
 - to what extent are current knowledge and existing measurement tools being used?
- Identification of key indicators:
 - Indicators identified throughout the mapping process
 - Indicators differentiation as being at the individual level or at the system level

- individual level indicators classified by age (0-3, 4 years and up)
- prioritization of indicators (according to process provided by Melanie Barwick)

Ranked indicators

Ages 0-3 years

1. Functioning between caregiver and child
2. Caregiver functioning
3. Mental Health conditions-
School readiness

Ages 4 years and over

1. Child/youth functioning (holistic)
2. Functioning between caregiver and child/youth
3. School readiness
4. School dropout
5. School functioning
6. Caregiver functioning
7. Suicidal behaviour

System indicators

1. Wait lists (time)*
2. Training in evidence-based practice
3. Use of best/ most promising practices (uptake)

- Identification of gaps in our knowledge (see attached framework)
- Identification of Resources (partnerships and groups to consult) (see attached framework)

RECOMMENDATIONS:

- Use holistic view of functionality as an indicator (in the individual, in the caregiver, in the relationship between that individual and others)
- Reorganize individual level indicators to differentiate youth
- Need tools that can capture functionality in an easy to administer, culturally competent way that permits tracking over time and across situations (geography, culture, etc.)
- Need a better nomenclature that fits for the mental health of infants
- School has to be a key partner (tracking, identification, assessing functionality)
- Development of indicators and means to use them must be done with participation of key stakeholders in the physical health arena as well as in education (other key sectors also include child welfare, and justice)

- Add mental health components to all longitudinal surveys
- Need to assist in the valuation of promising practices developed outside of the lab
- Need to identify the quality (key components) of services to achieve positive outcomes in different communities
- Need to focus on infant child and youth mental health trajectories (biological, interpersonal, temperamental, psychological indicators)
- Need to build capacity in the area of mental health economics in order to strengthen our knowledge on effectiveness and efficiency
- Need a national agenda for infant child and youth mental health

NEXT STEPS:

- Reconvene group with additional key partners (CACAP, education, child welfare, youth justice, health)
- Review work to date and re-prioritize indicators by age (infant/child/youth) with cross cutting system indicators
- Pick top indicator(s) for further refinement
 - where indicator lacks development undertake research
 - where indicator is well-validated, roll out systematically
- Engage funding partners
 - national level, CIHR (Human Development Child and Youth Health, Neurosciences and Mental Health, Aboriginal Health, Gender and Health), Sick Kids Foundation, Canadian Psychiatric Research Foundation, other national organizations, C's of E)
 - provincial level (key ministries, C of E, OMHF)
 - engage those currently funded to do work in this area

Mental Health Expert Panel – Key Questions Framework

Questions	Potential data sources	Limitations / Gaps	Recommendations	Resources/ Potential Partnerships/ Groups to consult
<p>What do we know about child mental health conditions</p> <ul style="list-style-type: none"> • As a function of developmental level? • As a function of region or geographical area? • As a function of country of origin? 	<p>-Longitudinal Survey for Children and Youth -Child and Adolescent Health Measurement Initiative (U.S. project) - CAFAS and BCFPI in Ontario</p> <p>Also: The advent of highly structured, computer-driven assessment tools, such as the NIMH Diagnostic Interview Schedule for Children, which comes in a spoken version that can be given through headphones to children and/or their parents (Shaffer et al., 1996a), promises to greatly improve the ability of professionals outside of the mental health field to obtain robust diagnostic information, which can guide them in decisions about further referral or treatment. More information at http://www.c-disc.com/t_disc.htm</p> <p>-INTERESTING REPORT COSTELLO AMJGENPSCY2003;60;837 -PEDSCLINNAV114#5,676</p> <p>-ROURKE BABY RECORD HAS SOME FUNCTIONAL COMPONENTS, AS DOES NIPPISING</p>	<p>-Lack of true understanding of a nomenclature that fits for infants</p> <p>-Specific information that relates to cultural groups (cultural issues) -Aboriginal -New Canadians -sensitivity is important when obtaining information from these groups (culturally fair assessment tools, sensitivity to respondent and their perspective on issue etc.)</p> <p>-Biological influences on mental health conditions at different ages</p> <p>-Is there a tool that is used currently for mental health screening on a regular basis at different age levels in a family doctor's or paediatricians office? There appears to be no standardized global tool. -Need for right tool for identification and functional outcome -Need proper uptake (translation of tools, which includes different partners including physicians and schools)</p> <p>-Need tool to capture relationships that are formed by infants with caregiver, mother, etc. on a day-to-</p>	<p>-Fully explore the instruments that currently exist in and outside of Canada, and where such measure can be adapted for use that they be used, at minimum, to develop some information about their utility in Canada and where they do not exist or where they need to be modified that research be directed to do so</p> <p>Indicators</p> <ul style="list-style-type: none"> • Use of functionality as an indicator <ul style="list-style-type: none"> • Infant/Child/Youth • Caregiver/Parent • School • Between caregiver and infant/child/youth 	<p>Alberta Centre for Child, Family and Community Research</p> <p>Human Early Learning Partnership, BC www.earlylearning.ubc.ca - Clive Hertzman - Dan Keating</p> <p>Ministry of Child and Family Development, BC - Jayne Barker</p> <p>BC Children's Health Plan - Jayne Barker</p> <p>Dr. Joanna Anneke Rummens – Immigration, Race, Ethnicity identity among children</p> <p>Morley Beiser – Immigration Mental Health</p> <p>Emerging Teams -Deb Pepler – abuse -Richard Tremblay – population health – ADHD -Cyndie Koning -To forward program from meeting</p>

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	<p>BCFPI (diagnostic symptoms) and CAFAS (level of functioning) regional and provincial benchmarks will be available March 2005. BCFPI is also being adopted by British Columbia, and several one-off agencies in Saskatchewan and Alberta are using CAFAS; which, incidentally is available in French, as is BCFPI.</p> <p>CPS DOCUMENT HEALTH CARE OF CHILDREN AND YOUTH NEW TO CANADA</p>	<p>day basis</p> <p>-Need tool to capture relationships that are formed by children and youth with peers</p>		
<p>Are there trends in mental health conditions over time? (Historical) To answer this question we must review cross-sectional data on a longitudinal survey for Children and Youth</p>			<p>-Epidemiological surveys be completed on a regular time period (ie. Every ten years)</p> <p>-Development/use of a tool that can be used both longitudinally, as well as cross-sectionally</p> <p>-Add Mental Health component to all longitudinal surveys</p> <p>Indicators:</p> <ul style="list-style-type: none"> • School readiness for young children • School drop-out • Child mental health diagnosis • Suicidal behaviour 	<p>Twins Study – KidNet</p> <p>Trends in eating disorder, drug abuse, self harm</p> <p>Trend of older mothers</p> <p>Trend in more time in day care. -More time in daycare shown to put children at risk: Jean Wittenberg to provide more references</p>
<p>Are we providing the "right services" to the right children in the right time frame (both developmentally and in terms of practical wait lists)?</p> <ul style="list-style-type: none"> ▪ The answers to this 	<p>-Best practices and evidence based documents</p> <p>-wait list data for current services (region by region) - could be used as an indicator (I think this would be an indicator of access / system responsivity to</p>	<p>-Don't know the major characteristics of the children that are being treated or whether the treatments are the best ones for them. In Ontario, we will know something about the children and youth being treated in March 2005, and we have</p>	<p>-What do we choose to accept as operational criteria for EBTs in Canada?</p> <p>-Need for evaluation of what EBT is producing in terms of outcomes considering reinventions and the particular</p>	<p>Alberta BCFPI</p> <p>Melanie Barwick's group</p> <p>Brian O'Hara -Children's Mental Health Ontario (BCFPI)</p>

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<p>question would address the coalition's goals (page 1 of August 10 document). It would also address the dimensions of accessibility, efficiency, appropriateness and effectiveness.</p> <ul style="list-style-type: none"> To answer this question we will need age-specific data on specific mental disorders, utilization data of various levels of intervention (primary, secondary, tertiary) by specific populations, etc. 	<p>system responsivity to mental health needs of children & youth. The BCFPI allows agencies to “manage” or triage their waitlists because it provides data for the service provider about the number of days individuals have been waiting for service (since their first call) relative to the severity (number of areas with T scores higher than 70). This way, providers get a sense of who on the list needs priority, and they can manage how long they sit on the wait list. Some agencies are doing this with very good effect.</p> <p>Just as a FYI: one agency in the SW region experimented with offering Webster-Stratton to all those families on the waitlist – for many families, this was sufficient, and they did not remain on the wait list post-program. This agency virtually did away with their wait list.</p> <p>My point here is, service providers can use data and innovative approaches to address the wait list issue.</p> <p>-A TELEPHONE SURVEY OF MAJOR PROVIDERS WILL GIVE A PICTURE OF</p>	<p>preliminary data now for some regions. Some research is ongoing @ Sick Kids regarding the EBTs currently used by Ontario CMHCs (n=58) and this information can be matched up against EBTs known to have good evidence.</p> <ul style="list-style-type: none"> -No standardized method on determining how many children need early services. What do we mean by early services? Prevention? -Need to identify what active ingredients of specific treatments are. <ul style="list-style-type: none"> -component analysis -need to know who can and cannot benefit from specific treatments -Which components of treatment can be tailored to meet the needs of a specific community -need to determine the quality of treatment necessary to achieve positive outcomes -Screening youth that are leaving the school system due to negative reasons, for mental conditions <ul style="list-style-type: none"> -could utilize system similar to immunization record <p>Sick Kids is under contract with the Ministry of Education (Ontario) to do a very large study of school leavers.</p>	<p>environment</p> <ul style="list-style-type: none"> -Identify current best practices across the developmental stand from children to adolescence and find the evidence to support them -Indicator: -Need as a nation of researchers, practitioners, and decision makers to assist in the evaluation of promising practices as they are developed outside the lab in the real world. -Need to develop/strengthen opportunities (infrastructure) for dialogue, exchange and partnership between academic institutions and researchers, and front line practitioners who should be adding to our knowledge base <p>Indicators:</p> <ul style="list-style-type: none"> • Wait lists as an indicator; however wait lists can be affected by things other than the true prevalence of conditions (eg. Changes in policies regarding service provision) • Extent to which service providers are using best practices –what format and 	<p>Quebec – ongoing research in rehab centre looking at access</p> <ul style="list-style-type: none"> -Eric Fontbonne to send references <p>Canada Health Systems Research Foundation</p> <p>Centre of Excellence for Childhood Disability - Julia O’Sullivan</p> <ul style="list-style-type: none"> -Kids with developmental delays that go on to have psychiatric issues <p>Alberta Health and Wellness</p> <ul style="list-style-type: none"> -Tom Noseworthy

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	WAIT LISTS, WITHOUT SCREENING TOOLS THESE LISTS ARE UNNECESSARILY LONG (OFTEN 9M-1YR)	leavers.	<p>what outcome (re-invention)?</p> <ul style="list-style-type: none"> • Training in CMH EBT and Outcome management 	
<p>What is the value of the psychiatric diagnosis in the first place (i.e. classification by mental health condition)</p> <ul style="list-style-type: none"> ▪ what are the real sequelae of a disorder in the short term and the longer term? ▪ what are the implications for practice for both the mental health practitioner as well as for the physical health practitioner? ▪ what are the physical health concomitants? ▪ what are the relevant mental health co-morbid diagnoses for any condition as this will have a significant impact on the burden of 	<p>-A GREAT PUBLICATION BY THE AMERICAN ACADEMY OF PEDS THE CLASSIFICATION OF CHILD AND MENTAL HEALTH DIAGNOSIS IN PRIMARY CARE DICUSSES DIAGNOSES BY DEVELOPMENTAL AGE BEAUTIFULLY</p> <p>-Australian, New Zealand and UK literature on Trajectories</p>	<p>-Families are more concerned with how their child functions, while practitioners are more concerned with psychiatric diagnosis</p> <p>-Specific issues related to development, may appear in a different form in early childhood, childhood, and adolescence but there are some of the same underlying functional difficulties</p> <p>-Tremendous variability in children's development, with no fixed trajectory where contextual and developmental issues impact in both a positively and negatively - much needs to be learned in this area</p>	<p>-Physical health practitioners to be sensitive to the fact that they also need to be examining the infant/child/youth more holistically considering the mental health concomitants of the physical health disorders, but also the mental health results of some of the interventions</p> <p>-Examine trajectories of health, looking at both biological early indicators and the interpersonal, temper mental, psychological indicators</p> <p>-A National Agenda for Children's Mental Health</p> <p>Need to include school as a key player in mental health</p> <p>Indicators:</p> <p>-Functionality as an indicator</p>	<p>Kimberly Hogue</p> <p>OHIP collection data</p> <p>School data – referrals to services</p> <p>Michael Boyle - McMaster</p>

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<p>the disease and the resource, intensity of its treatment?</p> <ul style="list-style-type: none"> ▪ How well do current diagnostic categories capture the complexity of etiology, clinical symptoms and developmental trajectory of childhood and adolescent health conditions? 	<p>I don't think diagnostic categories alone will capture this complexity. I think it's relatively well recognized that level of functioning, together with diagnosis, offers a more complimentary and comprehensive description.</p>			
<p>What are the true costs of the mental health condition identified (short term and long term included real and projected costs including those relating to lost opportunities or productivity)?</p> <ul style="list-style-type: none"> ▪ cost to the individual (disease burden)? ▪ cost to the health care system (burden of care)? 	<p>Note: this information is more available in the US (Surgeon General report on MH)</p> <p>SEE GUEVARA, PEDIATRICS, 2003;112(6) or www.pediatrics.org/cgi/content/full/112/6/e440 on economics</p>	<p>-Mental Health Economics -Very little information on costing -Lack of cost-effectiveness data which leads to lack of funding dollars -Few health economists -Impact of diverting children into a program (preventative measure) that is less costly at the forefront</p>	<p>-Inclusion of Mental Health Economics -Develop cost-effectiveness data -Effectiveness and efficiency data -Cost to provider and recipient in terms of mental health care</p>	<p>Clive Hertzman and Dan Keating -Developmental Health and the Wealth of Nations</p> <p>-Gina Brown -Carolyn Burn -COPE groups</p>

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<ul style="list-style-type: none"> ▪ cost to society (decreased productivity, burden on family members and others)? ▪ How do costs compare across conditions? 				
To what extent are current tools being used?	There is the possibility of looking closely at the level of adoption of the CAFAS and BCFPI; specifically, to what extent are the tools used in clinical practice (beyond the bureaucratic reporting to the ministry)? Sick Kids expects to look at this systematically in 2005-2006.			
What are the key etiological factors and interactions at sensitive periods of development that determine mental health in childhood and adolescence?			Long-term – Clive Hertzman’s work can be seen as a goal for the future	Clive Hertzman and Dan Keating -Developmental Health and the Wealth of Nations