INSIGHTS TO IMPROVING CLIENT FLOW AND ACCESS TO CARE IN YOUTH TRANSITIONS

SE LHIN – TRANSITIONAL AGED YOUTH (TAY) RESEARCH FINAL REPORT

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Submitted by Youth Habilitation Quinte Inc.

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SE LHIN – TRANSITIONAL AGED YOUTH (TAY) RESEARCH
FINAL REPORT

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Acknowledgements
Sincere thanks to all participants for their generosity and engagement in the Transitional Aged Youth (TAY) project.
The insights that each agency contributed will enable a more seamless transition and increase access to care for transitional aged youth.
EXECUTIVE SUMMARY

Implemented through Youth Habilitation Quinte (Youthab), the youth transition research examined existing services to help improve the flow and access to care of youth aged 15 to 19 with mental health and/or addictions (MH&A) issues who are transitioning primarily from the children’s to the adult MH&A system. Transition is defined as the process of change when youth move from one organizational system to another for service. Once the youth has been accepted by the new organization, their case is then closed by the referring organization. Through paper and on-line surveys, research interviews and focus groups with youth and service providers, the objectives were to determine service gaps and barriers for these youth who are transitioning. Funded by the South East Local Health Integration Network (SE LHIN), this study was conducted in the Counties of Hastings-Prince Edward (H-PE), Lennox & Addington (L & A), Frontenac, Leeds & Grenville (L & G) and Lanark. In addition to the research, the mapping of services for these areas has been undertaken and will be maintained.

Prevalence of Mental Illness among Youth

In the SE LHIN, at least 15% of children and youth have a mental illness\(^1\) and it is estimated that the prevalence of mental illness between the ages of 15 and 24 is approximately 10,323 individuals.\(^1, 2\) The prevalence of serious mental illness for youth between the ages of 15 to 24 is estimated at 5.4% or 3,716 individuals.\(^3\) (Please refer to page 7.) Only 1 in 5 youth or 2,065 individuals aged 15 to 24 within our region who are in need of mental health services actually receive care.\(^3\) By deduction, this would imply that 8,258 youth aged 15 to 24 within the SE LHIN who require mental health services do not receive care and need additional support. This may be due to the stigma of being labeled, the lack of information to access services, capacity limits, a lack of specialized services, disinclination to access services, lack of transportation or a lack of knowledge of potential services.

Research Methodology

There were two stages to the youth and service provider research:
1. Completion of a paper survey for youth and an on-line survey for MH&A agencies
2. Participation in a research interview/focus group

The research was conducted with:
- 9 - transitional aged youth (TAY)
- 14 - MH&A agencies and the Child and Adolescent Psychiatric Clinic
- 13 - community agencies/services (participated in the qualitative research only)

The research objectives were to identify, understand and assess:
- Barriers for youth who are transitioning;
- Services that are missing or needed for youth to transition seamlessly; and
- The scope of the problem with youth transitions.

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1. Waddell & Shepherd, 2002; Ministry of Children and Youth Services, 2006
2. Statistics Canada estimates, July 1, 2011 and Ontario Ministry of Finance projections
3. Improving Quality of Care and Patient Safety for Transitional Youth and Young Adults, submitted to the Champlain LHIN, 2010
Youth Demographic
Youth are transitioning into adulthood with a myriad of concerns around education, employment, relationships and striving to be independent. For youth with MH&A issues, coordinated services, support and engagement are required to facilitate their transition in accessing services and in becoming an adult. Youth can still be vulnerable as their adolescent brain continues to develop until the age of 25. Maturity varies for each youth. For these reasons, MH&A and community agencies view Transitional Aged Youth (TAY) as being 16 to 24 years old, with age-appropriate services corresponding to their developmental and life domain needs.

Transitional Aged Youth Research:
Over half (56%) of youth participants reported a transition or an attempted transition from one agency to another for service. Of these respondents, 20% or one young person did not follow through with the transition because the counsellor was perceived as being abrupt and did not engage the youth.

The key themes identified from the youth research are:
- Ensure youth feel comfortable accessing services and supports
- MH and supportive counselling are services most often accessed
- Youth are not aware that transitioning from Children’s Mental Health (CMH) to Adult Mental Health (AMH) is an option
- Youth often do not know how to ask for help or what services they need
- Youth strive to acquire life skills to be successful

*These themes will be described more fully in the Emergent Themes section below.*

Perceived Demand
Most (87%) MH&A agencies perceived an increase in demand for services in the next few years. This is due to increased MH awareness, decrease in stigma, socio-economic factors and drug dependency.

EMERGENT THEMES
Analysis of the summary information from the surveys and the qualitative data informed the development of the emergent research themes. In providing context for the long-term improvement of client flow and appropriate access to care for TAY, the themes are grouped by access to care issues, requisites for building a solid foundation and the development of an effective transition process.

ACCESS TO CARE ISSUES:
Access to care is hindered by:
- Limited capacity
- Systemic barriers
- Cultural differences
- Lack of specialized, intensive services
- Lack of appropriate programming for TAY
- Lack of resources
There is limited capacity to community clinical counselling for those with a mid-range of mental health issues over the age of 18. Youth under the age of 18, can still access services from CMH. Youth over 18, who do not qualify for AMH or are not diagnosed have limited access to free clinical counselling. Even when clinical counselling is available, some CMH and community agencies perceive that those with moderate MH issues are not adequately served. This is critical as youth respondents highlighted that MH and supportive counselling are services most often accessed.

There are simply not enough psychiatrists, especially for adolescents in the adult system. Wait times are lengthiest in Lanark at 3 months. Access to public psychiatric and psychological assessments is limited. Depending on the school board, each school is only allotted 2 to 5 psychological assessments per year.

Systemic barriers and differences in ministerial culture prohibit the access to programs, services and information resources. Systems were not set-up originally as being client-centred. Although CMH accepts anyone who has mental health issues and needs help, AMH agencies were established historically as requiring a diagnosis and as such, there are potential clients who would not receive services. Most AMH agencies accept referrals without a diagnosis but some may still request a diagnosis and will assist the client to access a psychiatrist to obtain an assessment. This practice presents an additional hurdle and has created confusion for clients, and referring CMH and community agencies.

Part-time psychiatrists with an AMH&A service cannot consult with clients under 18. Some justice-related prevention programs are only available for those who have committed a crime, not for those who are at risk. Case files cannot be transferred between Youth and Adult Probation.

The adult MH&A system lacks specialized, intensive services and appropriate programming for TAY. Specialized services and counselling for eating, mood, complex behavioural and Autism Spectrum disorders are needed. Youth who have been severely abused or traumatized, but do not have a diagnosis often require more specialized, intensive services and support. For youth transitioning from CMH, AMH is a culture shock. There is no wraparound service; group sessions and supported housing can include 40 to 50 year olds. Youth are expected to be forthcoming and advocate for the services that they need. Youth addictions programming does not exist in most areas. There are no residential treatment facilities between Toronto and Ottawa for youth with addictions.

The lack of resources and time constraints is a barrier for community agencies/services as well as MH&A agencies. Hospitals lack psychiatric resources and indigenous services do not have sufficient resources to meet their demand. Adult Probation need more time for psychological and sexual risk assessments, while schools need more time to support students who are not attending classes regularly. Additional AMH&A counsellors are needed to reduce lengthy wait lists. To transition youth properly, extra resources and time are required for meetings and to transport and accompany youth. For indigenous services, the lack of cross-cultural training and indigenous staff is perceived as a barrier in accessing mainstream community MH&A services. Having indigenous workers would provide an improved cultural understanding and perspective of this youth population.
REQUISITES TO BUILDING A SOLID FOUNDATION:

Identified as a barrier, a service gap or both, the following components if improved would provide the core requisites in building a strong infrastructure for youth transitioning and can lead to successful outcomes for TAY.

- Communication, awareness, and the sharing of information
- Comprehensive youth services, supports and engagement
- Affordable, supported and emergency housing for youth
- Accessible public transportation
- Prevention and early intervention strategies

Identified as a key barrier, agencies and ministries lack information and understanding of one another’s services. Different ministries (Child and Youth, Health and Long-Term Care, Education and Community and Social Services, Community Safety and Correctional Services) need to better understand each other’s roles and differences. The differences make connections difficult. Better communication is needed between agencies, schools, hospitals, and justice services to understand each other’s services and how resources can be available for each agency and to avoid duplication of services. Some MH frontline staff are unaware that clinical counselling services are available at Family Health Teams (FHTs) and Community Health Centres (CHCs).

Perceived as a gap, TAY require comprehensive, coordinated services, support and engagement. Youth feel most comfortable when counsellors are youth-friendly, helpful and flexible. Appropriate, enhanced services and supports including holistic case management, counselling, recreational activities, vocational and educational programs, and housing can help youth succeed. But ultimately, youth strive to acquire practical skills as in life, social, coping, employment readiness, and supports that build their confidence and self-esteem so that they can be independent and successful.

Youth may not know what services are available, how to access them and often do not know how to ask for help. From the youth research, they were not aware that transitioning from CMH to AMH is an option. Engagement is required to inform and assist youth to access services and advocate for themselves. Texting is the preferred means of accessing help among youth as it can be anonymous. Some agencies expressed the need to meet youth’s reliance on technology by engaging them differently yet providing them with the support that they require.

Age appropriate, supportive and emergency housing was indicated as a gap and barrier. Stable and affordable housing is a key foundation of support. Without it, youth have a difficult time accessing MH counselling and/or pursuing employment needs. More semi-independent living programs like the Transition Home (Youthab) and supportive housing in rural centres are required. For youth who have criminal records or have high needs, a significant gap exists in supported housing and supported emergency housing.

There is a lack of public transportation particularly in rural areas. Identified as a barrier and gap, counsellors would often drive select clients to appointments and meetings. This places a challenge on limited resources needed for counselling.
Education, prevention and early intervention strategies are needed. Youth and their families, service and care providers would be more knowledgeable, be able to better manage MH&A issues and prevent escalating destructive behaviours if these strategies are in place. Identified educational and intervention topics would include: suicide prevention and intervention for TAY, primary care and in-school staff awareness of MH&A services, concurrent disorder education for non-MH&A service providers, psycho-education on substance use to avert potential criminal offences, and creative early intervention or prevention programs or services.

DEVELOPMENT OF EFFECTIVE TRANSITION PROCESSES IS NEEDED:
Current transitions are not tracked and can be improved. Youth transitions in L&G, L&A, Lanark, and addictions in Frontenac are informal to semiformal with good collaboration among agencies. For the Youth and Adolescent Psychiatric Clinic, transitions are seamless for First Episode Psychosis and Personality Disorder services. In H-PE, youth services are better coordinated and integrated as Youthab provides MH counselling, housing and employment services. However, agency referrals for transitioning into AMH are infrequent as the need for a diagnosis and the lack of clinical counselling services limits access. In Frontenac, there are communication and perception issues. CMH do not know who to contact at AMH in transitioning youth and are not aware that AMH offers clinical counselling and can assist clients to obtain a diagnosis. Addictions services in H-PE, L&G and Lanark can coordinate services but do not transition youth.

Overall, some transition processes are working well; however, others are working less well. Solutions have been suggested for their improvement. If the developmental processes are adapted, they would contribute to a more effective youth transition process.

Transition services and supports working well:
- Good collaborative relationships
- Practices that are client-centred and facilitate the transition process

Transition services and supports working less well:
- Lack of information and communication processes
- Less than optimal coordination
- Lack of transition planning
- Limited sharing of information and collaborative decision-making at the operational level
- Lack of cultural understanding
- Lack of resources

Collaborative relationships enable a positive flow and facilitate a successful transition. Good communication and support enhances the overlap bridging of clients. Practices that are client-centred in facilitating introductions and sharing information, increase youth’s willingness to engage, make their lives easier and improve the client flow.

Transition processes can be improved through better planning, communication, coordination, collaboration, additional resources, flexibility and supports. Proposed solutions by the respondents include:
- Protocols to outline the transition process from initial referral to follow-up
• Enhance frontline staff’s knowledge regarding transition processes, agencies’ roles and of workers at other agencies
• Initiate better coordination with other agencies and services to facilitate client flow and follow-up
• Improve the sharing of information and collaborative decision-making at the operational manager level
• Additional resources and flexibility to bridge services between CMH and AMH

Framework Ideas
The ideas generated ranged from the practical, the expected and an innovative alternative. The options were aggregated from MH&A and community agencies/services.

The most frequently cited idea is to have dedicated transition workers. Some MH&A agencies preferred to have one dedicated worker at each agency to work collaboratively with each other and the client to facilitate the transition. Among community agencies/services, it was suggested that a Transition Worker/System Navigator would bridge the two systems, with dedicated workers in each system.

Extend current children’s mental health services to age 24. TAY need wraparound services including youth services under one roof. It was also suggested that the youth offender system be extended to age 24.

Provide a quality, comprehensive youth service. Proposed by some MH&A agencies, services would incorporate best practices for youth services programming and engagement, making transitions invisible.

Incorporate MH&A into primary care teams. Suggested by some community agencies/services, primary care becomes the entry point. This would minimize the stigma and normalize the treatment of mental health.

Building capacity, improved communication, engaging youth and frontline staff, and developing an effective transition framework are required to facilitate the flow and access to care for TAY. Enhanced services and TAY programming within AMH&A, and prevention and early intervention strategies would address some of the service gaps. The sharing of information and the flexibility to coordinate resources across ministries and community services can resolve some of the cultural barriers but would require a dedicated collaborative effort. Likewise, systemic barriers and gaps such as, affordable housing and public transportation would require collective advocacy and commitment from appropriate levels of government.

In conclusion, it is aspired that some of the recommendations summarized above will be implemented to assist TAY to acquire the appropriate services, skills and supports to build their confidence and self-esteem. Clarifying and streamlining the referral and diagnosis process can make life easier for youth and their families. Engagement, early intervention, age appropriate services and supports can help TAY manage issues and overcome difficulties. Practical transition processes and dedicated transition workers can ensure transitional aged youth are comfortable and supported during the bridging of services.
OVERVIEW

Funded by the South East Health Integration Network (SE LHIN), the TAY research project examines and assesses existing services for the transitioning of youth aged 15 to 19 primarily from the children’s Mental Health and Addictions (MH&A) system to the adult MH&A system. The overall goal of the Transitional Aged Youth project is to design and implement a youth transition framework for the long-term improvement of client flow and appropriate access to care.

Through Youth Habilitation Quinte (Youthab), the research was conducted to determine perceptions, service gaps and barriers through survey tools and research interviews. Perspectives were garnered from TAY, and MH&A and community agencies/services. This report is based on research conducted in the Counties of Hastings-Prince Edward (H-PE), Lennox & Addington (L&A), Frontenac, Leeds & Grenville (L & G), and Lanark. In addition to the research, the mapping of services for these areas has been undertaken and will be maintained.

Transition is defined as the process of change when youth move from one organizational system to another for service (e.g. from children’s mental health to adult mental health). Once the youth has been accepted by the new agency, their case is then closed by the referring organization.

PREVALENCE OF MENTAL ILLNESS AMONG YOUTH

It is estimated that between 15 and 21% of children and youth in Canada have at least one mental health illness.¹ The mental health data below is based on research percentages for youth aged 15 to 19 cited from the Children’s Hospital of Eastern Ontario (CHEO) report to the Champlain LHIN. Assumptions are made that the prevalence of mental illness among youth is 15% and data percentages can also be applied to youth aged 20 to 24. According to a backgrounder of key facts by the Mental Health Commission of Canada, children who experience mental health problems incur a much higher risk of experiencing illness as adults; suggesting that if mental health issues are left untreated, it can likely get worse over time. It is also stated that mental health illnesses are most prevalent in the early working years.

<table>
<thead>
<tr>
<th>Counties</th>
<th>Total population aged 15 to 24²</th>
<th>Prevalence of Mental Illness among Children and Youth is 15%¹</th>
<th>Prevalence of Severe Mental Illness among Children and Youth is 5.4%³</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frontenac</td>
<td>21,140</td>
<td>3,171</td>
<td>1,142</td>
</tr>
<tr>
<td>Hastings</td>
<td>17,690</td>
<td>2,654</td>
<td>955</td>
</tr>
<tr>
<td>Lanark</td>
<td>8,450</td>
<td>1,267</td>
<td>456</td>
</tr>
<tr>
<td>Leeds &amp; Grenville</td>
<td>13,000</td>
<td>1,950</td>
<td>702</td>
</tr>
<tr>
<td>Lennox &amp; Addington</td>
<td>5,280</td>
<td>792</td>
<td>285</td>
</tr>
<tr>
<td>Prince Edward</td>
<td>3,260</td>
<td>489</td>
<td>176</td>
</tr>
<tr>
<td>Total SE LHIN</td>
<td>68,820</td>
<td>10,323</td>
<td>3,716</td>
</tr>
</tbody>
</table>

Only 1 in 5 Children and Youth in Need of Mental Health Services Receive Care³

Only 1 in 5 Children and Youth in Need of Mental Health Services Receive Care³
<table>
<thead>
<tr>
<th>Estimated number of youth aged 15 to 24 in the SE LHIN who are in Need of Mental Health Services and Receive Care</th>
<th>2,065</th>
<th>743</th>
</tr>
</thead>
<tbody>
<tr>
<td>By deduction, estimated number of youth aged 15 to 24 in the SE LHIN who are in Need of Mental Health Services but Do Not Receive Care</td>
<td>8,258</td>
<td>2,973</td>
</tr>
</tbody>
</table>

1. Waddell & Shepherd, 2002; Ministry of Children and Youth Services, 2006
2. Statistics Canada estimates, July 1, 2011 and Ontario Ministry of Finance projections
3. Improving Quality of Care and Patient Safety for Transitional Youth and Young Adults, submitted to the Champlain LHIN, 2010

At least 15% of children and youth have a mental illness and it is estimated that the prevalence of mental illness between the ages of 15 and 24 within the SE LHIN is approximately 10,323 individuals. The prevalence of serious mental illness for youth between the ages of 15 to 24 is estimated at 5.4% or 3,716 within the SE LHIN. Only 1 in 5 youth or 2,065 youth aged 15 to 24 within our region who are in need of mental health services actually receive care. This may be due to the stigma of being labeled, lack of information to access services, capacity limits, lack of specialized services, disinclination to access services, lack of transportation or a lack of knowledge of potential services. By deduction, this would imply that 8,258 youth aged 15 to 24 within the SE LHIN who need mental health services do not receive care and need additional support.

**METHODOLOGY**

The research was conducted through online surveys and research/focus group interviews. Survey tools, focus group guides and consent forms were developed for the study. The survey tools and focus group guides were based on validated tools from the Transition from CAHMS to Adult Mental Health Services (TRACK): A Study of Service Organization, Policies, Process and User and Carer Perspectives by Singh et al. (2009). Development processes were also adapted from Dr. Mario Cappelli’s research team at the Children’s Hospital of Eastern Ontario (CHEO) on a similar project of Improving Quality of Care and Patient Safety for Transitional Youth and Young Adults for the Champlain LHIN. Permission was obtained to use and adapt the tools from both sources. Further development of the questions was vetted with clinical and administrative staff at select MH&A agencies within the SE LHIN.

The research with TAY was conducted through a questionnaire and individual/focus group interviews. (Please refer to Appendices V and VI). Originally based on a validated tool, the survey questions were amended and vetted through a youth worker and youth. A poster was developed to inform and entice youth participation (See Appendix XII).

Three versions of the on-line survey were created and implemented with Adult Mental Health Services (AMHS), Children’s Mental Health Services (CMHS), and Addictions (ADDs). (Please refer to Appendix VII). Similarly, the qualitative questions were designed for each of the above three segments, other community agencies and those MH&A agencies that did not transition youth. (Please refer to Appendix VIII & IX).
Focus group guides and consent forms explained the research and confidentiality. (Please refer to Appendices X and XI). Consent forms were completed by all participants.

**Youth research:**
In total, 9 transitional aged youth ranging in age from 16 to 20, completed a questionnaire on services accessed and participated in an interview or focus group. The objective was to obtain a better understanding of the transition issues facing TAY, and the services and supports they require.

Children’s MH and Adult MH services in Belleville, Kingston and Smiths Falls were contacted to recruit possible candidates for the research along with youth services (Youthab) in Belleville and Bancroft. The ideal criteria for participation were youth aged 16 to 21 who had transitioned from children’s MH to adult MH or were in the process of transitioning between the two systems.

**On-line MH&A agency survey:**
All 14 MH&A agencies participated in the on-line survey via Survey Monkey to:
- Determine the number of youth aged 15 to 19 being served;
- Identify what youth services are needed and available;
- Obtain a snapshot of the transition process; and
- Assess the demand for MH&A services.

Agencies included children’s mental health services (4), adult mental health services (4), addictions services (4), adult mental health and addictions (1), and youth services (1). Only one person from each agency completed the on-line survey. The one integrated agency completed two surveys – one pertaining to mental health and the other to addictions. Youth services were classified under adult mental health. For the purpose of tabulation, there were 6 adult mental health, 4 children’s mental health and 5 addictions agencies.

**Research/focus group interviews:**
In total, 14 MH&A agencies, the Child and Adolescent Psychiatric Clinic and 13 community agencies participated in a one-on-one research interview or a focus group to:
- Determine the barriers for youth who are transitioning;
- Identify any services that are missing or needed for youth to transition seamlessly; and
- Obtain a better understanding of the scope of the problem with youth transitions.

Perspectives from community services included primary and acute care, private counselling service, Children’s Aid Society (CAS), district school board, Kingston-based youth housing, police services, youth justice and support, adult probation and indigenous mental health and addictions services. All interviews were recorded and transcribed.

**Limitations:**
For the youth research, the criterion was broadened to include youth who have moved into the Transition Home (TH) due to challenges in accessing participants who had transitioned or were in the process of transitioning from CMH to AMH. Participants from the Transition Home accounted for 67% of total respondents and may skew the results of the youth research. Respondents outside of H-PE only
represented 33% of total respondents. Therefore, the youth research results are presented on an aggregate basis only.

For the MH&A agency online survey, the numerical data does not allow for equal comparisons. Some service provider systems are not able to extrapolate data for youth aged 15 to 19 as their classifications are different. Some agencies cannot determine referrals by age group. There are also inconsistencies with the numerical input for the number of youth serving and the number of youth transitioned. Often, the number of transitioned youth exceeded the number currently serving. When questioned, the former mostly reflected the number of youth served within the last year and not the number of youth transitions.

Service provider awareness of youth services at other organizations within the community can affect the accuracy of community services for youth results.

For the qualitative MH&A and community agencies research, the views expressed by those interviewed may not represent the views of the Executive Director or the Board of the organizations.
YOUTH RESEARCH SUMMARY

The research with Transitional Aged Youth (TAY) was conducted through a questionnaire and individual/focus group interviews. The objective of the youth research was to obtain a better understanding of the transition issues, services and supports needed. Due to challenges in accessing youth participants who had transitioned from children’s MH to adult MH or were in the process of transitioning between the two systems, the criterion was broadened to include youth who have moved into the Transition Home (TH). This latter group accounted for 67% of total respondents and may skew the results of the youth research. Geographic participation outside of H-PE was 11% for KFL&A and 22% for Lanark. Therefore, the youth research results are presented on an aggregate basis only. In total, nine youth ranging in age from 16 to 20 years participated in the research.

KEY THEMES
The key themes identified from the youth research findings are:
- Ensure youth feel comfortable accessing services and supports
- MH and supportive counselling are services most often accessed
- Youth are not aware that transitioning from CMH to AMH is an option
- Youth often do not know how to ask for help or what services are needed
- Youth strive to acquire life skills to be successful

THE TRANSITION EXPERIENCE
Fifty-six (56%) percent of youth reported a transition or an attempted transition from one agency to another for service. Services and supports needed were:
- Learning to manage emotions and to avert crisis
- Having a MH professional who provides guidance, is respectful, and with whom youth can speak candidly
- Learning life and social skills
Most needed guidance and support and some needed occasional intervention. The percentages in the Transition Experience section are based on 5 respondents who have transitioned or attempted a transition.

Of those who reported a transition or an attempted transition, the agency flows mentioned were from: CMH to AMH (60%), AMH to TH (20%), and CAS to TH (20%). At least 80% of these transitions were not direct. In these cases, the agency transition flow meandered with breaks in service, of which one-third was voluntary. For more information, please refer to Appendix I – Youth Research Findings.

Factors that contribute to successful client transitions:
Sixty (60%) percent of the transitions were positive experiences. Factors that contribute to successful transitions are:
- Agencies collaborating
- Having strong advocates within the referral agency
- Counsellors initiating the transition process, making arrangements, accompanying and ensuring youth are comfortable and supported at the intake appointment
• Referral agency providing counselling to manage a crisis and facilitate a relationship change, and continued case management support
• Learning to speak openly about emotions as CMH prepared youth for AMH, where the onus is on youth to be forthcoming

Factors that contribute to less successful transitions:
• **CMH did not inform youth of the option to transition to AMH.** Youth did not know that transitioning from CMH to AMH was an available option. CMH felt that youth did not need the service and could rely on the crisis line as required. As a result, youth was dropped from service and spent a year in and out of shelters. In another scenario, youth opted out of service voluntarily after 5 months.

• **Referral agencies did not prepare youth for the intake appointment or to live independently.** In one example, CAS would arrange a meeting and only inform them that they were seeing a counsellor. In addition, CAS do not teach youth to live independently prior to leaving group homes at 18. Youth “had to fend for themselves” without life skills.

• **AMH counsellors may not think about their difference in operational culture with CMH and how it may affect youth.** CMH works holistically using a wraparound approach. At AMH, the onus to participate is placed on the youth. If the AMH counsellor does not make a young person feel welcomed, youth may not feel comfortable advocating on their own.

Factors that led to a decision to not transition to AMH:
• **Counsellor was abrupt and did not engage youth during the initial intake appointment.** First impressions count; the intake counsellor was not welcoming. “What do you expect from me?” was how the conversation began after initial introductions. No information was provided about the services offered, no questions were asked of the client’s background. The youth was not comfortable asking questions and was visibly upset after the meeting.

Lessons Learned: how the intake or transition could have been made easier:
• Engage the client to make them feel comfortable. Provide information about the services offered.
• Knowing that a transition from CMH to AMH is an option. CMH could have suggested a transition to AMH.
• Youth often do not know what questions to ask, how to ask for help, or what services or supports are needed. A good counsellor who works with youth would engage the client, identify the need and assist the youth to advocate for themselves.

**A WISH LIST OF SERVICES AND SUPPORTS TO HELP YOUTH SUCCEED AS SUGGESTED BY ALL YOUTH RESPONDENTS:**
• **Acquire life skills, coping skills and supports to live independently (78%).** Practical skills would include:
  - Money management, cooking skills, living independently and assuming responsibilities
  - How to obtain a health and SIN card, birth certificate, family doctor and dentist
  - Proper self-care and hygiene
  - Better coping and decision-making skills, how to manage anxiety
- Teamwork and how to be independent
- Self-confidence and self-esteem
- Respect for self, others, elders and property
- Employment readiness skills, resume writing, job hunting and preparation
- Subsidies and more support on getting a drivers’ license, how to apply, and where to go
- Knowledge of local resources and programs
- General support is needed from family, friends, government services, peers, mentoring and coaching

- **Ensure youth feels comfortable in receiving counselling and support (56%).** Youth need to feel comfortable and know that they can ask their counsellor to accompany them to appointments. Having a counsellor or advocate present in a meeting would make youth more comfortable asking questions. The quantitative research results indicate that supportive and MH counselling were the most accessed services for this group of youth. (Please refer to Appendix IV for more details.)

Ensure the physical environment is more casual and flexible. Meet with clients in a more relaxed atmosphere that is more comfortable for youth such as, their home or at a café. More handholding support in a psychiatrist’s office and more in-school counselling are needed.

- **Funding recreational facilities and supports build social skills and self-confidence (44%).** Have affordable recreational activities other than movies, WiFi X boxes in coffee houses, more skateboarding facilities, drumming, sports subsidies and programming, subsidies for music programming. Musical programs allow for “learning business, how to operate...making friends...it’s really social and it just builds confidence.”

- **Vocational, educational programs and supports (44%).** Some youth are restricted by resources to attend college or there may be a lack of local college programs. Specialized courses such as, esthetics, sewing and fashion design, modeling and acting, help build confidence and self-esteem. Having support in applying for college and completing OSAP forms would be helpful. Application fees should not be charged. “…should not have to pay to apply to a college...got bursary from CAS...all got used...making application to...college..I’m applying to OSAP so I can pay my rent...School is very expensive...If there was more help and support for that it would be good.”

- **Health and safety education (44%).** This includes First Aid, CPR, MH First Aid (knowing what to do in crisis and what services to access), healthy lifestyles group, anti-bullying and sexual health education.

- **Housing (33%)** Finding and paying for housing and quicker access to housing. No emergency housing for young people in Belleville. “Couch surfing doesn’t really set up routine structure.”

**How to Support a Friend who is Hesitant to Get Help:**

- **Ask for help (56%).** Direct someone to an appropriate resource that can assist them. Suggest calling CMH. Text # to answer questions. Text is the preferred means of getting help among youth. Texting is simpler and anonymous. “Almost everything that teens do nowadays runs around their cell phones.”

CONCLUSION

Youth rely heavily on their current counsellor to initiate the transitioning, advocate and ensure youth are comfortable and supported during the bridging process. All of these factors contribute to successful client transitions. The transition process can be made easier if youth are informed that a transition from CMH to AMH is an option. AMH counsellors must recognize that youth need to feel welcomed and comfortable. Often, youth do not know what questions to ask, how to ask for help, how to do something, or what services or supports are need. Youth need guidance, support and occasional intervention.

Youth feel most comfortable when counsellors are youth-friendly, helpful and flexible. Youth suggested that counselling, recreational activities, vocational and educational programs, health and safety education and housing services and supports can help them succeed. But ultimately, youth strive to acquire practical skills as in life, social, coping, employment readiness, and supports that build their confidence and self-esteem so that they can be independent and successful.
MENTAL HEALTH AND ADDICTIONS AGENCIES RESEARCH SUMMARY

The TAY research examined existing services to help improve the flow and access to care of youth aged 15 to 19 with mental health and/or addictions (MH&A) issues who are transitioning primarily from the children’s to the adult MH&A system. This research was conducted primarily with MH&A providers in Hastings-Prince Edward (H-PE), Lennox & Addington (L & A), Frontenac, Leeds & Grenville (L & G) and Lanark, through on-line surveys, research interviews and focus groups. For more information, please refer to Appendix III – Mental Health and Addictions Agencies Qualitative Research Findings.

The research objectives were to identify, understand and assess:

- Barriers for youth who are transitioning;
- Services that are missing or needed for youth to transition seamlessly; and
- The scope of the problem with youth transitions.

Youth Demographic:
Youth are transitioning into adulthood with a myriad of concerns around education, employment, relationships and striving to be independent. For youth with MH&A issues, coordinated services, support and engagement are required to facilitate their transition in accessing services and in becoming an adult. Their frontal lobes continue to develop until the age of 25. Development and maturity for each youth varies. For these reasons, MH&A agencies view Transitional Aged Youth (TAY) as being 16 to 24 years old, with age-appropriate services corresponding to their developmental and life domain needs.

Perceived Demand:
Most (87%) MH&A agencies perceived an increase in demand for services in the next few years. Increase in demand is due mainly to higher awareness, decrease in stigma, socio-economic factors and drug dependency. For more information, please refer to Appendix II – Mental Health and Addictions Agencies Online Survey Findings.

KEY THEMES

The key themes were identified from the aggregate findings of the youth transition on-line surveys and the core questions of the qualitative interviews/focus groups. The themes are based on the perspectives of the 14 MH&A agencies and the Child and Adolescent Psychiatric Clinic within the SE LHIN.

- Limited capacity to community clinical counselling for those with moderate mental health issues aged 18 and up; more acute in H-PE and Frontenac.
- Accepting a referral where the client does not have a diagnosis can be unclear in some geographic areas.
- Limited specialized services for those with a mid-range mental health issues.
- Psychiatric services for assessment, diagnosis and treatment are needed, more acute in some areas.
- Access to care is hindered due to systemic barriers and differences in ministerial culture.
- Agencies and ministries lack information and understanding of one another’s services, how their services work and coordinate to facilitate connections.
• Adult MH&A services lack programming, wraparound services and supports appropriate for TAY.
• Lack of public transportation.
• Lack of affordable housing for youth.
• A residential treatment facility for youth is needed.
• Education, prevention and awareness as an early intervention strategy.
• Some MH agencies are unaware that clinical counselling services are available at Family Health Teams (FHTs) and Community Health Centres (CHCs).
• Collaborative relationships and services and supports that connect with youth are working well.
• Lack of protocols, infrastructure and standardized processes for the transition of youth.

MAJOR BARRIERS are a lack of communication, differences in ministerial culture, transportation and housing. As a result of system differences, challenges and communication issues permeate.

Lack of Communication:
• Ministries operate in silos and do not communicate with one another. Different ministries (Child and Youth, Health and Long-Term Care, Education and Community and Social Services) need to better understand each other’s roles and differences. The differences make connections difficult. “What does each sector do for clients to ensure those needing care do not fall through the cracks?”
• A diagnosis is generally required for AMH&A with varying criteria for each agency, creating confusion among providers and clients. Some AMH agencies provide services for those with diagnosed Moderate Mental Illness (MMIs); however, their CMH counterparts may understand that only those with Serious Mental Illness (SMIs) are served or perceive those with moderate MH issues are not adequately served.
• Agencies lack information and understanding of one another’s services. Better communication is needed between agencies, schools and hospitals to determine what resources are available in the community, who provides what, and how resources can be available for each agency to address identified service gaps and avoid duplication of services. Front-line staff in the children’s system may not know who their adult counterpart workers are.

Differences in Ministerial Culture:
• The mandate and culture between Children’s Mental Health (CMH) and Adult Mental Health (AMH) are significantly different. Systems and approaches to care differ. CMH services have a referral criterion that captures anyone who has mental health issues and needs help. Wraparound, clinical and youth-and-family-friendly services are provided. The criteria for AMH services are more restrictive and focus on the individual. Clients need to be proactive in advocating for services; if not, they may not receive support.
• Systems-centred and not client-centred. The AMH system is set-up in a way that if potential clients do not meet its criteria, they would not receive services. Due to systems restrictions, access to services between organizations and the integration of services is hindered. Part-time psychiatrists with an AMH&A service cannot consult with clients under 18. Only a psychological and not a psychiatric assessment would be accepted at Developmental Services. If a client is rostered with an independent family physician, there is limited access to social worker services at FHTs and CHCs.
Transportation:
- **There is a lack of public transportation particularly in rural areas.** Indicated as a barrier and service gap, case workers would pick up and drive clients from rural areas in some instances. Even when public transportation exists, MH counsellors would drive select clients to ensure that they keep their appointments with other agencies. This places a challenge on limited resources needed for counselling.

**Challenges arise due to systems’ limitations with a need for increased flexibility.** In working around the differences of CMH and AMH, cultural challenges and fragmentation of services restrict access. The lack of youth-specific programming in AMH&A creates challenges, including those to avert potential criminal behaviours. Systems require different assessments, creating bureaucracy. There are limited community services for youth with conduct and autism spectrum disorders in the adult system. “For some patients like the Autism disorders, it is with a trembling heart that we transfer to AMH.” Children’s and youth services are not aware of other community services that youth can be transitioned to without a diagnosis or with disorders not covered by AMHS. Providers should not have to make more than 2 phone calls to be connected to the right person.

**Lessons learned from service and support improvements involve communication and collaboration:**
- **Collaborate to do what is best for the client.** Service providers need to communicate with one another and allow frontline staff to collaborate and use their judgment to do what is best for the client.
- **Communicate, collaborate and integrate to optimize client access and flow** through the effective use of resources, increased awareness of services and pre-emptive intervention engagement.
- **Mitigate barriers through understanding, communication and awareness.** If front-line communication is not successful, initiate operational director-to-director conversations. When in doubt, ask for clarification.

**MAJOR SERVICE GAPS** are youth services, community clinical counselling for those with moderate mental health issues, other clinical resources, housing, and education. Applicable challenges and lessons learned include catering to youth and their families.

**Youth Coordinated Services, Support and Engagement:**
TAY require appropriate services and supports that can provide guidance in developing a solid foundation. These include holistic case management, supportive counselling, social and recreational activities, opportunities for employment and post-secondary education, and life skills. Youth are harder to engage; their inclination to access services readily needs to be recognized. If coordinated services are available where youth congregate, such as counselling in all high schools, access would be easier. Youth may proclaim independence but can still be vulnerable. All services that youth may access need to offer hand-holding support to ensure transition success. Engagement is needed with youth who are not in school or without support.

Adult MH&A systems lack youth focused programming and wraparound services. Some adult providers require knowledge of how to engage with youth. Youth are not comfortable participating in adult groups or living in adult supported housing with 40 to 50 year olds, nor are these situations appropriate.
Challenges in catering to youth include not showing up for appointments. If youth are no longer in crisis, they assume that they no longer need service. This becomes an issue if they really need long-term support. There is a high attrition rate with youth during triage and while on the wait list. It can be difficult to maintain contact with youth. “We can lose over 50% of youth if we cannot contact them.”

Lesson learned in youth service enhancements include services to guide youth to develop good decision-making skills, allowing them to manage their conditions throughout their lives. Hand-holding support from agency to agency would make youth feel more comfortable. Youth prefer one-on-one counselling in school as they would not want their friends to know. For some, counselling for parents would improve the mental health and well-being of their children.

Community Clinical Counselling, Specialized Services for Those with Moderate Mental Health Issues:
Access to general community clinical counselling and specialized services are lacking for those who need a mid-range of mental health services and supports. Youth over 18, who do not qualify for AMHS or are not diagnosed, have limited access to free clinical counselling. This group includes those with conduct disorders, general anxiety and reactive depression; it would also include those with Aspergers, those between the 5th to 7th developmental percentile, individuals with no familial support and parents with moderate MH issues, who, if provided with proper support, could have a positive familial impact.

Increase access to specialized services and counselling for eating, mood and complex behavioural disorders are needed. Applicable to MMIs and SMI, there is a lack of resources within the adult system for Autism Spectrum Disorders; experts are concerned that AMHS are not ready for the capacity and the varying needs and complexities.

Additional Clinical Resources:
Psychiatric services are needed for assessment, diagnosis and treatment. Access to services is hindered by capacity limits in AMH, especially in Lanark (3 months) and in L & A (6 to 8 weeks). In L & A adult services, in-school clients, who are under 18, do not have access to a Psychiatrist. The need for adolescent psychiatry is more acute with limited access in the adult sector. There are no residential treatment facilities between Toronto and Ottawa. Distance and a 6-month wait time for an OHIP bed are major deterrents for youth.

Age Appropriate, Supportive and Emergency Housing:
Indicated as a service gap and barrier, there is a lack of affordable housing for youth. Transition homes, supportive housing in rural centres and for young men in L & G, and housing with supportive services for violence prone youth are needed. Youth shelters with support services are needed in Lanark, L & A and H-PE.

Education, Prevention and Awareness:
Youth and their families, service and care providers would benefit from a better understanding and prevention of MH&A issues, facets, services and supports. Gaps include suicide prevention and intervention for transitional aged youth (TAY), MH&A services awareness for primary care and in-school staff, concurrent disorder education for non-MH&A service providers, psycho-education on substance use to avert potential criminal offence, and prevention programs for high-risk youth who have not committed an offence.
CURRENT TRANSITION PROCESSES can be improved. Youth transitions are not tracked. Adult services in L & A and L & G do not require a diagnosis for service. Some adult agencies would accept referrals without a diagnosis, however, a referral may include a request for a diagnosis. Providing services are available in community agencies, the transitioning of youth ranges from informal to semiformal within MH&A in L & A, addictions in Frontenac, and MH services in Lanark and L & G, with very good collaboration among agencies. For the Youth & Adolescent Psychiatric Clinic, transitions are seamless for First Episode Psychosis and Personality Disorder services. Addictions services in L & G and Lanark do not transition youth.

In H-PE, Youth (Youthab) services are in a unique position with integrated MH counselling, housing and employment services. The process is established for those transitioning into housing, with coordination and support. However, there are very few transitions from CMH services to Youth services. There is no established process within AMH with infrequent referrals from CMH and Youth services. Given the collaborative relationships and tight knit service community, the infrequent referrals are surprising. Addictions services would coordinate services but do not transition youth.

In Frontenac, AMH do their best to try to build overlapping resources around client needs. However, youth transitions have been mainly ad hoc and can be a complex “don’t fit me” system’s rigidity. Transition referrals may be routed through 2 to 3 levels of coordinated access. After an assessment, if the individual did not appear to fit into the services that are being offered, the referral would be denied. Counsellors within the children’s system would often not know who to contact at AMH in transitioning youth. From CMH’s perspective, Frontenac clients would need to have all necessary information and diagnosis in advance as AMH would not be expected to assist youth to obtain the diagnosis. In reality, AMH has the flexibility to approach their mobile crisis team to obtain a diagnosis.

Adult Wait Lists: The average length of stay for AMH is 8 weeks. Lanark had the longest ranging from 8 to 12 months for individual counselling. In L & A, Napanee had the longest at 6 months for intensive psycho-therapy. Half of AMH agencies triage their cases on a weekly basis with two-thirds using a priority system, which could mean that moderate cases may not move much. The average number of days between 1st call and 1st appointment within addictions is 7 days.

TRANSITION SERVICES AND SUPPORTS WORKING WELL are relationship-building and client-centred services.

Collaborative relationships facilitate a successful transition. Both agencies’ services and supports can be enhanced during the overlap bridging of clients. Direct counsellor-driven transitions, where youth and the other agency are prepared, work well. “Having a reliable contact that one can build trust and a relationship with over time provides stability and makes the transition easier.”

Services and supports that connect with youth and make their lives easier. Integrated, supported youth services in MH clinical counselling, housing and employment increase youth’s willingness to engage and facilitate their movement (H-PE). Facilitated introductions and remaining involved until a connection has been established with the new worker works well. Indicated by the higher number of youth served in the online survey results, in-school programs connect with youth, particularly among addictions agencies in Frontenac and L & A.
**TRANSITION SERVICES AND SUPPORTS WORKING LESS WELL** include communication and planning processes, lack of resources and managing the clinical relationship change between systems. These processes **CAN BE IMPROVED** through better planning, additional resources, flexibility and supports.

- **Lack of information and communication processes:** Suggested solutions include: better knowledge of agencies’ roles and workers to facilitate “picking up the phone”; better client follow-up with agencies and care providers; manager-to-manager access to address difficulties; and align with how youth communicate by texting and using social media.

- **Less than optimal coordination:** Proposed strategies include: assigning agency case management based on the best fit; navigating information effectively; coordination of mental health and youth employment programs; and better coordination with CHCs and FHTs to increase capacity and access.

- **Lack of transition planning:** Suggested solutions include: protocols to outline the transition process from initial referral to follow-up - who does what with each agency, how to resolve disputes and help youth connect; and provide both youth services and evidenced-based interventions in the AMH&A system.

- **More relationship building is needed:** Enhance the sharing of information and best practices; and collaborate on decision-making at the manager operational level to resolve difficult cases.

- **Lack of cultural understanding:** Staff do not know whom to speak with in addressing differences (Frontenac). There is a need for ongoing information exchange between 2 culturally different systems (CMH and AMH).

- **Lack of Resources** relate to the identified service gaps and the integration of services for youth in some areas. Additional resources and flexibility are needed to bridge services between the two systems.

- **Managing Clinical Relationship Change between Systems:** The lack of protocols can make it challenging if workers do not know what to do, who needs to be involved and where to take youth. To manage anxiety, supports are needed to ensure youth are comfortable in developing a new clinical relationship.

**Functional Centres:**

**Clinical counselling as a functional centre across the SE LHIN is not consistent.** The lack of clinical counselling at an adult MH agency in H-PE restricts the transition of youth over 16. As a result, standard access to service cannot be achieved consistently throughout the SE LHIN. Although the adult service in Frontenac offers clinical counselling, it is not listed as having a functional centre. Youth may not be aware or informed of where they can access adult mental health service after the age of 16.

**EMERGENT FRAMEWORK IDEAS**

Dedicated transition workers, one at each agency to work collaboratively with each other and the client to identify issues, determine treatment plan and supports. The adult worker could be an ICM/Counsellor who would provide counselling, wraparound service and the flexibility to bridge services. The current worker engages with youth until they are comfortable with their new counsellor.

**Extend current children’s mental health services to age 24 which would include youth services.** TAY need wraparound services under one roof. Ideally, the youth MH system would be within the children’s MH system. Programming consistency would occur if one Ministry provides funding up to age 24.
Quality, comprehensive youth service would make any transitions invisible. Incorporate best practices for youth services programming and engagement (Frontenac). Services would guide youth to better manage their conditions throughout their lives.

Ownership and Accountability Models – Ideas include a wraparound collective with a facilitator; and models of continuous care with interagency collaboration. Governmental ministries and agencies have a responsibility to collaborate, plan and not pass the “kids” onto each other.

CONCLUSION

Collaborative relationships, services and supports that currently connect with youth are working well; however, a standard youth transition framework does not exist. Better communication between systems is needed to understand one another’s services, and how these services can be coordinated. Psychiatric services are needed to increase access and flow. There is limited access to community clinical counselling for those with moderate mental health issues aged 18 and up; and is more acute in H-PE and Frontenac. In order for a youth transition model to succeed, clinical counselling needs to be available as a core service at all adult mental health services. Youth over the age of 18, who need mental health and addictions services, should not need to encounter system process restrictions.

Transitional aged youth with mental health and addictions issues need age-appropriate services and personal support to bridge organizational changes. A standardized transition process for youth would facilitate a more stable outcome. “When we pass the baton, we don’t let go until the person on the other side has a good grip. Need to establish a consistent process that ensures that this happens.”
COMMUNITY AGENCIES/SERVICES Research Summary

In order to form the transition process framework for Transitional Aged Youth (TAY) which will be piloted in Hastings and Prince Edward Counties, interviews were also conducted with 13 community-based agencies/services. These community-based agencies/services included police services, Children’s Aid Society, Kingston-based youth housing, primary care, Belleville General Hospital, Hastings and Prince Edward District School Board, private counselling services, youth justice and support, adult probation, and indigenous mental health and addictions services.

Identical in scope to those of the Mental Health & Addictions (MH&A) agencies, the research objectives were to identify, understand and assess:

- Barriers for youth who are transitioning;
- Services that are missing or needed for youth to transition seamlessly; and
- The problem and scope of youth transitions.

These agencies/services provide either direct clinical support or intervening services to youth with mental health and addictions issues. To obtain a better understanding of these agencies’ roles and services for youth, please refer to Appendix IV – Community Agencies/Services Research Findings.

KEY THEMES

Similar to the MH&A results, the key themes identified from the 13 community agencies/services findings are:

- Capacity and access to adolescent psychiatrists and psychologists
- Lack of supported and emergency housing for youth
- Youth addictions programming is lacking
- Community Mental Health (MH) counselling is not adequate for those with less severe MH issues
- Access to care is hindered due to systems’ barriers, capacity issues and lack of time and resources
- Specialized, intensive services and supports are needed
- Youth engagement, culture and the need for flexibility
- Awareness and understanding of services within the community
- A residential treatment facility for youth with addictions is needed
- Transition practices and collaborative relationships which support youth are working well
- Lack of creative early intervention or prevention pre-conviction programs or services
- Lack of indigenous staff and cultural understanding at community MH&A agencies

MAJOR SERVICE GAPS are clinical resources, suitable housing, youth addictions programming, community MH counselling for those with moderate mental health issues, and the need for more specialized, intensive services and supports.

Capacity and Access to Psychiatrists and Psychologists:
There are simply not enough child and adolescent psychiatrists. Wait times are long, and access to public assessments and treatment is limited. Depending on the school board, each school is only allotted
2 to 5 psychological assessments per year. Consequently, many learning disabilities do not get diagnosed.

**Suitable, Adequately Supported and Emergency Housing:**
Identified as a service gap and a barrier, stable and affordable housing is a key foundation of support. Without it, youth have a difficult time accessing MH counselling and/or pursuing employment needs. More semi-independent living programs like the Transition Home (Youthab) are required. For those youth who have criminal records or have high needs, a significant gap exists in supported housing and supported emergency housing.

**Youth Addictions Programming:**
Access to addictions services for youth is self-directed and in-school outreach is limited to one school board. In a rural area such as, Bancroft, addictions support is available two days per week but schools find the service insufficient when a student requires immediate access. In addition, there are no local addictions residential treatment facilities for youth.

**Community MH Counselling Services Are Not Adequate:**
Youth over 18 years of age with less severe MH issues, have a harder time accessing services. Many CAS youth do not have a diagnosis, but have been severely abused or traumatized and often require more specialized, intensive services and supports. Even with a diagnosis, young people who have a disorder that is not debilitating will not qualify for intense services. “Addictions and Adult Mental Health systems are not set up to deal with these youth.” With proper counselling, these youth can develop coping skills that could avert further problems. There are also evidence-based programs in the justice support services that are preventative; but without funding, these services cannot be offered to the broader community.

**Youth Engagement, Understanding Youth Culture and Having the Flexibility to Enhance Services:**
Perceived as a gap, engagement of youth would determine challenges in accessing services and obtain feedback on the quality of services. Youth are often not aware that they need help; or they may not be ready to accept help; or when and how to access services. Likewise, agencies need to engage youth to identify places where they could easily access supports or address the feasibility of texting to access counselling.

Perceived as a challenge, youth often do not see themselves as having a MH issue. They need to be willing to engage in service; otherwise they may not follow through on accessing services. The critical piece is does the youth truly WANT service? “We can talk...educate...suggest...but ultimately if we’re going to have a system that says they get to choose, then I think that...is part of the challenge.”

Technology has evolved into an instant access to everything. Yet as youth, they are still developing with intense emotions that are not easily shared. There is a need for agencies to meet youth’s reliance on technology by engaging them differently yet providing them with the support that they crave.

**Other Gaps and Challenges:** Another notable gap is the lack of knowledge of other agencies’ services, supports and how to access services. This also applies to the services offered by Family Health Teams (FHTs) and Community Health Centres (CHCs).
Cited as a challenge, parental influence and resistance can make it difficult to engage them. The parental home environment may have chronic negative influences with untreated abuse, addictions and MH issues. This can have an adverse effect on youth who have adapted behavioural changes and become more responsible.

**MAJOR BARRIER**

The major barrier is access to care; hindered due to systems’ barriers and the lack of time and resources. Systems’ barriers prohibit the access to programs, services and information resources. There are different funders and silos, resources and information are not shared making the youth transition process “incredibly difficult.” Some justice-related prevention programs can benefit the broader community of youth with MH&A issues but would require funding. Case files cannot be transferred between Youth and Adult Probation. Adult Officers can only review the physical files and take notes on site. “…the Ministries have got to get together and work out some policies for information sharing that are more suitable.”

The age overlap of 16 to 18 between CMH and AMH is an opportunity for better planning but can also be a way out for not accepting responsibility. At 17, “no one wants to take ownership...so you have someone who says okay I’ll do this and then turn around and say you’re not worth the money to continue working with you... to discover what the problem is. Do you know how sad that is?”

Each mental health system is perceived as being distinct, with differences in culture. CMH and AMH serve different populations. MCYS and MOHLTC have different assessments and do not have a common electronic platform for sharing information.

Hospitals lack psychiatric resources and indigenous services do not have sufficient resources to meet their demand. Adult Probation need more time for psychological and sexual risk assessments, while schools need more time to support students who are not attending classes regularly. If current MH workers were involved in meeting with the new counsellor and advocating for their clients, transitions would be more seamless. Although one-on-one consultations have been proven more effective with youth, agencies are often limited to implementing group sessions.

**CURRENT TRANSITION PROCESS**

Among the participating community agencies, 46% transition youth, 15% actively support and advocate for youth during the transition, and another 39% do not transition youth. Transitions are mainly informal: referrals are made; an appointment is set-up; and youth are connected to needed services. Workers may accompany youth to appointments depending on client needs or established relationships. Only 23% of community agencies engage and prepare youth for the transition.

**TRANSITION SERVICES AND SUPPORTS CITED AS WORKING WELL:**

**Ensuring good practices** for the transitioning of youth from one agency to another which comprise of:
- Obtaining client consent
- Being knowledgeable of what the need is, the available services and contacts within the community
- Having a dedicated worker or one that is willing to help facilitate the process
Setting up the initial meeting and case conferences
Sharing information with other organizations
Accompanying youth until they are receiving services at the new agency

For some agencies, the process is client-centred, self-determining and empowers youth to build on their strengths. This approach engages the client and helps show respect for their decisions. For one agency, preparation and engagement is being aware of the next step, not being afraid to ask difficult questions, and recognizing the need to slow the process down. “Have you ever considered that this might be becoming a problem for you. You go to the next stage; and work on that. You really need to hold in the reins...The successes are when we slow it down.”

**Good collaborative relationships** enable a positive flow to the transition. Collaboration works well with the schools as the client is supported during the court diversion process. There is good communication and collaboration for internal transitions within indigenous services. Police services receive very good support from administrators and counsellors. For hospital MH services, being client-centred is a team effort and it is important to acknowledge and build on the team strength. “We don’t do enough patting each other on the back and saying thanks, you’re doing a great job and we’re doing the best we can with what we have.”

**TRANSITION SERVICES AND SUPPORTS CITED AS WORKING LESS WELL:**
Access to care is limited due to systems and capacity issues. A diagnosis is needed to access AMH services. Wait lists are lengthy; often, the agency is notified that youth do not meet AMH’s criteria for services (Frontenac). There is a lack of specific youth programming in Addictions. The CAS system is set up as being reactive versus pro-active.

The sharing of information is missing in the transition process. Major system barriers exist, thus creating a duplication of processes. The 2 Ministries in Probation operate on different case note systems. Case and summary notes cannot be accessed electronically or photocopied resulting in inefficiencies and possible inaccuracies. A fee is often required to obtain a copy of a private Psychologist’s report on a youth that was previously paid by the Youth Probation system.

Workers at the operational level lack awareness and familiarity with the transition process, which hinders service provision.

**SUGGESTED FRAMEWORK MODELS**

Dedicated transition worker(s) build a relationship with youth and bridge the process with the children’s and adult MH&A systems. It has been suggested that a Transition Worker/System Navigator would bridge the two systems, with dedicated workers in each system. The former would act as liaison between the two systems and keep the family physician informed. As a variation, an Intensive System Navigator would provide services for youth with the most complex needs.

Extend the CMH and youth offender systems to age 24. At age 18, youth are not fully matured. The adult MH and offender’s systems lack youth programming. In the latter system, youth are being bundled with older offenders who can be a poor influence on them.
Incorporate MH&A into primary care teams. Make primary care the entry point, as this will minimize the stigma and normalize the treatment of mental health.

CONCLUSION
Quality practices and collaborative relationships contribute to transition processes that are working well; however, a formalized youth transition framework does not exist. Greater capacity and access to public psychiatric and psychological assessments, age-appropriate supported and emergency housing, and addictions programming are required. There is limited capacity in, and access to, community MH counselling services; current services are not adequate, especially for youth over 18 years of age with less severe mental health issues. More specialized, intensive services and supports are needed.

Similar to the MH&A agencies’ findings, access to care is limited due to systems’ barriers. The sharing of information can be better designed and coordinated. A critical strategy that is underutilized is to engage youth; understand their culture; meet their reliance on technology by connecting differently; yet providing them with the support that they crave, as challenging as this may be. Ultimately, flexibility is the key to enhancing services and supports for transitional aged youth.
STRATEGIC ASSESSMENT

1. STRENGTHS:
   - Services exist within the community (CMH, AMH, FHTs, CHCs, Hospitals, etc.)
   - Transitional age overlap between CMH&A and AMH&A allowing for planned transitions
   - Some adult MH services do not require a diagnosis and strive to help those with moderate mental health issues
   - Integrated mental health, supportive housing and employment youth service in H-PE
   - Addictions agencies who serve in-school youth tend to have more collaborative frameworks in place
   - Co-location of MH&A services in select locations
   - Protocols are being developed for youth transitions between CMH & AMH in one geographic area
   - Increased collaboration and flexibility in rural areas
   - Good collaborative relationships
   - Services that connect make life easier for youth
   - Decision-making process is driven by youth
   - Youth transition awareness has increased
   - Increased MH funding for youth in-school

2. CHALLENGES:
   - Working around systems’ limitations and philosophical cultural differences
   - Fragmentation of services between organizational systems
   - Transitional age overlap between CMH&A and AMH&A allowing opportunities to pass the buck
   - Engaging and catering to the youth demographic
   - Lack of protocols for managing clinical relationship change for TAY between organizations
   - Dedicated time and resources allocated to youth transitions
   - Parental issues and resistance
   - Inter-agency communication and collaboration at the operational level
   - Bottom-up communication and collaboration
   - Stigma
   - Turnover of operational staff and time needed for orientation and education
   - Youth transition processes are at the infancy stage, requiring guidance, development and support

3. ISSUES:
   - Inter-ministerial communication, collaboration, culture and accountability
   - Systems-centred vs. client-centred structures
   - Lack of information sharing within and between organizations
   - Frontline agency staff have limited knowledge of MH counselling services at FHTs and CHCs
   - Definition of mild to moderate MH issue versus a serious MH illness
   - Confusion around referrals being accepted without a diagnosis
   - Limited capacity and access to free clinical counselling for youth aged 18 and up
   - Limited capacity and access to psychiatrists
   - AMH&A system lacks specialized clinical services, appropriate TAY programming and engagement
• Connecting with youth using technology needs to be acknowledged
• Lack of affordable, supportive and emergency housing for TAY
• Lack of public transportation in rural areas
• Lack of coordination of services and supports between organizational systems
• Clinical counselling as a functional centre in AMH agencies is inconsistent within the SE LHIN
• Lack of protocols, infrastructure and dedicated transition workers for transitioning youth
• Lack of local residential treatment for youth with addictions
• There is a need for prevention and early intervention programs

4. OPPORTUNITIES:
• Initiate an inter-ministerial round table to collaborate on resolving systemic differences and issues
• Increase flexibility to share, coordinate and integrate resources across ministries and services
• Design service flow from the clients’ perspective in making it easy for them to connect
• Enhance awareness of roles and the sharing of information within and between organizations
• Clarify the definition of mild to moderate MH issues versus a serious MH illness
• From a client’s perspective, facilitate the flow and clarify referrals being accepted without a diagnosis
• Increase capacity and access to community clinical counselling for youth aged 18 and up
• Increase capacity and access to public psychiatric services
• Enhance resources for specialized clinical services, appropriate TAY programming and engagement within the AMH&A system
• Create strategies to engage youth effectively through technology yet providing them with needed support
• Develop an effective supportive and emergency housing infrastructure for TAY
• Develop a rural transportation strategy and plan
• Increase flexibility and improve coordination of services and supports between organizational systems
• Establish clinical counselling as a functional centre in all AMH agencies across the SE LHIN
• Establish clear, practical transition protocols and effective processes to ensure youth are supported prior, during and after the transition
• Build a residential treatment facility in our region for youth with addictions
• Increase awareness, enhance education, prevention and early intervention of MH&A issues
• Develop creative prevention and early intervention programs for vulnerable and high-risk youth
STRATEGIC DIRECTIONS AND RECOMMENDATIONS

The key themes of this study encompass systemic barriers, access to care issues, communications, youth empowerment, prevention, and developing an effective framework for transitioning youth. Some solutions may require ministerial intervention, and many will require additional funding.

Stakeholders can contribute and assume some responsibility to improve the flow and access to care of TAY with mental health and addictions issues from one organizational system to another for service. These include ministries, MH&A and community agencies/services, and youth. Solutions involve engagement, a collaborative community effort and a commitment from all stakeholders. Some of the strategies listed below can be applied to more than one segment.

MINISTRIES and FUNDERS

Access to Care:
- Initiate a regional inter-ministerial round table to collaborate on addressing systemic barriers, cultural differences and access to care issues for youth with MH&A concerns.
- Provide flexibility in guidelines to share and coordinate resources across ministries and community services in order to assist youth with required services.
- Redesign the MH&A system from the clients’ perspective to make access to services easier.
- Clarify the definition of mild to moderate MH issues versus a serious MH illness.
- Invest in capacity-building to increase community clinical counselling for youth aged 18 and up.
- Mandate clinical counselling as a functional centre in all regional AMH agencies.
- Increase funding for building capacity and access to public psychiatric services.
- From a client’s perspective, mandate and facilitate the flow, clarify referrals being accepted without a diagnosis, and minimize the additional hurdle of obtaining a diagnosis to access service.
- Increase funding for specialized, intensive services, appropriate TAY programming and engagement within AMH&A.
- Invest in building a residential treatment facility in south eastern Ontario for youth with addictions.

Requisites to Building a Solid Foundation:
- Establish an inter-ministerial funding collective to develop and implement creative prevention and early intervention programs for TAY.
- Provide funding for local professional development days to enhance youth engagement, MH&A education, prevention and early intervention. This would also promote networking and the sharing of information among frontline agency staff.
- Fully fund and enhance an existing resource on a regional basis like Openline, Openmind which has some top-of-mind awareness, to communicate available services to TAY, their families, service and care providers, and community partners. Incorporate the mapping of H-PE, KFL&A and L,L&G services to this centralized resource.
- Invest in comprehensive services for youth to include engagement, prevention and early interventions where youth services exist.
- In collaboration with the larger community, advocate with the appropriate levels of government to develop an effective supportive and emergency housing infrastructure for TAY.
In collaboration with the larger community, advocate with the appropriate levels of government to develop a rural transportation strategy and plan.

**Development of Effective Transition Processes:**
- Expand the Transitional Connector position for KFL&A and L,L&G Counties pending the pilot outcomes in H-PE.
- Share the transition protocols to be developed in the H-PE pilot as a reference for other SE LHIN regions.
- Allocate resources required for collaborative meetings, time to transport and accompany youth in order to transition clients properly.
- Share lessons learned from the H-PE pilot with other SE LHIN TAY initiatives.
- Develop an indicator for measuring the quality of client outcomes for high needs and hard to serve TAY.

**MH&A and COMMUNITY AGENCIES/SERVICES**

**Access to Care:**
- Improve client flow within the AMH&A systems by closing inactive cases and reducing long-term cases where clients can self-manage.
- Adapt education/self-management workshops, wellness activities/programs to improve client flow.
- From the client’s perspective, enhance flow to make access to services easier.
- Provide or coordinate practical skills development for TAY such as life, social, coping, decision-making and employment readiness that builds their confidence and self-esteem.
- Consider implementing MH counselling in AMH where currently not available. A plan would need to be developed to mitigate potential issues that could arise. Agencies would need time to adapt to the change of introducing this new service.
- Introduce youth addictions programming within AMH&A.
- Implement and expand specialized, intensive services within AMH.
- Advocate with appropriate ministries in collaboration with the larger community to build a residential treatment facility in south east Ontario for youth with addictions.

**Requisites to Building a Solid Foundation:**
- Strive to improve cross-sectoral collaboration and coordination of services for TAY, including team-based primary care and prevention programming.
- Implement local professional development days to enhance youth engagement, MH&A education for non-MH&A providers, prevention and early intervention, as well as promoting the sharing of information among frontline staff.
- Empower frontline staff to collaborate with other community agencies/services to develop solutions, advocate and do what is best for the client.
- Initiate working groups for operational agency staff to collectively develop creative prevention and early intervention programs for TAY.
- Engage TAY effectively through social media and texting yet providing them with the support they require.
• Coordinate and integrate TAY programming, prevention, services and supports to improve client flow. Services include employment and vocational/educational readiness, housing, recreational, primary and dental care, and justice services and supports. If a gap exists, adapt or cross-train staff to provide specific programs, services and supports.

• Expand services for TAY to include engagement, prevention and early interventions where youth services exist.

• Adopt youth services (Youthab) as a template for implementing TAY MH and skills development programming within AMH&A and coordination with age-appropriate employment and housing services.

• Engage a resource to implement TAY programming within AMH&A services in KFL&A and L,L&G.

• Advocate with appropriate levels of government in collaboration with the larger community to develop an effective supportive and emergency housing infrastructure for TAY.

• Advocate with appropriate levels of government in collaboration with the larger community to develop a rural transportation strategy and plan.

Development of Effective Transition Processes:

• Assign a dedicated transition worker with intensive case management skills in the Children’s and Adult systems who can work collaboratively with each other and youth clients to handle simple, straightforward transition cases from one organization to another directly.

• Designate a “go to” transition worker within each community agency to facilitate the transitioning of youth.

• Utilize the services of the local Transitional Connector (beginning in April 2013 in H-PE only) to coordinate supports, resolve complex cases and facilitate the transition as needed.

• Utilize the transition protocols to be developed in the H-PE TAY pilot as a reference.

• Apply lessons learned from the H-PE TAY pilot.

• Prepare and ensure frontline staff are knowledgeable on established youth transition processes and service mapping resources.

YOUTH

• Participate in skills development programming to build their confidence and self-esteem.

• Learn to effectively advocate for themselves.

• Seek out mentors that can provide guidance, coaching and assist with engagement in age appropriate recreational activities.

• Learn about existing resources and services that they may need to access through friends and family, web-based technology, and school.
APPENDICES
APPENDIX I: YOUTH RESEARCH FINDINGS

In total, nine youth ranging in age from 16 to 20 years of age, completed a questionnaire on services accessed and participated in an interview or focus group. Results of the quantitative and qualitative research are summarized below.

Quantitative Research Results:
As there were multiple responses to each question, the percentages were based on total responses per question, rather than the number of participants.

Agencies accessed for service were:  
Youth services (Youthab) - 29%  
Children’s MH services – 29%  
Children’s Aid Society (CAS) – 21%  
Adult MH services – 14%  
Other – 7%

Aggregate services accessed were:  
Supportive counselling – 33%  
Mental health clinical counselling – 25%  
Case management – 17%  
Life and social skills – 8%  
Other – undefined 17%

Considering AMH’s role and importance as a key service in the transition process, it is interesting to note that AMH accounted for only 14% of agencies where youth accessed services, which is half the rate of CMH and youth services. For this group of youth, the most accessed services cited were: supportive and MH clinical counselling which combined for an aggregate total of 55%. The data cited would indicate that counselling services are in high demand for youth.

Qualitative Research Findings:
The qualitative research findings and percentages are based on 9 youth respondents. The geographic participation rate is 22% for Lanark, 11% for KFL&A and 67% for H-PE.

The Transition Experience:
Fifty-six (56%) percent of youth reported a transition or an attempted transition from one agency to another for service. Diagnoses include borderline personality, eating disorder, trauma and abuse. Services and supports needed were:
- learning to manage emotions and to avert crisis
- having someone professional who provides guidance, is respectful, and with whom youth can speak candidly
- learning life and social skills
The majority of respondents are leading normal lives with many moving toward post-secondary education. Most need guidance and support and some needed occasional intervention. The percentages in the Transition section are based on 5 respondents who have transitioned or attempted a transition.

Of those who reported a transition or an attempted transition, the agency flows mentioned were:
From CMH to AMH – 60%
From AMH to TH – 20% and with ongoing AMH services and support
From CAS to TH – 20%
At least 80% of these transitions were not direct. In these cases, agency transition flow meandered with 60% having breaks in service, of which one-third was voluntary. Indirect pathways recorded were:

- From CMH to voluntary break to in-school counsellor to AMH
- From CAS to independent living to TH
- From hospitalization to AMH to TH
- From CAS to CMH to women’s shelter to hospitalization to women’s shelter to AMH and Psycho-Social Rehabilitation ACT Team

Factors that contribute to successful client transitions:
Sixty (60%) percent of the transitions were positive experiences. Factors that contribute to successful transitions are:

- Agencies collaborating
- Having strong advocates within the referral agency
- Counsellor calling from the referral agency to initiate the transition process, making arrangements and advocating for youth
- Counsellor and / or advocate accompanying, transporting and ensuring youth are comfortable and supported at the intake appointment
- Continued case management support from the referral agency
- Learning to speak openly about emotions at CMH prepared youth for AMH, where the onus is on youth to be forthcoming
- Referral agency providing counselling to manage a crisis and facilitate a relationship change

Factors that contribute to less successful transitions:

- **CMH did not inform youth of the option to transition to AMH (40%).** Youth did not know that transitioning from CMH to AMH was an available option. CMH felt the client did not need the service and could rely on the crisis line as required. As a result, youth was dropped from service and spent a year in and out of shelters. In another scenario, youth opted out of service voluntarily after 5 months.

- **Referral agencies did not prepare youth for the intake appointment or to live independently (20%).** Although CAS arranged the meeting, “lots of kids get…drop[ped] off, you’re going to see [a]counsellor, go talk to them. Won’t tell them anything. Will pick [them] up when done.” In addition, CAS do not teach youth to live independently when they leave group homes at 18. Youth “had to fend for themselves” without life skills such as, money management, cooking, personal hygiene, where to get a birth certificate, a Social Insurance Number and health card, the basics of finding an apartment, etc.

- **AMH counsellors may not think about their difference in operational culture with CMH and how it may affect youth. As a result, youth may not be optimally received in AMH (20%).** CMH works holistically using a wraparound approach for youth. At AMH, the onus to participate is placed on the youth. At the initial intake meeting, youth may not feel comfortable advocating on their own if the AMH counsellor does not make the youth feel welcomed first.
Factors that led to a decision not to transition to AMH – Lanark:

- **Counsellor was abrupt and did not engage youth during the initial intake appointment (20%).**
  
  First impressions count; the intake counsellor was not welcoming and it was not a positive experience for the young person. The client chose to attend the intake meeting on her own. "What do you expect from me?" was how the conversation began after initial introductions. No information was provided about the services offered, no questions were asked of the client’s background. The youth was not comfortable asking questions. Aside from a handshake and informing the client that a letter would be sent, no further next steps were given or explained. Youth was visibly upset after the meeting and “felt like he (counsellor) didn’t really want to be there…”

What would have made the intake or transition easier:

- Engage the client to make them feel comfortable. Provide information about the services offered.
- Knowing that a transition from CMH to AMH is an option. CMH could have suggested a transition to AMH.
- Youth often do not know what questions to ask, how to ask for help, or what services or supports are needed. A respondent with major trust issues found establishing a new counsellor relationship difficult and did not feel specific services or supports would help. A good counsellor or go-to resource person who works with youth would engage the client, identify the need and assist the youth to advocate for themselves.

Differences in experience between agencies:

- **Agencies and counsellors that are youth-friendly are more resourceful, helpful, flexible and make youth feel comfortable (40%).** A respondent reported that staff listened at both AMH and TH, hence youth is comfortable talking to them. Comparing CAS to the Transition Home, the latter’s programs are designed to make it easier to learn something new. A methodical, step-by-step process of how to do something is demonstrated. “Help you do what you want.., listen to you, figure out what you need, help you reach your goals.” For example, if one is looking for a place to live, a list of apartments would be provided, phone calls are made, relevant questions are asked such as security deposits for utilities, and an appointment is set up for viewing. A life skills assessment, an evaluation on budgeting and cooking is conducted at intake to determine “what you know, what you are capable of, so you will be successful when you get housing and are on your own. Think it’s really cool!” At CAS, “they assume what you need..”

- **CMH is more flexible and make the extra effort for youth to feel comfortable (40%).** There is more flexibility in meeting with the CMH worker once per week at school, at home or in the office. Whereas at AMH, the counsellor would perhaps be seen once per week or once every two weeks at the group home where the counsellor works and the youth lives. Compared to AMH, counsellors at CMH are more hands-on using interactive tools such as visuals, writing and creating diagrams. CMH makes the extra effort to engage whereas the style of work at AMH is more distant.
The following sections are based on all nine (9) youth respondents:

**Services and supports received that have been helpful:**

- **Counselling, empathy and coping skills (44%)** Counselling is helpful to youth; they have the ability to talk to someone, develop coping skills and strategies such as cognitive behavioural therapy, managing emotions, knowing what next steps to take, overcoming a crisis, what is suitable and healthy decision-making. “Someone that understands and knows what to say.” Friends and family do not always know what to do or say. Some counsellors utilize visual aids such as diagrams to help explain how emotions work. AMH teaches meditation and provides tools (CDs) with calming music to relax.

- **Life skills (44%)** such as learning to live with others, finding common interests, teamwork, and cooking skills provide stability and the ability to be independent.

- **Housing (22%)** provides stability. “Being accepted into housing and not having to go back to shelters.” Youth can focus on improving other areas of their lives such as employment and education.

Other helpful services and supports mentioned:

- Knowledge around nutrition to stabilize eating disorders and improve health
- Being in a regional urban hub to access and gain employment

**Services and supports that are needed now:**

- **Counselling and support (33%)** If transitioning to AMH, youth would not be comfortable with group sessions initially; prefer one-on-one counselling to start, and then transition over to groups. A counselling professional would listen and provide guidance by using cognitive behaviour therapy to cope, keep youth calm, and help stabilize certain situations. Workshops to understand how the mind works and to balance emotions would make it easier.

A young person needs someone who can listen and help by providing strategies to deal with conflict and other people. For example, a supportive counsellor is perceived as being argumentative and does not know how to help the youth who is having interpersonal conflicts. The young person is afraid to stand up to the counsellor. Youth may benefit from assertiveness training and developing interpersonal skills. When a young person has trouble accessing services such as, not being able to contact a sexual assault worker for almost 2 months; youth do not necessarily think about approaching a case manager or a resource person who can intervene and advocate for them.

- **Housing support (22%)**: Support is needed for moving and finding a place to live. Being educated on tenant rights and responsibilities and where to go for help would be beneficial for those wanting to live independently.

Other services and supports that are needed now:

- Access to psychiatrist
Transportation

A Go-to Resource Person who youth feel comfortable approaching, does not judge, is respectful, and provides guidance and education. “she runs the Resource Room...she’s like in her 60’s, she just has a sweet personality...always try to give her best advice to try to deal with [the] situation.”

Grief counselling for losing a close friend – “my counsellor didn’t really know what to do and it made things kind of hard.”

In-school peer support - a respondent was referred by the counsellor to support a student who was not comfortable in “coming out” “... as he thought all his friends would abandon him.”

Access to artistic programs like arts groups and therapy

Groups to help youth to quit smoking

Supports for young moms such as daycare, babysitting and supplies

A Wish List of Services and Supports to Help Youth Succeed as Suggested by Youth:

Acquire knowledge of life skills, coping skills and supports to live independently (78%). Practical skills would include:
- How to obtain a health and SIN card, birth certificate, family doctor and dentist
- How to cook and make double meals
- Money management, living independently and responsibility, moving away to university
- Respect for self, others, elders and property
- Employment readiness skills, resume writing, job hunting and preparation
- Knowledge of resources and programs in the area
- Subsidies and more support on getting a drivers’ license, how to apply, and where to go
- Learn proper self-care and hygiene
- Build self-confidence and self-esteem
- Learn teamwork and how to be independent
- Learn coping skills and how to manage anxiety
- Better decision-making skills
- Enjoy what you do
- General support is needed from family, friends, government services, peers, mentoring and coaching

In a CAS group home, basic life skills are supposed to be taught one night per week; however, only 2 of the suggested 50 topics were taught. “They took the simple way out, have a good time and keep everyone happy, to make sure there are no freak outs instead of actually teaching these girls.”

Ensure youth feels comfortable in receiving counselling and support (56%) Having a counsellor or advocate present in a meeting would make youth more comfortable asking questions. Youth need to feel comfortable and know that they can ask their counsellor to accompany them to appointments. Nutritional counselling was available at the hospital but one youth was too timid to attend. Specialized counselling for eating disorders was helpful. Having a counsellor who is able to connect with youth “someone who would listen...not talk over me and give me information that actually makes sense. Someone that can help me get through dealing with stresses and anxieties.”

Ensure the physical environment is more casual, flexible and not enclosed. Meet with clients in a
more relaxed atmosphere that is more comfortable for them such as, their home or at a café. More handholding support in a psychiatrist’s office and more in-school counselling is needed.

- **Funding recreational facilities and supports build social skills and self-confidence. (44%)** Have affordable recreational activities other than movies, WiFi X boxes in coffee houses, more skateboarding facilities, drumming, music venues and government support to promote local bands. Have sports subsidies for expensive sports such as hockey; programs to introduce different sports – “soccer for 1 week, something else a 2nd week, etc.”; ju jitsu, thai boxing, kickboxing and self-defence. Musical programs allow for “learning business, how to operate the system, making friends, doing stuff for the community….it’s really social and it just builds confidence.”

- **Vocational, educational programs and supports (44%).** Some youth are restricted by resources to attend college or there may be a lack of local college programs. Specialized courses such as, esthetics and make-up; sewing and fashion design; art mediums such as, blown glass and vinyl art; modeling and acting, help build confidence and self-esteem. Through courses in modeling and acting, one youth is more confident and “able to speak out and read in front of people”. Having support in applying for college and completing OSAP forms would be helpful. Application fees should not be charged. “...should not have to pay to apply to a college, ...got bursary from CAS...all got used...making application to...college...I’m applying to OSAP so I can pay my rent...School is very expensive; it can be very discouraging...If there was more help and support for that it would be good.”

- **Health and safety education (44%).** This includes First Aid and CPR, MH First Aid (knowing what to do in crisis and what services to access), healthy lifestyles group and anti-bullying. Sexual health education would include holding sexual identity workshops and sexual health education to begin in elementary school.

- **Housing (33%)** Finding and paying for housing. Quicker access to housing – was on the wait list for 6 months. No emergency housing for young people in Belleville. “Couch surfing doesn’t really set up routine structure.”

More services and supports that would help youth succeed:
- Transportation – having someone to drive to and from appointments and interviews
- More financial help for families and youth
- More support for LGBTQ – tried to start a Gay Spirit Alliance in school but was not allowed
- Giving oneself more time to explore interests and in deciding what post-secondary school to attend

**How to Support a Friend who is Hesitant to Get Help:**
- **Ask for help (56%).** Direct someone to an appropriate resource that can assist them. Suggest calling CMH. Text # to answer questions. Text is the preferred means of getting help among youth. Most do not like talking to people. Texting is simpler and anonymous. “It’s quick, discreet...Almost everything that teens do nowadays runs around their cell phones.” Texts can be quickly deleted or saved and more frequently used than Facebook.
• **Ask questions and get them talking (44%).** Ask if they need help. Talk, get them to disclose their feelings, and help to determine what is going on.

• **Support them and ask for help (22%).** Talk to them, find out what is going on, and provide them with information and resources that can help. Accompany them to the school counsellor to hear what options are available and what services can help them. “Being there...made her feel comfortable...she knew...she didn’t have to do all the talking... The conversation can be started and the other person would not be alone. “I love that I can sit there and feel that things can get better for you and I’ll come with you because I’ve been there.”

**Experiences that can be improved:**

• The Health Unit is not approachable. It is very awkward for youth to access help related to birth control. They ask very personal questions.

• In-patient psychiatric nurses at Hotel-Dieu were not helpful when youth with a borderline personality felt the urge to inflict self-harm. The nurses would not intervene “you try to talk to them about a problem and they shut you down...because you’re going to talk negative...that’s the point...I need to talk about it or else I’m going to [do] something seriously detrimental to my health.”
APPENDIX II: MENTAL HEALTH AND ADDICTIONS AGENCIES ON-LINE SURVEY FINDINGS

In total, 14 agencies within the SE LHIN participated in the on-line survey conducted via Survey Monkey mainly between March 9th and April 6th, 2012. Agencies included children's mental health services (4), adult mental health services (4), adult mental health and addictions (1), youth services (1), and addictions services (4).

The objectives were:
- to determine the number of youth 15 to 19 being served
- to identify what youth services were needed and available
- to obtain a snapshot of the transition process
- to assess the demand for mental health and addiction services

Methodology:
Only one person from each agency completed the on-line survey. The one integrated agency completed two surveys—one pertaining to mental health and the other to addictions. Youth services were classified under adult mental health. For the purpose of tabulation, there were 6 adult mental health, 4 children’s mental health and 5 addictions agencies. As a result, the aggregate percentages are based on 15 respondents.

Numbers and referrals:
- Agencies with in-school programs had the highest current number of youth being served.

Adult Mental Health Services (6 agencies):
- Estimated at 273, adult mental health services had the lowest current number of youth aged 16 to 19 being served within the SE LHIN. Those aged 20 to 24 (est. 353) representing 56% of all youth clients was the majority group being served. The lower numbers of youth may be reflective of an adult system that only accepts youth with a diagnosed moderate or serious mental illness. It is interesting to note that agencies that have in-school counsellors (youth services and a MH&A agency) accounted for 69% of youth being served.
- Of total referrals to adult mental health, the most frequently mentioned referrals were children’s mental health (67%) and independent family physicians (67%). When prompted to provide the top 3 referrals, the aggregate responses were high schools, family and self, each cited by 33% of adult agencies. The top 3 referrals varied greatly by agency. The top 3 referrals accounted for an average of 83% of all referrals, with a low of 75% in Leeds & Grenville (L&G) and in Hastings Prince Edward (HPE) Youth to a high of 95% in HPE Adult.

Children’s mental health services (4 agencies):
- Children’s mental health served a higher number of youth than adult mental health. There were 388 youth aged 15 to 18 being served within the SE LHIN.
- For youth leaving the system, referrals were diverse indicating that youth require a myriad of services. Of total out-referrals, the most frequently mentioned, each by 50% of children’s agencies included: adult MH, addictions, MH outpatient, Crisis Intervention, Early Psychosis, primary care, justice and employment services, shelters and Ontario Works. When prompted to provide the top 3 referrals, adult MH was cited by 75% of children’s agencies, addictions (50%), MH outpatient (50%), youth services (50%), and supportive housing (50%). The top 3 referrals accounted for an average of 52% of all referrals, with a low of 10% in Lanark to a high of 75% in HPE.
Addictions services (5 agencies):

- Addictions had the highest current number of youth aged 15 to 24 being served with approximately 1,349 within the SE LHIN due primarily to two agencies (Frontenac & L & A) being represented in high schools.
- Of total referrals to addictions, children’s mental health, family, and self were mentioned by 100% of respondents, followed by high schools (80%) and justice-probations (80%). When prompted to provide the top 3 referrals, justice-probation and family were cited by 80%, respectively.
- Of total out-referrals, most frequent mentions were employment services (80%), followed by adult mental health (60%), Early Psychosis (60%), community health centre (60%) and shelters (60%). Adult mental health was reported as the highest top 3 referral by 80%.

Youth Services:

- Eighty-three (83%) of AMHS, 80% of addictions and over 50% of an integrated MH&A agency have counsellors trained or specialized in working with youth.
- Top services requested by youth were mental health clinical counselling (80%), employment, skills and support (73%).
- Top services requested by others were mental health clinical counselling (80%), supportive counselling for youth and families (73%), and systems navigation (73%).
- Services specifically for transitional aged youth are limited within adult mental health and addictions. Sixty percent (60%) of addictions and at least 33% of AMHS noted that they do not have specific youth services. Anecdotally, the AMHS percentage could be higher as some agencies reported that their services can also be accessed by youth aged 16 and over.
- Most prevalent services specific to youth were mental health clinical and supportive counselling, both at 73%.
- Prevalent services for youth within the community were primary health care (93%), justice and support (87%), mental health clinical counselling (80%) and employment (80%).
- Services least available for youth within the community were intangible skills supports to empower youth such as youth engagement, links to advocacy, and mentoring and peer support. Other critical services included shelter and independent housing.

Transitions and processes:

- Youth transitions are not tracked. The number of youth transitions was estimated.
- Only 23% of agencies have a written policy, tools or guidelines to help with the process of transition.
- Average length of stay on the agency’s wait list within the adult sector is 8 weeks.
- Average number of days between the first call and the first appointment within addictions is 7 days.
- One year prior (33%) garnered the highest responses as being the ideal time to initiate the transition.
- The majority (86%) of agencies that transition youth planned a meeting to initiate and prepare youth.
- All agencies (100%) involved youth in decisions about meeting their needs.
- Over half (54%) stated that a meeting is planned with the current and new counsellor, and the client.
- Thirty-eight percent (38%) reported that a meeting is planned only if it is requested by the client.
- Highest incidences of collaborative activities were: decision-making between agencies (69%); follow-up if transition has not occurred or there were problems (62%); and with other teams/professionals (54%).
- Only one agency or 14% of addictions and children’s mental health agencies conducted follow-ups after the client transitions.

Addiction agencies who serve in-school youth tend to have more collaborative frameworks in place. These agencies tend to serve a higher youth clientele and may anecdotally transition more youth.

**Awareness and Knowledge of Youth Services:**
- Service providers thought youth and families’ awareness and knowledge was low. They perceived health care providers’ awareness to be average and knowledge to be low.
- Perceptions of each group’s awareness and knowledge were lowest among children’s mental health service providers.

There is a strong need to broaden awareness and knowledge of services available for youth through communication and education with health care and service providers, youth and their families.

**Demand for Mental Health & Addiction Services:**
- Most (87%) perceived an increase in demand in the last few years and in the next few years.
- Based on responses, the increase in demand is due mainly to increased awareness (35%), decrease in stigma (22%), socio-economic factors (13%) and drug dependency (13%).

  “Growing awareness of the need for support... that it is a free service.”
  “...social media presence.”
  “Increased awareness of MH&A provincial focus and better understanding of the importance of early intervention.”
  “Destigmatization allows individuals with MH&A issues to be more receptive in asking for help.”
  “Limited family income, no emergency housing, low socio-economic growth, increased pressures on youth to leave home after high school, lack of jobs” “not addressing fundamental socio-economic issues that contribute to drug misuse.”
  “Drug dependencies” “OxyContin unavailability” “Society use of drugs has become more active...”
APPENDIX III: MENTAL HEALTH & ADDICTIONS AGENCIES QUALITATIVE RESEARCH FINDINGS

The following provides a summary of the aggregate findings of the qualitative interviews and focus group core questions. The percentages listed are based on the 15 respondents comprising of the 14 MH&A agencies and the Child and Adolescent Psychiatric Clinic.

The findings have been organized by service gaps, barriers, challenges, the current transition process, transitional services that are working well, transitional services working less well and how to improve, lessons learned and emergent framework ideas.

1. SERVICE GAPS

A. Youth Coordinated Services, Support and Engagement (80%)

First and foremost, youth are transitioning into adulthood – considering educational/vocational options, striving to be independent, developing relationships and so forth. Age appropriate services and supports can provide guidance in developing a stable foundation that will help youth better manage their emotions and behaviours over the long-term, thus reducing their need for greater resources in the future. The following age appropriate services and supports could provide that guidance in developing a solid foundation:

- Holistic case management in establishing goals, connecting to resources and helping youth to be organized and mindful of appointments.
- Top needs for individuals with addictions were employment, social isolation, interpersonal problems and school.
- Supportive counselling for youth over 18 who need to talk to someone about relevant issues such as relationships, sexuality, peer pressure, substance use, staying in school, etc. “There’s been this subtle process of helping them to be stronger about managing the issues that make them vulnerable... We try to empower them ... give them coping skills and tools.”
- Informal supports for families and friends “tools to... keep themselves calm when dealing with a situation”
- Affordable, age appropriate social and recreational activities.
- Opportunities for employment and post-secondary education and support.
- Life skills. Among those missing life skills are some youth from wraparound with 5th to 7th developmental percentiles (missing basic life skills).
- Trusteeship (indicated by L & A).

As a group, youth are hard to engage; their inclination to access services readily, where and when it is convenient for them needs to be recognized. Having coordinated services where youth congregate would make access easier. Counsellors are needed in all high schools, rural offices and supportive housing. Youth focused addictions and drop-ins must be geared to high school aged youth. Young people may proclaim independence but can still be vulnerable. All services that youth may access such as AMHS, housing, shelters, court diversion and employment need to offer guidance and hand-holding support to ensure their transition success.
The adult MH&A systems still lack youth-focused programming and wraparound services. “Some youth need supports to keep them stable, bridge the gaps and move them forward. These services are needed, not medication.” Some adult providers require knowledge of how to engage and connect with youth. Youth are not comfortable participating in adult groups or living in adult supported housing with 40 to 50 year olds.

Engagement is needed with youth who are not in school or without support. It is important to determine how these youth can access services – addictions counsellor appointments at the youth shelter, and street level mental health workers to engage marginalized youth. In some areas, there is a lack of engagement and preparation in youth transition planning. “The adult system is not youth friendly.”

B. Community Clinical Counselling, Specialized Services for Those with Moderate MH Issues (60%)

Services are lacking for those who need a mid-range of mental health services and supports. Youth over 18, who do not qualify for AMHS or do not have a diagnosis, have limited access to free clinical counselling.

This group includes those with:
- Emotional and conduct disorders
- General anxiety and Aspergers
- Reactive depression who have difficulty coping with life stress and may be suicidal
- 5th to 7th developmental percentile who need a lot of support
- No familial support
- Parents who have trauma issues and if provided with proper support, could have a positive familial impact

K3C in Kingston offers counselling on a sliding scale; welfare may pay for a portion. Some private counselling services may also provide a similar sliding scale. Awareness of the cost structures is very low.

Access to specialized services and counselling for eating, mood and complex behavioural disorders should be increased. Likewise, community service programs for complex behavioural issues and play therapy need to be provided. There is a lack of resources within the adult psychiatric system for Autism Spectrum Disorders. Experts are concerned that AMHS are not ready for the capacity and the varying needs and complexities.

Greater access to clinical services is also needed in the adult system. Having FTE youth counsellors would better serve their in-school clientele instead of operating like a crisis service as is the situation currently with part-time staff in L & A. More AMHS counsellors would help reduce the wait times in Lanark (for individual counselling - 8 to 12 months) and L & A (for intensive psychotherapy - up to 6 months).

C. Additional Psychiatric Resources (60%)

Psychiatric services are needed for assessment, diagnosis and treatment. Access to services is hindered by capacity limits in adult services, especially in Lanark (3 months) and in L & A (6 to 8 weeks). In L & A
adult services, in-school clients who are under 18 do not have access to a Psychiatrist. Access is needed for those with Serious Mental Illness (SMI), forensic assessment, concurrent disorders, as well as in supportive housing and schools (Lanark). A diagnosis is needed to access adult services, but clients may not have the ability to pay for it. There are limited resources around clinical access to diagnosis and best practice treatment for dialectical behavior therapy for individuals with personality and some conduct disorders. Some Family Physicians need psychiatric expertise and support with medication for complex SMI clients.

The need for adolescent psychiatry is more acute with limited access in the adult sector. This specialized service has a better understanding of youth issues and the ability to work with youth and their families during the transition into adulthood.

There is a lack of resources within the adult psychiatric system for Autism Spectrum Disorders. Experts are concerned that AMHS are not ready for the capacity and the varying needs and complexities.

D. Additional Addictions Services (40%)
Access to local residential treatment and detox for youth is required. There are no residential facilities between Toronto and Ottawa. Motivating youth to engage in treatment is a huge step; the distance is a major deterrent. A 6-month wait time for an OHIP bed is an impediment; youth will often back out. The adult Detox in Kingston is “a tough place and not youth oriented.”

Access to more diagnostic and specialty addictions services is needed for concurrent, conduct and disorders other than moderate to severe psychosis and personality. The latter may present as a personality disorder or co-morbid addictions.

E. Psychological and Family Physician Services (20%)
- Access to more psychologists (L&G and Lanark).
- Shortage of Family Physicians in Lanark; clients released from in-patient care need to be followed by Family Physicians.

F. Age Appropriate, Supportive and Emergency Housing (53%)
There is a lack of affordable housing for youth. Transition homes, supportive housing in rural centres and for young men in L & G, as well as housing with supportive services for violence prone youth, are needed. “If a kid is really violent...who’s going to take them? I would not take them because I do not have a facility that I feel that the client or my staff could be safe in. Whose responsibility is it?” Youth shelters with support services are needed in Lanark, L & A and H-PE. A comprehensive behavior treatment home with 24/7 monitoring for youth that is not attached to CAS or justice is needed in Lanark.

G. Education, Prevention and Awareness (47%)
Youth and their families, service and care providers would benefit from a better understanding, prevention and increased awareness of MH&A issues, facets, services and supports. Proposed strategies include:
- Early education and preventative health promotions should begin in-school as early as grade 6.
Suicide awareness, prevention and intervention for transitional aged youth.
Cross-sector collaboration and the use of new media are necessary to reach youth.
MH&A services’ awareness aimed at primary care and in-school teachers and counsellors.
Concurrent disorder education for non-MH&A service providers to recognize the complexities and how each component feeds into the other.
Education around the complexities of those with MH, addictions and developmental disability.
Psycho-education on substance use as a prevention strategy to avert potential criminal offences.
There are no prevention programs available to high risk youth who have not committed an offence.

“Dr. Rob Rowe, a psychologist has developed a proposal on prevention to intervene but has not been granted funding... need to break through barriers to reach high-risk-to-offend youth that have ongoing mental health issues.”

H. Transportation (27%)
The lack of transportation in rural areas limits access to needed services and supports for youth.

I. Transition Age Overlap (13%)
Some adult outpatient agencies are reluctant to accept patients until their 18th birthday. As well, those with a dual diagnosis cannot access ODSP until their 18th birthday. Unless they are under Extended Care and Maintenance (ECM), there is a 2 year gap for CAS youth aged 16 to 18, where they have difficulty accessing needed services. When testing is required to access services, who pays?

It would appear that they way the systems have been set up, youth who are vulnerable, and need the services the most, are not able to access the help that they deserve. An overlap of at least one year would be beneficial in planning and coordinating the transition process between systems.

2. BARRIERS

A. Lack of Communication and Differences in Ministerial Culture (60%)
Ministries operate in silos and do not communicate with one another. Different ministries and systems need to better understand each other’s roles and differences. The differences make connections difficult. “What does each sector do for clients to ensure those needing care do not fall through the cracks?” The Ministry of Child and Youth Services (MCYS), Ministry of Health and Long-Term Care (MOHLTC), Ministry of Education (MEd) and Ministry of Community and Social Services (MCSS) need to actively collaborate to facilitate solutions based on connection points. Often, Ministries do not have the same geographic boundaries. Services could be viewed holistically through a centralized intake system. There is also an opportunity to streamline assessment tools.

Agencies lack information of one another and need to foster better communication with each other. Better communication is needed between agencies, schools and hospitals to determine what resources are available, where in the community, and who provides what; how resources can be available for each agency for identified service gaps, such as conduct youth, and avoid duplication of services. There is “a responsibility to navigate the client into services they need.” Front-line staff in the children’s system may not know who their adult counterpart workers are.
“Barriers can be addressed with close collaboration, clear understanding of each agency’s mandate, scope of practice...and not feeling like you are being dumped on...knowledge of each others’ strengths and weaknesses is necessary.”

The mandate and culture between CMH and AMH are significantly different. Systems and approaches to care differ. CMH services focus on the client and family with a referral criterion that captures anyone who needs help and has mental health issues. Wraparound, clinical and youth-friendly services are provided. Services for AMH focus on the individual with more restrictive criteria. If clients are not proactive in advocating for service, they may not receive support. In some adult agencies, only case management services are offered. One system is client-centred; the other is systems-centred. This is the result of the mandate and requirement differences of the two Ministries, MCYS and MOHLTC.

“The policy piece is missing. We have great anxiety about [youth] being not received in a system that’s going to really work for them. Twenty (20) years on, we can safely predict that a good percentage of them will struggle with addictions and more intense MH issues. By then, they will be eligible for those services and bring their children to CMH. It becomes generational and we can see that trajectory."

Clarity of Ministry criteria would create less confusion among agencies and clients. One Ministry requires a diagnosis, while its agencies have varying criteria; this mandate may be shifting within some agencies to include those with moderate MH issues. Sometimes, there is conflicting information within the same AMH agency to the degree that their CMH provider understood that only those with Serious Mental Illness (SMIs) would receive service. Even when an AMH agency specifies that services are provided to individuals with diagnosed moderate to severe mental illness, their CMH counterpart perceives major cultural differences and service gaps imprinting that those with moderate mental health issues are not adequately served. Is a diagnosis of SMI required? “What is true and is this the same throughout SE Ontario? ...confusing for staff, how confusing is this for the client?”

Separation of funding makes programming and age group flexibility between agencies difficult. Hospital-based child psychiatry programs usually get bypassed by MCYS in favour of funding community-based programs. An adult agency stated it would be helpful if a 15 or 16 year old could be offered a spot in an AMH&A group program and continue to have individual counselling with their current children’s counsellor.

“In a perfect world...I don’t think it’s necessarily best serving youth to be completely transitioned to another agency...if you’re working with a client, built a relationship...they fit within your age range...why not have them access another agency’s education and experience.”

Internal MH&A resources are not integrated for concurrent disorders at an AMH&A agency. IT systems are different between an internal Addictions and MH resources regarding concurrent disorders. Co-location, internal collaboration with MH counterpart in the treatment process, and MH case managers having the opportunity to attend appointments, would make it easier to develop relationships, keep up-to-date and be really beneficial for the client.
B. Transportation (60%)
There is a lack of public transportation particularly in rural areas. In some instances, case workers would pick up and drive clients from rural areas. Even when public transportation exists, MH counsellors would drive select clients to ensure that they keep their appointments with other agencies. This places a challenge on limited resources needed for counselling.

C. Systems-Centred, not Client-Centred (40%)
The AMH system is set-up in a way that if potential clients do not meet its criteria, they would not receive services. In comparison, CMH has developed comprehensive services to strive to meet the needs of anyone with a mental health issue. Youth over the age of 18, who need mental health services, should be able to access community services whether they are transitioning between systems or not; they should not need to know or encounter system processes or restrictions.

Due to system restrictions, access to services between organizations and the integration of services are hindered. Systems are incredibly complex on both a systemic and operational level. A generic approach with some flexibility would create a more seamless service. Parents of some CMH clients who have experienced significant trauma would benefit from AMH services but parents must have a diagnosed mental illness to access services. Part-time psychiatrists funded by an AMH&A integrated service cannot consult with clients under 18. If a client has their own independent family physician, there is an inability to access social worker services at Community Health Centres (CHCs) and Family Health Teams (FHTs). A psychiatric assessment would not work in Developmental Services; only a psychological assessment would be accepted.

“It’s enormously frustrating that youth clients under 18 cannot access a psychiatrist in-house and have to go outside for service.”

There is a lack of youth-centred services and strategies within AMH&A services. The mandate of AMH&A services include transitional aged youth 16 to 24. Youth as a group need to be recognized as a unique client demographic with different priorities and issues that include life skills, educational and vocational pursuits, job readiness skills, substance use and healthy relationships. Services and strategies are needed to engage and guide this client population through a comprehensive life domain plan to support them. There is a need to contemporize the approach to successfully engage youth via social media. Meeting youth where they are comfortable with less stigma such as at school, at home or in a café, would also be helpful.

D. Limited Resources (27%)
Additional AMH&A counsellors and increased funding is needed to increase access, reduce lengthy wait lists, and transition youth in a planned process. Transporting youth can be a time-consuming process for MH&A counsellors, especially transitioning youth from one organization to another. Counsellors have very little spare time and access to counselling is often delayed.
E. Housing (27%)
More affordable, safe and youth appropriate housing is needed. This includes supportive, transitional and emergency housing.

F. Socio-Economic (20%)
- Poverty, marginalization, generational mental illness, addictions, incarcerations and unemployment.

G. Other Barriers (20%)
- The developmentally delayed are not identified in the education system.
- Stigma – clients do not want to acknowledge MH illness; “Children’s Mental Health” and “Adult Mental Health” are stigmatizing.
- Where services do not exist in AMH, youth are referred to their family physician (FP). Training is inadequate for FP to manage non-complex behavioural or emotional disorders.

3. CHALLENGES

A. Systems’ Limitations and the Need for Flexibility (47%)
Cultural differences and fragmentation of services restrict access. There are inherent cultural challenges in working around the differences of the two systems – CMH and AMH. The lack of youth-specific programming in AMH&A creates challenges, including those to avert potential criminal behaviours. Systems require different assessments, such as between MCYS and MOHLTC and for those with dual diagnosis between MCSS and MOHLTC. There is fragmentation of services between agencies with limited community services for youth with conduct and autism spectrum disorders in the adult system. For these youth, AMH do not have the right type of services; they need a team intervention approach with case management. “For some of our patients like the Autism disorders, it is with a trembling heart that we transfer to AMH.”

Children’s and youth services are not aware of other community services that youth can be transitioned to without a diagnosis or how to transition youth with disorders not covered by AMHS. Although access to supportive counselling may be limited, CHCs and FHTs offer a viable option for those with mild to moderate mental health issues.

Clear criteria, flexibility and a good attitude would help providers and clients navigate the system within AMH. Providers should not have to make more than 2 phone calls to be connected to the right person. “If the baton gets passed to you, you have to grab it...you can’t say, no sorry, I’m the wrong guy.”

There are challenges due to resource limitations. Due to gaps in psychiatric services, CMHS have a limited ability to conduct comprehensive psychiatric assessments. Due to the lack of essential services such as housing, transportation and recreational activities, the need to collaborate and better coordinate in rural areas is greater; challenges may occur where there is resistance to proposed solutions with community residents. Increased community resources for the most vulnerable population would reduce unnecessary use of hospital ER or inpatient services. Some L&G youth attend counselling sessions at their Lanark schools but would not be able to access family therapy in Lanark.
B. Catering to Youth (40%)
When transitioning, youth may resist change. Their counsellor would utilize their therapeutic relationship to break down obstacles where possible. Youth tend to live in the moment and may not show up for appointments. If youth are no longer in crisis, they assume that they do not need service. It becomes an issue if they think MH services are a quick fix but they really need long-term support. There is a high attrition rate with youth during triage and while on the wait list. Often, youth do not have a landline telephone and it can be a challenge to maintain contact. “We can lose over 50% of youth if we cannot contact them.”

C. Lack of Protocols and Managing Clinical Relationship Change (40%)
The lack of protocols can make it challenging if workers do not know what to do or who needs to be involved, or where to take the youth. Managing the client’s anxiety during a period of change can be challenging. Youth may be apprehensive of meeting a new counsellor and think they might not need counselling. Joint sessions with the current and new counsellor are needed to instill trust and confidence in the new service for the client. Coordination and collaboration among providers and possibly other community partners are needed to support youth through the transition. There is referral uncertainty when a 17½ year old accesses MH services for the first time due to wait lists and determining the most appropriate services – children’s or adult? CMH is more flexible and might not need a diagnosis.

“...the clinical relationship would still be the biggest challenge. The time has to be right... how do we help that youth to develop trust in a new counsellor and how can we support the new counsellor in instilling trust in the youth. The most important aspect of [the] intervention is the relationship.”

There is a need for a dedicated “go to” person to help navigate the array of services and the adult system. For the latter, it would be a resource person to either take cases forward or facilitate connections for CMH to move cases forward. For example, the person would speak with adult providers regarding parents who have MH needs and work together regarding family issues.

“The biggest challenge is there is no responsible person, service or array of services to navigate and figure out how to get support. There is no infrastructure. Right now, the navigator is the person with the lived experience to try to find out what they need. The children’s system does it better.”

D. Parental Issues and Resistance (33%)
Parent MH issues are sometimes at the root of a youth’s behaviour and difficulties. Generational addictions, unemployment and marginalization contribute to the situation. Parents tend to resist getting help for themselves. “It’s not about me, it’s about my kid.” Some clients and families do not follow through or follow-up.

E. Communication (27%)
Lack of optimal communication among care providers. Better collaboration amongst agencies, follow-up interagency communication with consent, would facilitate a more comprehensive process for sharing client information. The lack of understanding and coordination regarding services makes it difficult to
ensure clients receive the care they need. “…would not know AMH processes. In bridging the gap, would not know who we should talk to first.” “In the adult domain, there is a paucity of information about who does what, how and where.”

When accepting youth from another organization, a standardized process to provide pertinent information would be helpful as there are differences in charting.

F. Other (20%)
- Reluctance to provide diagnosis due to stigma; sometimes it prevents the transition.
- People do not want to be identified as needing MH services due to fear of being labeled.
- Time challenge due to the volume of clients and turnover of front-line workers; transition process takes time.
- Service processes may be implemented differently in each school, creating additional challenges.

The following sections provide detailed information on the current transition processes, what’s working and not working well, lessons learned and emergent framework ideas. The percentages listed below are based on 13 respondents or agencies, excluding the 2 addictions agencies that do not transition youth.

4. CURRENT TRANSITION PROCESS
A. Current Transition Processes Can Be Improved.
Providing services are available within community agencies, the youth transition process ranges from ad hoc to semi-formal. Youth transitions work better in some regions than others but all can be improved upon. Adult services in L & A and L & G do not require a diagnosis for service. For Lanark, clients do not require a formal diagnosis, but a request for a diagnosis may be required. Consent must be obtained from the youth to initiate referrals and the exchange of information with another agency. The transition process would often be based on what the client prefers.

In Hastings-Prince Edward, Youth (Youthab) services are in a unique position within the SE LHIN with integrated MH counselling, housing and employment services. Youth transitions with CAS have improved and the process is established for those transitioning into housing. Clients are accompanied by their worker and given a tour of the Transition Home, the rules are explained and services are voluntary. If the client is interested, an assessment would be done. Clients are accompanied to new services. The Transition Home and co-op housing offer ongoing guidance and support for youth. The current worker is also invited to attend regular interdisciplinary clinical team meetings at the Transition Home to keep informed of issues in their client’s life. There are very few actual transitions from CMH services to youth services. There is no established process within AMH with infrequent referrals from CMH and Youth services. Given the tight knit service community and collaborative relationships that are in place, the infrequent referrals are surprising. CMH and AMH are located in the same building which could facilitate communication and may enhance opportunities for youth transitions. Addictions services coordinate services with other community providers but do not transition youth.

In Lennox & Addington, youth transitions are informal, flexible and mainly internal, from high schools to integrated MH&A services. A diagnosis is not required, services attempt to address all MH needs. Case consults occur with the current and the new counsellors and the client is encouraged to attend.
Counsellors look for the best fit; for example, if there are criminal charges, a criminal justice case manager may be involved. A plan is then developed for the transitioning youth. With occasional transitions from children’s services, youth would be connected to a community support worker and to needed adult services. Consultations with children’s services occur regularly in high schools.

In Frontenac, AMH do their best with CMH to try to build overlapping resources around client needs but there are no focused services and programs for TAY. Youth transitions have been mainly ad hoc and can be a complex “don’t fit me” systems’ rigidity with a lack of communication. Transition referrals may be routed through 2 to 3 levels of coordinated access. After an assessment, if the individual did not appear to fit into the services that are being offered, the referral would be denied. Counsellors within the children’s system would often not know who to contact at AMH in transitioning youth. From CMH’s perspective, Frontenac clients would need to have all necessary information and diagnosis in advance as AMH would not be expected to assist youth to obtain the diagnosis. In contrast, “AMH&A in L & A is more flexible, meets more often, is accessible in getting through the door without the full requirements/package. It’s a less intimidating process and [they] are more willing to figure out the diagnosis piece with the client.” There is a lack of communication and differences in perception. In reality, AMH has the flexibility to approach the mobile crisis team to obtain a diagnosis. Clinical counselling is also offered within AMH.

Addictions in Frontenac have informal processes for the transitioning of youth. Counsellors collaborate to ensure youth are comfortable with services and the new worker. Youth are often accompanied by their current worker to the initial intake meeting for support. When youth are connected to their new counsellor, their current worker stays involved. Counsellors work together until youth are ready to move into the new system. Adult addictions in Frontenac would facilitate the process if youth wanted their family to be involved.

In Leeds & Grenville, youth transitions were initiated between CMH and AMH as a result of this project. The AMH service is open to anyone with a mental health issue who needs help. Processes are being established and refined on an experiential basis. Protocols have since been formalized. There are dedicated transition workers, one at each agency. The initial pilot process included an orientation meeting with both workers and the CMH psychologist to understand roles and what services can be provided. One to two case consult meetings may occur with the transition worker at the new agency, family, current worker and manager. Recommendations are shared, available programs and services are reviewed, and discussions on how they can assist with life skills, vocational planning and so on are held. A follow-up evaluation may include meetings with program directors from both agencies to keep everyone informed, to monitor the transitioning and ensure its success.

Lanark has the benefit of addictions, children’s and adult mental health services being co-located, making it easier to build collaborative relationships. AMH serves youth with moderate to severe mental illnesses, and may require a diagnosis. The referral process is initiated at age 17 for youth who are stable, and earlier for those who have more complex needs. CMH can accompany clients to their intake appointment and provide information at the weekly AMH triage. Regular meetings and case conferences with both workers are scheduled as required, dependent on the needs of the youth. The
CMH worker stays engaged with the youth until the latter is connected to the AMH service. Addictions services in L&G and Lanark do not transition youth.

For the Youth & Adolescent Psychiatric Clinic, transitions are seamless for First Episode Psychosis and Personality Disorder services. Referrals provide an explanation of why patients need ongoing follow-up service in adult psychiatry. The recipient service would connect with the patient for intake and an assessment. A written report of the process would be sent to the originating service. If patients have transitioned prior to their 18th birthday but need admission, they would be admitted to the adolescent ward and their treatment team would provide follow-up. There is an effort in process to try to provide a similar service for youth with mood and anxiety disorders.

**Typical Transition Processes Include:**

- The transition process begins with a referral anywhere from 6 months prior to the youth’s 17th birthday.
- Counsellors may broach the subject of turning 18, prepare and consult with youth and family, if involved.
- Documentation and diagnosis would be obtained with consent. The process varies by client needs, readiness and agency.
- The process would often be based on what the client prefers. Counsellors meet with youth to discuss how they would, with consent, like the agency to facilitate the referral.
- Counsellors can call the other agency on behalf of the client, set-up the intake appointment, share information with consent, and accompany the client to the initial intake for support. Counsellors would follow-through to ensure the interview occurred if they are not attending.
- If youth are comfortable in making the call to the contact person at the adult agency, attending the first intake meeting or first appointment on their own, they would be encouraged to do so.
- There may also be regular transfer meetings and case conferences. Workers at both agencies collaborate until an adult counsellor can be assigned.
- The case worker could meet with the new agency but this does not always happen.
- During the bridging overlap, the CMH worker can stay engaged with youth until they have been assigned a counsellor at their new agency.
- In addictions, there is usually a lot of trepidation with a new counsellor. Sometimes, more effort is needed or there could be a personality clash. As a result, counsellors collaborate first to ensure youth are comfortable with the services and the new counsellor.
- One CMH agency facilitates the transition of youth without familial supports by forming a wraparound team as well as natural supports.
- Follow-up after the transition depends on the youth and varies by agency. An agency might advocate on youth’s behalf at their request. The counsellor might provide extra support to see them through. In some cases, client follow-up would not occur unless it is requested.

**Transition specifics within the adult system:**

Services in Lanark and H-PE use a triage and priority system to manage referrals. Priority of service is determined on a weekly basis.
B. Protocols Are Being Updated to Include Transitions Between Organizations.

CMH and AMH in L & G have developed protocols for the transitioning of youth. Youth addictions in Frontenac have written protocols with youth justice and AMHS in two counties on where and how to transition clients with each person’s responsibility defined in a Memorandum of Understanding (MOU) format. Within addictions in Frontenac, the process is less formal. In H-PE, AMH’s protocols with CMH include some provisions for youth transitioning such as, setting up meetings between two agencies if the case is complex and taking on ad hoc moderate cases.

Agency protocols may need to be updated to include transitions from one organization to another. Protocols and service agreements are only helpful when they are actually being used. They may be shelved by some agencies.

C. Youth Currently Drive the Decision-Making Process (77%)

The process is client-centred and decisions are made collaboratively with the client. In ongoing casework, probing includes what is working and not working, what have they liked and not liked. Youth are engaged in how they would like to proceed and how they can achieve their goals. Based on knowledge and collaborative relationships, front-line workers would try to match the client’s needs to the most suitable organization and services. Youth are more likely to be engaged and follow-through if they want counselling.

D. Youth are Engaged in Relationship Building and Goal-Setting (54%)

Youth are engaged in a client-centred conversation. If they could have anything, what would it be? Probing is conducted to identify their goals, what might be helpful, and how to achieve them. The better the therapeutic relationship, the more comfortable the client feels. Counsellors coach self-advocacy and empower youth to be in charge of ongoing treatment needs.

“Degree of engagement depends on how much trust youth have in a counsellor...believing that they can get stuff done.”

E. Adult Wait Lists Are Shortest for Addictions, MH in Frontenac and L & G and Longest in Lanark

Fifty-percent (50%) of AMH agencies triage their cases on a weekly basis with two-thirds using a priority system, which could mean that moderate cases may not move much. For youth services, the wait list is managed by date on a first come, first serve basis. In Frontenac, those leaving the hospitals and crisis are offered case management services for 8 weeks with no wait list. Those who are not ready to transition from case management to ACTT to recovery would be integrated into a community of wellness, such as, volunteerism, spirituality, employment, vocational and education. These services and supports create flow and movement into recovery. ‘Do not have a wait list in case management due to ‘opening the back door where there is no wrong door’.”
Length of Wait Lists:

- Frontenac does not have a wait list in crisis or transitional case management. For regular case management, the wait list can range from 3 to 9 months due to resources affected by the ebbs and flows of discharge. Addictions had less than 1 week and ACTT only had 2 people.
- Leeds & Grenville also had a very small wait list with casework and counselling being accessed within 7 days, psychiatric referral and Prescott counseling within 30 days.
- In Hastings-Prince Edward, youth services’ current wait list ranges from 4 to 6 weeks depending on the location. Recently funded by MCYS, the in-school wait list is the shortest at 2 weeks. Most clients are short-term with less than 90 days of service. AMH’s wait list ranged from 30 to 70 days.
- In Lennox & Addington, Napanee had the longest wait times at 3 and 6 months for community support and intensive psychotherapy, respectively. Crisis is next day service and addictions is 2 weeks.
- Lanark had the longest wait list ranging from 8 to 12 months for individual counselling and from 7 to 8 months for groups. Case management was 2 months while group sessions were 2 to 3 months.

5. TRANSITION SERVICES AND SUPPORTS THAT ARE WORKING WELL

The following processes are currently utilized by some agencies and have been identified as working well.

A. Relationship Building and Collaboration (85%)

Collaborative relationships facilitate a successful transition. Collaborative relationships allow for the enhancement of both agencies’ services and supports during the overlap bridging of specific youth clients. Direct counsellor-driven transitions, where youth and the other agency are prepared, work really well. Success is based on respect and well-established relationships with other agencies; and help with services as needed. “We recognize that everyone has a role to play and nobody has the resources to duplicate services. There are gray areas where we’ll support clients due to limited resources in the area and relationships.”

Communication and collaboration between clinicians and clients generate new ideas. Individual workers who engage make a difference. Early psychosis, personality disorder and addictions transitions are working well. Directors collaborate and the work is implemented by an interdisciplinary clinical team (Frontenac). Good information sharing, flexibility and a desire to ensure a successful transition facilitates the process. “Having a reliable contact that one can build trust and a relationship with over time provides stability and makes the transition easier.”

Increased communication due to relationship building helps to reduce the cracks and be kept informed of cases. Community intake workers meet and problem-solve around difficult cases. Youth-at-risk committee ensures gaps are identified. AMH nurses help with medication and education with the CMH clinician present. Collaboration evolves out of necessity in smaller communities with quicker response times.

B. Client-Centred Services (62%)

Services and supports that connect with youth and make their lives easier. Integrated youth services in MH clinical counselling, housing and employment programs and support services increase youth’s
willingness to engage and facilitate their movement (H-PE). The following processes are currently utilized by some agencies to enable the transitioning of youth:

- Pace and tailor the transition process to meet youth’s needs.
- Direct and support clients to the right services.
- Facilitate introductions by accompanying youth to meet with the new counsellor.
- Provide vocational bridging services.
- CMH remains involved with the client until a connection with the new worker or service has been established.
- MH counsellors in every high school promote convenience and confidentiality for youth.
- Parental involvement may ensure follow-through.

In smaller communities where there is co-location between CMH and AMH, youth are more likely to be hand-held to the next agency. In Bancroft, a worker can be dispatched for a same-day service call. One agency offers flexibility in scheduling and tries to accommodate families with early morning service and one evening a week until 8pm. In addition, the agency provides tailored client information packages that list resources such as mental health services, coping strategies for families, and harm reduction. (ADDS – Frontenac). Emotional support and participation in recreational activities provide stability and social interaction for youth living in community housing services. “If youth has been at the Transition Home (TH) and moved on to co-op [housing], there’s a connection... they can return to have dinner. If they are lonely, they are encouraged to come...to the TH. We have recreational programs...Co-op youth are invited...and [we] will go and get them. There is a sense of community in our housing programs in Belleville.”

C. Other (38%)

- Overlap in age 16 to 18 facilitates the transition process by allowing the time to move to another agency properly while accessing current services.
- Referrals move to an intake process within 2 weeks; issues of urgency and eligibility are reviewed.
- Non-formalized agreements between agencies work well; it would be great if they were formalized.
- Good youth homelessness strategy in Kingston; teen youth shelter works well and transitions clients wonderfully. (Frontenac)

6. TRANSITION SERVICES AND SUPPORTS WORKING LESS WELL, HOW TO IMPROVE

A. Better Transition Planning is needed. (77%)

Communication: Issues include lack of information and communication among AMH&A providers. AMH services are understood as being different but there is still uncertainty about each of their processes (Frontenac). There is a disconnect in communicating with youth and a lack of understanding with social media. Suggested solutions include:

- Understand each agency’s services, their roles and boundaries, which agency is good at doing what, how each would enhance collaboration, where they fit and how to navigate each system effectively.
- Increase education around MH&A issues with community service providers (e.g. CAS, schools, etc.) on what to do, how to work with the MH&A issues, and how to connect within their organizations.
- Clarify whether AMH provides services to youth who are not seriously mentally ill. “If they do, will they be put on a wait list because they are not a priority...?”

- Network to know each other’s systems and workers to facilitate “picking up the phone.”

- Better follow-up communication from other services to keep informed of clients.

- Manager-to-manager access to address any difficulties during negotiations without the client being stuck in the middle.

- Align with how youth communicate; workers to text youth and connect via social media.

**Coordination:**

- In complex cases, case management is not always assigned to an agency with the best fit; part-time counsellors’ time is not optimized by coordinating case conferences and follow-up (L & A).

- CMH case workers need to know how to transfer information from another agency and navigate the AMH system effectively. An example would be to have the current psychologist refer and transfer the client information directly, with written consent, to adult psychology services at the MH outpatient centre (L & G).

- North and Central Hastings CHCs and FHTs lack coordination with community services to increase capacity and access.

- If employment services are not integrated with MH&A, the latter may not be aware of summer employment service changes.

- There are many youth within CAS that could use MH, employment, transition or co-op housing services but are not referred to Youth services. CAS often purchases services privately and youth may not enter the community transition system.

**Planning:** There is a lack of youth services in the AMH&A system, making it easy for youth to slip through the cracks. Evidenced-base interventions and appropriate interdisciplinary clinical teams are needed within the adult system to facilitate recovery for mood, anxiety and autism spectrum disorders. The transitioning of youth would flow better if standardized processes were in place. Recommended strategies include:

- Make referrals early in advance of the age limit to ensure service access with the current agency while on the wait list for the new agency.

- Ideally, the client and the current worker should be present at the transition meeting along with a copy of the treatment plan.

- Develop protocols to outline who does what with each agency, how to resolve disputes and help youth connect.

- Establish an inter-agency committee to meet on specific TAY cases quarterly, determining solutions collectively.

- Include CMH, AMH and other pertinent community agencies’ clinical youth workers with the authority to navigate youth through the transition process. “This also improves the success, the chance that the linkage will actually be made and the person will follow through with the transition.” (L&G)

**More Relationship Building is Needed:** Enhance the sharing of information, best practices, and collaborate on decision-making with other service providers. Community agencies need to work...
together more often, have round table discussions at the manager operational level to resolve difficult cases. An opportunity exists to develop better relationships with addictions around youth transitioning.

**Cultural Understanding:** There is a need for ongoing information exchange between 2 culturally different systems (CMH and AMH) in the use of diagnosis, streaming and orientation to work. Staff do not know who to speak with in addressing cultural differences (Frontenac). Youth struggling to maintain their mental health do not perceive themselves as a person who has a mental illness; they do not want to be seen going to AMHS or be in the same room with mentally ill people.

“Our model is all of us have mental health vulnerabilities. There are circumstances and events that impact on what we genetically bring to the table that mean we are healthier at times and less healthy at times. That’s very different than the medical model of...we are all mentally ill and some of us are in a recovery phase. That’s a really different mindset.”

In contrast, a wellness approach focuses on health, development and how to move forward by engaging and empowering youth to manage on their own.

“There’s been a subtle process of helping them to be stronger about managing the issues that makes them vulnerable. It’s a very delicate process.”

**B. Lack of Resources (62%)**
If youth could access adult addictions programming prior to being 18 while seeing their current counsellor, this would facilitate the connection (Frontenac). Identified in some areas, supportive housing that recognizes and coordinates services for youth with untreated MH problems and employment issues would be beneficial. “Youth need to have someplace to live and meaningful work. An hour per week of counselling is not enough.” Case loads are high; there aren’t enough workers. “There isn’t a dedicated person to focus on the transition movement and we all have numbers to meet.” Issues around the lack of free counselling services in some AMH agencies for those with moderate mental health issues who do not have a diagnosis (excluding L & A, L & G), lack of housing, transportation and recreational activities make it difficult to transition. Youth services need to be enhanced; an ideal transition time into AMH would be 20 to 21 years, any signs of a long-term mental illness would become more apparent.

7. **LESSONS LEARNED** from service and support improvements for youth in transition

**A. Communication and Collaboration (77%)**
Collaborate to do what is best for the client. Service providers need to communicate with one another and move toward the goal of what is best for the client. Allow frontline staff to collaborate and use their judgment to do what is needed for the client. Have case conferences with the client and the current worker present, thus improving the chances that a linkage would actually be made and the person follows through. Have operational managers meet more often in a round table discussion, bringing difficult cases forward to problem-solve collectively.

“When things have worked smoothly, there is no turf or ego issue. Genuine will to collaborate effectively and efficiently without undermining or undercutting each other, keeping the needs of the patients’ front and center.”
Communicate, collaborate and integrate to optimize client access and flow. Collaboration is necessary for more effective use of resources and increased awareness of services. Engage with other community services to identify youth and family members-at-risk as a pre-emptive intervention.

“Based on past learning with the youth court diversion, would like to see a shared-care model using a holistic approach with an overlap of services as a 1-year pilot for some clients. Psychiatrist, client, counsellor or case worker would meet and liaise with FHT and CHC. Workers would attend the latter’s team meetings, share client lists, and accompany clients to medical appointments with consent. Family physicians would be informed and have a comprehensive overview with everyone in the loop.”

Mitigate barriers through understanding, communication and awareness. If there is not much success communicating at the front lines, move up the chain of command; initiate operational director-to-director conversations, and if required, executive director discussions. When in doubt, ask for clarification, e.g. confusion around AMHS referral criteria. Initiate memorandums of understanding (more informal than service protocols) at the operational level, thereby agencies and counsellors know how the transition process works, can support the process and work collaboratively.

“Ministries need to understand differences in both systems [CMH and AMH]. The differences make connections difficult.”

B. Service Enhancements (46%)
Services for youth and how to reach youth: Services to guide youth to develop good decision-making skills, allowing them to manage their condition throughout their lives. At 16 to 18, support or hand-holding from agency to agency would make youth feel more comfortable. Youth prefer one-on-one counselling; youth were not comfortable speaking in front of their peers at a psycho-educational school group. There is stigma and they would not want their friends to know. Service providers need to learn how to outreach and communicate with youth; how to engage them to utilize MH and substance use services. The sooner a youth can access good therapeutic interventions, the more likely they are to have a better outcome.

Family involvement and counselling: At 16, youth still need the support of their family. If the youth has significant MH issues and a very engaged family, how can they be involved and informed within AMH? “...if a truly engaged family is ...at every appointment and the youth consents ..., AMH&A would accommodate.” For some, counselling for parents would improve the mental health and well-being of their children.

Working with community partners to determine which services are more appropriate and provide the connection. For one adult agency, an array of links was developed to facilitate the re-integration process through employment, spirituality, vocational, educational and volunteerism into a community of wellness. “How clients can move from the treatment world into the well world, successfully. There’s a difference in perception when integrating into wellness versus managing illness. It is a hopeful approach...”
8. TOOLS TO ACHIEVE SUCCESSFUL TRANSITIONS

Processes to Manage Clinical Relationship Change between Systems (46%)
The following solutions have been suggested to better manage the clinical relationship change between systems.

- Supports need to be in place to instill trust in developing a new clinical relationship and to ensure youth are comfortable during the process.
- Youth and adult counsellors can facilitate and collaborate.
- A dedicated MH&A transition counsellor can provide ongoing guidance, support and intensive case management (ICM) services for youth in the AMH&A system.
- Program directors and counsellors from both agencies can review, troubleshoot and monitor to ensure a smooth transition.
- A monitoring tool used with the client and service provider could include: did the person connect, was the transition appropriate, and what can we do to ensure a smooth and seamless transition.

9. EMERGENT FRAMEWORK IDEAS

A. Client-Centred Youth Transition, Worker-to-Worker Coordinated (46%)
Dedicated transition workers, one at each agency to work collaboratively with each other and the client to identify issues, determine treatment plan and supports. Youth would stay engaged with their current counsellor until they are comfortable to continue with their new counsellor. Referrals would be directed to the youth transition worker, who would have an overview of what services are available and appropriate, act as a liaison and provide hand-holding. Ideally, one person would coordinate needed services such as housing, activities of daily living, employment and education. The transition worker could be an ICM/Counsellor who would provide a wraparound service, mirroring the work of the children’s service youth counsellor within the adult system. This person would have the flexibility to bridge and build services around the youth but also provides counselling. “Use the baton metaphor. When we pass the baton, we don’t let go until the person on the other side has a good grip. Need to establish a consistent process that ensures that this happens.” The adult worker could attend internal case conferences for youth to get to know the players, the family, and a sense of history and treatment goals. “Share the baton for awhile.” Specific youth programming within adult services would also be beneficial.

B. System/Organizational Cultural Shift (31%)
Extend current children’s mental health services to age 24 which would include youth services. TAY need wraparound services under one roof. Ensure vocational services are attached. Have an agency that provides MH, housing and employment services for youth. Provide access to nearby residential treatment with mentoring, supported housing with at least 3 spots for youth with MH needs, bridging to employment and a nurse on-site to manage medications for youth in crisis. Provide informal outreach support as clients have been conditioned to access counselling in locations where it is convenient and comfortable for them. Ideally, the youth system would be within the children’s system. Workers must want to work with youth. There would be consistency in programming if one Ministry provides funding up to age 24.
“Drop the expectation that age is the defining factor...blur those lines and build in [the] culture that...it’s okay to be flexible...whether it be 16 to 18 or 16 to 21... There are some 21 year olds that could probably be better served by children’s services...let the client go wherever they feel most comfortable with the services...almost a way to let the client [decide] in conjunction with the counsellor, what service is going to work best for them.”

There needs to be recognition that the services are in the same stream; where a client could flow seamlessly regardless of what that need may be, whether it’s a gap or a need for services – for example, those who have experienced trauma, but are not necessarily mentally ill.

“Recognition that it is best to intervene with the least intrusive services and move along a continuum where they are not perceived as having a serious mental illness [that also has] a strong stigma attached.”

C. Quality, Comprehensive Youth Service (23%)

Youth service architecture that would make any transitions invisible to youth. Services would continue for all youth from the children’s system to the youth system and then on to the adult system when they are stable and ready. Youth services would incorporate best practices in programming and engagement (Frontenac). Services would guide youth to develop decision-making skills that will enable them to better manage their conditions throughout their lives. Have youth counsellors in every high school and rural town hubs such as Picton and Bancroft, youth housing in every community and more transition homes. This model would clarify streaming of short-term youth related issues versus ongoing community service needs. “Some CAS youth could be averted from AMHS if there was a more comprehensive youth support network.”

Engage youth to create a service environment that will help them recover. Connect with youth to determine what services they need, how to communicate and outreach to youth, how to get youth to utilize mental health and substance use services. Ideally, involve youth in decision-making through outreach where youth congregate.

“They just need to have support and...be able to grow...live...play. There needs to be music, laughter, food...peers and...the use of social media.”

D. Ownership and Accountability Models (23%) Ideas include:

1. A dedicated committee with representation from each agency to discuss cases involving youth and youth transitioning.
2. Wraparound collective with a facilitator.

All models would clarify agency roles, who provides what and how. Regular reviews would determine if the framework is working or not working with accountability and responsibility from each organization. For the first model, the committee would take ownership in collaborating with others to move the transition process forward. The second model is based on collective resources to support the family and the integration of services including AMH, addictions, CAS services, family physician and primary care clinicians, public health and schools. The facilitator is wherever the entry point is and takes ownership of
the process. Thirdly, models of continuous care with interagency collaboration exist. For the latter models, governmental ministries and agencies have a responsibility to collaborate, plan and not pass the “kids” onto each other. “Everyone needs to take ownership...contribute...collaborate, be accountable and responsible.”
APPENDIX IV: COMMUNITY AGENCIES/SERVICES RESEARCH FINDINGS

In order to form the transition process framework for Transitional Aged Youth (TAY) which will be piloted in Hastings and Prince Edward Counties, interviews were conducted with 13 community-based agencies/services, along with the core Children’s and Adult Mental Health and Addictions agencies. These community-based agencies/services included police services, Children’s Aid Society, Kingston-based youth housing, primary care, Belleville General Hospital, Hastings and Prince Edward District School Board, private counselling services, youth justice and support, adult probation, and indigenous mental health and addictions services.

These agencies/services provide either direct clinical support or intervening services to youth with mental health and addictions issues. The findings have been summarized to enhance our understanding and knowledge of their services and how these services impact youth transitioning from one system to another. The percentages in the community findings are based on these 13 agencies/services. Their roles and applicable services for youth are recapped below:

**Police Services:**

A Liaison Officer works within the high schools to provide emergency response, education on prevention and safety matters such as cyber bullying, internet safety, drugs, etc. The Liaison Officer can provide intervention and follow-up with youth who are experiencing suicidal thoughts, are criminally charged, need to be warned or need admittance to the ER. Outside of the school, Patrol Officers may apprehend youth under the Mental Health Act if youth demonstrates bizarre behaviour, is not able to take care of himself/herself, is a threat to others or is suicidal. In these cases, the Police will determine if there are grounds for apprehension and take youth to the nearest hospital. Police officers can also act as 1st responders; working with CMH, AMH, centralized access, youth probation.

**Children’s Aid Society (CAS):**

Children’s Aid Society protects and cares for vulnerable children and youth and provides programs and services that help to empower them and their families. Children and youth are brought into care for a variety of reasons such as they have been harmed or are at risk of being harmed, they have been exposed to domestic violence, their natural parents or guardians may not be able to take care of them or they may need a permanent housing placement apart from their biological family.

Each child or youth in care is assigned a Children’s Services Worker, who is a qualified Social Worker responsible for the coordination of care. The Children’s Services Worker is the designated legal guardian for children in care, and is part of the team working together to help support and meet the child’s or youth’s specific needs. Child & Youth Workers (CYWs) provide supportive counselling for youth and foster
parents. There are also some skills-based groups and ongoing youth groups.

Children can remain in the care of the CAS until the age of 18 and after that, there is additional support available to the youth until the age of 21 in the form of an Extended Care and Maintenance Agreement (ECM). The ECM Agreement can be extended on a case-by-case basis past the age of 21 for those in post-secondary education. Those on an ECM Agreement are expected to have a program plan for school and/or employment in moving toward a successful transition to adulthood. Financial support is $850.00 per month.

A Family Enhancement Team is also available to families in the community who are experiencing difficulties with teens and offer parenting skills to keep the family together.

**Supportive Housing (Kingston):** This program provides supportive housing in Kingston for young people over the age of 16 who are at risk of being homeless. There are 3 transition homes specifically for youth aged 16 to 24; one with 24/7 support, one with support 5 days per week, and one that offers rent-g geared-to-income housing. Case Managers provide support and collaborate with local agencies in order to facilitate required services and ongoing supports for youth up to 1 year. These supports include developing plans for school, employment and counselling; and intensive life skills to assist the youth to become more independent. All applicants are screened for past violence and aggressive behaviour to ensure safety.

**Primary Care:**

Includes a Family Health Organization and a Community Health Centre (CHC). The family physician or nurse practitioner (CHC only) acts as the primary point of care contact, provides direct health care to patients, and coordinates with other specialists or clinical services as needed. The CHC provides primary health care, health and wellness promotion, and disease and illness prevention. For CHC clients with MH&A issues, a social worker provides counselling, therapy and facilitates case management support. Therapy and counselling is goal-directed and short-term in nature (6 to 8 months). Once the goals are achieved, the case is closed. If clients feel they need more support, they would be referred elsewhere.

The CHC engages youth 13 to 24 to take an active role in the planning, delivery and evaluation of programs, services and activities that are
provided to youth, including the sexual health clinic. Access to general health and wellness programs such as, food basics, healthy cooking on a budget, and services of a dietitian, are also available.

**Hospital MH&A Services:** Quinte Health Care is designated under the Mental Health Act of Ontario as a Schedule 1 facility providing a continuum of mental health services from acute admissions, crisis intervention to day hospital, community and outpatient clinic support. Their programs include:

- Acute Mental Health Inpatient Unit
- Crisis Intervention Centre
- 310 OPEN/Coordinated Access
- Transitional Outpatient Centre
- Assertive Community Treatment Team
- Parent, Child and Youth Program
- Mental Health Clinic

Most programs offered are not specifically geared to youth other than the Parent Child and Youth Clinic which serves youth 15 years of age and younger. Interprofessional teams provide clinical assessments, therapeutic intervention and support community integration. Services are provided to individuals with a psychiatric condition or significant MH issues involving bipolar, early signs of schizophrenia, some adjustment anxiety disorder. For behavioural, conduct or parenting-oriented disorders, referrals would be made to CMH and/or Youthab if the client can live at home.

**Public School Board Child & Youth Counsellors:** Child and Youth Counsellors (CYCs) are a school-based resource to help students, their families and school personnel. CYCs assist students with attendance, readiness, emotional, interpersonal or behavioural problems. They can coordinate support services with the local hospital, the Crisis Intervention Centre, CMH, Youthab or with the In-School Counsellors. They are immediate responders in a crisis situation; ensure a safety plan is developed; and keep parents and students informed that other agencies may become involved. CYCs may coordinate case management services, provide counselling and support, education and prevention, advocacy and facilitate connections, bridging mental health and well-being services with community resources. CYCs are an important part of the Threat Assessment Protocol and they assist in implementing strategies with community partners after a serious incident.

CYC services begin in grade 8. Up to 9 sessions can be provided over 4 years. Drug awareness and risk, awareness of harm reduction, bullying,
safe partying, sexual health and healthy relationships are some classroom education topics facilitated by CYCs. Youth who have left school can still call in. These youth can be connected to other community agencies such as housing, employment, and post-secondary education.

**Indigenous Community Wellbeing Programs:**

At the Mohawks of the Bay of Quinte on the Tyendinaga Mohawk Territory, health and social programming are housed in one location. Holistic services are geared to meet emotional, intellectual, physical, and spiritual needs within the indigenous community. Health care services are delivered through a nurse practitioner and community nurses. One-on-one, family or circle group MH&A counselling is provided from an indigenous perspective. This cultural programming provides a venue to reach youth through educating circle groups and activities such as fasting on land, sweat lodge or socials.

Youth groups provide culturally appropriate activities that develop self-esteem, leadership, identity and land skills. A Youth Counsellor is also available to mentor youth and work with young people who have addictions issues. Outreach can be provided to communities in the local area. The goal is to build linkages and relationships with on and off-Territory agencies.

**Private Counselling Service:**

Provides psychological assessments, psychotherapy and counselling to individuals, couples and families. Psycho-vocational, trauma response and debriefing, parenting capacity and skills development along with a range of other services can be delivered.

Employee Assisted Programs (EAP) are benefits offered by many employers to help employees and their families deal with personal problems that might have a harmful impact on work performance, health and well-being. Youth with parents who have an EAP can access services. Depending on each employee’s EAP, services may include general and short-term counselling, psychological and psycho-vocational assessments, and trauma response. Contracted therapy services are provided to youth in CAS care and through the private group home system.

**Justice and Support Services:**

These services include Ontario Youth Justice Court, Community Court Diversion Programs, and Adult Probation. The Youth Justice System holds youth aged 12 to 17 responsible at the time of their offence. The Youth Justice Services Act looks at the least intrusive measures and
rehabilitation to address a young person’s underlying issues. Their goal is to help youth in trouble with the law to make better choices, learn life skills and contribute positively to their communities.

Ontario Youth Justice Court refers to the local John Howard Society in accessing services for youth up to age 17. These services can include addictions awareness, prevention, skills development and recreational programs. In addition, the Ontario Youth Justice Court refers to the Youth Mental Health Court Worker who provides support to youth who struggle with their mental health, and are between 12 to 17 years of age at the time of their charge.

Mental Health Court Diversion is a cooperative program between the criminal justice system and the mental health system to provide direct services to individuals who have been charged with a minor offence. With the approval of the Crown Attorney, a Diversion Plan will address the mental health factors contributing to the offense.

If a young person is considered for a diversion, a Court Diversion Mental Health Counsellor will complete an assessment. After the assessment is complete, the Crown Attorney will decide whether to proceed with a Diversion Plan or proceed with charges in the court.

The Youth Mental Health Court Diversion Program works with youth aged 12 to 17 to address underlying MH issues, provides court support and case management with counselling as a bridge to MH&A services. In order to qualify for this program, youth must be suspected of or identified as having a mental health issue and committing a minor offence. A diagnosis is not required.

An Adult Mental Health Court Diversion Program also exists; however, they were not included in the research. In order to qualify for the adult program, a young person must be 16 years of age or older; must be diagnosed with a mental illness or must be suspected of being mentally ill; they must be charged with a minor offence; the young person must agree to participate in the voluntary program; and the Crown Attorney must recommend the diversion option.

Although Youth Probation did not participate in this initiative, they play a key role in the justice process. Probation is a court enforcement that authorizes the offender to remain in the community subject to conditions established within the order. Youth Probation supervises and works with youth up to age 17 and their family, to avoid getting into
trouble with the law again. The officer would develop a plan, assist with education and skills training, and refer youth to services and supports that will help them make better life decisions.

Adult Probation supervises people over the age of 18, who are in conflict with the law. Their goal is to reduce the likelihood of re-offending. Their role encompasses assessing the risk that an offender poses to society, makes effective case management decisions, and determines rehabilitative interventions to reduce the risk to re-offend.

A Community Oriented Sentencing Program is also available to youth up to the age of 17. Youth aged 18 and 19 are only eligible for services if under a youth order. The program is an alternative to custody and focuses on justice-related support and prevention for youth, with a referral from a Probation Officer. The goal is for clients to take ownership and accept responsibility for their actions and not return to court.

In Hastings and Prince Edward County, the Community Oriented Sentencing Program provides the following programs.

- **The P.A.S.S. Program (Positive – Alternative-School-Suspensions)** is for students who have been suspended from a Secondary or Senior Elementary School. One-on-one tutoring and support is provided.
- **Youth Justice Committee** – is an alternative to the court system, it helps reduce waiting time and gives the community a chance to problem solve with respect to criminal activities. In order to be eligible for this program, the young person must be between the ages of 12-17 inclusive at the time of the offence, reside in the Belleville area, committed an offence in the Belleville area, be willing to take responsibility for the offence and want to make amends by completing directed measures, have a parent or responsible adult who agrees to participate in the process. It should be noted that only young people with certain offences are eligible. If the young person participates in this program the charges will be stayed by the Crown Attorney and there will be no youth court or criminal record once the measures have been completed satisfactorily.
- **Extrajudicial Sanctions** – allows a young person aged 12 to 17 who is charged with certain types of criminal offences to take responsibility for their offence without being sentenced by a judge. Instead the young person completes an agreement through Community Organized Support and Prevention. Successful completion of this program means that the young person will not have a Youth Court Record.
- **Attendance Centre** – is a non-residential program and provides an alternative to custody, placed on conditional discharge or probation order. Youth are referred by their probation officer (case manager) and are willing to address those factors identified as offending behaviours. The goal is to work with youth in an attempt to reduce the recidivism rate of youth crime. Counsellors engage youth until they think they are ready to participate in 3 self-directed skills development programs.
which youth believe “...would benefit them.” Youth are given the power to make decisions and to assume responsibility. “You’re the expert on you, you know in your head, what you need to work on...common goal is that they do not return to court.” Groundwork is laid for youth to be more accepting of help from others.

- **Prime Worker Program** – provides young people 12 to 17 years of age who are at risk of breaching probation with one-on-one mentoring, positive role modeling and cognitive learning/thinking errors.

- **Community Service Order** – requires a young person to donate a specified number of volunteer hours to the community. This program supports the rehabilitation of the offender – the youth is given an opportunity to contribute to society by working for the community.

- **Youth Reach** – is a crime prevention program that offers programming to youth aged 12 to 17. These youth may be experiencing difficulty at home or school and may be displaying anti-social behaviour such as petty acts of vandalism or theft. The program provides life skills development sessions to assist youth in developing the ability to make positive choices in various life areas.

**Gaps in Services:**

- **Lack of psychiatrists and psychologists (62%).** There are not enough child and adolescent psychiatrists in the system. This could be due to a combination of a lack of human and/or funding resources. Wait times are long, and access to public assessments and treatment is limited. For youth who are suicidal and need to be hospitalized, there is a need for inpatient treatment and beds. There is limited capacity in the school system for psychological assessments and, as a result, there are long wait lists; consequently, learning disabilities do not get diagnosed. Depending on the school board, each school is only allotted 2 to 5 psychological assessments per year.

- **Lack of suitable, adequately supported and emergency housing (54%).** There is a high need for affordable, supported and transitional housing. Stable housing is a key foundation of support. Without it, youth have a difficult time getting mental health counselling and/or in pursuing employment needs. Although there needs to be more semi-independent living programs like the Transition Home, its criteria is strict. A significant gap in supportive housing and supported emergency housing exists for youth who have criminal records, are on probation or have high needs; many cannot return home due to unstable environments. These youth are often at risk of being homeless. Supported housing and supported emergency shelters are also needed in rural community hubs. The supported housing in Madoc and Trenton are usually occupied by young families or teen moms versus youth.

- **Lack of youth addictions programming (54%).** Access to addictions services for youth is self-directed and outreach is limited. The Algonquin Lakeshore Catholic District School Board has some community addictions in-school support. Bancroft has addictions support two days per week but schools find the service insufficient when a student needs immediate access. Some advocate for harm reduction programming in employment and in school. For one provider, good support to stop drug use is lacking. Solutions include: establishing a harm reduction resource link through the schools and coordinating addictions services with community agencies working with youth.
Education around addictions is needed. In general, it was felt that youth who are heavy users of marijuana end up with a First Psychosis diagnosis; and this may be misleading as marijuana usage must be halted prior to obtaining an accurate diagnosis.

- **Community MH counselling services are not adequate (54%).** Young people above 18 years of age with less severe MH issues, have a harder time accessing services. With proper counselling, these youth can develop coping skills that could avert further problems. “Especially with...young people that have fallen through the cracks their whole lives and don’t have that diagnosis, or ...don’t have a family doctor.. They’ve never been assessed properly...might have a variety of disorders...affecting them now...then to get access to a psychiatrist is even harder.” Many CAS youth do not have a diagnosis, have been sexually, physically and emotionally abused and are at high risk for substance abuse; they often need intense psychotherapy through a skilled therapist. “Addictions and Adult Mental Health systems are not set up to deal with these youth.” Even with a diagnosis, young people who have a disorder that is not debilitating will not qualify for intense services. There is a lack of MH counselling for youth in rural areas (Picton). More MH professionals are needed to serve youth in the community.

For those with moderate and behavioural issues, there are cognitive behaviour evidence-based programs in the justice support services that are preventative and could halt disruptive actions; locally, these services could be offered but they do not have the funding. It was suggested that MH community agencies could develop a Cognitive Behaviour Therapy kit to train and provide nurses or family physicians to implement group sessions for their clients. Programs that are tailored to clients’ needs require more energy, effort and resources. In addition, programs for TAY are needed to build self-confidence, core social and life skills, especially for the 17 to 19 age group.

- **More specialized and intensive services and supports (46%)** Supported employment services, such as, apprenticeship or skills training, LGBTQ services, access to male and female counsellors, and intense in-house supports such as, intensive therapy and case management services would be beneficial. “Good support would mean positive opportunities – volunteering, work, recreation, creating positive peer interactions, self-esteem, work on family issues...” For high needs youth leaving CAS group homes, advance planning of 2 years prior to the transition and intensive services to build a bond, set a plan, keep them on track and check-in regularly is necessary. A solution could also include 1 to 2 years of supported independent living in preparing youth to live on their own. “They need to know they can call you and say that they lost their job, and then somebody needs to help them get another job. Better off having one person who is a life line, is a navigator.”

Other gaps in specialized services included:
- the lack of supports and counselling services for students in remote areas, who participate in a work placement through Supervised Alternative Learning (SAL) or work from home on an Independent Learning Centre (ILC);
- the lack of indigenous staff and cultural understanding at community MH&A agencies;
- the lack of creative early intervention or prevention pre-conviction programs or services;
- the lack of intensive in-home programs to assist youth with MH&A similar to ACTT and Court Diversion in providing in-home family preservation support; and
- the lack of youth programming in adult probation rehabilitation.

- Youth engagement and flexibility to enhance services and supports (31%) It was suggested that youth be engaged to determine challenges in accessing services and to obtain feedback on quality of services.
  - Are services youth friendly?
  - Can texting be used to get MH services?
  - Are there places where youth could easily access supports all the time?
  - Are home visits possible?
  - Is anyone willing to provide this kind of assistance?

Suggestions for increased flexibility included: having the ability to meet youth “on Friday night” if there is a crisis; allow school programs to accommodate learning difficulties; and allow primary care team members and AMH workers to conduct outreach or meet clients outside of the clinic or office.

Youth are often not aware that they need help; or when and how to access services. Youth need to be willing to engage in service otherwise; they may not follow through on accessing services. More education on what behaviours are appropriate, what resources exist and more hands-on intervention are needed. Youth also need to recognize their own readiness to access services and supports, such as, addictions or MH counselling; encouragement to report a sexual assault, and the need to have an advocate. Suggested improvements included: providing resource materials and supports on how to manage while waiting to access service; a one-stop shopping to provide youth with direction and stability through different services including addictions, MH, Babies and Beyond, and supports for needy parents. For females, “It’s that healthy relationship piece, getting rid of the stigma.” For males, it is “about sexual boundaries and responsibilities, healthy sexual relationships.”

- Awareness and understanding of available services within the community (31%) Agencies lack information of one another’s services, supports and how to access services. This also applies to knowledge of services offered by Family Health Teams (FHTs) and Community Health Centres (CHCs). All community agencies would benefit from the sharing of information. For new clinicians to the area, an understanding of what community services are available and where they are located would be helpful. Parents would also benefit from resources on how to approach and talk to their kids about drugs, where and how youth can access help confidentially. Also mentioned were services and informal supports for individuals and families with some programs like the ones in NAMI that are peer-based.

- There are no local addictions residential treatment facilities (31%) for youth. There is only Detox in Kingston that is geared to adults with a 3 to 5 night stay. Any longer-term treatment is 2 to 4 hours away.
• Lack of transportation especially in rural areas (23%)

• More case management services (15%) There is a huge gap for MH supports for those that do not have a diagnosable MH issue and do not fit the criteria for AMH services. At risk are youth between the 6th and 7th developmental percentile who do not qualify for many services, are fairly high functioning but require assistance, especially if there is depression, bi-polar, borderline personalities and other MH issues. These youth may be at risk of developing SMI and can easily fall through the cracks. For former CAS youth post-21 years of age who are receiving psychotropic medications, they need someone to advocate on their behalf, facilitate meetings, help with basic medical appointments and grocery shopping for special diets. “Independent living can be tough...these kids don’t do well...when all their supports are gone. Especially if they do have MH issues, they’re not mature enough or emotionally stable enough to make good decisions and choices.”

• Limited capacity at CMH resulting in 3 to 6-month wait lists (15%)

Other gaps in services include:
• More communication is needed between MH and Addictions; they need to be treated concurrently with services provided within one organization
• Gap with CMH (Frontenac) for youth who at 17, are aging out of the system often get mixed messages as to either pursue a referral at Children’s or Adults MH services
• Community recreational programming or positive peer social opportunities for youth aged 18 and up are lacking
• Other than an agency referral, there is no process to engage with AMH collaboratively concerning youth aged 18 and over
• Mental health education and stigma training for teachers and administrators
• An inability to access MH counselling, due to wait lists, during a time limited period in the context of a probation order “Timely intervention is extra important when dealing with youth in court.”
• The 72-hour Police Form 1 for someone who is deemed to need further assessment from a doctor, is sometimes not enough. After 72-hours, individuals may repeat their behaviour and nothing has changed
• Limited resources at Adult Probation to access some private service assessments, creating gaps in coverage and a waiting period of up to one year
• OW support is not sufficient to live independently

Barriers:
• Lack resources and time constraints (54%) within the indigenous community, for psychiatric services in hospitals, for psychological and sexual risk assessments in Adult Probation and for students who are not coming to school as “they’re the ones that need us the most.” The transition would be quicker and more seamless if MH professionals were involved in meeting with the new counsellor and advocating on the client’s behalf. Due to financial constraints, agencies are limited to implementing group sessions versus individual counselling sessions. One-on-one consultations have been proven more effective especially in smaller communities as youth do not want to share
information with their peers. Rumours spread through social media can be very damaging for youth.

- **Systems’ barriers (54%)** prohibit the access to programs, services, and information resources, and can be geographic. Support and access to programs can only be granted when youth are in custody or convicted, on probation or parole. There are different funders and silos, resources and information are not shared making the youth transition process “incredibly difficult. Coordinating groups in H-PE have been meeting for over 5 years; the transition issue is still a problem.” Case files cannot be transferred between Youth and Adult Probations. Adult Officers can only review the physical files and take notes on site. Ministries need to communicate, collaborate and ensure information is easier to access. “…the ministries have got to get together and work out some policies for information sharing that are more suitable.”

A diagnosis is needed to access MH services at age 18. The age overlap of 16 to 18 between CMH and AMH is an opportunity for better planning but can also be a way out for not accepting responsibility. At 17, “the biggest pitfall... is that transition age into the adult system... no one wants to take ownership... No one wants to accept this, so you have someone who says okay I’ll do this and then turn around and say you’re not worth the money to continue working with you... to discover what the problem is. Do you know how sad that is?”

There are differences in ministerial culture as the perception of each mental health system is distinct. Generally, CMH serves lower income families and deals with parenting or conduct and behavioural issues. CAS relies on both the private and public MH systems. AMH focuses primarily on individuals with SMI. MCYS and MOHLTC have different assessments and do not have a common electronic platform for sharing information. “These are totally different client groups and you’re trying to bridge the gap.”

Supportive housing does not accept those with serious MH issues. These youth need to develop independent living skills but are not able to be at home with their parents. Depending on one’s residential location, access to specific CHCs and FHTs may be restricted.

- **Housing (23%)** Shelters and supported housing are needed for youth with serious mental health issues, and youth who have limited social and life skills. Dedicated resources are required to develop and implement programs and support services.

- **Transportation (15%)** is both a barrier and a gap. Workers would often have to transport youth to access programs.

- **Stigma creates a barrier to accessing services (15%).** For some youth, stigma becomes an obstacle in accessing mental health and addictions services.

Other barriers include:
- Sometimes being client-centred is forgotten. Clients should drive the process; having a MH issue does not mean that “they can’t come to some logical conclusion”
• Lack of cross-cultural training and indigenous staff to provide a better cultural understanding of the indigenous perspective – struggles, prejudice and loss
• Knowledge of what services other systems offer

Challenges:

• Youth culture, client resistance and motivation (69%) Youth culture is changing. Technology has evolved into an instant access to everything. Yet as youth, they are still developing with intense emotions that are not easily shared. There is a need for agencies to meet their reliance on technology by engaging them differently yet providing them with the support that they crave. Choice is also client-driven. They do not always agree or want what is suggested. The critical piece is do they truly WANT service? “We can talk...educate...suggest...promote...but ultimately if we’re going to have a system that says they get to choose, then I think that...is part of the challenge.” Services are for individuals 16 years and over, implying that core programming is open to all adults. However, programming for youth can be adapted to suit their needs and be implemented differently.

Youth often do not see themselves as having a MH issue or a disability. They are not willing participants but can only access services if they choose to engage voluntarily. Youth can be resistant; have problems building relationships and trust. Breaking down and understanding resistance is critical. Education about harm reduction, tools to help youth with decision-making and support are helpful in getting youth to buy in.

As programs are voluntary, using motivational therapy to be supportive can be beneficial. “It’s tough to motivate young people. How do we deter them to keep them out of trouble?” At John Howard Society, there are life coaches that meet youth where they are at. Youth are engaged to determine what their life goals are and how to work towards attaining them. In primary care, youth do not come in often. When youth do visit the doctor’s office, a preventative approach is taken. Youth are engaged to determine how their school life and friendships are going, whether there is a lot of drug use in school, have they been experimenting and are they sexually active. Communication can be via a secure email or blog. An additional suggestion includes a webpage with youth content on an agency’s website with relevant resources, fun and healthy events, concerts and health information.

• Parental influences and resistance (31%) Sometimes it is difficult to engage the parents. Agencies connect with youth to adapt behavioural changes and become more responsible; but their parental home environment may have a chronic negative influence with untreated abuse, addictions and MH issues. Parents may not acknowledge that they need counselling and treatment, better parenting skills, such as setting boundaries and a balance of love and discipline. In smaller communities, some mothers may be reluctant to advocate for help within the education system as they may have had a poor experience in school or were outsiders with current staff when they were younger.
• **Relationship changes (23%)** Community agency workers change often, this makes it challenging to establish relationships. A transition meeting rarely occurs between the school and a community agency. It takes time to build relationships and trust. For youth to build a comfort level with a counsellor also takes time. Therefore, changes to an established clinical relationship can create a set back and frustration. It would be more beneficial if funding could flow between the 2 ministries to continue the counselling service (Probation).

• **Follow-up communication is needed (23%).** In approximately 10% of cases, there is no return communication from agencies on the referrals sent. From a primary care point of view, follow-up communication of what is happening is critical to ongoing client care. For schools, once a referral is sent, rarely is there communication to indicate that a student has been accepted into a service or at a specialist. This applies to meeting outcomes as well. “...80% of a kid’s week is at school... all we’ve continue to ask is there something we can put in place at the school to help support the student.”

• **Systems’ challenges (8%)** occur when an overlap period is lacking and the onus is placed on youth to self-refer in the adult system. Challenges happen when there are gaps in between the two services. For example, a referral has been made and assessments have been obtained to transition to ODSP at age 18; CAS financial support is severed but there is a wait time of 3 to 6 months before receipt of ODSP funds. The client can apply for OW for the interim period but cannot obtain ECM. Youth will often stay on ECM and forgo disability supports and the services of an Adult Protective Services Worker (APSW).

Some agencies will not accept referrals until the case is closed with the other service. The onus is on youth to self-refer to Developmental Services over the age of 18. Young adults often have difficulty in self-referral and in acknowledging their MH needs. For CAS youth who have been institutionalized, issues may only materialize when they, at age 18, have the freedom to live independently; and any diagnosis is more likely to emerge at that time.

**Other challenges include:**

• “Anger management” perceived as stigmatizing and would deter participation. Regardless of issues, youth want to be seen as normal. Would recommend changing the name to something that would empower rather than disengage youth

• Philosophical differences in CMH and AMH systems and cultures, creating challenges in access and communication

• Not being accountable at the Belleville General and Hotel Dieu crisis unit where they would not treat the mental health issue until drug use or “addictions” is under control “It makes it very hard ... to advocate for a student when we don’t have back-up. If we can say the doctor called or the worker from CMH called, it carries a lot more weight with the staff.”

• Do not always have the appropriate services for MH or addictions issues when connecting youth in trouble with the law, that would allow for rehabilitation and reintegration into their community

• Youth are vulnerable when there are no family supports and have not reached maturity; they can be easily influenced by negative connections made in adult jails and continue to offend
From CAS’s perspective, the process for accessing free psychiatric assessments and obtaining documentation for youth who are transitioning into Developmental Services or to a new organization

**The Current Transition Process**

Among the participating community agencies, 46% transition youth, 15% actively support and advocate for youth during the transition, and another 39% do not transition youth. Most transitions are informal. Generally, referrals are made, an appointment is set up; and youth are connected to needed services including case management. Counsellors or workers may accompany youth to appointments depending on client needs, established relationships or complexity of cases. Transition processes vary by organization.

If youth are on ECM, Child Welfare services would either transition out-of-care at 18 or 21 years old. The agency would connect youth to needed services and with a family physician to follow-up on MH&A issues. Workers are willing to help facilitate the process, to accompany and support youth as required. For hospital-based MH services, planning with the client begins several months prior to the discharge to determine what services are required long-term. Typically, with consent, a referral is sent as directed by the client. Collaboration occurs with other organizations as required. The current counsellor would continue to see the client until a new clinical relationship has been established. Meetings would only be scheduled if a case is complex and based on need. The onus is on the client to follow up. The client can always call if there are issues and problems with the transition.

Adult Probation Services will work with individuals who have been on a youth probation order and have committed a new offence after turning 18. The sharing of information is limited by systems barriers between Youth Probation services and Adult Probation services. Case notes can only be accessed by perusing through the physical files and noting pertinent information. As the 2 Ministries operate on different case note systems, computerized summary notes cannot be accessed. Assessments are redone due to the use of different tools. Fees are charged for private psychologists’ reports of youth even though the same document was previously paid by the Youth Probation system. These system processes hinder the transitioning of youth as they may not be able to readily connect to the services they require.

For the public school board, CYCs initiate the referral and coordinate meetings with youth and the new agency. Usually, there is no further follow-up contact with the CYCs after the meeting. CYCs who see the student the most, have knowledge of who is in crisis but are often excluded in the transition conversation. The insight that CYCs could provide about a student would help facilitate the work of the recipient agency.

For indigenous services, the transition process is mainly an internal collaborative team approach. There is good communication and the process works well. External transitions would primarily be for serious mental health disorders.
Housing and justice support services provide encouragement and advocate for youth in preparing for the transition. For housing, the average client is 17 with limited support, someone needs to advocate for them. “whether it’s making...appointments, going to those first meetings with the youth, speaking on their behalf to the professionals, the psychiatrist to try to make the transition smooth. That would be our role.” Staff following up with recipient agencies ensures the process is moving along and that youth continue attending their appointments. Likewise for justice support services, appointments will be set up, youth will be accompanied to different services, and some groundwork would be provided for youth to engage with someone new. Agency staff will attend plan-of-care meetings with CAS and advocate for youth in the school system. “While we have them, anything that we can do to make their life better, if they’re willing to accept our help...we work it into our schedule to help them...”

Engaging and Preparing Youth for the Transition:

A client-centred approach to engage the client helps show respect for their decisions. In one instance, the agency tries to engage the clients, to convince them that service would be beneficial considering their current situation. Everything can be tried to engage the client, but ultimately the onus is on the young person to agree to the service.

Another approach used to avoid resistance is not telling youth what to do. Instead, an approach developed in the UK assigns different star outcomes for 5 areas of their life. Youth are asked to complete a survey in rating themselves on the different issues. If a low score is achieved in an area, the agency would try to determine what is needed to move them up. Youth build strong relationships with staff and feel more comfortable having support. A third approach used in justice support, prepares and coaches clients to communicate and learn to take some responsibility by providing tools to ask questions on how decisions can impact them. “There are ways you can ask a question without getting people feeling hostile.” Where there is coaching and support, the youth will think: “no one has ever said nice things like that about me; they always focus on what I can’t do, or my problems and not what I’m capable of doing.”

What’s Working Well:

- **Ensuring good practices (54%)** for the transitioning of youth from one agency to another. This comprises of obtaining client consent, ensuring through phone calls that information is shared with other organizations, and accompanying youth until they are receiving services at the new agency. If the client has agreed to have the new service contact them directly, phone numbers are given to the client and the message is reinforced with them to contact the referring agency 24/7 should any difficulties arise. The process is client-centred, self-determining and empowers youth to build on their strengths. There is always a chance that the client will drop the ball but they get to determine what they want and how to access services.

Having a dedicated support staff and workers to facilitate the transitioning process, including setting up the initial meeting and case conferences; and accompanying and supporting youth as required.
The Wraparound model is effective for family treatment, everyone is accountable ...“it was one of the most effective tools.”

Knowledge of what the need is, the available services and contacts within the community

Awareness of the next step, not being afraid to ask difficult questions, recognizing the need to slow it down in order to prepare and engage youth: “Have you ever considered that this might be becoming a problem for you. You go to the next stage; and work on that. You really need to hold in the reins...get in there, see what the problem is, and we want to fix it...The successes are when we slow it down.” When youth decide to disclose unsettling information, “you really have to be open. There is something I want to ask you and I’m a little concerned to ask, but can I ask you? How long has it been happening? Have you told anyone? You want their permission to talk to their mom and their probation officer, can I do that?”

Authorizing CYCs to be more proactive and provide support to manage difficult youth in a foster setting versus placing youth in a group home

By having a masters level clinician conduct the initial intake assessment, the client is referred to the appropriate service. The Crisis Centre does this well.

- **Good collaborative relationships (46%)** enable a positive flow to the transition. Collaboration works well with the schools. They also support the client during the court diversion process. Within indigenous services, there is good communication and collaboration for internal transitions. Police services receive very good support from administrators, counsellors, MH workers during day patrol. For hospital MH services, being client-centred is a team effort. It is important to acknowledge and focus on the strength-building and successes. “We don’t do enough of patting each other on the back and saying thanks, you’re doing a great job and we’re doing the best we can with what we have.” Collaborative networks such as the H-PE Children & Youth Services Network enable organizations to improve upon what’s already working, what elements contributed to successes, and how barriers were handled.

More services mentioned that are working well:
- One Social Worker at Belleville General Hospital’s Psychiatric Ward keeps the CYCs at the schools informed and is a point of access for adolescents.
- More success in transitioning with addictions services, easier processes from initial referral to accessing services (Frontenac).
- Early Psychosis program at Hotel Dieu provides excellent MH services and supports for SMIs.
- Emergency services and crisis intervention.
- AMH services are more effective in rural areas, such as Sharbot Lake, where case managers work with clients in their environment, perhaps due to smaller caseloads.
- Supportive families contribute to the successful outcomes of those with SMIs.
What’s Working Less Well:

- **Access to care is limited due to systems and capacity issues (31%).** A diagnosis is needed to access AMH services. There are roadblocks with transitioning into AMH; the wait list is lengthy particularly in Kingston. Often, while on a wait list, the agency is notified that youth do not meet their criteria for services (Frontenac). Sometimes, youth would already have left the housing service. There is a lack of specific youth programming in Addictions. The CAS system is set up as being reactive versus pro-active. Youth can only qualify for crisis services and some supports when they have had a breakdown. There is a perception that CAS do not want to pick up youth at 15, “*they’ll do whatever they can not to*”. Youth at 15 may not be able to access interim services until they are 16 through Crisis Intervention.

- **The sharing of information is missing in the transition process (23%).** Major system barriers exist in the sharing of information; thus creating a duplication of processes. The 2 Ministries in Probation operate on different case note systems. Case and summary notes cannot be accessed electronically or photocopied resulting in inefficiencies and possible inaccuracies. Assessments often need to be redone due to the use of different tools. A financial fee is often required to obtain a copy of a private Psychologist’s report on a youth that was previously paid by the Youth Probation system.

Very few calls take place between public schools and CMH in the Bancroft area. Problems include the inability to access staff and fast-track clients, as well as the lack of transportation, residential care and emergency housing. “…*got 14 services...here but none of them seem to be able to work properly because nobody talks to anybody else...we’re still having issues and problems that haven’t changed in 25 years*...”

Workers at the operational level lack awareness and familiarity with the transition process, which hinders service provision.

- **There is no follow-up communication flow back to the referral agency (15%).** Once a referral is sent, schools do not know if a youth has been accepted into the service. Similarly, primary care may not receive any return communication from agencies.

More services mentioned that need to be improved:

- Some organizations have bypassed the 310-OPEN single intake triage system in favour of accepting self or direct agency referrals, creating an unnecessary wait list. Clients “*may not get to the right service. If Open Line Open Mind worked the way it’s supposed to... go through that first step of a proper assessment by a masters level clinician. Half the time it can be solved, and other times it makes you go to the right place.*”

- Transitions do not work well most of the time for CAS youth as they do not engage post-21. Services can be set-up but youth do not follow through.

- For indigenous services, SMLs are transitioned off-Territory; organizations in the larger community do not have a cultural understanding of the indigenous view. A possible solution would be using a
more collaborative approach with CMH and AMH in how aboriginal youth can best be supported. Cross-cultural staff training is key for teams to understand how to support aboriginal youth.

- Track feedback for clients who do not return due to a bad experience with their counsellor, psychiatrist or service. A suggestion would be to notify these clients that they can change clinical providers.
- Transition planning is not started early enough.

Lessons Learned:

- **Establishing trust with the client facilitates the transition.** “For some..., it's incredibly huge if they even begin to trust you...” “Counsellor was able to say, do you trust me? Have I led you astray? Do you believe that this is going to be helpful for you? Then if you do, you can sign the consents...” Youth may appear not to have fear at 15 to 19 years of age but when given a number to call and to follow-up, it can be difficult. Handholding is helpful.

- A warm hand-off is only as effective as front-line clinicians have built-in time to make the connections for their clients. This can be difficult to achieve when there are targets to meet even with a transitional worker to coordinate activities.

- An accurate diagnosis needs to be obtained from psychiatric care. Although front-line clinicians see symptoms, there might be underlying issues where psychiatric resources are needed.

Suggested Transition Framework Models:

- **Dedicated transition worker(s) build a relationship with youth and bridge the process with the children’s and adult MH&A systems (31%).** It has been suggested that a Transition Worker/System Navigator would bridge the two systems, with dedicated workers in each system. The former would meet with both systems to identify youth for transitioning, act as liaison between the two systems and keep the family physician informed. A dedicated worker at each MH&A agency would improve collaboration with agencies and the client. In either case, building trust with the client is a priority to discourage youth from disengaging. Dedicated worker positions can be assigned or created; but sufficient resources must be available to manage more complex cases. By initiating transitions early, youth can participate in creating their treatment and transition plans. A combination of intense case management, family support, liaison with the group homes, education and legal systems has been suggested in preparing youth for entry into the adult system. At the same time, the adult worker can initiate building a relationship with youth to enhance the transition.

As a variation, an Intensive System Navigator would provide services for youth with the most complex needs. Community AMH provide case management services but, do not offer the intense therapeutic services required for difficult-to-manage moderate cases where there has also been abuse. These intense therapeutic services need to be created. A master’s level of clinical therapeutic expertise and the ability to provide both MH and supportive counselling are needed. Youth with complex, conduct disorders and abused backgrounds would need regular cognitive behaviour therapy or psychiatric interventions with medication to support them in transition. “A good example...would be...a young woman who is 17..., who was sexually abused as a child, and as she gets older she’s at risk; a lot of drinking,...drugs, partying, and very promiscuous, and it’s
impacting negatively on her daily functioning...she’s not going to school, or ...she’s sleeping through the day..” The intervention needs to be intense at the front end, then the client can be weaned off; and the person can always return. “Youthab might fill some of that role...”

- **Extend the CMH and youth offender systems to age 24 (15%).** At age 18, youth are not fully matured. The adult MH and offender’s systems lack youth programming. In the latter system, youth are being bundled with older offenders who can be a poor influence on them.

- **Incorporate MH&A into primary care teams (15%).** Make primary care the entry point, this will minimize the stigma and normalize the treatment of mental health.

Other options cited include:
- Have a youth centre that addresses emergency housing, addictions and mental health services
APPENDIX V – (a) YOUTH SURVEY H-PE

SE LHIN Youth Transition Research

Survey Questions for Youth:

1. Which of these agencies did you get service from?
   __ Children’s Mental Health Services
   __ Mental Health Services – Hastings Prince Edward
   __ Children’s Aid Society
   __ Addictions Centre
   __ Other, please specify:
   _______________________________________________________________________

2. What services did you get?
   __ Mental health clinical counselling
   __ Addictions treatment
   __ Supportive counselling
   __ Life and social skills
   __ Case management
   __ Other, please specify:
   _______________________________________________________________________

3. How old are you?
   ____________
Survey Questions for Youth:

1. Which of these agencies did you get service from?
   __ Pathways for Children and Youth
   __ Frontenac Community Mental Health Services
   __ Children’s Aid Society
   __ Youth Diversion
   __ Other, please specify:
   _____________________________________________________________________

2. What services did you get?
   __ Mental health clinical counselling
   __ Addictions treatment
   __ Supportive counselling
   __ Life and social skills
   __ Case management
   __ Other, please specify:
   _____________________________________________________________________

3. How old are you?
   __________
Survey Questions for Youth:

1. Which of these agencies did you get service from?
   - Open Doors for Lanark Children and Youth
   - Lanark County Mental Health
   - Children’s Aid Society
   - TriCounty Addictions Services
   - Other, please specify:
     ___________________________________________________________

2. What services did you get?
   - Mental health clinical counselling
   - Addictions treatment
   - Supportive counselling
   - Life and social skills
   - Case management
   - Other, please specify:
     ___________________________________________________________

3. How old are you?
   ______
APPENDIX VI

SE LHIN Youth Transition Research

Focus Group Questions for Youth:

Transition is defined as a process of change when you move from one organizational system to another for service (e.g. children’s mental health to adult mental health).

1. If you have transitioned, what differences did you experience between Children’s Mental Health and Adult Mental Health?
   - Thinking back, how were you prepared or told to change services? What was helpful in preparing you to change services? What would have made it easier for you? How would you make the service more comfortable for youth?

2. What services have made it easier and more beneficial for you at Adult Mental Health?

3. What type of services and supports have you had trouble getting? Why?

4. From what is available now, what type of services or supports can be made more helpful for you? How?

5. What do you need help with?

6. What do you need to be more successful in life?

7. If you can design your own program, what would it be and how would you do it?

8. If a friend needed help but was hesitant, what would you do to help them?

9. Is there anything else you would like to share?

10. Do you have any questions?
APPENDIX VII – (a): MENTAL HEALTH AND ADDICTIONS ON-LINE SURVEY - AMH

SE LHIN Youth Transition Research - AMH

Facilitate the Transitioning of Youth in your Community!

The Youth Transition Project is funded by the South East Local Health Integration Network (SE LHIN) to examine services, help improve the flow and access to care of eligible youth aged 15 to 19 transitioning from the children's mental health to the adult mental health system. Phase One of this project is to conduct research to:

1. determine the number of eligible youth aged 15 to 19 who are transitioning;

2. identify services that are missing or needed to transition seamlessly; and

3. identify the barriers to transitioning.

By participating in this on-line survey, you will assist in determining factors that facilitate a more seamless transition and in identifying service needs and gaps for transitioning youth within our community.

The survey should take about 10 minutes to complete. All information obtained in this study is private and strictly confidential. The survey findings will be analyzed on an aggregate and theme basis, and no information will be shared or released that could identify individual respondents. If you have any questions, or if you encounter any problems completing this on-line survey, please contact Lily Lee at (613) 969-0830 Ext. 256 or lilyl@youthab.ca.

Thank you in advance for your support and participation in this initiative. Each member's input is valuable to improve the youth transition process.

On-line Survey for Adult Mental Health Service Providers:

1. Please indicate which geographic area your agency services.
   ___Frontenac
   ___Hastings – Prince Edward
   ___Lanark
   ___Leeds & Grenville
   ___Lennox & Addington

2. How many youth aged 16 to 19 are you serving? _______

3. How many youth aged 20 to 24 are you serving? _______
4. For youth 16 to 19, please indicate where your referrals come from and the top 3 referrals. Please check all that apply.

<table>
<thead>
<tr>
<th>All referrals</th>
<th>Top 3 referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children’s Mental Health Services</td>
<td></td>
</tr>
<tr>
<td>Addictions services</td>
<td></td>
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<tr>
<td>Centralized intake/coordinated access</td>
<td></td>
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<tr>
<td>Hospital – Mental Health outpatient</td>
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<tr>
<td>Providence Care Mental Health Services</td>
<td></td>
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<tr>
<td>Royal Ottawa Mental Health Services</td>
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<tr>
<td>Children’s Aid Society – CAS</td>
<td></td>
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<tr>
<td>Youth centres</td>
<td></td>
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<td>Youth services</td>
<td></td>
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<tr>
<td>High schools</td>
<td></td>
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<tr>
<td>Post-secondary counseling services</td>
<td></td>
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<tr>
<td>Private counseling services</td>
<td></td>
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<tr>
<td>Independent primary health care provider (family physician)</td>
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<tr>
<td>Ontario Works</td>
<td></td>
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<tr>
<td>Justice – Police</td>
<td></td>
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<tr>
<td>Justice – Court Support &amp; Diversion</td>
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<tr>
<td>Justice – Correctional Facilities</td>
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<tr>
<td>Justice – Probation</td>
<td></td>
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<tr>
<td>Aboriginal services</td>
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<td>Shelters</td>
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<td>Supportive housing</td>
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<tr>
<td>Employment services</td>
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<tr>
<td>Family</td>
<td></td>
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<tr>
<td>Friends</td>
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<tr>
<td>Self</td>
<td></td>
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<tr>
<td>Other, please specify:</td>
<td></td>
</tr>
</tbody>
</table>

5. The top 3 referrals account for approximately what percentage of the total?   ____%

6. What services are needed for youth? Please check all that apply.

<table>
<thead>
<tr>
<th>Requested by Youth</th>
<th>Requested by Others</th>
</tr>
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<tbody>
<tr>
<td>Mental health clinical counseling</td>
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7. What programs and/or services within your organization are available specifically to transitional aged youth? Please check all that apply.

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<td>Supportive counseling for youth and families</td>
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<tr>
<td>Employment, skills and support</td>
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<tr>
<td>Educational/vocational, skills and support</td>
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<tr>
<td>Recreational</td>
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<tr>
<td>Other financial assistance, e.g. trusteeship, bursaries, etc.</td>
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</tr>
<tr>
<td>Ontario Works</td>
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<td>ODSP</td>
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<tr>
<td>Systems navigation (provide information about services)</td>
<td></td>
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<tr>
<td>Case management</td>
<td></td>
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<tr>
<td>Links to advocacy, empowerment and mentoring</td>
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<tr>
<td>Respite care for families</td>
<td></td>
</tr>
<tr>
<td>Other, please specify:</td>
<td></td>
</tr>
</tbody>
</table>
Youth Services Offered

| Mental health clinical counseling | At other Organizations In your Community |
| Addictions counseling | |
| Access to a psychiatrist | |
| Access to a psychologist | |
| Primary health care (family physicians, nurse practitioners, Family Health Teams, Community Health Centres) | |
| Supportive counseling for youth and families | |
| Independent living and social skills | |
| Shelter | |
| Supportive housing | |
| Independent housing | |
| Employment, skills and support | |
| Educational/vocational, skills and support | |
| Justice and support | |
| Mentoring and peer support | |
| Youth engagement (sustained involvement of a young person in an activity outside of his/her self, developing confidence and interpersonal skills) | |
| Youth drop in centre (promotes positive and social opportunities, recreation and skills development) | |
| Recreational | |
| Other financial assistance, e.g. trusteeship, bursaries, etc. | |
| Systems navigation (provide information about services) | |
| Case management | |
| Respite care for families | |
| Links to advocacy, empowerment and mentoring | |
| Don’t know | |
| Do not have specific services for youth | |
Skills set:
9. Do you have any mental health counsellors who are trained in working with youth?
   ___Yes ___No

10. Do you have any addictions counselors who are trained in working with youth?
    ___Yes ___No ___Not applicable

Youth Transitions:
11. Please state the average number of youth (16 – 19) transitions you deal with per year: ____

12. Please state the average number of youth (20 – 24) transitions you deal with per year: ____

13. Do you have a written policy, tools or guidelines to help with the process of transition?
    ___Yes ___No

14. What is the average length of stay on your agency’s wait list? ________________

15. Do you have service agreements or protocols with children’s Mental Health services?
    ___Yes ___No

16. In a planned transition process, when would be the ideal time or age to initiate the transition?
    ____2 years prior
    ____When stable and developmentally ready
    ____1 year prior
    ____6 months prior
    ____3 months prior
    ____Other, please specify:

17. When youth 16 to 19 are transitioning into adult mental health:
   a. Is a transition meeting planned with the current youth counsellor or worker, the client and the new adult counsellor?
      ___Yes ___No ___Only if the client requests it

   b. Is the client involved in decisions about meeting their needs?
      ___Yes ___No ___Comment:

18. Which of the following activities are currently used to facilitate youth transitioning? Please check all that apply.

<table>
<thead>
<tr>
<th>Activity</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Team meetings between children’s and adult mental health services</td>
<td></td>
</tr>
<tr>
<td>Collaborative decision-making between children’s and adult mental health services</td>
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</tr>
<tr>
<td>Collaboration with other teams/professionals during transition</td>
<td></td>
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</table>
Follow-up with the client, youth counsellor/worker where the transition has not occurred or there are problems
Do not have specific activities to facilitate youth transitioning
Other, please specify:

19. For each of the following groups, how aware do you think they are of organizations that provide youth services in your community?

<table>
<thead>
<tr>
<th>Awareness of Organizations that Provide Youth Services Among</th>
<th>Degree of Awareness</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Very High</td>
</tr>
<tr>
<td>Health care providers in your community</td>
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<tr>
<td>Service providers in your community</td>
<td></td>
</tr>
<tr>
<td>Transitional youth (15 – 19) in your community</td>
<td></td>
</tr>
<tr>
<td>Families of transitional youth (15 – 19) in your community</td>
<td></td>
</tr>
</tbody>
</table>

20. For each of the following groups, how knowledgeable do you think they are of the youth programs and services within each organization?

<table>
<thead>
<tr>
<th>Knowledge of Specific Youth Services within Each Organization Among</th>
<th>Degree of Knowledge</th>
</tr>
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<tbody>
<tr>
<td></td>
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21. How do you perceive the demand for Mental Health services and supports among youth 16 to 19 in the last few years?
   ___ Increase in demand   ___ Decrease in demand   ___ Demand is the same

Comments:
____________________________________________________________________________

22. What do you anticipate the demand for Mental Health services and supports among youth 16 to 19 to be in the next few years?
   ___ Increase in demand   ___ Decrease in demand   ___ Demand is the same

Comments:
____________________________________________________________________________
23. What reason(s) do you attribute these trends?
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   ___Hastings – Prince Edward
   ___Lanark
   ___Leeds & Grenville
   ___Lennox & Addington

2. How many youth aged 15 to 18 are you serving? ______

3. For youth 15 to 18 who are about to leave the children’s mental health system, please indicate to whom do you refer and the top 3 referrals. Please check all that apply.
For youth 15 to 18 who are about to leave the system, to whom do you refer?

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<thead>
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<tr>
<td>In-school supports</td>
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<tr>
<td>Post-secondary counseling services</td>
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<td>Private counseling services</td>
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<td>Family Health Team</td>
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<td>Justice services</td>
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<td>Shelters</td>
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<tr>
<td>Supportive housing</td>
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<td>Employment services</td>
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<tr>
<td>Aboriginal services</td>
<td></td>
</tr>
<tr>
<td>No referrals leaving the children’s mental health system</td>
<td></td>
</tr>
<tr>
<td>Other, please specify:</td>
<td></td>
</tr>
</tbody>
</table>

4. The top 3 referrals account for approximately what percentage of the total? ___%

5. What services are needed by youth? Please check all that apply.

<table>
<thead>
<tr>
<th>Demand for services</th>
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<th>Requested by Others</th>
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</tbody>
</table>
6. What programs and/or services within your organization are available specifically to transitional aged youth?  *Please check all that apply.*

<table>
<thead>
<tr>
<th>Services Offered</th>
<th>Services Specific to Youth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health clinical counseling</td>
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<tr>
<td>Systems navigation (provide information about services)</td>
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7. What youth services are offered at other organizations in your community? *Please check all that apply.* The responses to this question will contribute to the development of a collaborative framework for transitioning youth and to determine service provider awareness.

<table>
<thead>
<tr>
<th>Youth Services Offered</th>
<th>At other Organizations In your Community</th>
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<td>Links to advocacy, empowerment and mentoring</td>
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<td>Don’t know</td>
<td></td>
</tr>
<tr>
<td>Do not have specific services for youth</td>
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</tr>
<tr>
<td>Other, please specify:</td>
<td></td>
</tr>
</tbody>
</table>

**Skills set:**

8. Do you have any mental health counsellors who are trained in working with youth?
   - ___Yes
   - ___No

9. Do you have any addictions counselors who are trained in working with youth?
Yes  No  Not applicable

Youth Transitions:
10. Please state the average number of youth (16 – 18) transitions you deal with per year: ____

11. Do you have a written policy, tools or guidelines to help with the process of transition?
   ___Yes ___No

12. Do you have service agreements or protocols with Adult Mental Health services?
   ___Yes ___No

13. In a planned transition process, when would be the ideal time or age to initiate the transition?
   ___2 years prior
   ___When stable and developmentally ready
   ___1 year prior
   ___6 months prior
   ___3 months prior
   ___Other, please specify:____________________________________________________________________

14. When youth 16 to 18 are transitioning to another counselling service outside of Children’s Mental Health,
   a. Is a meeting planned with the youth to initiate and prepare for the transition process?
      ___ Yes  ___No  Comment: __________________________________________

   b. Is the youth involved in decisions about meeting their needs?
      ___ Yes  ___No  Comment: __________________________________________

   c. Is a transition meeting planned with the current youth counsellor or worker, the client and the
      new adult counsellor?
      ___Yes ___No ___Only if the client requests it

15. Which of the following activities are currently used to facilitate youth transitioning? Please check all that apply.

| Team meetings between children’s and adult mental health services     |
|----------------------------------------------------------|------------------|
| Collaborative decision-making between children’s and adult mental health services |
| Collaboration with other teams/professionals during transition      |
| Follow-up with the adult mental health services and with the client where the transition has not occurred or there are problems |
| Follow-up with the client after the transition with phone calls or texting |
| Do not have specific activities to facilitate youth transitioning    |
| Other, please specify:                                             |
16. If there is a follow-up with the client after the transition, how often is the follow-up?
   ____ monthly phone call or texting
   ____ bi-weekly phone call or texting
   ____ weekly phone call or texting
   ____ do not follow-up
   ____ other, please specify: __________________________

17. For how long is the follow-up after the client transitions?
   ____ 1 – 2 months
   ____ 3 - 4 months
   ____ 5 – 6 months
   ____ not applicable
   ____ other, please specify: __________________________

18. For each of the following groups, how aware do you think they are of organizations that provide youth services in your community?

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<tr>
<th>Awareness of Organizations that Provide Youth Services Among</th>
<th>Degree of Awareness</th>
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<tr>
<td></td>
<td>Very High</td>
</tr>
<tr>
<td>Health care providers in your community</td>
<td></td>
</tr>
<tr>
<td>Service providers in your community</td>
<td></td>
</tr>
<tr>
<td>Transitional youth (15 – 19) in your community</td>
<td></td>
</tr>
<tr>
<td>Families of transitional youth (15 – 19) in your community</td>
<td></td>
</tr>
</tbody>
</table>

19. For each of the following groups, how knowledgeable do you think they are of youth programs and services within organizations in your community?

<table>
<thead>
<tr>
<th>Knowledge of Specific Youth Services within Each Organization Among</th>
<th>Degree of Knowledge</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Very High</td>
</tr>
<tr>
<td>Health care providers in your community</td>
<td></td>
</tr>
<tr>
<td>Service providers in your community</td>
<td></td>
</tr>
<tr>
<td>Transitional youth (15 – 19) in your community</td>
<td></td>
</tr>
<tr>
<td>Families of transitional youth (15 – 19) in your community</td>
<td></td>
</tr>
</tbody>
</table>

20. How do you perceive the demand for Mental Health services and supports among youth 16 to 19 in the last few years?
   ____ increase in demand  ____ decrease in demand  ____ demand is the same

   Comments:
   _____________________________________________________________________

97
21. What do you anticipate the demand for Mental Health services and supports among youth 16 to 19 to be in the next few years?

___ increase in demand  ___ decrease in demand  ___ demand is the same

Comments:
_______________________________________________________________________________

22. What reason(s) do you attribute these trends?
APPENDIX VII – (c): MENTAL HEALTH AND ADDICTIONS ON-LINE SURVEY - ADDICTIONS

SE LHIN Youth Transition Research - Addictions

Facilitate the Transitioning of Youth in your Community!

The Youth Transition Project is funded by the South East Local Health Integration Network (SE LHIN) to examine services, help improve the flow and access to care of eligible youth aged 15 to 19 transitioning primarily from the children’s mental health to the adult mental health system. Transition is defined as a process of change when youth move from one organizational system to another for service (e.g. children’s mental health to adult mental health). Once the case has been accepted by the new organization, the case is closed. Phase One of this project is to conduct research to:

1. determine the number of eligible youth aged 15 to 19 who are transitioning;

2. identify services that are missing or needed to transition seamlessly; and

3. identify the barriers to transitioning.

By participating in this on-line survey, you will assist in determining factors that facilitate a more seamless transition and in identifying service needs and gaps for transitioning youth within our community.

The survey should take about 10 minutes to complete. All information obtained in this study is private and strictly confidential. The survey findings will be analyzed on an aggregate and theme basis, and no information will be shared or released that could identify individual respondents. If you have any questions, or if you encounter any problems completing the on-line survey, please contact Lily Lee at (613) 969-0830 Ext. 256 or lilyl@youthab.ca.

Thank you in advance for your support and participation in this initiative. Each member's input is valuable to improve the youth transition process.

On-line Survey for Addictions Service Providers

1. Please indicate which geographic area your agency services.
   ___Frontenac
   ___Hastings – Prince Edward
   ___Lanark, Leeds & Grenville
   ___Lennox & Addington
   ___Other, please specify: _______________________________________________________

2. How many youth aged 15 to 19 are you serving? (If you are unable to answer this question as listed, please indicate the most comparable age range and number serving) ______________________
3. How many youth aged 20 to 24 are you serving? (If you are unable to answer this question as listed, please indicate the most comparable age range and number serving) _______________________

4. For youth 15 to 19, please indicate where your referrals come from and the top 3 referrals. Please check all that apply.

<table>
<thead>
<tr>
<th>Where do your referrals come from?</th>
<th>All referrals</th>
<th>Top 3 referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children’s Mental Health Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult Mental Health Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Centralized intake / coordinated access</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Addiction agencies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital - Crisis intervention</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital - Early psychosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital – Eating disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children’s Aid Society – CAS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Youth centre</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Youth services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High schools</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-secondary counseling services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private counseling services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Independent primary health care provider (family physician)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Health Team</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Health Centre</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse Practitioner Clinic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ontario Works</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Justice – Police</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Justice – Court Support &amp; Diversion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Justice – Correctional Facilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Justice – Probation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aboriginal services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shelters</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supportive housing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employment services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Friends</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other, please specify:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5. The top 3 referrals account for approximately what percentage of the total? ____%

6. For youth 15 to 19 who need community support services, please indicate to whom do you refer and the top 3 referrals. Please check all that apply.
For youth 15 to 19 who need support services, to whom do you refer?

<table>
<thead>
<tr>
<th>All referrals</th>
<th>Top 3 referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other addiction programs</td>
<td></td>
</tr>
<tr>
<td>Problem gambling services</td>
<td></td>
</tr>
<tr>
<td>Children’s mental health services</td>
<td></td>
</tr>
<tr>
<td>Adult mental health services</td>
<td></td>
</tr>
<tr>
<td>Centralized intake/coordinated access</td>
<td></td>
</tr>
<tr>
<td>Hospital – Early psychosis</td>
<td></td>
</tr>
<tr>
<td>Hospital – Eating disorder</td>
<td></td>
</tr>
<tr>
<td>Youth centres</td>
<td></td>
</tr>
<tr>
<td>Youth services</td>
<td></td>
</tr>
<tr>
<td>In-school supports</td>
<td></td>
</tr>
<tr>
<td>Post-secondary counseling services</td>
<td></td>
</tr>
<tr>
<td>Private counseling services</td>
<td></td>
</tr>
<tr>
<td>Independent primary health care provider (family physician)</td>
<td></td>
</tr>
<tr>
<td>Family Health Team</td>
<td></td>
</tr>
<tr>
<td>Community Health Centre</td>
<td></td>
</tr>
<tr>
<td>Nurse Practitioner Clinic</td>
<td></td>
</tr>
<tr>
<td>Ontario Works</td>
<td></td>
</tr>
<tr>
<td>Justice services</td>
<td></td>
</tr>
<tr>
<td>Aboriginal services</td>
<td></td>
</tr>
<tr>
<td>Shelters</td>
<td></td>
</tr>
<tr>
<td>Supportive housing</td>
<td></td>
</tr>
<tr>
<td>Employment services</td>
<td></td>
</tr>
<tr>
<td>Other, please specify:</td>
<td></td>
</tr>
</tbody>
</table>

7. The top 3 referrals account for approximately what percentage of the total?
   ____%

8. What services are needed by youth? Please check all that apply.

<table>
<thead>
<tr>
<th>Demand for services</th>
<th>Requested by Youth</th>
<th>Requested by Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addictions treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Problem gambling services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental health clinical counseling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access to a psychiatrist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access to a psychologist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supportive counseling for youth and families</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary health care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Independent living and social skills</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shelter</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supportive housing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Independent housing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employment, skills and support</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Educational/vocational, skills and support</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Justice and support
Mentoring and peer support
Youth engagement (sustained involvement of a young person in an activity outside of his/her self, developing confidence and interpersonal skills)
Youth drop in centre (promotes positive and social opportunities, recreation and skills development)
Recreational
Other financial assistance, e.g. trusteeship, bursaries, etc.
Ontario Works
ODSP
Systems navigation (provide information about services)
Case management
Links to advocacy, empowerment and mentoring
Respite care for families
Other, please specify:

9. What programs and / or services within your organization are available specifically to transitional aged youth? *Please check all that apply.*

<table>
<thead>
<tr>
<th>Youth Services Offered</th>
<th>Within your Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addictions treatment</td>
<td></td>
</tr>
<tr>
<td>Problem gambling services</td>
<td></td>
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<tr>
<td>Mental health clinical counseling</td>
<td></td>
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<td>Access to a psychiatrist</td>
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<tr>
<td>Access to a psychologist</td>
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<td>Primary health care</td>
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<tr>
<td>Supportive counseling for youth and families</td>
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<td>Independent living and social skills</td>
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<tr>
<td>Independent housing</td>
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<tr>
<td>Educational/vocational , skills and support</td>
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</tr>
<tr>
<td>Justice and support</td>
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<tr>
<td>Mentoring and peer support</td>
<td></td>
</tr>
<tr>
<td>Youth engagement (sustained involvement of a young person in an activity outside of his/her self, developing confidence and interpersonal skills)</td>
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<tr>
<td>Youth drop in centre (promotes positive and social opportunities, recreation and skills development)</td>
<td></td>
</tr>
<tr>
<td>Recreational</td>
<td></td>
</tr>
<tr>
<td>Other financial assistance, e.g. trusteeship, bursaries, etc.</td>
<td></td>
</tr>
<tr>
<td>Systems navigation (provide information about services)</td>
<td></td>
</tr>
<tr>
<td>Case management</td>
<td></td>
</tr>
<tr>
<td>Links to advocacy, empowerment and mentoring</td>
<td></td>
</tr>
<tr>
<td>Do not have specific services for youth</td>
<td></td>
</tr>
</tbody>
</table>
10. What youth services are offered at other organizations in your community? Please check all that apply. The responses to this question will contribute to the development of a collaborative framework for transitioning youth and to determine service provider awareness.

<table>
<thead>
<tr>
<th>Youth Services Offered</th>
<th>At other Organizations In your Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addictions treatment</td>
<td></td>
</tr>
<tr>
<td>Mental health clinical counseling</td>
<td></td>
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<tr>
<td>Problem gambling services</td>
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<tr>
<td>Access to a psychiatrist</td>
<td></td>
</tr>
<tr>
<td>Access to a psychologist</td>
<td></td>
</tr>
<tr>
<td>Primary health care (family physicians, nurse practitioners, Family Health Teams, Community Health Centres)</td>
<td></td>
</tr>
<tr>
<td>Supportive counseling for youth and families</td>
<td></td>
</tr>
<tr>
<td>Independent living and social skills</td>
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<td>Independent housing</td>
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<tr>
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<tr>
<td>Educational/vocational, skills and support</td>
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<td>Youth engagement (sustained involvement of a young person in an activity outside of his/her self, developing confidence and interpersonal skills)</td>
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<tr>
<td>Recreational</td>
<td></td>
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<td>Other financial assistance, e.g. trusteeship, bursaries, etc.</td>
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<tr>
<td>Systems navigation (provide information about services)</td>
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</tr>
<tr>
<td>Case management</td>
<td></td>
</tr>
<tr>
<td>Respite care for families</td>
<td></td>
</tr>
<tr>
<td>Links to advocacy, empowerment and mentoring</td>
<td></td>
</tr>
<tr>
<td>Don’t know</td>
<td></td>
</tr>
<tr>
<td>Do not have specific services for youth</td>
<td></td>
</tr>
<tr>
<td>Other, please specify:</td>
<td></td>
</tr>
</tbody>
</table>

Skills set:

11. Do you have counsellors who are specialized in working with youth?

___Yes        ___No
Youth Transitions (Transition is defined as the process of change when youth move from one organizational system to another for service (e.g. children’s mental health to adult mental health). Once the case has been accepted by the new organization, the case is closed.

12. Do you transition youth 15 and over? ____Yes      ____No
   Answering No will automatically skip to Q. 21.

13. a. Please state the average number of youth (15 – 19) transitions you deal with per year: ____
   b. Please state the average number of youth (20 – 24) transitions you deal with per year: ____

14. Do you have a written policy, tools or guidelines to help with the process of transition?
   ____ Yes         ____No

15. Do you have service agreements or protocols regarding transitions for youth with other service providers?
   ____ Yes         ____No

16. In a planned transition process, when would be the ideal time or age to initiate the transition?
   ____ One year prior
   ____ When stable and developmentally ready
   ____ 6 months prior
   ____ 2 -3 months prior
   ____ Other, please specify:

17. When youth 15 to 19 are transitioning to another provider,
   a. Is a meeting planned with the youth to initiate and prepare for the transition process?
      ____ Yes         ____ No         Comment:

   b. Is the youth involved in decisions about meeting their needs?
      ____ Yes         ____ No         Comment:

   c. Is a meeting planned with the current youth counsellor or worker, the client and the new counselor or worker?
      ____ Yes         ____ No         ____Only if the client requests it

18. If applicable, which of the following activities are currently used to facilitate transitioning for youth? *Please check all that apply.*

<table>
<thead>
<tr>
<th>Activity</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Team meetings between addiction services and other organizations</td>
<td></td>
</tr>
<tr>
<td>Collaborative decision-making between addiction services and other orgs</td>
<td></td>
</tr>
<tr>
<td>Collaboration with other teams/professionals during transition</td>
<td></td>
</tr>
<tr>
<td>Follow-up with client, youth counsellor/worker where the transition has not occurred or there are problems</td>
<td></td>
</tr>
<tr>
<td>Follow-up with the client after the transition with phone calls or texting</td>
<td></td>
</tr>
</tbody>
</table>
19. If there is a follow-up with the client after the transition, how often is the follow-up?
   ___ monthly phone call or texting
   ___ bi-weekly phone call or texting
   ___ weekly phone call or texting
   ___ do not follow-up
   ___ other, please specify:
   ______________________________________________________

20. For how long is the follow-up after the client transitions?
   ___ 1–2 months
   ___ 3–4 months
   ___ 5–6 months
   ___ other, please specify:
   ______________________________________________________

21. What is the average number of days between the first call and the first appointment in your agency?
   ______

22. For each of the following groups, how aware do you think they are of organizations that provide youth services in your community?

<table>
<thead>
<tr>
<th>Awareness of Organizations that Provide Youth Services Among</th>
<th>Degree of Awareness</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Very High</td>
</tr>
<tr>
<td>Health care providers in your community</td>
<td></td>
</tr>
<tr>
<td>Service providers in your community</td>
<td></td>
</tr>
<tr>
<td>Transitional youth (15 – 19) in your community</td>
<td></td>
</tr>
<tr>
<td>Families of transitional youth (15 – 19) in your community</td>
<td></td>
</tr>
</tbody>
</table>

23. For each of the following groups, how knowledgeable do you think they are of youth programs and services within organizations in your community?

<table>
<thead>
<tr>
<th>Knowledge of Specific Youth Services within Each Organization Among</th>
<th>Degree of Knowledge</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Very High</td>
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<td>Health care providers in your community</td>
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<tr>
<td>Service providers in your community</td>
<td></td>
</tr>
<tr>
<td>Transitional youth (15 – 19) in your community</td>
<td></td>
</tr>
<tr>
<td>Families of transitional youth (15 – 19) in your community</td>
<td></td>
</tr>
</tbody>
</table>
24. How do you perceive the demand for Addictions services and supports among youth 15 to 19 in the last few years?

___ increase in demand  ___ decrease in demand  ___ demand is the same

Comments:
____________________________________________________________________________

25. What do you anticipate the demand for Addictions services and supports among youth 15 to 19 to be in the next few years?

___ increase in demand  ___ decrease in demand  ___ demand is the same

Comments:
____________________________________________________________________________

26. What reason(s) do you attribute these trends?

____________________________________________________________________________
APPENDIX VIII – (a): MENTAL HEALTH AND ADDICTIONS QUALITATIVE RESEARCH QUESTIONS - AMH

SE LHIN Youth Transition Research

Research Interviews with Adult Mental Health Service Providers

Transition is defined as a process of change when youth move from one organizational system to another for service (e.g. children’s mental health to adult mental health).

Section A: Achieving Successful Transitions from CMHS to AMHS

1. Please describe your current transition process. Take us through step-by-step.

2. Are there gaps in clinical services when you need to make a referral for one of your clients? If so, what are the gaps?

3. What type of service agreements or protocols do you have with CMHS?

4. How does centralized intake (coordinated access) work in your region?

5. How do you manage your wait list?

6. How long is the approximate wait list in terms of weeks or months to transition for each of your locations?

7. Specific location:
   ___________  ___ weeks  OR  ___ months
   ___________  ___ weeks  OR  ___ months
   ___________  ___ weeks  OR  ___ months
   ___________  ___ weeks  OR  ___ months
   ___________  ___ weeks  OR  ___ months

Section B: Preparing and engaging youth for and in the transition process

8. Are youth prepared and engaged in the transition process? If so, how?

9. Are youth involved in decisions about meeting their needs? If so, how?

Section C: Services and supports to achieving successful transitions

10. What transition services and supports are working well and why?

11. What transition services and supports are working less well and why? How can they be improved?

12. What are the challenges?
13. Are there any lessons learned from service and support improvements for youth in transition that you would like to share?

14. What services and supports are missing or needed for youth?
   a. With addictions?
   b. With moderate mental illnesses?
   c. With severe mental illnesses?

15. With a severe mental illness, is at risk of being homeless, has had a conviction and has dropped out of school?

Section D: Barriers and facilitators to achieving successful transition (i.e., a planned, orderly and purposeful process of change from the children’s to adult’s Mental Health system)

16. Are there obstacles / barriers in transitioning youth from the Children’s Mental Health system to the Adult’s Mental Health system? If so, what are the obstacles? (e.g., time, training, organizational differences between CMHS and AMHS, lack of programming, resistance from client/service providers)

17. How can these obstacles / barriers be addressed?

18. What tools or aids would be helpful in achieving successful transition (e.g., tools, guidelines, collaborative decision-making, training)?

Section E: Determining needs and priorities

19. Which youth are more difficult / problematic to transition? Why?

20. Which youth have a higher risk to fall through the cracks in transitioning?

21. Which youth do you perceive to have the greatest transitional need in your community?
   a. If you could design a framework model that would transition youth seamlessly from the Children’s Mental Health system to Adult’s Mental Health system, what would it look like?
   b. What are the services that would be required to do this?

Section F: Communication and collaboration

22. a. If the client has a number of care providers, are you sharing client information with the other care providers? If so, how?
   b. How can the current system be improved?

23. What is needed to collaborate effectively with other teams/professionals during transition?

24. How can collaboration improve the transition process?

Section G: Other

25. Is there anything else you would like to share?
APPENDIX VIII – (b): MENTAL HEALTH AND ADDICTIONS QUALITATIVE RESEARCH QUESTIONS - CMH

SE LHIN Youth Transition Research

Research Interviews with Children’s Mental Health Service Providers

Transition is defined as a process of change when youth move from one organizational system to another for service (e.g. children’s mental health to adult mental health).

Section A: Achieving Successful Transitions from CMHS to AMHS

1. Please describe your current transition process. Take us through step-by-step.

2. Are there gaps in clinical services when you need to make a referral for one of your clients? If so, what are the gaps?

3. What type of service agreements or protocols do you have with AMHS?

4. How does centralized intake work in your region?

Section B: Preparing and engaging youth for and in the transition process

5. Are youth prepared and engaged in the transition process? If so, how?

6. Are youth involved in decisions about meeting their needs? If so, how?

Section C: Services and supports to achieving successful transitions

7. What transition services and supports are working well and why?

8. What transition services and supports are working less well and why? How can they be improved?

9. What are the challenges?

10. Are there any lessons learned from service and support improvements for youth in transition that you would like to share?

11. What services and supports are missing or needed for youth?
   a. With addictions?
   b. With moderate mental illnesses?
   c. With severe mental illnesses?
   d. With a severe mental illness, is at risk of being homeless, has had a conviction and has dropped out of school?
Section D: Barriers and facilitators to achieving successful transition (i.e., a planned, orderly and purposeful process of change from the children’s to adult’s Mental Health system)

12. Are there obstacles / barriers in transitioning youth from the Children’s Mental Health system to the Adult’s Mental Health system? If so, what are the obstacles? (e.g., time, training, organizational differences between CMHS and AMHS, lack of programming, resistance from client/service providers)

13. How can these obstacles / barriers be addressed?

14. What tools or aids would be helpful in achieving successful transition (e.g., tools, guidelines, collaborative decision-making, training)?

Section E: Determining needs and priorities

15. Which youth are more difficult / problematic to transition? Why?

16. Which youth have a higher risk to fall through the cracks in transitioning?

17. Which youth do you perceive to have the greatest transitional need in your community?

18. a. If you could design a framework model that would transition youth seamlessly from the Children’s Mental Health system to Adult’s Mental Health system, what would it look like?
   b. What are the services that would be required to do this?

Section F: Communication and collaboration

19. a. If the client has a number of care providers, are you sharing client information with the other care providers? If so, how?
   b. How can the current system be improved?

20. What is needed to collaborate effectively with other teams/professionals during transition?

21. How can collaboration improve the transition process?

Section G: Other

22. Is there anything else you would like to share?
SE LHIN Youth Transition Research

Research Interview with Addictions’ Providers

Transition is defined as a process of change when youth move from one organizational system to another for service (e.g. children’s mental health to adult mental health). Once the case has been accepted by the new organization, the case is then closed.

Section A: Achieving Successful Transitions

1. Please describe your current transition process. Take us through step-by-step.

2. Are there gaps in clinical services when you need to make a referral for one of your clients? If so, what are the gaps?

3. Is there a difference in the level of support for youth when receiving services from the children’s mental health system versus the adult mental health system? If so, how?

4. What type of service agreements or protocols do you have with other service providers in transitioning youth?

Section B: Preparing and engaging youth for and in the transition process

5. Are youth prepared and engaged in the transition process? If so, how?

6. Are youth involved in decisions about meeting their needs? If so, how?

Section C: Services and supports to achieving successful transitions

7. What transition services and supports are working well and why?

8. What transition services and supports are working less well and why? How can they be improved?

9. Are there any lessons learned from service and support improvements for youth in transition that you would like to share?

10. What are the challenges?

11. What services and supports are missing or needed for youth?

   a. With addictions?

   b. With concurrent disorders?
c. With addictions, is at risk of being homeless, has had a conviction and has dropped out of school?

Section D: Barriers and facilitators to achieving successful transition (i.e., a planned, orderly and purposeful process of change from one organizational system to another):

12. Are there obstacles / barriers in transitioning youth? If so, what are the obstacles? (e.g., time, training, organizational differences, lack of programming, resistance from clients/service providers)

13. How can these obstacles / barriers be addressed?

14. What tools or aids would be helpful in achieving successful transition (e.g., tools, guidelines, collaborative decision-making, training)?

Section E: Determining needs and priorities

15. Which youth are more difficult / problematic to transition? Why?

16. Which youth have a higher risk to fall through the cracks in transitioning?

17. Which youth do you perceive to have the greatest transitional need in your community?

18. If you could design a framework model that would transition youth seamlessly from one organizational system to another, what would it look like?
   a. What are the services that would be required to do this?

Section F: Communication and collaboration

19. a. If the client has a number of care providers, are you sharing client information with the other care providers? If so, how?
   b. How can the current system be improved?

20. What is needed to collaborate effectively with other teams/professionals during transition?

21. How can collaboration improve the transition process?

Section G: Other

22. Is there anything else you would like to share?
APPENDIX VIII – (d): MENTAL HEALTH AND ADDICTIONS QUALITATIVE RESEARCH QUESTIONS
ADDICTIONS (Non-transition)

SE LHIN Youth Transition Research

Research Interview with Addictions’ Providers (non-transition):

Services for youth:

1. What are some of the specific services for transitional aged youth with addictions available within your community? Can you elaborate on some of these services?

2. Are there gaps in clinical services when you need to make a referral for one of your clients? If so, what are the gaps?

3. Is there a difference in the level of support for youth when receiving services from the children's mental health system versus the adult mental health system? If so, how?

4. What services and supports are missing or needed for youth?
   a. With addictions?
   b. With concurrent disorders?
   c. With addictions, is at risk of being homeless, has had a conviction and has dropped out of school?

Communication

5. a. If the client has a number of care providers, are you sharing client information with the other care providers? If so, how?
   b. How can the current system be improved?

6. Is there anything else you would like to share?
APPENDIX IX: COMMUNITY AGENCIES / SERVICES RESEARCH QUESTIONS

SE LHIN Youth Transition Research

Research Questions for Community Service Providers

Services for youth:

1. What specific programs or services are available for youth (aged 15 to 24) with Mental Health & Addictions issues within your organization?

2. Are there gaps in clinical services when you need to make a referral for one of your clients? If so, what are the gaps?

3. Is there a difference in the level of support for youth when receiving services from the children’s mental health system versus the adult mental health system? If so, how?

Transition is defined as a process of change when youth move from one organizational system to another for service (e.g. children’s mental health to adult mental health). Once the case has been accepted by the new organization, the case is then closed.

Achieving Successful Transitions:

4. Do you transition youth aged 15 to 19?

5. Do you transition youth aged 20 to 24?

Questions 6 to 9 apply to those who transition youth; otherwise Skip to Question 10.

   - Is a meeting planned with youth to initiate and prepare for the transition process?
   - Are youth involved in decisions about meeting their needs? If so, how?
   - Is a transition meeting planned with the current counsellor or worker, the client and the new counsellor?
   - Do you meet and collaborate with other organizations during the transition?
   - Is there follow-up with the new agency and with the client where the transition has not occurred or there are problems?
   - Is there follow-up with the client after the transition with phone calls or texting?
   - How often is the follow-up and for how long?

7. What transition services and supports are working well and why?

8. What transition services and supports are working less well and why? How can they be improved?

9. Are there any lessons learned from service and support improvements for youth in transition that you would like to share?
**Services and supports to achieving successful transitions:**

10. What services and supports are missing or needed for youth?
    
    a. With addictions?
    
    b. With moderate mental illnesses?
    
    c. With severe mental illnesses?
    
    d. With a severe mental illness, is at risk of being homeless, has had a conviction and has dropped out of school?

**Barriers and facilitators to achieving successful transition (i.e., a planned, orderly and purposeful process of change from one organizational system to another):**

11. What are the challenges in youth transitioning?

12. Are there obstacles / barriers in transitioning youth? If so, what are the obstacles? (e.g., time, training, organizational differences, lack of programming, resistance from client/service providers)

13. How can these obstacles / barriers be addressed?

**Determining needs and priorities:**

14. Which youth are more difficult / problematic to transition? Why?

15. Which youth have a higher risk to fall through the cracks in transitioning?

16. a. If you could design a framework model that would transition youth seamlessly from one organizational system to another, what would it look like?

    b. What are the services that would be required to do this?

**Communication and collaboration:**

17. What is needed to collaborate effectively with other teams/professionals during transition?

18. How can collaboration improve the transition process?

**Other:**

19. Is there anything else you would like to share?
APPENDIX X (a): GUIDE FOR YOUTH FOCUS GROUP

Introduction

Hi everyone, my name is Lily Lee. Thank you for agreeing to take part in this focus group. I am working on a study on youth aged 15 to 19 who are receiving mental health services and had their care transferred to adult mental health services. I am interested in hearing from you about your experiences in transitioning from one mental health agency to another for service.

During this focus group, I would like to get your thoughts on what is working and not working when transitioning to another mental health agency for service. We want to understand how services and supports can be made easier for you and find out what you need help with.

Information

All the information collected from today will be stored on a computer with each youth focus group identified only by a number code. No individual identities will be transcribed. Only the researcher and the executive assistant transcribing the interview will be able to see the information and when this data is used in future reports no one will be able to recognize you from the information.

I would like to record the discussion that takes place during this focus group. No one outside of the researcher and executive assistant will hear the tapes, and the tapes and paper transcripts will be kept in a locked filing cabinet in a locked office. Are you willing to be recorded during this focus group so that it is easier for me not having to write while we are talking?

To make the research more useful, we need to know both positive and negative perspectives and any problems you may have experienced and would like to share. When the results are reported, the comments from everyone taking part in these focus groups will be combined anonymously, so no one can be identified. Please respect the confidentiality and opinions of the other people in this room.
APPENDIX X (b): GUIDE FOR COMMUNITY PROVIDERS FOCUS GROUP/RESEARCH INTERVIEW

Introduction

Thank you for agreeing to take part in this focus group / research interview. My name is Lily Lee. I am working on a study looking at youth aged 15 to 19 who are receiving mental health services and has their care transferred to youth and adult mental health services. I am looking specifically at youth who are transitioning from their current mental health service to another organizational mental health service.

During this focus group we specifically want to determine the types of services offered to youth within your organization as well as identify organizational factors that facilitate or impede effective transition of clients from their current mental health services to youth and adult mental health services. We want to understand if transitions are planned and how it is planned, how the process is implemented and what problems, if any, are perceived by those undergoing the transition.

Information

All the information collected from today will be stored on a computer with each person identified only by a number code. Only the researcher and the executive assistant transcribing the interview will be able to view the information and when this data is used in future reports no one will be able to recognize you from the information.

I would like to record the discussion that takes place during this focus group. No one outside of the researcher and executive assistant will hear the tapes, and the tapes and paper transcripts will be kept in a locked filing cabinet in a locked office. Are you willing to be recorded during this focus group so that I do not have to write while we are talking?

To make the research most useful, we need to know both positive and negative perspectives and any problems you may have experienced and would like to share. The comments from everyone taking part in these focus groups/research interviews will be combined anonymously when the results are reported so no one can be identified.
Dear Participant,

Through Youthab Quinte, the South East Local Health Integration Network (SE LHIN) has funded a project to study the transitioning of youth from children’s mental health to the adult mental health system for service.

Goals of the Research
We would like to get your thoughts on the following topics:

1. what is working and not working in the current transition process;
2. how can services be made easier for you; and
3. what do you need help with.

Research Process
Participation in this research is voluntary. Before the focus group, you will be asked to fill out a brief survey about services used. You will participate in a focus group with other youth. Up to 2 hours have been set aside for the focus group depending on the number of participants. With your permission, the focus group will be recorded on audiotape to make it easier to take notes on the discussion. Your input will be highly valuable in creating ways to make it easier for youth to transition from one agency to another for service.

There are no known risks associated with participating in this research although talking about one’s experiences might make one feel uncomfortable. If this should happen, the focus group can be stopped and support be given by a counsellor.

Confidentiality
All information obtained in the course of this study is strictly confidential and your identity will be protected at all times. You will not be identified in any reports produced for this project. Each youth focus group will be classified by a code number and no individual identities will be transcribed. All electronic data will be password protected and secured in locked offices. Only Lily Lee, the researcher in
the study and the executive assistant who will be typing up the interview will be able to view the information, no one outside the research team will hear the audiotapes.

Copies of audiotapes or paper records will be stored in locked cabinets in locked offices. Audiotapes and data will be destroyed in seven years time. You will be provided with a copy of this form for your records.

If you have any questions regarding the study, you may contact Lily Lee, Transition Facilitator at lilyl@youthab.ca or at 613-969-0830, ext. 256.

I agree to fill out the survey: Yes ☐ No ☐
I agree to participate in the focus group: Yes ☐ No ☐
I agree to the focus group being taped: Yes ☐ No ☐

I agree to participate in this study: Signature: __________________________ Date: ______________

Print Name: _____________________________________________

Thank you in advance for your participation in our research project.

Sincerely,

CATHIE WEST
Executive Director
Youth Habilitation Quinte Inc.
210A Front Street,
Belleville, ON K8N 2Z2
613 969 0830 ext. 225
cathiew@youthab.ca
SE LHIN Youth Transition Research
Interview Consent Form

Dear Participant,

The Youth Transition Project is funded by the South East Local Health Integration Network (SE LHIN) to examine services, help improve the flow and access to care of eligible youth aged 15 to 19 transitioning primarily from the children’s mental health to the adult mental health system. Transition is defined as a process of change when youth move from one organizational system to another for service (e.g. from children’s mental health to adult mental health). Once the case has been accepted by the new organization, the case is then closed. Phase One of this project is to conduct research to:

4. determine the number of eligible youth aged 15 to 19 who are transitioning;
5. identify services that are missing or needed to transition seamlessly; and
6. identify the barriers to transitioning.

Facilitate the Transitioning of Youth in your Community:

This research project phase includes:

1. Participation in a research interview / focus group

Your input will be highly valuable in developing processes for the transitioning of youth into another organizational system, and ultimately improving services and care. The research interview / focus group will follow the format of the research questions that will be sent in advance. Up to two hours have been set aside for our interview depending on the number of participants. With your permission, the interview will be audio taped to facilitate relevant data being transcribed.

Interview transcripts will be analyzed to identify key themes. All information obtained in the course of this study is strictly confidential and your anonymity will be protected at all times. You will not be identified in any publications or reports produced for this project. All identities will be classified by code numbers. All electronic data will be password protected and secured in locked offices. Only Lily Lee, the
researcher in the study and the executive assistant who will be typing up the interview will be able to view the information, no one outside of the research team will hear the audiotapes.

Copies of audiotapes or paper records will be stored in locked cabinets in locked offices. Audiotapes and data will be destroyed in seven years time. You will be provided with a copy of this form for your records.

If you have any questions regarding the study, you may contact Lily Lee, Transition Facilitator at 613-969-0830, ext. 256.

I agree to participate in the research interview/focus group:  Yes ☐ No ☐
I agree to the interview / focus group being taped: Yes ☐ No ☐
I agree to participate in this study: Signature: __________________________ Date: ______________

Print Name: ___________________________________________

Thank you in advance for your participation in our research project.

Sincerely,

CATHIE WEST
Executive Director
Youth Habilitation Quinte Inc.
210A Front Street,
Belleville, ON K8N 2Z2
613 969 0830 ext. 225
cathiew@youthab.ca
Your Opinion Matters!

Has your counselling transitioned from one mental health agency to another?

Are you 15 to 21 years old?

Do you want a $15.00 gift card?

We want to hear from you!

Date & Time:  
Food & Drinks Provided

What has your experience been like with a children’s agency compared to an adult agency? Tell us what you think works and doesn’t work so you can help us make the services and supports better and more beneficial for youth in this area. If this interests you, Register and join us to share your thoughts and hear what other young people have to say.

Register with:  

Sponsored by  

Funded by  

Youth Habilitation Quinte Inc.