

# An Innovative Model of Care: The Psychosocial Adjustment and Help-Seeking Behaviour of Children/Youth Accessing a Walk-In Service

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# Research Team

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## Supported By

The Provincial Centre of Excellence for Child & Youth Mental Health



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# Background

- 1 in 5 children/youth experience mental health disorders at any given time (Waddell, et al., 2002).
- Only 20% of children with disorders receive specialized services=Unmet need.
- Often barriers (e.g. waiting) that prevent access.
- May be worse for certain families (e.g. immigrants).
- Implications of untreated problems serious.
- Dilemma of how best to respond:
  - In a timely manner.
  - Without compromising quality of services.
- Requires change in thinking about current services, mode of delivery.

# Background

- Need alternate methods of service delivery.
- Brief forms of therapy delivered in an accessible manner?
- Walk-In treatment is an innovative, relatively new method of delivery (e.g. Miller, Protinsky, & Slive, 1997; Miller, & Slive, 2004).
- Created in Calgary, Alberta under the umbrella of Woods Homes (Slive, et al., 1995).
- Evolved as service providers have responded to expectations of immediacy / convenience.
- Response to increasing demand / expanding need for service.
- Eliminates many barriers that traditionally prevent access , such as waiting.
- Where does this take us??

# Walk-In Centre - History

- West End Walk-In CC initially conceived in 1999.
- Response to growing need for immediate & accessible treatment.
- Began as a partnership of 4 CMHC's - YCFC, Oolagen, Hincks-Dellcrest, & Youthdale.
- Clinical directors & front-line staff worked together / year to develop a response to delayed access.
- Adapted after the Calgary walk-in model (Woods Homes, A. Slive).
- Proposal=Trillium Foundation, funding received for 3 years.
- Located at YCFC=Former city of York, high risk, underserviced area.
- Annualized grant in 2002 from United Way.
- Yorktown currently sole sponsor, funded by UW, RBC, others.

# WEWCC – What We Offer

- Offer a free, immediate, accessible session to clients.
- At chosen time of need - no waiting.
- Brief & culturally relevant counseling geared towards children / families.
- Flexible - Serves a wide range of clientele.
- Operates during 2 nights /week, no appt. or referral, no intake.
- Qualified counselors=Shift coordinator, YCFC SW, Walk-In counselor, volunteers.
- Case consultation or a reflecting team process=Ensures a broad perspective & accountability.
- Counseling offered in English and Spanish.

# The Session

- Each session is a unique therapeutic encounter.
- Treatment is based on a systemic & brief therapy orientation.
- Builds on existing client strengths.
- Interventions are pragmatic, and aim to provide a clear outcome for clients when they leave.
- Clarify issues, determine possible goals, identify resources, first steps to desired change.
- Competency-based.
- Client-responsive, collaborative.
- Invited to return, but no guarantee of same therapist.
- Referral to other resources provided when needed.

# Unique Elements

## Volunteer Therapist Program

- Incorporates training in walk-in therapy for service.
- Therapists who have a post-graduate clinical degree.
- Minimum 1 shift/month, for 12 months.
- Purpose is to build capacity, spread expertise, increase capacity.

## Multi-Cultural Outreach

- Serves diverse range of ethno-specific, special needs clientele.
- We are able to provide service in Spanish.
- COSTI provided an Italian-speaking worker to serve this community.
- Bi-monthly basis, Jan-June 2003; monthly, March 05-May 06.

# Have We Been Effective??

- Response when client most motivated=Critical to success.
- Immediate access for a variety of concerns, like parent /child conflict, school problems, depression / anxiety.
- Have served many clients with serious / acute problems.
- Linkages across sectors & with ethno-specific organizations has promoted access for those who would not normally use services (e.g. immigrants).
- Wide variety of referral sources (e.g. schools, GP's, CAS).
- Volunteers have expanded ability to meet need, skills transferable.
- Since March 2000 - 67 volunteers, 4,670 hours.

# Have We Been Effective??

- High level of satisfaction with the service (93% of 284 clients asked bt. April 2000-Feb 2002), and self-reported improvement in problem(s) (70%).
- Others (e.g. Miller, et al., 1997) have reported similar findings.
- HOWEVER: Based on informal/pilot satisfaction data, anecdotal reports.
- No standardized assessment /outcome studies (Miller, & Slive, 2004).
- How do we really know how effective we've been??



# We Needed to Know .....

- What are the MH characteristics of Walk-In clients (e.g. std.)?
- Outcomes (e.g. MH) after access?
- What additional services have clients used?
- In order to....learn how it “fares” as an accessible alternative source of care.

# The Study / Objectives

- Implemented in fall of 2006 as a result of those questions.
- Academic / community-based partnership.
- Supported by the Provincial Centre of Excellence for Child & Youth Mental Health (research grant).
- Preliminary evaluation of outcomes.
- Objectives:
  - To describe the MH characteristics of Walk-In clients / examine outcomes.
  - Examine help-seeking behaviour.
  - Compare adjustment & service use with those accessing “usual” care at YCFC.

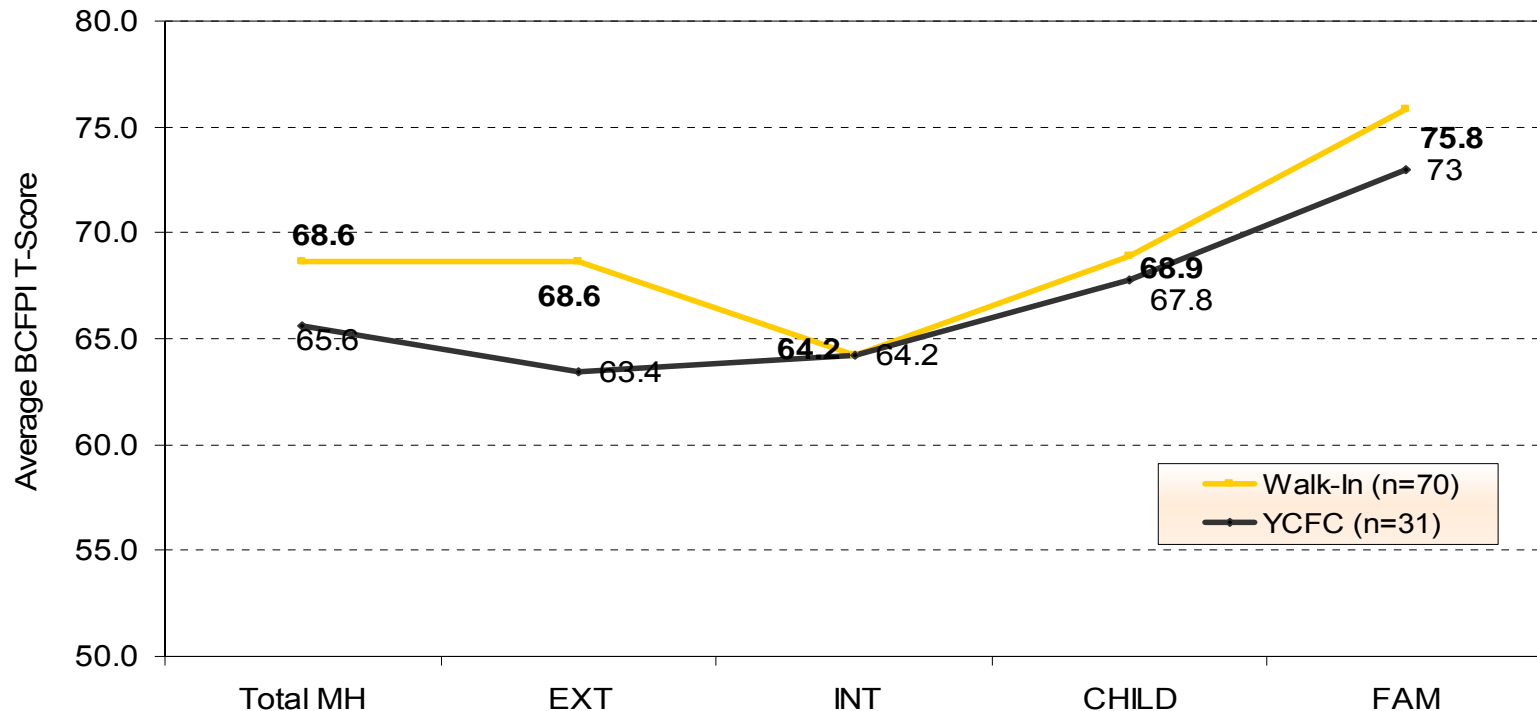
# Methodology

- Children/youth 4-18 years (n=85) who access the WEWCC.
- Recruited as they “walk in”, 2 evenings/week (implemented 2<sup>nd</sup> night of service).
- Comparison group of YCFC clients (n=35), standard intake for CORE program.
- Recruited at Initial Client Consultation meeting, usually within 2 wks of intake.
- Baseline study measures are the BCFPI (Cunningham, et al., 2003), satisfaction survey.
- Families are contacted by phone for post (2 wk) and 3-mth follow-up assessments.
- Follow-up measures are BCFPI, satisfaction, service use.

# What Have We Found?

## Mental Health / MH Outcomes

- Global baseline BCFPI T-scores with parent as informant.
- WI clients ~ 2 SD's above the mean (M=50, SD=10) for externalizing difficulties (T=69), child (T=69) & family (T=76) funct.



# Mental Health / Outcomes

- Average WI client presents with behavioural problems & impaired self / family functioning.
- WI children had slightly more severe beh. problems than YCFC clients ( $t=2.1$ ,  $p < 0.05$ ).
- BUT=Parents of both groups reported greater impact on family, than child.
- Next....what about outcomes?
- Using average post & 3-month follow-up BCFPI T-scores.
- Will allow us to track changes in psychosocial adjustment over time.
- E.g. Impact of the service, gains, were gains sustained?

# Mental Health / Outcomes

## Walk-In Clients

- Significant reduction on most subscales.
- Continued to make gains as of 3 months post-access.
- Less improvement, emotional adjustment ( but T-scores < 65 to begin with).

Table 1. Repeated Measures Analysis for Baseline, 2-Week, and 3-Month Follow-Up BCFPI Scores for WI Clients  
(\*p < 0.05, \*\*p < 0.01, \*\*\*p < 0.001)<sup>†,‡</sup>

BCFPI Scale	Baseline Mean (SD)	Post (2-Wk) Mean (SD)	3-Month Mean (SD)
Total (MH)	67.1 (12.0)	60.3 (9.9)**	57.2 (12.7)***
Externalizing	68.3 (11.6)	59.8 (9.8)***	55.8 (13.7)***
Internalizing	61.7 (12.6)	58.5 (10.6)	57.0 (10.7)*
Child F.	66.9 (13.4)	60.4 (13.9)**	58.9 (17.2)**
Family F.	75.9 (29.3)	65.3 (21.2)**	61.3 (19.0)**

<sup>†</sup>Parent report and those with BCFPI data at all time points (n=27).

<sup>‡</sup>Post and 3-month p's (e.g. \*\*) represent comparison to baseline.

# Mental Health / Outcomes

## YCFC Clients

- Improvements as of 3 months.
- Particularly family functioning; some slippage, e.g. emotional.
- Same pattern as Walk-In clients?

Table 2. Repeated Measures Analysis for Baseline, 2-Week, and 3-Month Follow-Up BCFPI Scores for YCFC Clients (\*p=marginally sign. at 0.05, \*\*p < 0.05)<sup>†,‡</sup>

<b>BCFPI Scale</b>	<b>Baseline Mean (SD)</b>	<b>Post (2-Wk) Mean (SD)</b>	<b>3-Month Mean (SD)</b>
Total (MH)	66.7 (10.6)	68.4 (11.3)	63.1 (12.7)
Externalizing	67.0 (11.4)	64.3 (10.8)	59.0 (13.5)*
Internalizing	62.3 (10.9)	68.4 (16.1)	63.9 (11.8)
Child F.	72.6 (19.0)	68.8 (18.2)	63.7 (12.9)*
Family F.	78.3 (17.7)	76.5 (14.4)	67.4 (17.9)**

<sup>†</sup>Parent report and BCFPI data at all time points (n=10).

<sup>‡</sup>Post and 3-month p's (e.g. \*\*) represent comparison to baseline.

# Outcomes / Service Use

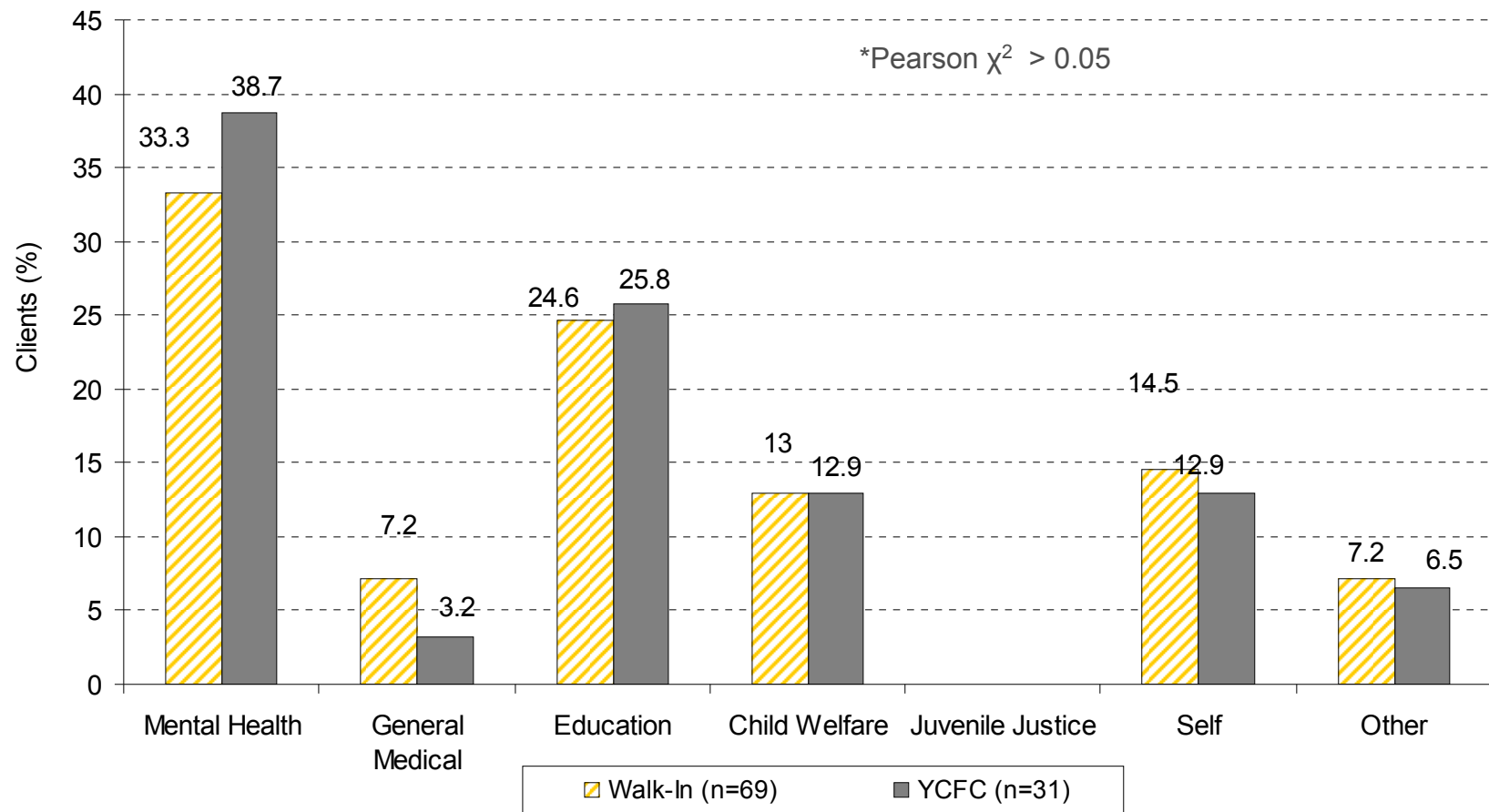
- Perhaps....need to interpret follow-up results with caution, likely unstable.
- Esp. for YCFC group, very low n for post.
- Are gains due to the use of other services?
- Where are clients - both Walk-In & YCFC - coming from?

## Referral Source

- Main sources of referral for both groups=MH & Education sectors.
- Slightly more YCFC clients referred from MH.
- Few referred from General Medical sector.
- Is this what we would expect?

# Referral Source

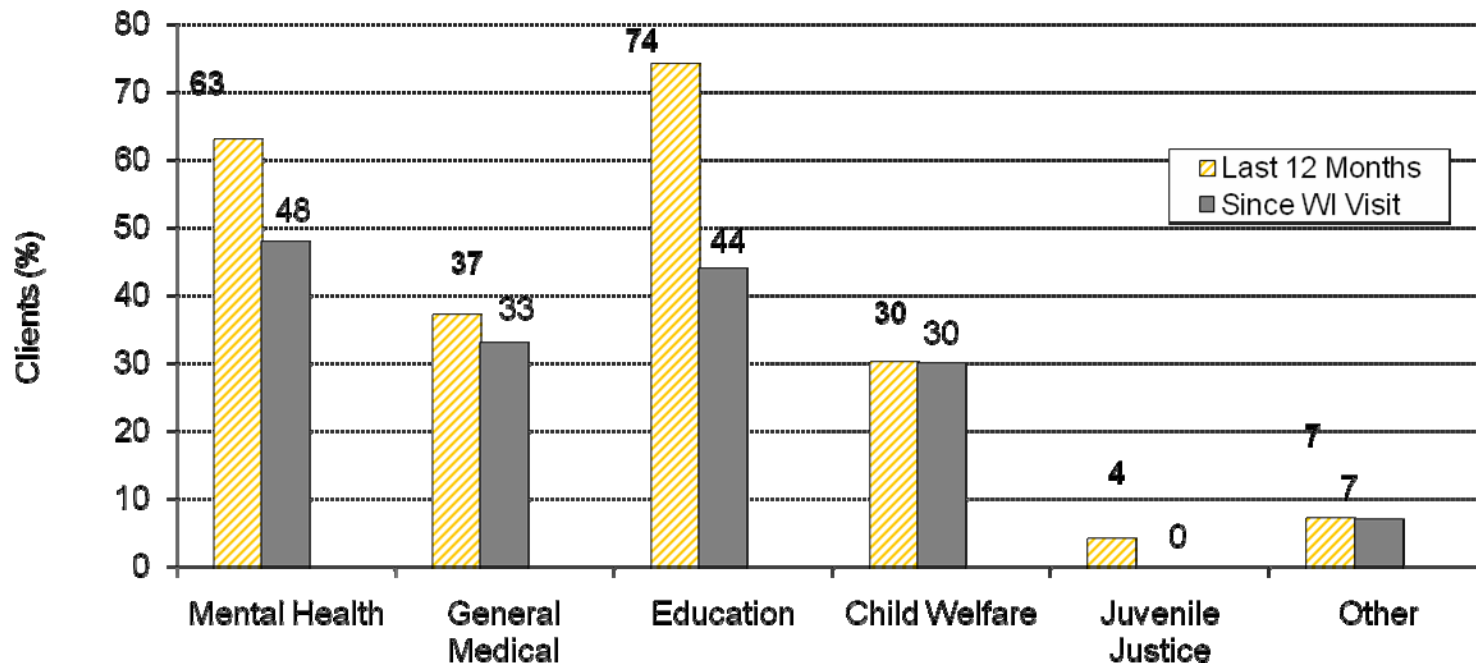
Referral Source, Walk-In & YCFC Clients (%)



# Service Use

## Walk-In Clients

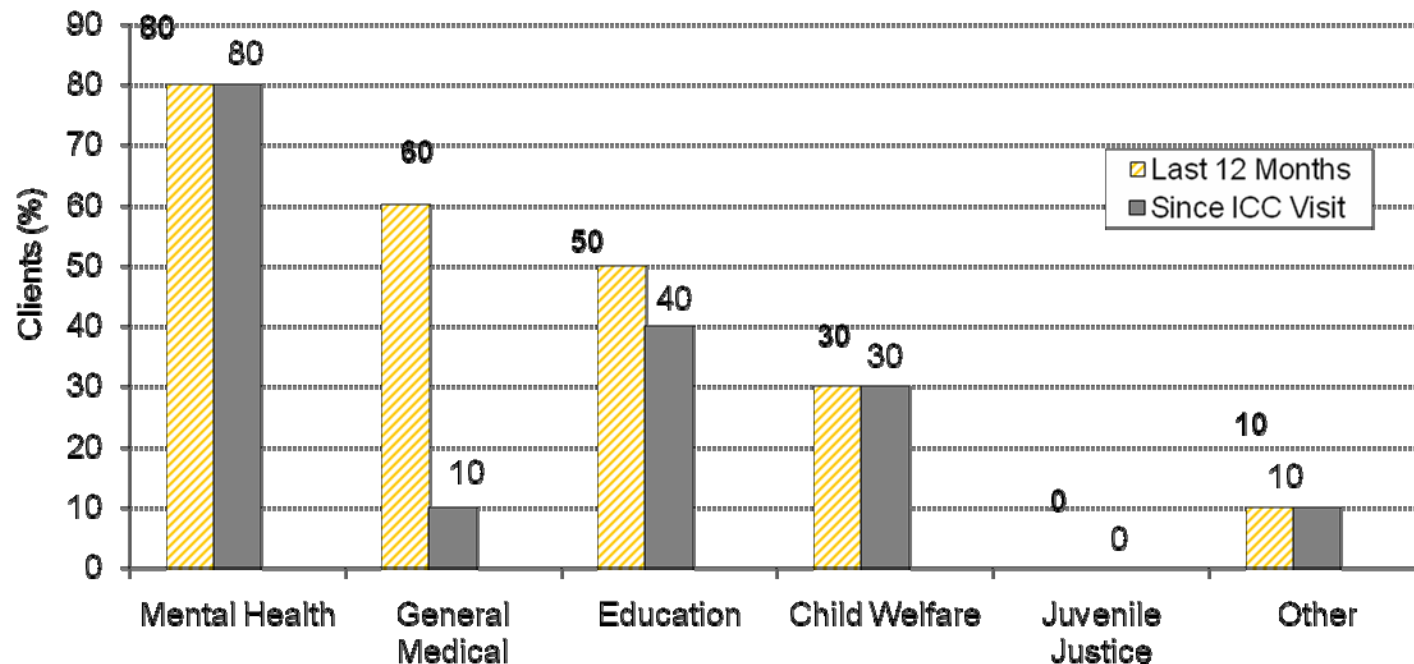
- Close to three-quarters of parents had contact with school.
- Over 60% had contact elsewhere in the MH sector.
- 70% had contact in more than one sector; several (41%) tended to be complex cases with ongoing involvement at 3-months.



# Service Use

## YCFC Clients

- The majority had some contact with MH services (last 12 mths).
- Half with school, nearly 60% in GM sector (e.g. family doc).
- All=More than one sector; MH & Child Welfare, ongoing involvement at 3-months.



# Summary / Lessons Learned

- Results largely descriptive / preliminary pending more data.
- How can we explain the observed patterns?
- Walk-In effective alternative for clients? First steps....
- Might not be “enough” - but IS for some families.
- Further work, more complex analyses:
  - WI with YCFC comparison.
  - Adjustment, association with service use.
  - Clients who did not report using services after baseline.
  - Repeat visits to WI, multiple service use.
  - Subsets of children, e.g. youth.
- Treatment dose / specific interventions not addressed.

# Lessons Learned

- Increased capacity /ability to serve clients when most in need, access.
- Useful resource to community providers, flexible.
- E.g. Expansion to second night (~ 30% higher weekly usage).
- Promotion / community outreach.
- Training continues to be successful, volunteers=Service hour increase of 21% over previous years.
- There is a need to increase usage by children / parents, families.
- ~ 65% over a year period not age-eligible, includes couples, adult issues.
- Targeted promotion, e.g. on-site presentations, strategic use of volunteers?

# Lessons Learned

- Biggest challenge to-date: Recruitment of YCFC clients for comparison group.
- Confluence of factors:
  - Client flow, eligibility
  - Staff turnover
  - Nature of client problems
  - Cancellations / no show
- Have stakeholders involved from the onset - including clinicians!
- Successful with getting staff "on-board".
- Regular research / YCFC staff consultation, e.g. meetings.
- Client tracking, hiring.
- Get others on-board, e.g. agency partners / other sites.

# Lessons Learned

- Academic / community-based partnership, alliance.
- YCFC Strategic Framework: “Research & Promising Practices,” “Strategic Alliances” - enhanced these processes.
- Study taps into already existing agency measures / procedures.
- Enhances outcomes “culture,” e.g. impacts HOW think about research, questions, & to what end (goals).
- EBP=Nature of the model, outcomes, contribute to EB.
- Feasibility=Less is better esp. to begin with!
- Results & feedback continually inform work.
- Service delivery, e.g. procedures / compare with clients in other programs.

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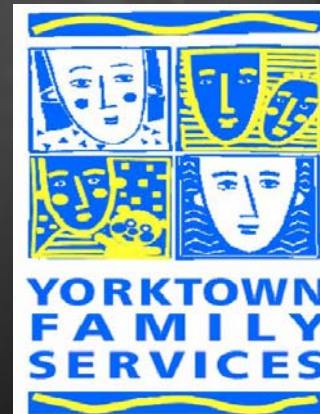
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# Thank You!

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