

Podcast – Client Centered Care and Child and Youth Mental Health

Interviewer: Sue Thompson

Interviewee: Dr. Mitchell

Introduction: Today's topic is Client Centered Care and Child and Youth Mental Health. Today's interviewer is Sue Thompson who has been at CPRI for 30 years and has worked in various clinical positions. Currently, she is enjoying working in tele-mental health services and supporting education and video conferencing across CPRI. Sue will be interviewing Dr. Clare Mitchell, who is an associate professor at the Schulich School of Medicine and Dentistry at Western University in London. She is a developmental paediatrician in the department of pediatrics and does her clinical work at CPRI. Dr. Mitchell provides assessment and treatment to children and adolescence with developmental delay/mental health concerns as part of a multi-disciplinary team. Dr. Mitchell has a particular interest in fetal alcohol spectrum disorder, turrets syndrome and assessment of children with social deficits and global health.

Interviewer: We really want to thank Dr. Clare Mitchell who is with us today and we have some questions that we are going to ask her. To start, since consent to treatment is a mandatory requirement for clients of all ages, ***what are some of the specific challenges in the child and youth population that you see?***

Interviewee: I think when any kind of treatment is recommended one of the really important things to do is have a good discussion with everybody that is involved about what the treatment is for, sometimes what it is not for, what kinds of benefits might be expected and what kind of things might go wrong or side effects. In the end, someone has to consent for that, so while the discussion goes on with everybody, and I think it is very important for kids and people of all ages to be involved in the end, the actual consent has to be someone who truly understands and appreciates the treatment as well as the risks involved. When we are treating children and youth and assessing whether a child is capable of being that consenting person or not, it is an important thing to do because the capability depends on the kind of treatment that is being offered. Some are more simple than others and because it is an evolving process of kids growing and changing, and while last year they might not be capable, this year they might. It is a bit of a challenge at times to continually make those assessments; however, I think that if the discussion is there from the beginning, then it becomes easier to see as you go along. For example, when the child is able to truly appreciate the nature of the treatment and its risks and when we need to ask a parent or other substitute decision maker.

Interviewer: I know that's actually one of the things because both you and I have been sort of working in this field for a long period of time, having worked on facilities where we didn't always get the consent from the families or didn't have a long discussion it was sort

of they came, they told them what it was and you carried on. That's one of the nice things that I see, is that there is a lot more discussion, there's a little bit more back and forth and real information gathering and providing to the families now and to the kids which I think is really, really nice.

Interviewee: And as I said, I think talking to the children, even when the parent is the one giving the consent, is very important because it sets the stage for what they are going to have to do for the rest of their life.

Interviewer: I agree - excellent. Another question for you, *what in your opinion are some of the most noteworthy changes in the children's mental health service delivery in the past five years?*

Interviewee: In the last number of years, I think there has really been a genuine effort to try and make the system a little bit easier to access and a little bit simpler. I think there is a long way to go but it is a complex system that is often hard for families to negotiate and I think it is hard for clinicians sometimes to know exactly where a particular problem is addressed best, where to refer someone when treatment might not be available or might be available in a different setting or far away. So I think trying to simplify that so that really no door is the wrong door as some have phrased it, has been an ongoing effort and I think that families will really benefit from that so that whoever they talk to can at least send them along the right path rather than having to start again. I think also there's been quite a lot of work to try and provide quicker access to families so drop-in centres for example are quite common in some of the local mental health centres. Families don't have to wait to have something addressed and I think that makes it so much easier for them. Often if something is addressed early, it doesn't become a big problem. The families get some advice and can move on rather than waiting. And this becomes a very big problem sometimes. I think the last thing that really has been part of mental health services is to work on education. So not just to children and families, but also to broader service components within mental health but also things like youth justice, to schools, to education. We have been aided there by electronic media, teleconferencing, video conferencing, webinars, that kind of thing to help people be provided with information about what kinds of problems can arise and the kinds of treatments that might be helpful.

Interviewer: I agree, and on the line talking about having more access and working in the tele-mental health department here at CPRI, that's one of the things of the last couple of years we've really seen the tele-mental health program is a little bit ahead of the broader ministry. We have actually within our program, opened up to schools that at one point, we just had access to mental health agencies and we took referrals from them. However, having opened up now, we have schools that make referrals physicians like family doctors, family health teams, social workers that work within schools and within small groups. We have really seen that there is a capacity to actually provide greater access to families and in rural remote areas, as well as in larger communities.

Interviewee: It has been very helpful and I think there is really a growing comfort with using that kind of method of communication. We get to see what the weather is like in far places around the province and country.

Interviewer: *Next question, what changes and improvements to child and family centred mental health care do you predict in the coming years? I know we've talked about a few of them in your past statement, but what else can you see coming?*

Interviewee: I think some of the things that are coming down the road, and in part to make things a bit simpler is to provide some access a bit closer to home, so that certainly across the province and Ontario there are local places where families can go to start the process of having a problem addressed. With that, there would be more efficient use of expertise in consultation. Certainly, the increased use of technology and I think it's not just telemedicine but also just using email, text message reminders, and facilitating the use of apps and other online learning modules, I really part with the vision of the future. I think the other pieces that the province is focusing on are some particularly underserved groups. One example is the Fetal Alcohol Spectrum Disorder Initiative by which the province had a broad look at the needs within the province and got some expertise together to discuss that and it will be coming out with a strategy. I think that's just one of many specific areas that Ontario is trying to address.

Interviewer: *Can you share with us how telemedicine and telepsychiatry has changed how we offer health care choices to clients and families in Ontario?* You can talk a little bit and then I'll answer some more about that since I probably know more than you do, although, you have access to the video conferencing for some of your clients which I think has been fabulous.

Interviewee: I think the main thing is that it offers choice and flexibility to families and from the clinicians that is empowering to families to be able to offer a choice to them. They do something online, they can read about it, they can meet with someone through telemedicine or perhaps, they can come onsite to CPRI and have a group setting; simply providing to them those choices and allowing them to make the best one for their particular circumstance and family. I think families truly appreciate it and it really helps them take on their own concern and deal with it in a way that suits them best. Often I find people might choose one venue to start with and then come back and say, "OK I have learned a bit now and I would actually like to come and speak with someone in person," or the other way around. So, it really is that flexibility that I think is excellent and fits in with everybody's very busy schedules.

Interviewer: I think that's one of the nicest things, when we have all the expertise in one place and you expect families and the community partners to all come to one place, it's really nice to have some options in being able to stay in your own community, especially when the weather is bad or if there is a large team. Being very respectful of everybody else's times and having those options. I know when about five years ago, everybody was sort of expected to come to CPRI and I think when I first started using the video

conferencing, the video conferencing was used about 32 times total at CPRI. Just this past year for 2015, CPRI almost reached 500 uses. So allowing families and the partners the ability to be in their own home environments 500 times a year, it's huge. It is time saved for everybody and I think it has been wonderful.

Interviewee: It certainly shows that it is a choice that fits a lot of people's idea of what would be helpful for sure.

Interviewer: *Can you elaborate on the role parents or primary caregivers have in the child's treatment?*

Interviewee: I think they really are central and it's a very positive aspect of children's mental health, so we always have a team. There is the patient, or the child or youth, their parents and family, and then myself. That would be the smallest team we have and obviously other times, we involve many more treatment providers in a team to help the family with a particular problem. So, I think the parents are really the strength that the children bring with them, they are the ones that are going to often advocate for their child and often they are the ones that are going to provide the treatment. Although, we would provide some advice and suggestions around treatment, bringing children in to talk to them for a period of time or expect them to learn something in one session, whether it's by video conference or in person, is not really realistic. We have to have it incorporated in their day-to-day lives and parents are key in doing that. So often we are training parents how to provide a lot of the therapy and I think parents are also incredibly helpful in helping us prioritize what's important to the kids. Whether that is wanting to participate in the soccer game, do better in school, or just have some time to themselves, the parents are often the ones that can bring those and help us prioritize them. The kids of course as well - but parents put it in the context for us. I think as kids get older, parents are less in a role of providing the treatment and more in a role of being the coach, someone to give some encouragement, guidance, and really help with decisions. This brings us back to the consent piece so as they get older, to give some guidance in making healthy and good decisions for themselves. Again, in this essence compared to adult mental health, the children are really lucky to have that built in support around them so that they can do the best they can in the long run.

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