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From building blocks to care pathways: Working together to support timely access to infant and early mental health care

Knowledge Institute
on Child and Youth Mental Health and Addictions

Infant and Early Mental Health Promotion
IEMHP

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SickKids®

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Key partners

- The Knowledge Institute on Child and Youth Mental Health and Addictions (The Knowledge Institute) builds connections, shares knowledge and draws on expertise to enhance the skills of direct service providers and agencies across the province. The Knowledge Institute passionately promotes and shares the benefits of organizational learning and evidence-informed practice. Together with partners, the Knowledge Institute is working to strengthen Ontario's mental health and addictions programs and services for all children, young people, families and caregivers.
- Infant and Early Mental Health Promotion (IEMHP) works with practitioners, service providers and families to strengthen knowledge and best practice in infant and early childhood mental health. IEMHP strives to improve health outcomes across the lifespan through research, capacity building and knowledge translation on evidence-informed mental health care promotion.

About this resource

What is this resource guide and who should use it?

This guide is for all community partners and sectors who work to support infant and early mental health care, such as individuals in early learning and education, public health, primary care, child and youth mental health, parents/caregivers and government. The activities outlined in this guide build on and supplement the ongoing work of community-based partnerships between sectors that have come together to improve the access and care of infants, children and their families.

This document outlines project outcomes, process, expert knowledge and evidence on best practices to inform your community work. Here is what you will find:

- Guidance on what is needed to create cross-sectoral care pathways to support infants, children and families, prenatal to age six.
- Advice on how communities can plan for, implement and sustain care pathways.
- Practical, usable considerations for each phase of care pathway development.
- A suite of resources to support your community pathway project.

Learn more about our work on infancy and early childhood.

Learn more about our partners' work on infancy and early childhood at SMH-ON and IEMHP.

How to use and navigate this resource

This resource guide outlines the key activities and considerations for each phase. In the following sections, we highlight the main factors to think about when bringing community partners together to start your care pathway journey. As well, we identify three key phases of developing a care pathway for infant and early mental health in your community. Additional resources, activities and reference documents are included in the appendices.

What informed the development of this resource?

In 2014, the Knowledge Institute and early childhood mental health experts developed Supporting Ontario's Youngest Minds. This policy paper focused on the need for early mental health identification and intervention. Then in 2019, the Knowledge Institute, IEMHP and School Mental Health Ontario (SMH-ON) developed Beyond Building Blocks. This paper built on the work from 2014 and proposed recommendations for improved cross-sector supports and collaboration for children between ages three and six.

Together with IEMHP, the Knowledge Institute launched a pilot project in 2019 to support three communities in Ontario to develop, implement and evaluate mental health care pathways for prenatal to age six. This project was the first of its kind in Canada, spanning four phases with the following activities:

- Pilot site outreach, project planning, community partnership development and formation of a provincial steering committee.
- Community visits, service mapping, care pathway development and implementation planning.
- Virtual training series on the ASQ® (Ages & Stages Questionnaires®, n.d.) and Development Support Plan (DSP) facilitated by IEMHP, along with the IEMHP Coaching Connect (CC).
- Reporting on project process, lessons learned and project outcomes.

What you need to know

The importance of infant and early mental health

We know the earliest years of life are critical to healthy brain development and a child's capacity to respond to environmental influences. In fact, up to 70% of young adults living with a mental health problem say their symptoms began in childhood (Government of Canada, 2006). The prenatal period to early childhood is an optimal time to promote positive social-emotional development and identify and address early signs of mental health issues. Taking a preventive approach helps ease potential longer-term effects over the lifespan (Canadian Institute for Health Information, 2011).

Families are often in situations where they don't know where to get mental health support, relying on family doctors or emergency departments to access care (Canadian Institute for Health Information, 2022; Ipsos Public Affairs, 2017). However, family doctors and hospital teams face complicated care transfers, inadequate connections between clinical and community-based settings or a lack of appropriate services for young children. Also, access to care is often impacted by geography and household income, as well as other social determinants of health.

There is a need across Ontario to build community capacity for implementing clear, coordinated infant and early mental health service systems to improve access and outcomes for families.

Using a common language

The terms below are used throughout this resource. A full list of essential terms can be found in the Glossary of terms (p. 31).

- Community tables: A collective working group that brings together partners from all service delivery sectors.
- Early childhood: The total period from birth to age six (Ontario Centre of Excellence for Child and Youth Mental Health, 2014).
- Infancy: The period from birth to age two (Public Health Agency of Canada, 2016).
- Infant and early mental health: "The capacity of a child to form close/secure adult and peer relationships; experience, manage and express a full range of emotions; and explore the environment — all in context of family, community, and culture" (Cohen et al., 2012, p. 1).
- Prenatal: The time during pregnancy and before birth (University of Washington Medical Center, 2017).

What are care pathways?

Care pathways for mental health care offer an accessible, efficient and effective structure to help infants, young children and their families get the support they need (Infant and Early Mental Health Promotion, n.d.).

Care pathways:

- Use a community-based, collaborative approach to match families with the best service, at the right time and in the most appropriate format.
- Guide families through processes for care and services.
- Clearly explain access, screening, transitions and treatments.
- Streamline transitions from the point of service access to delivery and follow-up.

Key characteristics of care pathways include (Kinsman et al., 2010):

- Cross-sector collaboration.
- Evidence-informed care guidelines.
- Clear objectives to improve access and resources.
- Defined responsibilities for multidisciplinary teams.
- Meaningful engagement with population(s) receiving care.
- Evaluation plans to assess and improve services.

Where to begin: A community-driven approach

Care pathways require investment and commitment from all community partners involved in delivering mental health and social-emotional supports for infants, young children and their families. Collaboration across sectors can strengthen existing care pathways by supporting information-sharing, coordinated care planning and identifying opportunities for improvement.

Infant and early mental health community tables

Community tables are an essential part of success when preparing for pathway development. They include partners from all service delivery sectors, ensuring the experiences and needs of local populations are represented. Each community is invited to identify who needs to be "at the table" and actively engaged in conversations and decision-making.

Community tables identify collective goals, determine partners' readiness and define roles and responsibilities. They are a prerequisite to successful pathway work.

If your community is beginning this work, the Knowledge Institute and IEMHP can help. We understand that communities wanting to start pathway development have their own unique timelines, knowledge and capacity for implementation. We have included key information for this stage so communities can determine their readiness.

A first step is to determine your community's capacity for developing care pathways. This stage focuses on bringing people together across sectors to identify which services in your community are available for birth to six years old. With support from IEMHP, together you will take on these tasks:

IEMHP has completed 20 community reports that identify:

- Short term (1 year) opportunities to strengthen practices, services and policies.
- Long term opportunities to strengthen practices, services and policies.
- Organizational policies and procedures specific to infant mental health.

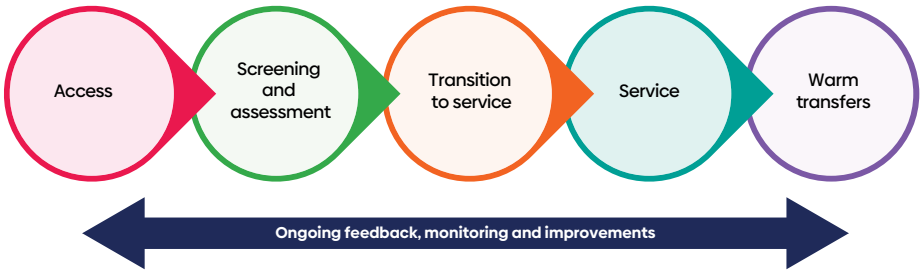
Reach out to Infant and Early Mental Health Promotion to learn more about Community tables

- Define the primary population(s) being served (current state).
- Define your shared vision, community strengths and areas for improvement.
- Identify existing mental health and social-emotional support.
- Identify current data available on the needs of children zero to six and their families.
- Identify the data collection capacity within your community.
- Clarify roles and responsibilities (terms of reference, partnership agreements).
- Outline necessary training, coaching and professional development.
- Put provisions in place for staff turnover and service changes.
- Establish equity, diversity and inclusion considerations at the outset.
- Engage with families in initial conversations and plans for engagement.

Are you ready to begin your care pathway journey?

A care pathway is a cyclical, ongoing process — one that includes monitoring, feedback loops and practice improvements. Care pathways will look different for each community. However, there are five common elements (Figure 1).

Figure 1: Care pathway phases



When taking your initial steps, this is a good place to start: Looking at your existing services and who is being served, what their needs are and how they are supported over time. We have included some questions to kick-start conversations.

Access

- Where are families accessing infant and early mental health care in your community?

Screening and assessment

- What are standard practices in your community now?
- Is your community using the ASQ® as a common screening tool? Are there other evidence-based tools used for this age range?
- Are there referral options for organizations that don't have screening capacity?

Transition to service

- Who is responsible for triaging families?
- What strategies do you have to identify alternate pathways for developmental risks or needs (motor, speech, sensory difficulties)?
- What other considerations need to be in place to support families (location of service, age of infant/child, crisis response)?

Service delivery

- What type of care will best meet the mental health need(s): Promotion, prevention, early intervention, treatment or all types?
- What support and resources are available for families?
- What current practices are in place to ensure the warm transfer of families between care providers or agencies in your community? Do they differ based on level of care?
- What processes need to be in place to ensure appropriate monitoring and follow-up?

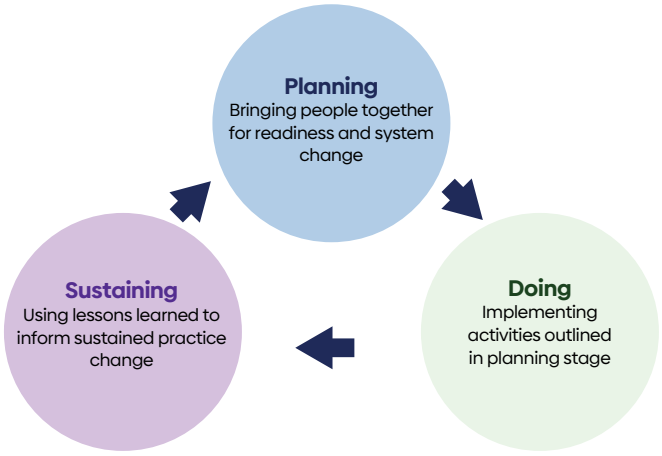
Implementation science is a collection of evidence-informed, established frameworks that use a set of activities to move programs or initiatives from concept to reality in real-world settings. A formula for this process includes effective innovation, effective implementation and enabling contexts to create socially significant outcomes. (Fixsen et al., 2015).

Planning for success

We have adapted an implementation science approach and use guidelines from Implementing evidence-informed practice: A practical toolkit. This process is influenced by a community's unique needs, strengths, available services, care settings and families involved. It is important to form community partnerships with a shared knowledge of service access and populations in need of infant and early mental health supports. This awareness will help determine the appropriate steps for establishing and maintaining care pathways over the long term.

There are three implementation phases: 1) Planning, 2) Doing and 3) Sustaining. These phases are universal and can be adapted to any project. In the next section, we present them in the context of implementing care pathways for infant and early mental health services.

Figure 2: Implementation phases (adapted from Implementing evidence-informed practice: A practical toolkit).



Phase 1: Planning

This phase focuses on leveraging the relationships and work that has been done in your community table and ensures all partners are ready to invest in system-level change. The information can be adapted to meet your local context, but each component is necessary to advance to Phase 2: Doing.

Before starting Phase 1, communities will have established community tables with all service providers and sectors involved in infant and early mental health care within your community. These tables will have already:

- Identified the available services in their community that support families and their children from prenatal to six years old.
- Identified capacity and readiness for care pathway development and implementation.
- Worked together to identify short-term and long-term opportunities to strengthen practices, services and policies.

Community engagement

Community engagement and long-term investment across sectors will increase opportunities for success and foster collaboration across organizations. Engagement requires representation at all levels (leaders, service providers, community members and families) and across sectors supporting infant and early mental health.

Leadership buy-in

Leadership support is the force behind implementation. In addition to bringing skills to overall pathway development, leaders can facilitate system change by approving and distributing resources.

Communities entering pathway work should have representation from leaders in all key sectors in their local area. Specific directives on leaders' responsibilities are fundamental for success. We suggest members of the core community team complete a senior management charter — a blueprint that outlines activities, partners' expectations, implementation objectives, community strengths and areas for support.

Community champions

Community champions can help plan, develop and report on activities. They represent their sector at community tables and help ensure coordination and consistency of activities. Champions bridge the gap between sectors to:

- Clarify roles and responsibilities.
- Leverage strengths.
- Identify barriers.
- Encourage commitment.

It is important to thoughtfully engage with community champions who may be involved at each level of developing the care pathway, from front-line service delivery to senior leadership. Champions may be from these, and other, sectors:

- Child and youth mental health and addictions.
- Young parent agencies (like the Ontario Association of Young Parent Agencies).
- Prenatal programs (like the Canada Prenatal Nutrition Program (CPNP)).
- Public health.
- Primary care.
- Acute care.
- Early learning and care.
- Child welfare.

- Education.
- Culturally responsive organizations and community programs.
- Indigenous organizations and service providers.
- Francophone organizations and service providers.
- Additional community support organizations for families and children including newcomer families, housing support or the Community Action Program for Children (CAPC).

Outlining roles, responsibilities and expectations will help mobilize pathway teams. Check out Appendix A (p. 36) for a partnership agreement template you can use when designing your community collaborative.

Family engagement

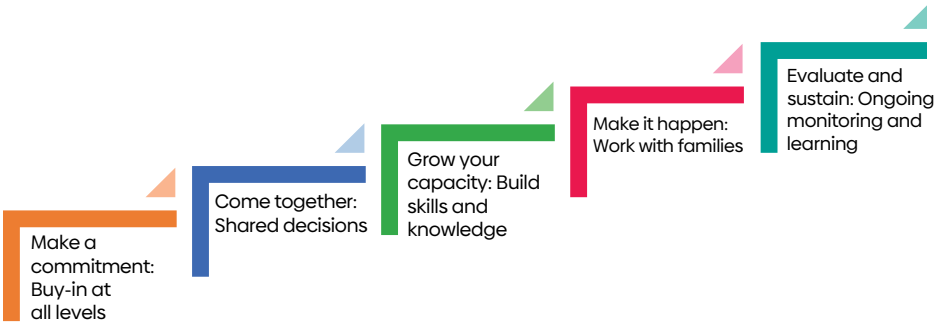
You can refer to our full family engagement roadmap, developed in partnership with Parents for Children's Mental Health (PCMH).

A system that supports the needs of our youngest does not work without the family at its core. To best address the needs of infants and young children, we need to learn from and meaningfully engage with families. Family engagement is an active partnership that prioritizes the voices of family members and involves them as allies to drive evidence-informed care practices at the project's outset.

The Knowledge Institute's quality standard for family engagement defines principles contributing to effective family engagement. The principles suggest things to consider when families and caregivers are included in system-level initiatives aiming to improve service transitions across different sectors.

Here are five key steps to consider:

Figure 3: Steps to family engagement. Adapted from Parents for Children's Mental Health and formerly the Ontario Centre of Excellence on Child and Youth Mental Health (the Knowledge Institute).



Intergenerational trauma is the transgenerational transmission (ripple effect) of personal trauma beyond the individual victim to the lives of their significant other(s), including children (O'Neill et al., 2018). For Indigenous families, the reverberation of trauma in subsequent generations differs from those impacted by other traumatic events, like war. This is because health outcomes are linked to the continued social, economic, and political factors created by colonial influence on their traditional ways of being (O'Neill et al., 2018).

For more information on the Knowledge Institute and IEMHP's work with Indigenous families, see:

- Working with Indigenous families: An engagement bundle for child and youth mental health agencies (cymha.ca)
- Engaging First Nation, Inuit and Métis families (cymha.ca)
- Infant and Early Mental Health Promotion - Nurturing the Seed: The Journey to Early Mental Health and Wellness (imhpromotion.ca)
- Natural Helpers for the Children - Learning Circle (imhpromotion.ca)

Equity, diversity, and inclusion

Families' experiences with mental health services are affected by the care they access and receive. Bias, prejudice and discrimination from mental health care institutions and service providers can impact families' engagement with the care system and the types of supports they access. Institutional barriers such as costs or wait times can also affect access to care, which can lead to poorer long-term health outcomes.

The needs of children and families experiencing disproportionately greater barriers must be acknowledged early in the planning stages. Factors such as language barriers, lack of culturally appropriate services, rural vs urban service gaps, and experiences of racism, sexism, homophobia, ableism or other forms of discrimination can hinder access to necessary care. Centering these needs from the beginning helps to ensure they are planned for in every step of the implementation process.

Colonialism has and continues to profoundly negatively impact the well-being and health outcomes of Indigenous Peoples, leading to intergenerational trauma within families and a deep mistrust of Western institutions. IEMHP embraces the following Principles of Practice as a first step to advance truth and reconciliation with Indigenous Peoples.

The Knowledge Institute and IEMHP are committed to working with Indigenous families to determine the best path forward in care planning for infants and young children, and to co-develop solutions that meet families where they are at.

It is critical to promote respectful engagement with Indigenous organizations, service providers and other community partners along each stage of the pathway development and implementation process.

Using an evaluation lens

Assessing care pathways requires a solid evaluation plan to determine best practices, lessons learned and recommendations for further development. Key evaluation components follow three main phases: 1) Planning, 2) Doing and 3) Using. These phases are outlined in greater detail in the Knowledge Institute's Program Evaluation Toolkit.

Before you start your evaluation planning, consider your community's capacity to collect, analyze and share data:

- Does your community have partners with evaluation knowledge, skills and capacity?
- If you require external support and capacity, what organizations and partners can you reach out to?
- How will you use the information you collect? How will this inform the development and improvement of your care pathway?

To introduce change, communities will collectively decide how information will be used to steer pathway development and implementation. This approach blends research, provider experience and judgment, traditional knowledge, lived experience and family preferences to create action from theory and ensure that infants and young children are advocated for.

It is important to remember that evidence-informed practice is not a one-time consideration during the planning phase. There should be constant reflection on engagement with team members, providers and families to inform rollout as knowledge evolves.

Questions to consider when developing your evaluation:

- What factors do service providers identify as important to implementing a care pathway?
- What factors do families identify as important to implementing a care pathway?

Your evaluation questions will be the reference points for assessing success of your pathway implementation and whether it achieves your intended outcomes.

We offer questions for consideration, but it is important and more effective to decide what questions your community wants to answer in discussions around evaluation.

Questions to consider when evaluating outcomes:

- Service providers
  - Has their knowledge or preparedness for referring to infant and early mental health services changed due to their involvement?
  - Has the level of infant and early mental health knowledge improved for providers across sectors?
  - What are the experiences of service providers referring to services within and outside of their organization?
- Families
  - What are the experiences of children and families accessing services in your community?
  - Has the level of families' understanding of infant and early mental health improved?
  - Have families reported a sense of empowerment in accessing services?

- Care pathway
  - Is the care pathway effective in supporting access to appropriate services?
  - What are the number of referrals and age of children at referral to services?
  - How many screening assessments (ASQ® and DSPs) have been administered?

Your evaluation questions will inform how you will collect and analyze data. For example, if you would like to capture process outcomes from the pathway implementation team, consider using focus groups for meaningful engagement. Focus groups encourage members to share their experiences and identify enablers and barriers to success, which will add value to the data you have collected. If you want to capture outcomes from how and when the pathway is accessed and used, you could track the number of assessments and warm transfers completed. This information helps to better understand where families are accessing care and which services can best support their unique needs.

Phase 2: Doing

The second phase focuses on implementing the activities scoped out in Phase 1: Planning. This section offers flexible recommendations to support effective implementation and how to navigate potential barriers.

In this phase, each of the steps outlined in Phase 1 should have been completed:

- Establish local pathway implementation team (built from your community table).
- Create a plan for community partner engagement.
- Create a plan for family engagement.
- Define partner roles, responsibilities and expectations.
- Build the evaluation plan and metrics for success.

Step 1: Lay the groundwork

Determine readiness and infant and early mental health competencies

It is important that all partners come to the table with a sufficient level of knowledge and abilities to support high-quality care services. Success relies on a community's ability to dedicate time and resources over a pre-determined period for implementation. Assessing readiness for pathway work considers factors such as mindsets of community members, competing demands and financial and human resources.

A first step is to assess competencies in infant and early childhood mental health. Competency is the level of understanding or skill that mental

health professionals, community teams and other service providers should have before entering this work. Ideally, your community will have several professionals whose combined proficiencies in this area cover the range of competencies needed.

We recommend using IEMHP's Mental Health Competencies Checklist to assess partners' competencies as one of the following:

- A high-level of understanding/skill.
- A moderate level of understanding/somewhat skilled.
- A low level of understanding/no skill.

Outline training requirements

It will be important that service providers in your community are trained in the tools and practices that best support families' needs. Your competency assessment will help you identify areas to bolster capacity and organize training.

Agency leaders, clinical providers and allied professionals should be equipped with current knowledge and skills specific to infant and early mental health and socio-emotional development. Clinical providers must also be trained in developmental screening tools and practices to support care transitions.

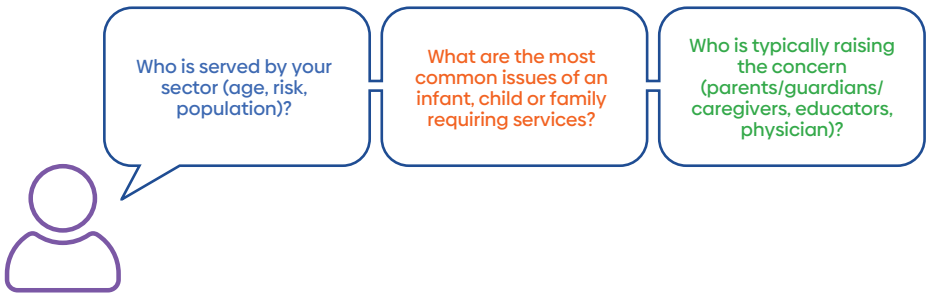
Specific training, coaching and professional development opportunities will depend on community-level capacity, needs and responsibilities.

Identify who is accessing your services and why

After answering these questions, reflect on the experiences and potential challenges encountered by the population(s) being served. Are there any gaps, considerations, or "flags" being noticed? Who is entering the service doors (across sectors) most frequently?

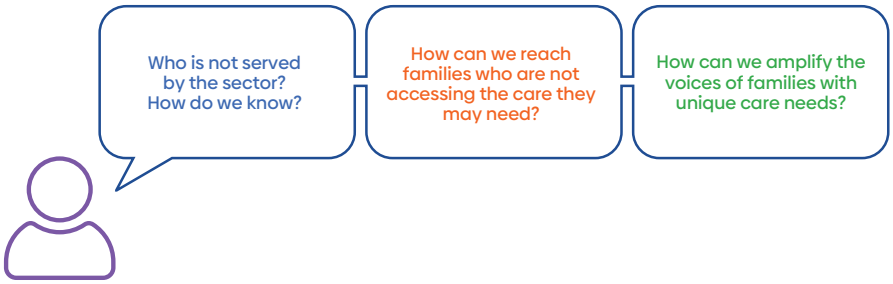
Together, identify the population(s) accessing and not accessing early mental health services across sectors in your community. Consider these questions:

Figure 4: Service considerations



At this point, discuss how the care needs of populations without equitable access have, or have not, been integrated into service planning. Consider the following questions:

Figure 5: Service gap considerations



Step 2: Develop your current and ideal state

In this step, reflect on existing community services and cross-sector relationships that are important for care pathway development. We offer guidance on three activities that can be done in any sequence:

- Create a goal statement (or statements).
- Determine the current challenges affecting that goal.
- Collectively map out the existing care pathway(s) in your community.

Create a goal statement

At the community-level, teams will have specific goals that fall within this broader objective. Focus on two factors when creating an actionable goal statement: What is working well and what can be built on? More specifically:

- What is working well that we can leverage to reach the goals of our community?
- What do we need to do differently to ensure a seamless, effective pathway for families to access the care they need, at the right time and in the right format for their child?

Determine challenges affecting community goal(s)

Using the 5W2H approach, identify barriers and challenges and kick-start conversations on ways things could be done differently. 5W2H refers to the 5Ws and 2Hs questions commonly used: Who, what, where, when, why, how and how much (or how often) (EQMS Limited, 2018). This approach asks:

- What is the problem?
- Why is it a problem?

Examples of goals statements from the pilot project:

- Our community will develop regional or community wide policies to support infant and early mental health. These are supported by commitment at all levels of government and are aimed at ensuring sustainable services for children under the age of six.
- Our community will work together to increase service provider capacity to provide tailored supports to populations who have unique needs (this includes but is not limited to Indigenous, Francophone, recent immigrant and newcomer families).
- Our community will work together to increase the use of appropriate screening tools and processes used for identifying social-emotional and mental health concerns in children under the age of six.

The Knowledge Institute's Quality Improvement team has created a useful template to ask these questions and gather information to better understand the challenges making care pathways difficult to implement in your community.

- When did we first encounter the problem?
- Where do we encounter the problem?
- Who is impacted?
- How did we know there was a problem?
- How often do we encounter this problem?

Visualize the current state

Map out existing care pathways and service transitions. Taking appropriate time to understand what your community has to offer for infant and early mental health services, and how these domains interact, is critical for effective implementation. Intermediary support from the Knowledge Institute and IEMHP to facilitate the mapping process can strengthen cross-sector conversations and community planning.

Mapping enables your community to learn about various services, organizations, resources and barriers by visualizing the current state, building consensus on how the community can work and moving forward together.

This exercise will identify who is raising the concern, who is assessing and screening to determine appropriate supports, and who is making the referral to service. Work together to determine who the key partners are in your community and how they support families through the care system in your local service area.

Consider the following when mapping out the existing services and processes:

- Identification of presenting concerns.
- Referral practices in each sector.
- Assessment and referral processes in the community.

During this exercise you will visualize how each sector in the community supports infant and early mental health. Consult the facilitator guides in Appendix B (p. 38) on current state mapping activities to see each step in this exercise.

This process will help your community:

- Understand the current state of infant and early mental health supports and services across all sectors in your community.
- Identify the qualities of the current pathway that work well, what you can leverage and what you want to include in your community's care pathway.

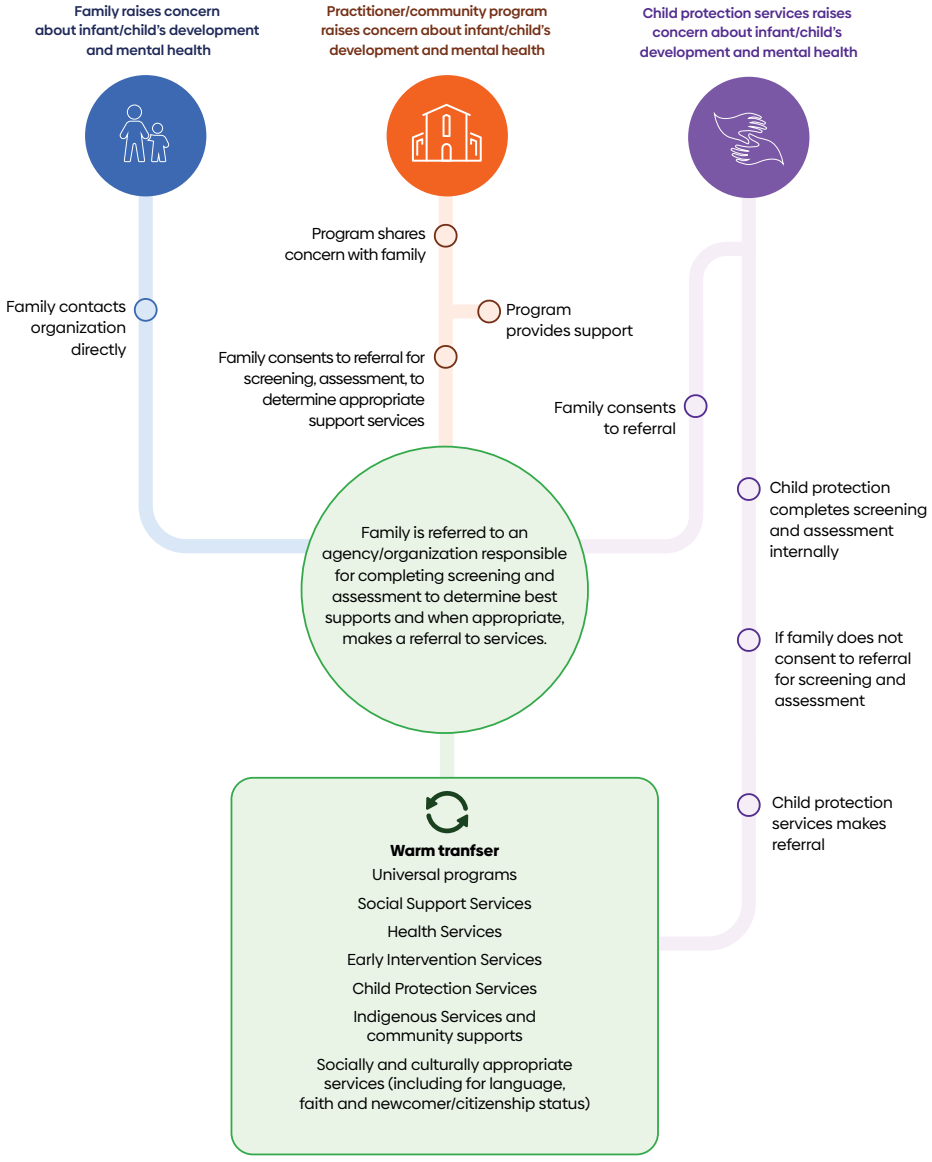
Need support? Here's how you can contact us:

- Knowledge Institute on Child and Youth Mental Health and Addictions (cymha.ca)
- Governance (imhpromotion.ca)

- Define who is being served by promotion/prevention/early intervention/intervention services across sectors.
- Define the referral process within each sector and bring back for discussion to identify the opportunities for collaboration, communication, and improvements for the community as a whole.
- Define the means to match family/child needs with optimal support services and identify gaps where there are opportunities to strengthen the availability of appropriate care.
- Identify action items to reach community goals.

In Figure 6, we show a high-level example of a current state map for children prenatal to age six accessing mental health services.

Figure 6: Example of a care pathway for children birth to six years old. See Appendix C for accessible text for this visual.



Visualize the ideal state

Once there is a shared awareness of the current state, the next step is to establish a collaborative vision of the "ideal state." What will things look like when an ideal pathway is in place?

Successful implementation requires a collective understanding and vision. An integral part of this vision are the voices of families in the community. Family needs and experiences navigating the current care system is evidence that can inform the ideal state. This can improve care transitions through actions such as reducing waitlist times, introducing resources to support warm transfers (care navigators) or reducing families' burden of retelling their story when accessing services. To begin this step, consider these questions:

- What would be the most straightforward entry into services?
  - How does this change for different populations, especially those with limited access?
- What are the steps that families would need to take to gain access to these services?
- What can care pathways look like for families entering the service door with a concern?
- How do we ensure the right care is delivered in a timely manner?

These features will be visualized in your ideal state map. Consult the facilitator guides in Appendix B (p. 38) on ideal state mapping activities to see each step in this exercise. The key features, improvements and factors of the current state that will be leveraged will inform the next step: Developing an implementation plan.

Step 3: Develop the implementation plan

Steps 1 and 2 set up the building blocks for moving care pathways from concept to actual practice. Having all community partners present to define the current state of services and using this information to map out the ideal state provides an opportunity to establish a collective understanding. It can help define responsibilities and the conditions needed to develop a plan for implementation.

An implementation plan puts your ideas and objectives into action. It allows communities to foresee potential barriers, and ensure consistent understanding of expectations, timelines, responsibilities and objectives

from the planning to sustaining phases. Think of this plan as a blueprint for pathway development and execution but acting as a living document that can change over time.

Community champions across sectors will share the role of implementation team at this step. Their role is to develop the plan and put it into practice as a core implementation team. Key responsibilities are to:

- Provide guidance and advice throughout the implementation.
- Identify relevant resources to inform implementation and evaluation of care pathways.
- Review relevant documents and provide feedback as required.

For effective implementation, this plan will be framed by community-specific drivers (factors) that teams decide on together to help create change (National Implementation Research Network, 2013).

Adapted from the National Implementation Research Network (2013), we recommend using drivers that fit into three categories:

- Competency drivers: Support development, improvement and sustainability of capacity implementation such as training and coaching.
- Organizational drivers: Create and maintain environments for high-quality services such as data systems, program evaluations and administrative supports.
- Leadership drivers: Commitment of leaders and decision makers to enable positive impact and sustain outcomes.

Work together to identify the capacity and expectations of all sectors in your team. What resources are needed to support this work? This may include investment, human resources and external help such as implementation consultants, evaluation and data analytic teams or intermediary organizations like the Knowledge Institute and IEMHP.

Monitor success

Monitoring both the implementation process and outcomes will strengthen your team's ability to recognize pathway enablers and barriers and learn from users' experiences. However, evaluation is a continuous process and not a one-time activity. The approach should be adapted to individual communities and populations being served. Refer to section

Using an evaluation lens (p. 15) for specific details on how to start the process of carrying out your evaluation.

Here are key elements to monitor outcomes and define success:

- What you already know before pathway implementation (rationale and objectives).
- What you want to know from pathway implementation (questions).
- How you will determine change (data collection and analysis).
- How you will show change (data interpretation).
- How you will use information for pathway maintenance, spread and scale (information-sharing).

After implementation, looking at pathway sustainability will inform future service delivery and improvements to support its long-term success. Evaluation approaches at this stage should consider your local context, infrastructure and capacity for ongoing system change.

Phase 3: Sustaining

Once your community's care pathway is in place, monitoring its sustainability will keep its relevance for families accessing care and help structure future practice changes.

At this phase, you have completed each of the steps outlined in Phase 2: Doing:

- Determine community readiness, competencies and training needs.
- Carry out training, coaching and competency development across your community.
- Identify the current state and ideal states.
- Plan your pathway implementation.
- Pilot your care pathway(s) and monitor success.

Community champions will ensure sustainability. Champions may include implementation teams or service navigators. Dedicated partners can advocate for funding and cross-sector collaboration in infant and early mental health. Having multiple champions within their organizations ensures succession planning that will be helpful when there is employee turnover.

Monitoring sustainability requires a strong understanding of community practices, lessons learned and recommendations to inform future development. Ongoing information-gathering and review methods should be in place to learn from providers' and families' experiences. These activities will be reflected in your evaluation plan and activities developed in Phase 1.

Check out our Program evaluation toolkit for resources to support planning, doing and using your program evaluation.

Another way to ensure sustainability involves staying up to date with your community's emerging priorities and the broader evidence on infant and early mental health needs and practice considerations.

The Knowledge Institute's Resource hub offers a variety of knowledge materials and tools with the latest, most relevant information and recommendations for evidence-based practice. If you need support to collect information in the field of infant and early mental health, the research and knowledge mobilization team members at the Knowledge Institute can help.

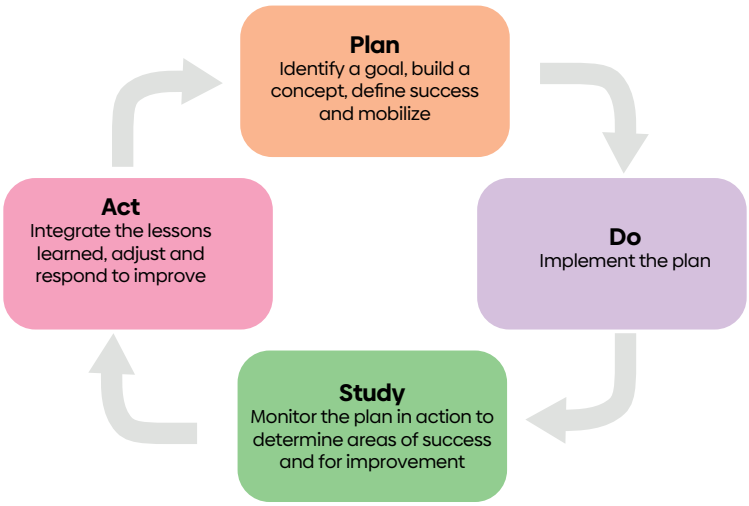
Plan, do, study, act (PDSA) cycles

An effective method to advance your pathway implementation outcomes and build sustainability is through plan, do, study, act cycles (The Deming Institute, 2022).

The PDSA cycle is a learning improvement model to guide system change and facilitate continuous improvement of an initiative or program (The Deming Institute, 2022). Using a PDSA cycle from the start of pathway development will strengthen your community's ability to review and revise as you move through each phase of implementation. The cycle has four steps but works as a cyclical process:

For more information on the PDSA cycle, check out the Deming Institute's (2022) PDSA resource page.

Figure 7: PDSA cycle (adapted from The Deming Institute, 2022)



Plan

- Establish local pathway implementation team (built from the community table).
- Create a plan for community and partner engagement.
- Create a plan for family engagement.
- Identify the current state and ideal states.
- Define partner roles, responsibilities and expectations.
- Determine community readiness, competencies and training needs.
- Outline pathway implementation.
- Build the evaluation plan and metrics for success.

Do

- Carry out training, coaching and competency development.
- Pilot your care pathway(s).

Study

- Monitor implementation process.
- Collect process and outcomes data.
- Review data to determine what is working well and what can be improved.
- Engage with pathway teams, providers and families.

Act

- Use information and evidence from the study phase to adapt.
- Integrate lessons learned and users' experiences to modify care access and transitions.
- Communicate change and mobilize knowledge through a strength-based approach for continuous improvement and system change within the community.

Mobilize: Turn knowledge into impact

Making good decisions requires gathering and sharing the latest, high-quality evidence. This means looking not only to academic research, but also at clinical expertise and the lived/living experience of families and young children in your community. Planning and implementing knowledge mobilization (KMb) strategies will show the success of your care pathway implementation. KMb activities have the goal of making evidence accessible, clear and useful for those who need it. Your community can use this information to inform existing care systems and move knowledge into actual practice.

Knowledge mobilization makes evidence and research information accessible through a wide range of activities including knowledge synthesis, dissemination, transfer and exchange.

Effective KMb requires meaningful engagement with your key partners and intended user. Consider how to engage community partners, service providers and families to best reflect the insights and experiences of those impacted by your work. Refer back to our guidance on community and family engagement (p. 12) to organize your engagement process and maximize knowledge uptake.

When developing knowledge mobilization strategies, think about target audiences and their specific knowledge needs. Refer to the Knowledge Institute's KMb toolkit, Doing more with what you know for additional tools and strategies. Different methods can be used to communicate community successes and lessons learned. Depending on who you are trying to reach, methods include:

- Infographics, fact sheets and takeaway resources.
- Conferences, presentations and webinars (in-person and virtual).
- Project reports and journal manuscripts.
- Social media campaigns.
- Communities of practice and community tables, at the local service and provincial levels.

Moving forward together

The journey to developing accessible, effective and efficient infant and early mental health care pathways may seem daunting. However, it can be accomplished with careful planning and dedicated efforts toward a common goal.

It is important to remember this work cannot be done without the commitment and collaboration of all community partners serving infants, young children and their families. It is also important to recognize there is no one-way to coordinate care – pathways vary by population needs and the capacity of mental health services and providers.

We encourage you to use this guide as a template to help your community build confidence and take actions to improve prenatal to age six mental health care access and service outcomes. No matter where your community is on this journey, the Knowledge Institute and IEMHP can help. Our organizations' support includes training and coaching, cross-sector relationship-building, research and evidence-gathering, and guidance on how to carry out all implementation phases.

If you require support, please contact us at:

The Knowledge Institute: info@cymha.ca

IEMHP: iemhp.mail@sickkids.ca

Glossary of terms

Care pathways: Guide children (prenatal to age 6) and their families to, through and out of care ensuring that they are matched with the best service, at the right time and in the most appropriate format for the family. Pathways for infant and early mental health outline care access, screening, transition and treatment processes to support families and young children navigate the appropriate programs and services to improve health outcomes (Infant and Early Mental Health Promotion, n.d.).

Community/sector partners: Individuals from (but not limited to) early learning and education, public health, primary care, child and youth mental health, parents/caregivers and government who contribute to knowledge and expertise for infant and early childhood care pathway development and implementation.

Community tables: A collective working group that has identified infant and early mental health as a priority across sectors.

Cross-sector: Cross-sector partnerships generally refer to long-lasting and intensive collaborations between organizations from at least two sectors that focus on addressing social or environmental problems (Clarke & Crane, 2018).

Early childhood: The total period from birth to age 6 (Ontario Centre of Excellence for Child and Youth Mental Health, 2014).

Early childhood learning: Also referred to as early childhood development, early childhood learning refers to the period from birth to age 6 where infants and young children experience foundational physical, social, emotional and mental development based on their interactions and experiences. Three core areas of development that impact architecture of the brain include lived experiences, interactions with adults and learning how to cope with stress responses (Center on the Developing Child, n.d.).

Early intervention: Includes knowledge and competencies in developmental support, applied theory, relationship-based approaches, case formulation and assessments to work with children under six years of age (Infant and Early Mental Health Promotion, 2018).

Equity, diversity, inclusion (EDI): Are three intersecting factors that support improved conditions for children and families to access mental health and addictions services and receive care. Equity is the fair treatment of all individuals; diversity involves acknowledgement of everyone's experiences and qualities; and inclusion involves the creation of settings where everyone feels welcome and able to fully participate (University of Toronto, 2019).

Evidence-based practice: In child and youth mental health and addictions, integrates high-quality research evidence, clinical expertise,

client data and perspectives to obtain measurable outcomes for children, young people and their families (Knowledge Institute on Child and Youth Mental Health and Addictions, 2023).

Implementation: The science of implementation uses multiple theories and methodologies grounded in evidence to bridge the gap between research and practice (Ontario Centre of Excellence for Child and Youth Mental Health, 2013).

Implementation team: Community-level teams made up of all key partners necessary to the roll out of care pathways in a specific community or region including (but not limited to) early learning and education, infant and early mental health and allied health professionals.

Infancy: The period from birth to age 2 (Public Health Agency of Canada, 2016).

Infant and early mental health: Also referred to as social-emotional development. "The capacity of a child to form close/secure adult and peer relationships; experience, manage and express a full range of emotions; and explore the environment — all in context of family, community, and culture" (Cohen et al., 2012, p. 1).

Prevention: Includes knowledge and competencies in trauma informed practice, care pathways, advocacy and mental health screening to work with children under six years of age (Infant and Early Mental Health Promotion, 2018).

Primary care: Includes all health services related to health promotion, illness and injury prevention, and diagnosis and treatment of illness and injury (Government of Canada, 2012).

Promotion: Includes knowledge and competencies in childhood development, parent engagement, interdisciplinary practices and advocacy to work with children under six years of age (Infant and Early Mental Health Promotion, 2018).

Public health: Refers to "the organized effort of society to keep people healthy and prevent injury, illness and premature death. It is a combination of programs, services and policies that protect and promote the health of all" (Canadian Public Health Association, n.d.).

Service access: Access to high-quality, mental health care services that meets the needs and circumstances of infants, children and their families. This is the process from "pre-contact (I know who to call), contact (first response to request for service/intake) and contact to service (I get the treatment I need in a timely fashion – the time between eligibility and service)." It includes physical access (service availability), financial access (service affordability) and sociocultural access (service acceptability between patients and providers) (The Child and Youth Mental Health Lead Agency Consortium, 2019).

Social-emotional development: Also referred to as infant and early mental health. "The capacity of a child to form close/secure adult and peer relationships; experience, manage and express a full range of emotions; and explore the environment — all in context of family, community, and culture" (Cohen et al., 2012, p. 1).

Social determinants of health (SDoH): Are societal and economic factors that can profoundly influence individual health and mental health outcomes (Canadian Mental Health Association, n.d.). Within the broader determinants of health, SDoH relate to individuals' place in society such as one's income, education, employment, health care access and early childhood development (Government of Canada, 2022).

Treatment: Includes knowledge and competencies in treatment planning, therapeutic approaches, clinical practice and diagnostic competency to work with children under six years of age (Infant and Early Mental Health Promotion, 2018).

Warm transfer: Are transfers of care between two health care providers where the transfer takes place with the patient and family present, providing opportunity for engagement and communication if there are questions or concerns (Agency for Healthcare Research and Quality, 2017).

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Appendix A: Partnership agreement template

PROJECT BACKGROUND AND GOALS

This project is led by _____. This initiative will focus on _____. Care pathways guide children and families to, through, and out of care, ensuring that they are matched with the best service, at the right time, and in the most appropriate format for the family.

TERMS OF REFERENCE

The Terms of Reference (ToR) intends to clarify the relationship between members of the _____ with the _____ in collaboration with _____ to effectively support our work together for the development of the community report(s) and implementation of care pathway(s) for mental health of young children from birth to six-year-olds and their families in Ontario. These may be modified at any time with consensus among the members. The following represents our understanding of the ToR for this committee.

ROLES OF THE COMMITTEE:

The primary role of the _____ is to: _____. In addition, the _____ will provide a forum for: _____. The committee will be called upon at _____ of the project's development. Please refer to section V of this document for further details. Participation and contribution are voluntary.

The core project team will work with the committee to discuss strategies related to feasibility, facilitators and barriers, family engagement, evaluation methods and knowledge mobilization.

ROLES OF THE CORE PROJECT TEAM

TEAM: Names

- Role(s)

TEAM: Names

- Role(s)

TERM

The membership term is for _____, from _____to _____ (anticipated completion).

DELIVERABLES

- Key deliverables

MEETINGS

Meetings will occur at critical points in the project as decided by the core project team and in consultation with all partners. Virtual meetings (if applicable) will take place via teleconference or videoconference depending on the preference of the committee for the purposes of that meeting.

Outside of scheduled meetings, e-mail will be used as another forum in the interim should anything arise. _____ (insert online platform) will be used to circulate key project documents. ____ will schedule meetings, coordinate, maintain and distribute agendas, minutes, action items and supporting materials, and develop a retention schedule for meetings and associated materials.

The _____ will meet at minimum ____ times throughout this project:

- Key dates

The target deadline for this project is _____. Outside of the scheduled meetings, e-mail can and will be used as another forum in the interim should anything arise.

Approved by core team:

Date:

Appendix B: Facilitator guides for pathway planning

Develop your current state

Objectives:

- Understand the current state of your community.
- Define who is being served by the existing services including all focused on social-emotional development and infant early mental health promotion, prevention, early intervention and treatment.
- Define the referral process by sector (primary care, community-based agencies, education) and for the community as a whole.
- Define the means to match each family with optimum treatment for the infant or child.
- Identify key action items for the community.

Activity features:

- Depending on the number of participants, groups should include 5-10 people and be divided by sector or organization.
- All groups will identify:
  - Who is served and who is not currently being served.
  - Referral process (or processes).
  - Program and service availability for infant and early mental health.
  - Triage and transfer process. Where are families being matched to?

Materials needed:

- Tape.
- Post-it notes (assorted sizes and colours.)
- Sharpies.
- Flip chart markers.
- Chart paper.

Activity 1: Group discussion to identify and understand current state of infant and early mental health services in your community.

Part A: Current state of community (small-group discussion).

Deliverable: Knowledge of who is served by your sector and who is not.

Time given: 1 hour

As a group, consider the following questions and record your answers in the chart paper for this activity.

- What are the most common issues/risks/symptoms of a child served by your sector?
  - Think about all levels of care including promotion, prevention, early intervention and treatment services.
  - Think of all health factors including behavioural, cognitive, emotional, physical, diagnostic and family capacity.
- How do we understand when a child needs services?
- How do we know when to make a referral?
- Which groups are we not serving well? What are the challenges?

Part B: Current state of community (large-group discussion).

Deliverable: Shared knowledge of who is served by your sector and who is not.

Time given: 30 minutes (5-8 minutes each, depending on number of groups)

Identify a group member to report back. Go around the room with each group providing a brief summary of their discussion considering the following questions.

- What are the gaps you are noticing about the groups your community serves? What services are available?
- Who is entering your door most frequently?

Activity 2: Group discussion for service matching to identify and understand the best pathway for assessment, referral and service delivery process.

Part A: The mental health concern and referral process.

Deliverable: Knowledge of matched service needs with optimum referral and treatment.

Time given: 30 minutes

As a group, consider the following questions and record your answers.

- How do we verify/screen/examine/check for this concern?
- What are the questions we might need to ask?
- How do we learn about the family history?
- What happens when there is not an agreement about a concern (between caregivers and providers – consider both ways)?

- Once there is agreement about the concern – what happens next?
- What is the current referral process and what is needed to make the referral?
- What are the challenges when making referrals (from both the provider and family perspectives)?
- What are areas of opportunity to strengthen the referral process?
  - What are the different needs of a child who requires a referral outside of your sector?

Part B: Community service matching process.

Deliverable: Outline of current infant and early mental health care pathways in your community.

Time given: 1 hour

With the information from previous activities, use the chart paper to begin mapping the current child and family care journey through services in your community. On the Post-it notes, plot out who is identifying the concerns and outline the steps needed to complete a successful referral to service. Assign colours for each pathway component.

- Who is raising the concern (who) – GREEN.
  - Including (but not limited to) parents, childcare provider, physician and child welfare services.
- Referral to agency/program (where) – ORANGE.
  - Where support services are being accessed.
- Steps made at each stage – BLUE.
  - Including (but not limited to) screening assessments, referral forms, consent forms, phone calls and intake meetings.
- Challenges – PINK.
  - These can be noted at any point or stage of the care pathway.
- Strengths – YELLOW.
  - These can be noted at any point or stage of the care pathway.

Consider the following questions as your group maps the care journey.

- Where are families accessing infant and early mental health care?
- Is your community using the ASQ® as a common screening tool? Are there other tools used for this age range? Are there referral options for organizations that don't have screening capacity?
- Which sectors have agreements or partnerships to facilitate a referral (from where to where)? Who is responsible for triaging families? Are there strategies in place to identify alternate pathways for needs such as motor, speech or sensory difficulties?

- What is currently working well when making referrals within and between sectors?
- What are the current challenges when identifying concerns or making referrals?
- How is a referral completed and communicated back to the referring agency or providers? Is there a method in place to do this?
- What is in place to support families receiving services? Do these supports differ based on level of care?
- What is in place to support families who are waiting for, or do not receive, services?
- What is the process for waitlists and what happens during this period?
- How are families engaged in the referral process?

Part C: Community service matching process (large-group discussion).

Deliverable: Shared knowledge of current care pathways in community.

Identify a group member to report back. Go around the room with each table providing a brief summary of their discussion reflecting on your community's current state.

- What are the biggest challenges?
- What can we do to improve?

At the end of Day 1, begin thinking about the ideal state for both your sector and community.

Visualize your ideal care pathway

Objectives:

- Agree on a complete, shared understanding of the current state.
- Define the ideal referral process per sector and for your community.
- Define the ideal state for the best means to match child needs with optimum service.
- Identify action items for your community.

Activity features

- Everyone who participated in the first activity (Develop your current state) should participate in visualizing the ideal state.
- Group numbers should be the same (5-10 people) in each sector or organization.
- All groups will identify:
  - Who is served and who is not currently being served.
  - Current referral process (or processes).

- Ideal referral process (or processes).
- Optimum pathway for families from service entrance to delivery and follow-up.
- Action items to address challenges and improve current pathways.

Materials needed

- Tape.
- Post-it notes with assorted sizes and colours.
- Sharpies.
- Flip chart markers.
- Chart paper.

Activity 1: Review current process for identification of the mental health concern and the pathway from identification to referral to service delivery and follow-up.

Part A: Review the current screening and identification process.

Deliverable: Groups have shared knowledge of the current steps after families enter the service door with a concern.

Time given: 5 minutes

Reflect on the discussion and outcomes from the activities completed in Day 1. Specifically, consider the following aspects of the current assessment process in your community.

- How are concerns screened and verified?
- What are the questions needing to be asked?
- How do we learn about the family history?
- What happens when there is not an agreement about a concern (between caregivers and providers) and what is the preventive action?
- Once there is agreement about the concern – what happens next?

Part B: Review the current referral process.

Deliverable: Groups have shared knowledge of the current steps after initial screening and identification of concern.

Time given: 5 minutes

Reflect on the discussion and outcomes from the activities completed in Day 1. Specifically, consider the following aspects of the current referral process in your community.

- What is the current referral process and what is needed to complete a referral?
- What are the challenges when making referrals (from both the provider and family perspectives)?
- What are areas of opportunity to strengthen the referral process?
- What are the different needs of a child that requires a referral outside of your sector?

Activity 2: Brainstorming session to map the ideal child/family journey into and through services.

Part A: Community pathway mapping.

Deliverable: Outline of ideal infant and early mental health care pathways in community.

Time given: 40 minutes

With the information from all activities completed so far, use the chart paper to map the ideal child and family care journey through services in your community, considering the current state maps created in Day 1.

Reminders:

- Remember the scope of your community – what are the beginning and end points from need identification to service matching.
- Stick to higher-level activities. Right now, there is no need to define specifics such as screening tools, diagnostic criteria, or others.
- Define key terms to support pathway mapping such as “screening”, “assessment” or “intake” when used in your maps.

Plot out the care pathway with colour-coding used in Day 1. Identify:

- Who can make the referral or identify the concern (GREEN).
- Where families can be referred to (ORANGE).
- Each step needed for a successful referral (BLUE).
  - Consider all pathway routes (from where to where).
  - Communication loops (between agencies/providers).
- Challenges needing to be addressed or acted on in ideal state (PINK).
- Areas along the pathway that are working well to continue and advance (YELLOW).

Part B: Summarize key discussion items.

Deliverable: Identified strengths (what is working well) and priorities (what needs actions).

Time given: 10 minutes

As a group, use the outcomes from your ideal state pathway mapping to write down:

- Up to three processes that are working well in your community's pathway system.
- Up to three action items that as a community, you can work together on to address and strengthen care pathways.

Activity 3: World café.

Deliverable: Multiple pathway maps for all participants to review and discuss; post-discussion, clearly defined preferences for ideal pathway steps and actions items to address these.

Time given: 1 hour

Facilitators are asked to take clear photographs of each pathway map created by small groups (for community record keeping) and stay at the table they facilitated. Participants are now asked to look at each table's map in 5-minute intervals thinking about:

- Pros and cons of each process map.
- What they like, what they don't like and why.

At the end of the rotation, facilitators provide participants "dots" (small paper circles) to walk around the room and use these dots to indicate:

- Favourite pathway options, ensuring to put dots on different maps for further discussion.
- Favourite action items, marking the specific action items on the chart paper not the map.

At the end of Day 2, supply participants with their session materials to take away for further discussion in community and provide contact information if needed to support ongoing pathway development and implementation. Plan for the implementation team to validate current state maps with respective members.

Appendix C: Example of care pathway for children birth to six years old (accessible text)

1. Who is raising the concern about the infant/child's development and mental health?
    a. If family: The family contacts the agency or organization responsible for completing screening and assessment to determine best supports for infant or child.
    b. If practitioner or community program: The program shares concern with the family. The program provides appropriate support, and with family consent, contacts the agency or organization for completing screening and assessment to determine best supports for infant or child.
    c. If child protection services:
        i. The family consents to referral to agency or organization for completing screening and assessment to determine best supports for infant or child.
        ii. Child protection services completes screening and assessment internally. If family does not consent to referral, child protection services makes referral to best supports for infant or child moving to step 3, the warm transfer.
2. Community screening and assessment
    - After the concern is identified, family is referred to the community-specific agency or organization responsible for screening and assessment of the infant or child's mental health concern.
    - After the screening and assessment, family is referred to the appropriate community service or support.
3. Warm transfer to community service or support
    - The agency or organization that completed screening and assessment completes referral to appropriate community service or support.
    - Family accesses service or support that best supports their need. These include:

        Universal care programs.

        Social support services.

        Heath services.

        Early intervention services.

        Child protection services.

        Indigenous services and community supports.

        Socially and culturally appropriate services for language, faith and newcomer or citizenship status.

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