# Selection and Prioritization of More Severe Cases at KL-Lwd

KidsLink and Lutherwood (KL-Lwd) are the primary provincially funded CMH providers in the Waterloo district. Kidslink specializes in pre-teens; Lutherwood in teens.

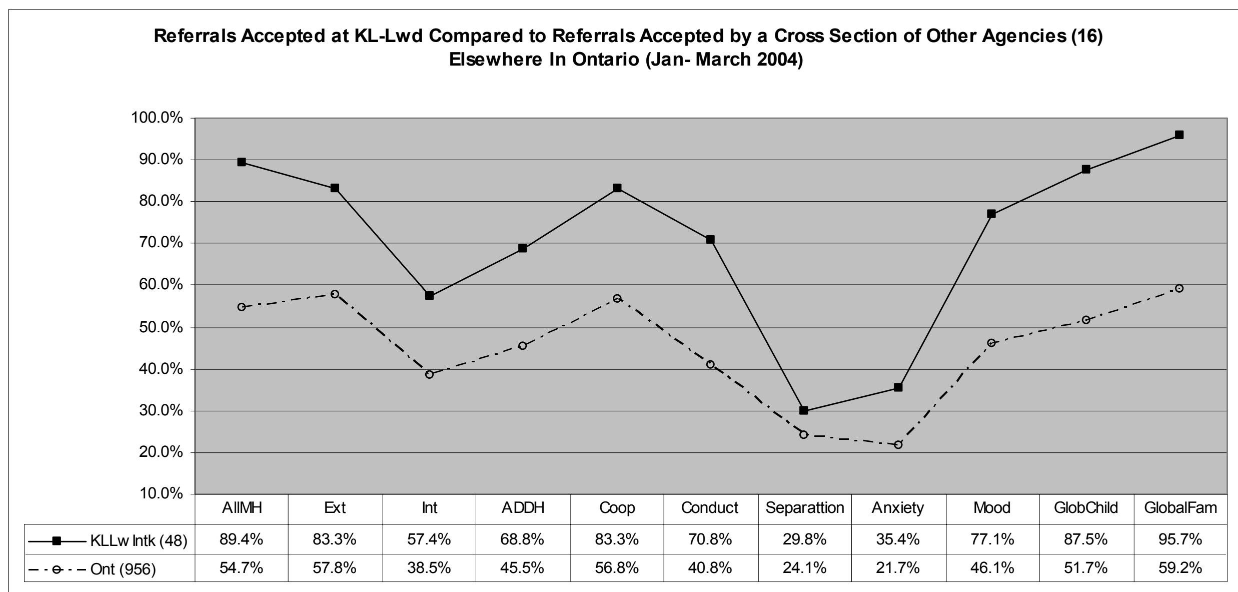
The 2 agencies run a common district Intake. All of their services for 6 – 18 year olds are ‘intensive’ services: Residence, Day Treatment, and Intensive In-Home service. Less intensive or Preventative services are offered to children who are under 6 years of age.

The intake worker ‘screens –in’ more severe cases (before conducting BCFPI interviews) and diverts less severe cases to other district agencies (Family Services, etc.)

This paper examines the following questions?

1. Is KL-Lwd achieving its intent to ‘screen in’ more severe cases?
2. If so, how is this being achieved?
3. How are they triaging amongst ‘screened-in’ referrals, and how ‘accurate’ is the BCFPI component of this process?

# 1. Is KL-Lwd ‘Screening in’ More Severe Referrals?




| | AllMH | Ext | Int | ADDH | Coop | Conduct | Separattion | Anxiety | Mood | GlobChild | GlobalFam |
|---|---|---|---|---|---|---|---|---|---|---|---|
| KLLw Intk (48) | 89.4% | 83.3% | 57.4% | 68.8% | 83.3% | 70.8% | 29.8% | 35.4% | 77.1% | 87.5% | 95.7% |
| Ont (956) | 54.7% | 57.8% | 38.5% | 45.5% | 56.8% | 40.8% | 24.1% | 21.7% | 46.1% | 51.7% | 59.2% |

The solid line in the above figure represents all 48 Jan- March 2004 referrals accepted be KL-Lwd; the dotted line, all 956 Jan- March referrals accepted by a cross-section of 16 agencies elsewhere in Ontario. The figure compares the % of cases scoring as high or higher than the most symptomatic 2% in the Ontario general population norming sample, for symptom clusters tabulated across the bottom of the graph. The prevalence of cases in the most symptomatic 2% averaged 56% higher for KL-Lwd cases (solid line), than cases admitted to a cross-section of Ontario agencies (dotted line). This higher prevalence for KL-Lwd ranged from 24% (separation) to 74% (Conduct).

This finding has been repeated in successive quarters for KL-Lwd.

**Thus, KL-Lwd appears to be succeeding in ‘screening-in’ more severe cases.**

## 2. How is KL-Lwd ‘Screening in’ More Severe Referrals?

KL-Lwd intake interviewers conduct a ‘pre-screening’ re basic eligibility for KL-Lwd’s intensive services. They have been instructed to use the following global criteria to assess a referral’s eligibility for KL-Lwd services.:

**The child served by the Intake and Assessment Service is experiencing bio-psycho-social problems which disrupt the functioning of the child in the home, neighborhood and/or school. These problems include behavior problems, aggression, self-harm, withdrawal, biologically based issues (e.g. Attention Deficit Hyperactivity Disorder) and/or psychiatric disorders.**

**The family served by the Intake and Assessment Service is experiencing bio-psycho-social difficulties that disrupt the stability and well being of the family system. They experience problems meeting the children’s physical, social, and emotional needs for reasons such as family breakdown, family violence, parental mental disorders, substance abuse, and financial stresses**

An initial segment of the intake interview assesses whether or not cases meet the above criteria.

- If they do, the intake proceeds, including the BCFPI interview.
- If not, they are re-directed to a community agency(s) or services, judged most suitable for the referral, by the intake worker.

The comparative data in section 1 suggests that this pre-screen is effective in screening in more severe cases, suitable for KL-Lwd intensive services.

## 3. How are they triaging amongst accepted referrals, and how ‘accurate’ is the BCFPI component of this process?

Kl-Lwd makes an initial priority grouping based on the number of 8 core BCFPI scores >70 (core = Regulation of Attention, Conduct, Cooperativeness, Management Separation, Anxiety and Mood, Global Child Functioning and Global Family Adjustment.) Cases are given a preliminary priority grouping, as shown below, based on these scores.

<u>However, additional criteria are applied by the Intake Screening team if the Intake worker reports that the informant did not seem to understand the interview, or if the informant appeared to be exaggerating or minimizing symptoms. These additional criteria are obtained from an initial clinical assessment</u>.

Many of these additional criteria are adapted from some of the more commonly reported severe or moderate functional criteria used in CAFAS. (http://www.cafas.com/) .

The table below, ‘*Number and % of Jan-March 2004 referrals with 0,1,..8 scores >70, Raw Priority and Overrides*’ suggests that approximately 10% of the raw priority ratings, based on BCFPI scores only, are increased or decreased, based on further clinical assessment. 90% are unchanged.

KL-Lwd's ranking system and service menu are summarized below:

| 0 – 2 core BCFPI scores >70<br>**<u>Lowest</u>** Priority Ranking<br>**- 3 -** | 3 - 5 core BCFPI scores >70<br>**- 2 -** | 6 -8 core BCFPI scores >70<br>- 1 - |
|---|---|---|
| Service Menu Options<br>❑ Refer to community agency<br>❑ Wraparound<br>❑ Bibliotherapy-Mail out information packages<br>❑ Pediatric or Psychiatric referral | Service Menu Options<br>❑ School Treatment Programs/Day Treatment<br>❑ Partners (In-Home)<br>❑ Mobile Crisis Services<br><br>Resources permitting<br>❑ CFTP out client services<br>❑ Wait list group (Partners) | Service Menu Options<br>❑ School Treatment Programs/Day Treatment<br>❑ Residential Treatment Services<br>❑ Mobile Crisis Services<br>❑ Partners (in Home)<br>❑ Service Resolution |

The following table indicates the extent to which priority ratings, based on counts of scores >70, or overridden, when other criteria are considered, for cases where the BCFPI data seemed questionable.

***Number and % of Jan-March 2004 referrals with 0,1,..8 scores >70, Raw Priority and Overrides***

| # of scores >70 | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | Total |
|---|---|---|---|---|---|---|---|---|---|---|
| Raw Priority (based on # of scores >70) | **Priority 3, Low** | | | **Priority 2, Moderate** | | | **Priority 1, High** | | | |
| # of cases with # of scores >70 | 0 | 1 | 1 | 4 | 5 | 9 | 18 | 6 | 4 | 48 |
| *% of cases with # of scores >70* | *0%* | *2%* | *2%* | *8%* | *10%* | *19%* | *38%* | *13%* | *8%* | 100% |
| Total # of cases in raw priority group | 2 cases | | | 18 cases | | | 28 cases | | | 48 cases |
| % of total cases in raw priority group | 4% | | | 38% | | | 58% | | | |
| Cases overridden, given ***higher*** priority | rare | | | **2 cases = 11% of Moderates** | | | n.a. | | | higher or lower |
| Cases overridden, given ***lower*** priority | n.a. | | | rare | | | **2 cases = 7% of Highs** | | | **5 cases = 10% of total** |

- Priority 3 (low) cases, based on BCFPI interview, are rarely 'overridden', and raised to a higher priority
- Approximately 11% of moderates = 2 /18 cases are 'bumped up' to high priority,
- Approximately 7% of high priority cases = 2 /28 cases are 'bumped down' to moderate priority,
- Approximately 10% of total group 4 (+ 1 rare low ->mod) / 48 = 5 / 48 = 10% are 'bumped' up or down

Thus, in this data set of mostly moderate to high severity cases, the raw BCFPI data corresponded to clinical judgments for about 90% of the cases (44/48). The total # of cases in each group remained unchanged after clinical adjustments, while there were small changes in group membership,

KL-Lwd still faces a daunting problem, with 46 high-moderate severity referrals for the quarter, for a far smaller number of intensive services slots, particularly since the majority (28) are high severity /priority.

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