REALIZING THE POTENTIAL:

STRENGTHENING THE ONTARIO MENTAL HEALTH SYSTEM FOR CHILDREN, YOUTH AND THEIR FAMILIES

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LEAD AGENCY PROVINCIAL PRIORITIES REPORT

PREPARED BY:
THE CHILD AND YOUTH MENTAL HEALTH LEAD AGENCY CONSORTIUM

NOTE FROM

THE CHILD AND YOUTH MENTAL HEALTH LEAD AGENCY CONSORTIUM PROVINCIAL PRIORITIES STANDING COMMITTEE

The Child and Youth Mental Health Lead Agency Consortium is committed to the goal of continually improving child and youth mental health services in Ontario so children and youth and their families receive the right services for their unique needs at the right time and in the right place. This is a commitment made with, and for, children and youth and their families. This Provincial Priorities Report, and our ongoing community mental health planning and service collaboration, are key contributors to this goal.

Lead Agencies for child and youth mental health are well placed to advise and inform the important healthcare changes in Ontario. Our focus has been, and will continue to be, on the creation of a system of high quality, timely, evidence-based, cost-effective services that are safe, locally-responsive and client centered. We are pleased to present ***Realizing the Potential: Strengthening the Child and Youth Mental Health System for Ontario Children, Youth and their Families***, a report that builds on the Lead Agencies' experience and work to date in local planning, youth and family engagement, collaboration and service provision.

This report provides our perspective on the current state of the child and youth mental health system and offers recommendations to government for positive change. It identifies four critical priorities that we believe require immediate attention as child and youth mental health services transfer to the Ministry of Health and Long Term Care. The four priorities are:

a) Improving our clients' service experience - through use of a standardized measure of perception of quality of care

b) Improving the quality and consistency of services – through the use of a standardized common assessment

c) Improving access to services – examining availability, affordability, and acceptability

d) Improving outcomes for children and youth with the most complex needs – through the design of a provincial system of supports

In each of these priority areas, this report provides the reader with key information and ideas that, if acted upon, will create sustained improvements for the people and communities who need these services most. It is truly an opportunity to make a difference for both the children and youth we serve and for the adults they will become as we work to create a better and stronger Ontario today and in the future.

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INTRODUCTION

The 2019 Provincial Priorities Report represents a fundamental shift in the focus of the work of the Consortium from planning at a system level to coordinated action at a service level.

The Consortium regularly undertakes collective system-level analysis to assist in identifying opportunities and priorities for action. In February 2019, Multi-Year Service Area Action Plans were reviewed to analyze common themes in the service gaps identified by each Lead Agency. The most common themes are aligned with the chapter priorities in this report: Perception of Care, Common Assessment, Access, and Live-in Treatment Services. Each chapter has a corresponding supporting documentation addendum, which summarizes the in-depth analysis and background information to support the recommendation.

The Consortium combined learnings from the Action Plan analysis, together with literature reviews in each of the chapter areas, and structured action-based recommendations that would fundamentally move the system forward in reflecting:

- What children, youth and families tell us are key areas for improvement,
- Our focus on improving standards of care and accessibility, and accountability for service delivery,
- What our partners have consistently identified through a February 2019 analysis of local action plans, undertaken by the Consortium,
- An emphasis on mental health across the lifespan.

Together with extensive experience and expertise in delivery of child and youth mental health services over many years, Lead Agencies and the Consortium have nearly four years of experience in formal community planning and collaboration with partners and ensuring the voices of children, youth and families are driving the design and delivery of services: they are well-placed to provide expert guidance and advice in implementation of the recommendations.

The challenges and opportunities documented in this Report – and the recommendations put forth – are intended to inform the work of all those with a major stake in system change. This includes the MOHLTC, Ontario Centre of Excellence for Child and Youth Mental Health (“The Centre”), Children’s Mental Health Ontario (CMHO), key cross-sectoral partners, child and youth mental health service providers and our own Consortium.

CONTEXT

This section provides an overview of the significant changes in the structuring of the child and youth mental health system, together with key considerations in the development of the 2019 Provincial Priorities Report.

CHILD AND YOUTH MENTAL HEALTH PLANNING, POLICY AND COORDINATION

In 2014 and 2015, a phased process was undertaken to identify Lead Agencies in all service areas across the province through calls for interested organizations. At this time the five functions of Lead Agencies were identified as:

- Leadership
- Planning
- Service Delivery/Service Alignment
- Performance Measurement
- Financial Management

Through this phased process, 31 Lead Agencies were identified for the 33 Service Areas[1]. The newly identified Lead Agencies came together provincially and formed an entity called the Child and Youth Mental Health Lead Agency Consortium (the Consortium). Local service area planning began, with the earliest Lead Agencies beginning planning in 2014 and the most recently identified Lead Agencies starting their local planning work in 2016.

Each Lead Agency undertook to lead local planning efforts to build a stronger mental health system for children, youth and families in its service area. But while Lead Agencies' efforts are focused locally, many of the opportunities and challenges they experience are similar and Lead Agencies recognize that they also have a role in planning for a stronger provincial child and youth service system. This provincial leadership has been a focus of the Consortium from its inception.

In the summer of 2016, MCYS removed the expectation that each Lead Agency would hold the MCYS child and youth mental health funding for its service area and contract with core service providers for the delivery of services.

In 2018, responsibility for the children and youth mental health services was transitioned from MCYS to Ministry of Health and Long-Term Care (MOHLTC).

For the last two years, the Child and Youth Lead Agency Consortium, representing the lead agencies from 33 service areas across Ontario, has provided annual Provincial Priorities Reports (PPRs) to the Ministry of Children and Youth Services (MCYS), and now the Ministry of Health and Long-Term Care (MOHLTC).

1 In two instances, one lead agency is overseeing two Service Areas.

THIS YEAR'S PRIORITIES REFLECT:

- The maturing of the child and youth mental health sector and lead agency structures, driven by the November 2012 Moving on Mental Health Strategy (MOMH) as part of the broader Open Minds, Healthy Minds,
- Striking increases in children and youth reaching out for service over the last decade, and
- The Consortium's commitment to move beyond crucial foundational planning into action.

FIGURE 1: OVERVIEW OF CHILD AND YOUTH MENTAL HEALTH SYSTEM EVOLUTION

OPEN MINDS, HEALTHY MINDS	IDENTIFICATION OF LEAD AGENCIES	LOCAL SERVICE PLANNING / PROVINCIAL COORDINATION	PLANNING USED TO INFORM ACTION AND INVESTMENT
• MCYS 2012 Policy Framework Moving on Mental Health • Crucial element: lead agencies responsible for planning and delivery of community child and youth mental health services	• 2014/15 • MCYS undertook phased approach to identification of lead agencies in 31 of 33 service areas • Core lead agencies' functions: Leadership, Planning, Service Delivery/Service Alignment, Performance Measurement, Financial Management*	• 2014-2016 local service planning initiated as lead agencies were identified • 2016 Lead Agencies created the Child and Youth Mental Health Lead Agency Consortium to provide provincial leadership	• 2017-19 • Transition to MOHLTC • Production / Action of Provincial Priority Reports • Development / implementation of local 3-Year Action Plans

The work of the Lead Agencies is central in improving system quality and accountability to children, youth, families and funders by bringing together key stakeholders, on an ongoing basis to plan, implement and evaluate service offerings in their service areas.

A key responsibility of each Lead Agency is the development of an annual Core Services Delivery Plan and a Community Mental Health Plan for their service area that is submitted to the government to inform annual service contracting. The Plans reflect the expertise that the Lead Agencies, and the Consortium, have developed in collaborative engagement of community partners to improve outcomes of children and youth accessing mental health services. While these Plans are unique to each area, many service areas are experiencing similar opportunities and challenges. Factors such as geography, size and needs of the population in service areas may cluster regionally and impact the process of developing inclusive and comprehensive planning and implementation.

2017 AND 2018 PROVINCIAL PRIORITIES REPORTS

The first two PPRs focused extensively on identifying foundation recommendations, built on input from lead agencies and their collaborative local planning across the province:

Recommendation 1: Increase public and partner confidence in the availability of high-quality child and youth mental health services in Ontario.

Recommendation 2: Increase meaningful engagement of youth and families in system transformation.

Recommendation 3: Build and maintain formal linkages between transformations in child and youth services.

Recommendation 4: Enhance engagement and integrated planning with health and education sectors.

Recommendation 5: Improve communication with key partners, core service providers and between MCYS and Lead Agencies.

For each of the recommendations the Report provided some specific actions or tactics directed to ourselves (the Consortium) and to the Ontario government, as the entity responsible for policy and funding for child and youth mental health in Ontario. The Consortium incorporated the recommended actions into our work plan for 2017-18 and beyond.

ALIGNMENT WITH GOVERNMENT PRIORITIES

In building this year's priorities, the Consortium utilized local and provincial analyses of gaps and opportunities to develop themes, and also reviewed two key reports to ensure alignment of recommendations with government priorities and recommendations.

AUDITOR GENERAL'S REPORT ON CHILD AND YOUTH MENTAL HEALTH

In the 2018 follow-up to the Auditor General's Report on Child and Youth Mental Health[2], the AG noted that while twenty-eight of the recommended actions were completed, twenty-seven actions had little to no progress. This Provincial Priorities Report recommended activities align with the outstanding actions in the AG report (see Appendix B for a detailed list of actions, below represents a summary by theme)[3]:

MEASURE EXPERIENCE

- Build client experience standards that will measure the service experiences of children, youth, and families; and enable continuous feedback

BETTER DATA FOR BETTER DECISION-MAKING

- Higher quality data and understanding changing indicators e.g. increasing presentations to hospital
- Develop consistent process for tracking and reviewing clients
- Implement performance indicators that measure the long-term outcomes of children and youth who have accessed mental health services to measure effectiveness
- Ensure publicly reported results are accurate and meaningful

ENSURE CONSISTENCY IN SERVICE ACCESS / DISCHARGE

- Consistency in service protocols and assessments tools
- Consistency in system navigations protocols to manage transitions between services and into adulthood, and following up during these transitions (including discharges from service)
- Explore opportunities to expedite the creation of clear and coordinated pathways to core mental health services, and services provided by other sectors

2 July 2018, http://www.auditor.on.ca/en/content/annualreports/arreports/en18/v2_301en18.pdf

3 See Appendix B for a summary of actions with little / no progress made

ENSURE CONSISTENCY AND QUALITY IN SERVICE DELIVERY

- Consistency in policy and program requirements across agencies
- Establish agency-specific targets for wait times, and monitor/take action on wait times
- Consistency in quality assurance reviews e.g. regular review of children and youth files
- Ensuring compliance with service delivery standards
- Develop caseload guidelines
- Implement a funding model that is commensurate with the needs served by an agency
- Further define Ministry of Children, Community and Social Services program requirements so that they can be consistently applied across Ontario by all agencies that deliver mental health services;
- Ensure consistency of mental health service delivery across agencies
- Identify and implement performance indicators and data requirements that are sufficient, consistent, and appropriate to use to periodically assess the performance of the program and the agencies that deliver it

MANAGING TRANSFORMATION: A MODERNIZATION ACTION PLAN FOR ONTARIO

This report, prepared in September 2018 by Ernst and Young, served to further inform and confirm the priorities for child and youth mental health. The recommendations serve to support the four major dimensions identified to implement a modernized Ontario Government[4]:

a) A better framework for public expenditure management that commits to evidence-based decision-making, a modern relationship with labour, a citizen-centered and digital-first mindset, modern risk-based regulatory management, renewed funding models that incent productivity and performance, a strong focus on intergovernmental coordination, and a clear understanding of the role of government acting as steward of taxpayer investment.

b) Strong leadership by the centre of government working with ministries and various delivery partners, to strengthen horizontal coordination and establish a renewed focus on improving the efficiency, productivity, and outcomes of the BPS and broader transfer payment partners, while at the same time delivering the most efficient OPS possible.

c) Major areas for Government to focus on to achieve efficiencies and improvements for both the OPS and through TP partners include: service delivery modernization, cost efficiency, individual and business supports, and one-time savings.

d) A Modernization Action Plan that would establish strong governance, clearly prioritize those opportunities for short term and longer-term efficiency and performance, initiate immediate steps to execute the Plan, and most importantly of all, drive the realization of benefits for all Ontarians.

4 Executive Summary, p. 3, https://files.ontario.ca/ey_report_2018_en.pdf

WHY THIS REPORT MATTERS

Ontario is struggling to adequately meet the mental health needs of its people: a recent analysis of emergency and inpatient hospital data over the last decade shows that, while emergency presentations are down 22% for all other conditions for children and youth, presentations for mental health issues are up over 70%[5]. Some of the other indicators of concern include[6]:

THE NEED IS SIGNIFICANT, AND TREATMENT NEEDS ARE NOT BEING ADEQUATELY MET:

As many as
1 in 5 children
and youth in Ontario will experience some form of mental health problem.

5 out of 6
of those kids will not receive the treatment they need.

1/4 of Ontario parents
have missed work to care for a child with anxiety. This is significantly higher among the 1/2 of Ontario parents who have had concerns about their child's anxiety.

Ontario's per capita
investment in health care was found to be $1,361 versus just $16.45 for mental health

Black Youth
are significantly under-represented in mental health and treatment-oriented services and overrepresented in containment-focused facilities.

First Nations youth
die by suicide about 5 to 6 times more often than non-Aboriginal youth.

LGBTQ youth
face approximately 14 times the risk of suicide and substance abuse than heterosexual peers.

Youth living in the
lowest-income
neighbourhoods had the highest rates of suicide, emergency department visits for deliberate self-harm, acute care mental health service use, treated prevalence of schizophrenia.

5 CMHO, 2018, https://www.cmho.org/images/miscellaneous/CMHO_2018%20CIHI%20Data_FINAL.pdf

6 All data, unless otherwise noted: CMHO, Key Facts and Data Points, https://www.cmho.org/education-resources/facts-figures

WE CAN MAKE A DIFFERENCE ACROSS THE LIFESPAN IF WE INTERVENE EARLY:

70% of mental health problems have their onset during childhood or adolescence: The disease burden of mental illness and addiction in Ontario is 1.5 times higher than all cancers put together and more than 7 times that of all infectious diseases. This includes years lived with less than full function and years lost to early death.[7]

Investing in early childhood services provides a **return on investment of 125%**[8]

Improving a child's mental health from moderate to high can lead to **lifetime savings of $140,000.**[8]

WE KNOW WHAT NEEDS TO CHANGE:

- Parents have told us where the gaps are, and this is supported through the Consortium's analysis of 3-year action plans: Half of Ontario parents who have sought mental health help for their child said they have faced challenges in getting the services they needed. The primary reason cited was long wait times (65%). Other challenges include: services don't offer what my child needs (38%), don't know where to go (26%), and don't offer services where I live (14%)
- Because of the maturity of the Lead Agencies and Consortium, our system is well-positioned to make strategic, data-driven recommendations, ensuring the optimization of enhanced mental health funding investments from both the provincial and federal governments

7 https://www.camh.ca/en/driving-change/the-crisis-is-real/mental-health-statistics

8 https://www.mentalhealthcommission.ca/English/case-for-investing-backgrounder

CHAPTER 1

PERCEPTION OF CARE

WHY THIS MATTERS TO CHILDREN, YOUTH AND FAMILIES

Being client-centered is a foundational principle of child and youth mental health agencies and client satisfaction surveys are commonly used as a way to measure the extent to which care in child and youth mental services is client-centered. Whereas client satisfaction is seen as a measure of the client's reaction to the services received, client **perception of care measures ask more directly about the care experience in relation to current quality standards of what should be expected as standard practice**. Perception of care is recognized as a crucial indicator of quality of care and results can inform continuous service delivery quality improvement and bring about necessary change in areas such as enhancing access, quality of care, client-centeredness and safety.

In addition, research shows that respondents are more willing to report infrequent exposure or use of a practice than to express dissatisfaction with this aspect of their care per se. Using a common perception of care tool across the child and youth mental health system standardizes how CYMH agencies obtain client perception of care feedback and gives voice to the youth and families accessing CYMH services.

RECOMMENDATION

That the Ontario Perception of Care Tool for Mental Health and Addictions (OPOC-MHA) be mandated and implemented as an annual tool across child and youth mental health agencies to be utilized with children aged 12 and over and that the Consortium continues to partner with the Centre for Addiction and Mental Health to refine the Caregiver version of the OPOC-MHA for clients under the age of 12.

IMMEDIATE NEXT STEPS, WORKING IN PARTNERSHIP WITH THE GOVERNMENT:

Utilize learnings from the Consortium's demonstration project to inform resource requirements (funding, training, evaluation / analysis) to support development of an implementation plan, together with how it will be utilized in quality improvement processes at a regional and provincial level.

WHAT SUCCESS LOOKS LIKE

FOR CHILDREN, YOUTH AND FAMILIES:

- Explicit opportunity for clients and caregivers to provide feedback on areas they perceive the CYMH service is doing well and also areas where service improvements can be made
- Service improvements are shaped by feedback provided through perception of care measures

FOR AGENCIES:

- Have access to a validated tool and implementation process that has been proven to work, rather than developing in-house, ad-hoc approaches
- Can identify areas for service improvement and good practices

FOR THE CHILD AND YOUTH MENTAL HEALTH SYSTEM:

- Standardized way of gathering perception of care data in the child and youth mental health system from clients and families
- Information gathered through this standardized tool contributes to a culture of data-driven decision making: system level areas of improvement can be identified and addressed locally, regionally and provincially
- Creates consistency in language across the province
- Informs evidence-based practice

HOW WE DEVELOPED THIS RECOMMENDATION

The **Supporting Documentation: Perception of Care** section provides a detailed overview and background on Perception of Care, the OPOC-MHA selection and pilot project process, and learnings to support implementation.

Currently, the overwhelming majority of child and youth mental health service providers across Ontario do not use a standardized satisfaction or perception of care tool but instead opt for a tool developed in-house. Having a mandated, standardized perception of care tool that works across the lifespan contributes significantly to our ability to continuously improve and measure quality of care, including in key areas such as access, clients' rights, environment, discharge planning, client-centeredness and safety, locally, regionally and provincially.

The working group did an exhaustive review in identifying a standardized tool that could be utilized across the province and decided that the Ontario Perception of Care – Mental Health and Addictions (OPOC-MHA) tool was the best suited to meet the needs of CYMH service providers given that:

- The OPOC-MHA tool is a tool that can be used across the lifespan and is being implemented in MOHLTC funded addiction, adult mental health, and concurrent disorder programs across Ontario.
- A central provincial database and report web portal gives organizations access to OPOC-MHA results which can be filtered and analyzed in a customized manner. Standardized reports are also available.
- OPOC-MHA is a validated and evidence-based tool that standardizes how mental health, addictions, and concurrent disorder services collect clients' perception of care to inform service and system improvement.
- The OPOC-MHA is a practical, consistent, and systemic tool that engages youth and caregivers in providing regular feedback to agencies, in addition to a myriad of ways that agencies currently engage them
- The OPOC-MHA is copyrighted by CAMH and identified by Accreditation Canada as an instrument approved for use for assessing client satisfaction/perception of care for accreditation purposes.

In order to test the suitability of the OPOC-MHA within the child and youth mental health system, the Consortium leveraged its partnerships and in-house resources to partner with the Centre for Addiction and Mental Health to pilot the OPOC across multiple agencies. The OPOC Demonstration Project involved 14 of 33 service areas in Ontario and ran in February 2019, with 410 client surveys and 485 caregiver surveys completed. In addition to giving the Consortium a first provincial glimpse of how our clients and their caregivers perceive their care, the Demonstration Project also monitored the resources required to administer the OPOC, tracked implementation success factors and challenges unique to the child and youth sector as well as the mitigations that were identified during the demonstration.

The demonstration project showed that, with proper resourcing, the OPOC-MHA is well suited to be implemented with those over the age of 12 as a common indicator across CYMH services in Ontario to inform quality improvement in the child and youth mental health sector. For clients under the age of 12, the caregiver version of the OPOC-MHA has strong potential to reflect the perception of care of these clients, with some further refinement of the tool.

CHAPTER 2

COMMON ASSESSMENT

WHY THIS MATTERS TO CHILDREN, YOUTH AND FAMILIES

An assessment tool should include the key components of screening, assessment, outcome measurement and follow-up that can be utilized across the lifespan. This tool does not replace secondary assessment tools utilized within specific program streams to ensure appropriate service planning. An evidence-based, validated Common Assessment Tool is a key building block in:

- Allowing for comparison of data across multiple systems and, eventually, facilitating E-Systems to "speak" to each other
- Facilitate care pathways as children and youth transition from one service to another, including as they age into the adulthood
- Ensure consistency in language across the province
- Increase evidence-based/evidence-informed practice
- Assist in identifying future allocation and priorities for service within the organization, service area and province.

RECOMMENDATION

The Consortium recommends that the inter-RAI[9] be mandated for all child and youth mental health services across the province where clinically relevant as a crucial enabler to measure and improve service quality, increase system efficiency (to decrease multiple assessments), and ensure there is system accountability to children, youth, families and funders.

IMMEDIATE NEXT STEPS, WORKING IN PARTNERSHIP WITH THE GOVERNMENT:

1. Implementation Plan – Training, Infrastructure to Support, Building Technology Capacity, Licensing
2. Will need in-depth and comprehensive implementation planning with a core team (preferably with a mix of current and new users, lead and core agency representatives)
3. Will need to ensure adequate funding for initial implementation activities (training, infrastructure) and ongoing operations and boosters over time.
4. Will need to build a foundation for implementation of new sites along with those who are currently using the tool (to get everyone on the same page
5. Sustainability Plan – Quality Practice and Supervision, Future Improvements, Shared Resourcing
6. Implement Change Management Strategy – Current organizational practice built around current assessment practices
7. Act upon Integration Opportunities with Adult Sector
8. Provincial Data Strategy

9 Specifically the inter-RAI ChYMH (Child and Youth Mental Health) version.

WHAT SUCCESS LOOKS LIKE

FOR CHILDREN, YOUTH AND FAMILIES:

- Children, youth and families complete a common assessment that enables better triage and service planning that fits their needs
- Because all agencies utilize the same assessment tool, clients and families will not need to re-do different assessment tools as they transition across different services or agencies, and their needs can be assessed over time, even as they transition into adulthood

FOR AGENCIES:

- Staff time will be more efficient because duplication in assessment will be minimized
- Assessment needs can be matched to services and appropriate care pathways in a standardized and consistent way
- Transitions through services and organizations will be streamlined
- Provides clarity to client population and needs served within the agency and within individual programs

FOR THE CHILD AND YOUTH MENTAL HEALTH SYSTEM

- Evidence-based informed practice and care pathways will be informed by data and trends at all service area levels
- Future allocation priorities will be identified using service-area level data
- A consistent language, data analysis strategy will inform provincial decision-making
- A foundation for e-collaboration will be established to facilitate information sharing across organizations.

HOW WE DEVELOPED THE RECOMMENDATION

See the **Supporting Documentation: Common Assessment** section for a comparative overview of current tools across multiple government ministries, together with a literature review and decision-making process for identification of the inter-RAI.

The ability for the government and service providers to collect and analyze consistent data provincially, across services areas, within service areas and between individual agencies is essential for improving the quality of services to children and youth, thereby improving outcomes. There is currently no standardized way of gathering data in the child and youth mental health system at point of assessment.

Every major report in our sector over the last number of years has stressed the importance of data-informed planning and services including the Children's Mental Health Ontario Report Card, the Office of the Provincial Advocate for Children and Youth reports, the Residential Services Panel report and MCYS' own Strategic Plan and Policy Framework for Child and Youth Mental Health.

Three tools were reviewed, together with a broader literature review to identify the Inter-RAI as the recommended common assessment tool moving forward. The inter-RAI is a tool that was created and validated through the Ministry of Health and Long-Term Care: the Consortium is confident that this is a validated, evidence-based tool. Two-thirds of lead agencies and nearly half of core service providers are already using the inter-RAI which will facilitate ease of broader implementation. Information gathered through a single mandated, validated tool that works across the lifespan contributes significantly to our ability to provide local, regional and provincial picture of needs

CHAPTER 3

ACCESSING CHILDREN AND YOUTH MENTAL HEALTH SERVICES IN ONTARIO

WHY THIS MATTERS TO CHILDREN, YOUTH AND FAMILIES

Access to mental health services is a complex concept that is often difficult to define. To clients and families, it is as simple as getting the right services where and when they are needed. Access is the process from pre-contact (I know who to call for service), contact (my first response to my request for service/intake), contact to service (I get the treatment that I need in a timely fashion – what happens between when you are eligible at the agency and when you get service; this is a function of wait times to get the service). Good mental health services are also based on a positive relationship being developed between provider and client. No matter how old you are, who you are, what you have or where you live, everyone should be able to access the full range of mental health services, treatments, and supports[10] as soon as the need for these services arises[11]. Yet every day across the province, people of all ages are facing barriers to getting the help they need, or simply giving up because the current system is too complex to navigate.[12] Key considerations in "access" include availability, affordability and acceptability.

Availability or physical access is often the concept that comes to mind when the notion of access is discussed. Fundamental to this domain is the concept of supply and demand or more specifically, the relationship between the volume and types of services offered and the volume and types of services that clients require and whether those appropriate providers and services are available at the right time and in the right place.[13,14]

Affordability or financial access refers to the degree of fit between costs of using the service and the individual's ability to pay. Affordability needs to consider the WHOLE cost of the encounter (not just the cost of service that the government pays for through funding to agencies, OR through an employer provided benefits program for the small percentage of the population that has one).

Acceptability or sociocultural access is one of the least-studied aspects of access. It concerns the relationship between clients' attitudes about and expectations of personal and practice characteristics of providers and actual characteristics of existing providers, as well as providers' attitudes and expectations regarding patients. These characteristics include attributes such as age, gender, or ethnicity of the provider or of the patient, and type, location and religious affiliation of the facility. These attitudes influence the individual's ability to receive care. Provider and patient expectations about respect for individuals, as well as respect for traditional or alternative beliefs about healing systems, also influence acceptability of services[15].

10 Mental Health Commission of Canada (2016). A Mental Health Strategy for Canada: Youth Perspective.

11 CMHA National (2018). Child and Youth – Access to Mental Health Promotion and Mental Health Care.

12 Select Committee on Mental health and Addictions (2010). Navigating the Journey to Wellness: The Comprehensive Mental Health and Addictions Action Plan for Ontarians.

13 Penchansky & Thomas, 1981

14 McIntyre et al., 2009

15 McIntyre etal., 2009, Penchansky & Thomas, 1981

RECOMMENDATION

The Consortium recommends that the government and Lead Agencies:

1. collaborate to develop key performance indicators for child and youth mental health to measure access to services within the framework of availability, affordability, and acceptability and;

2. work together to ensure that Ontario Health is appropriately accountable for increasing access to the full range of quality child and youth mental health services across the province through the Ontario Health Teams and other entities.

WHAT SUCCESS LOOKS LIKE

FOR CHILDREN, YOUTH AND FAMILIES:

- Standardized access mechanisms into, through, and out of the mental health system that are predictable, responsive, and sensitive to their needs.
- Will know where to go for service, how long it will take to get that service, and that the service will meet their needs.

FOR AGENCIES:

- Have clear expectations for their role in the system, access points to their services, and what KPIs they are working to address
- Are able to access support from their Service Area Lead Agencies on promising practices that can positively impact access
- Receive support in contributing to OHTs

FOR THE CHILD AND YOUTH MENTAL HEALTH SYSTEM:

- Standardized and benchmarked core services are established and consistently applied across the province: the value proposition for each core service is clear
- KPIs are in place to measure service availability, affordability and acceptability
- Ontario Health Teams provide real-time input to provincial monitoring on KPIs and adjustments can be made systematically to address barriers to service
- OHTs focus on ensuring timely access to the right services to reduce the need for more intensive services
- Reduce the pressures felt elsewhere in the system when left untreated (the experience of symptoms may increase to the point of crisis which results in an over-reliance on the emergency departments of the acute care hospitals)
- Experience of establishing standardized access mechanisms and service benchmarks
- OHTs will inform the structural changes needed in the system to facilitate access

HOW WE DEVELOPED THE RECOMMENDATION

The Supporting Documentation: Access section contains a comprehensive background on the three "As" of access and current challenges, a literature review of strategic areas of focus to improve access, examples of innovative practices in access in the province and current approaches to measuring access.

The Consortium's recommendations related to the implementation of the OPOC-MHA (common Perception of Care tool administered annually) and the inter-RAI ChYMH (mandated Common Assessment Tool) are crucial to facilitating consistency in access to the system.

- Facilitates matching appropriate treatment from a consistent, standardized basket of services to the needs identified through a common assessment tool
- Assesses perception of that treatment utilizing a common tool to continuously improve services (recognizing that access is a key element of the OPOC): bringing the voice of children, youth and families is essential to the design of a better system of access
- Facilitates development of common clinical care pathways for different groupings of children and youth (characteristics and/or needs of a particular group, tied to specific core services and intensity of those services) as they transition into the system, across service settings, and eventually out of the system

The Consortium recognizes that there are increasing issues in accessing children and youth mental health services – but CIHI's 2017 report provides important information about what is driving the current system pressures[16]:

- Prevalence is Steady. CIHI reports that the prevalence of mental disorders is unchanged over time, which suggests there are other causes of children and youth with mental health disorders increasingly seeking care in hospitals.
- Demand is Rising as Stigma is Declining. Bell Let's Talk reports that between 2010 and 2015, mental health awareness is growing, attitudes toward mental health are improving, and stigma surrounding mental health issues is declining. This has likely had the positive effect of empowering more children and youth to seek care.
- Capacity in the Community is Eroding. Since 1992, there have been only two base funding increases for child and youth mental health centres: 3% in 2003 and 5% in 2006. But since 1992, inflation has risen by more than 55%. As a result, the capacity of community agencies to deliver timely care to children and youth has been diminished by 50%.

16 CMHO – Backlog at community-based child and youth mental health centres sends kids to hospitals at alarming rates, May 2017, https://www.cmho.org/about-cmho/cmho-s-latest-work/item/download/257_33b40d58cea9660485c2254e67943b0f

The Consortium recognizes that structural changes are needed in the system to facilitate access: of critical importance is that the right types of changes are made in the right way to ensure the changes made build quality and reduce confusion – there are foundational elements that need to be put in place. Simply put, there is not currently a standardized data set or established targets that we can measure our system against, to ensure we have fully identified efficiencies and value propositions for each of our services.

There are innovative initiatives underway across the province that are promising examples of ways in which access can be improved, together with a substantive body of research to support implementing innovations in access[17]. Together with these learnings, the emerging Ontario Health Team model presents an important opportunity for the child and youth mental health sector to leverage as it seeks to improve access to services.

17 See Supporting Documentation: Access for summary

CHAPTER 4

LIVE-IN TREATMENT SERVICES

WHY THIS MATTERS TO CHILDREN, YOUTH AND FAMILIES

Live-in Treatment Services[18] (LITS; previously referred to as residential treatment) is defined as treatment within a 24 hour a day out of home placement by an inter-professional, multi-disciplinary team making therapeutic use of the daily living milieu. LITS often serve children and youth at the most vulnerable times in their young lives; when provided in an evidence-based, clinically sound manner, they can have a significant positive impact.

Currently, LITS in Ontario are a patchwork mix of public and private providers, and the government has no view into who is delivering what services to whom, or with what outcomes. Young people whose mental health issues require intensive treatment in a live-in setting face confusing and fractured service pathways, long wait lists, services far from home, limited follow up post-treatment and most concerningly, services that are determined by the availability of treatment or bed capacity rather than the young person's assessed needs.

The impact of this on young people is their needs are frequently unmet resulting in lack of school success, breakdown of critical relationships in community and at home and poor outcomes in adulthood (such as substance use issues, employment and education challenges, and criminal justice system involvement). In far too many cases, some of these young people are dying by suicide.

18 This model has historically been referred to as residential treatment but the Consortium has elected to utilize a new term that is more reflective of the model and philosophy.

RECOMMENDATION

The Consortium recommends that the government work in partnership with Lead Agencies and core service providers to design and implement a live-in treatment service system, well-integrated within the broader child and youth mental health system (including transitions across the lifespan), that is evidence-based, has clear clinical pathways, and can demonstrably meet the needs of children, youth, and families across Ontario.

IMMEDIATE NEXT STEPS, WORKING IN PARTNERSHIP WITH THE GOVERNMENT:

Because of the current state of the existing system, and the high degree of vulnerability of children and youth accessing these services, and the high costs associated with inadequately meeting their needs, the Consortium considers this an urgent priority, with a goal of initiating this planning in April 2019.

Providers of live-in CYMH treatment know that the system needs to be strengthened and redesigned, a perspective supported by the reports of the Residential Services Expert Panel, the former Provincial Advocate for Children and Youth and the Chief Coroner of Ontario. We believe that the starting point for forward-looking solutions is the design and implementation of a provincial plan for a system of quality services that will support these children and youth to achieve better life outcomes efficiently, effectively and sustainably.

Lead Agencies and the Consortium, given their collective expertise in service delivery, community planning and collaboration, are well-placed to provide expert guidance and advice in ensuring live-in treatment services are evidence-based and child and youth-centred.

WHAT DOES SUCCESS LOOK LIKE

FOR CHILDREN, YOUTH AND FAMILIES:

- Timely access (available, affordable, acceptable) for children and youth to evidence-based models of live-in treatment services that match with their identified needs, and are available as close to home as possible

FOR AGENCIES:

- Consistent understanding in what LITS are, what's available in their Service Area, and how to access that service
- LITS receive support and have clear expectations in what they provide to their clients and how to assess their fidelity to evidence-based models

FOR THE CHILD AND YOUTH MENTAL HEALTH SYSTEM:

- Consistent, equitable and adequately funded tiered model for LITS is established and understood across the system
- Children and youth outcomes are measurably improved through the support they receive in LITS
- Clinical effectiveness is optimized by ensuring the right staff is matched with the right type of LITS
- KPIs in place to measure service availability, affordability and acceptability
- Access to LITS placements is facilitated through OHTs and OHTs are accountable for the outcomes of children and youth in LITS placements.

HOW WE DEVELOPED THIS RECOMMENDATION

Supporting Documentation : Live-in Treatment Services provides a comprehensive background of live-in treatment services, current capacity, better practices, and an initial framework that proposes a tiered approach to LITS.

In 2014, when the then Ontario Ministry of Children and Youth Services (MCYS) established the seven child and youth mental health core services, one of the core services was 'intensive services'. In this core service, MCYS included 'residential treatment' programs operated by child and youth mental health transfer payment agencies. Intensive mental health services were those that were intended to provide treatment to children or youth affected by mental health problems that impair their functioning at home, school, and/or in the community, and who require an intensive level of intervention, in some cases, in an external setting. Although the government licenses both residential treatment and residential care homes, there is not a definition for child and youth mental health residential treatment, nor does it differentiate residential **treatment** from other forms of group residential **care**.

To succeed in meeting treatment needs, Ontario's CYMH live-in treatment services need to be organized in a tiered system, which distinguishes "care" from "treatment", and which categorizes services based on a provider's ability to meet escalating levels of need and complexity. These services must be planned provincially, with the most specialized (and most expensive / least utilized) services offered at the regional and provincial levels. All of these services must operate within the context of the broader CYMH sector and the health care system—for example, live-in treatment services being used as a step-down from hospital inpatient services as appropriate. The system needs to be designed around the needs of the children and youth and ensure that there is a specific assessment of suitability for any treatment environment

Although live-in programs are the most expensive and intrusive community child and youth mental health services provided in Ontario, they have developed in a fragmented and opportunistic manner in the absence of provincial assessment of need, strategic direction, or plan for distribution of programs across the province. Providers, whether they are not for profit transfer-payment agencies, government directly operated or private non-profit or for-profit per diem entities, typically design and develop programs based on the funding they have, their own skills, philosophies and priorities, and are informed by local demand at the time, and historical practices.

The resulting programs are likely not comparable in terms of program design, types of therapeutic services and professional disciplines involved, clinical profiles, staff-to-client ratios, characteristics of the living environment, lengths of stay, age requirements, geographical boundaries, and bed availability. Furthermore, they have limited capability to adapt as local needs evolve.

In this unplanned and largely undifferentiated set of programs, children and youth must fit into the program that individual providers build and government funds (or families/caregivers can afford) rather than have access to a program that is most likely to able to address their unique treatment needs.

As is the case across the CYMH service continuum, availability of live-in mental health treatment is not equitable across Ontario or across child and youth populations. There are significant populations in Ontario that either cannot access services or who are poorly served by the available services including[19]: socio-economically marginalized groups, Indigenous peoples, racialized peoples, individuals who identify as LGBTQI2S+, medically complex clients, newcomers, immigrants, Francophones and people living in remote and rural areas including northern Ontario.

19 Recognizing that many children and youth can experience multiple challenges.

THE GOVERNMENT HAS REVIEWED SYSTEM ISSUES IN THIS SECTOR MULTIPLE TIMES IN RECENT YEARS.

- Bay report (2006): "The overall direction for residential services should be to ensure that the right types of residential service are available at the right place at the right time and that each type of service has consistent expectations for quality, accountability and funding."[20]
- In 2015 the government established the Residential Services Review Panel to conduct a system-wide review of the province's child and youth residential services system, including foster and group care, children and youth mental health residential treatment, and youth justice facilities. The panel's report *Because Young People Matter* was released in 2016 and made ten recommendations toward system improvement.
- Also in 2016, the Ontario Child Advocate (then the Office of the Provincial Advocate for Children and Youth) released *Searching for Home*, a report focused on the youth experience in residential care in Ontario.
- In receiving the Panel's and the Advocate's reports, MCCSS (formerly MCYS) committed to building a blueprint for reform: released its Blueprint for Building a New System of Licensed Residential Services (the Blueprint)[ii] in July of 2017. In addition to identifying immediate plans for addressing fundamental issues like the basic health and safety of children and youth living in care, the Blueprint makes a range of important longer-term commitments, including: defining the scope of licensed residential services; enhancing the effectiveness of data and information management; and, designing and implementing an action plan for workforce development.
- In September 2018, the Office of the Chief Coroner (OCC) for Ontario released Safe with Intervention, the report of an Expert Panel that reviewed the cases of twelve very vulnerable children and youth who died while in out of home placements between 2014 and 2017. The report revealed a lack of crucial linkages between the child welfare sector and the CYMH sector. A common theme that emerged from the review of the deaths of these 12 young people is the numerous failures by the system to identify and diagnose escalating mental health challenges and a subsequent failure to ensure access to crucial treatment. The Panel wrote: "The response to their needs was primarily crisis driven and reactionary. The young people were identified as "safe with intervention" following a mental health crisis yet in practice "safe" often translated to a "bed to sleep in" and very little, if any, mental health treatment.[21].

20 Bay Consulting Group (2006). Children and Youth Residential Services Review. Submitted to the Ministry of Children and Youth Services, April 2006, page 4.

21 Office of the Chief Coroner (2018). Safe With Intervention. The Report of the Expert Panel on the Deaths of Children and Youth in Residential Placements, September 2018, page. 63.

APPENDIX A: MEMBERSHIP

PPR3 STANDING COMMITTEE:

Joanne Lowe (Chair)
Diane Walker
Cathy Paul
Cynthia Weaver
Monica Armstrong
Brenda Clarke
Mamta Chail-Teves
Michelle Hurtubise
Terra Cadeau
Hélène Fournier
Christine Penney
Deb Shime

PERCEPTION OF CARE CHAPTER GROUP:

Joanne Lowe
Monica Armstrong
Cathy Paul
Christine Penney

COMMON ASSESSMENT CHAPTER GROUP:

Cynthia Weaver
Mamta Chail-Teves
Purnima Sundar
David Willis
Hélène Fournier

LIVE-IN TREATMENT SERVICES CHAPTER GROUP:

Cathy Paul
Cynthia Weaver
Joanne Lowe
Monica Armstrong
Purnima Sundar
Chris Langlois
Reshem Khan
David Willis
Shaun Baylis
Diane Walker

ACCESS CHAPTER GROUP:

Michelle Hurtubise
Terra Cadeau
Deb Shime
Brenda Clarke
Tara McFadden
Alison Farough
Shaun Bayliss
Chantal Dubois
Linda Dugas

APPENDIX B: HIGHLIGHTS - AUDITOR GENERAL'S STATUS REPORT

Itemized recommended actions where the status is little to no progress according to the 2018 Status Update Report[22]:

- The Ministry of Children, Community and Social Services work in consultation with Children's Mental Health Ontario and Local Health Integration Networks to help hospitals develop and implement protocols and assessment tools for assessing the mental health needs of children and youth seeking treatment at hospitals
- The Ministry of Children, Community and Social Services work in consultation with Children's Mental Health Ontario and Local Health Integration Networks, hospitals, and lead child and youth mental health agencies to develop and implement system navigation protocols for better managing clients' transitions between hospitals and child and youth mental health services, as well as transitions between community-based services
- The Ministry of Children, Community and Social Services should work with lead child and youth mental health agencies in consultation with Children's Mental Health Ontario to ensure that:
  - service delivery policy and program requirements for agencies are clear and well understood by agencies, and that all agencies comply with these policy and program requirements for service delivery;
  - all agencies have policies in place to guide staff when a client is discharged and needs to transition to another agency or service system, including to adult mental health services;
  - agencies consistently follow up with children and youth after discharge to assess their status and facilitate access to additional services if needed;
  - agencies update clients on when they will receive service.

22 July 2018, http://www.auditor.on.ca/en/content/annualreports/arreports/en18/v2_301en18.pdf

- The Ministry of Children, Community and Social Services should work with lead child and youth mental health agencies in consultation with Children's Mental Health Ontario to:
  - establish agency-specific targets for wait times, monitor actual wait times against these targets to assess their reasonableness, and follow up with corrective action when wait times are not met;
  - assess whether periodic quality assurance reviews of agency files can help ensure that children and youth receive appropriate and effective services;
  - assess whether requiring supervisory approval of key caseworker decisions and documents that guide mental health services can help improve the quality and consistency of services provided;
  - when assessing agencies' compliance with service delivery standards, communicate the outcomes of these assessments to all agency staff to help ensure that issues of non-compliance are addressed agency-wide.
- The Ministry of Children, Community and Social Services should work with lead child and youth mental health agencies in consultation with Children's Mental Health Ontario:
  - to develop caseload guidelines;
  - ensure that agencies periodically compare themselves against these guidelines in order to help assess the effectiveness and efficiency of their operations.
- The Ministry of Children, Community and Social Services should work with Children's Mental Health Ontario, lead child and youth mental health agencies, and Local Health Integration Networks to:
  - develop a process for tracking and reviewing client complaints in order to identify trends that may require follow-up and/or corrective action;
  - build client experience standards that will measure the service experiences of children, youth, and families; and enable continuous improvement
- To ensure that children and youth with mental health needs across the province consistently receive timely and appropriate services, the Ministry of Children, Community and Social Services should:
  - implement a funding model that allocates funding to child and youth mental health agencies that is commensurate with the mental health needs of the children and youth they serve;
  - develop and implement a funding model to allocate funding to Indigenous-operated agencies that is commensurate with the mental health needs of the children and youth they serve
- To ensure that consistent and appropriate services are provided to children and youth across Ontario, the Ministry of Children, Community and Social Services should work with lead child and youth mental health agencies to:
  - further define Ministry of Children, Community and Social Services program requirements so that they can be consistently applied across Ontario by all agencies that deliver mental health services;
  - implement a process to monitor whether child and youth mental health agencies are delivering mental health services according to Ministry of Children, Community and Social Services requirements;
  - explore opportunities to expedite the creation of clear and coordinated pathways to core mental health services, and services provided by other sectors, so that children and youth are connected with the right service regardless of where they request services.

- To help ensure that the Child and Youth Mental Health program is performing as intended to deliver consistent and effective services to Ontario's children and youth who need it, the Ministry of Children, Community and Social Services should work with Children's Mental Health Ontario, and child and youth mental health agencies, to:
  - identify and implement performance indicators and data requirements that are sufficient, consistent, and appropriate to use to periodically assess the performance of the program and the agencies that deliver it;
  - implement performance indicators that measure the long-term outcomes of children and youth who have accessed mental health services to assist the Ministry of Children, Community and Social Services to measure the effectiveness of the program and inform future policy decisions;
  - collect data on the number of children and youth with specific mental health concerns that will help inform future policy decisions to better address the needs of children and youth;
  - set targets for the Ministry of Children, Community and Social Services performance indicators and use the data it collects to identify instances that may require follow-up and/or corrective action;
  - ensure that publicly reported results on the performance of the Child and Youth Mental Health program provide information that is both accurate and meaningful.

SUPPORTING DOCUMENTATION: PERCEPTION OF CARE

BACKGROUND: OPOC-MHA

The Ontario Perception of Care (OPOC-MHA) tool is a validated and evidence-based tool that standardizes how mental health, addictions, and concurrent disorder services collect clients' perception of care to inform service and system improvement.

The OPOC-MHA asks about the care experience in relation to what is expected as **standard practice** (not just whether the person was satisfied). The tool was developed and validated by the Centre for Addiction and Mental Health (CAMH) with funding from Health Canada's Drug Treatment Funding Program (DTFP) and the Ontario Ministry of Health and Long-Term Care. The OPOC-MHA is copyrighted by CAMH and identified by Accreditation Canada as an instrument approved for use for assessing client satisfaction/perception of care for accreditation purposes.

The OPOC-MHA tool is being implemented in MOHLTC/ Local Health Integration Network (LHIN) funded addiction, mental health, and concurrent disorder programs across Ontario.

Two versions in both English and French are available – one for registered clients and another for family members, significant others and supporters. The OPOC-MHA for registered clients contains 38 items and the family/supporters' version contains 17 items that focus on 7 quality improvement indicators as well as additional demographic questions, stage in treatment process question and two open ended questions about least/most helpful aspects of service. Participants require a literacy level of grade 6 or higher to complete, and completion time is roughly 10-20 minutes (depending on the version – clients or families).

Questions specific to a client's experience cover the following areas:

- Access/entry to services;
- Services provided;
- Participation/Rights;
- Therapists, staff, support workers;
- Environment;
- Discharge, program completion, treatment; and
- Overall experience
- Inpatient/residential treatment services (if applicable)

Analysis and interpretation of OPOC-MHA data may involve individual or grouped items and responses to each item may be reported as % OR averages. In addition to an "overall perception of care" score, subscale scores may also be calculated for "accessing services" and "within services":

SCALES	# OF ITEMS	ITEMS	SCORING
Overall Perception of Care	23	1-8, 12-15, 17-18, 20-25, 30-32	Average score of the 23 items
Accessing Services	6	1-6	Average score of the 6 items
Within Services	17	7-8, 12-15, 17-18, 20-25, 30-32	Average score of the 17 items

A central provincial database and report web portal gives organizations access to OPOC-MHA results which can be filtered and analyzed in a customized manner. For example, organizations can select specific indicators they wish to track over time, examine data through a health equity lens, and then look at specific programs to support quality improvement efforts. All providers have access to their own raw data, including open-ended comments as well as access to aggregated, comparable provincial data. Standardized reports are also available.

Data from the OPOC-MHA is intended to be linked to quality improvement efforts. OPOC enables this by capturing information on quality improvement indicators. Actionable items make it possible to develop strategies to address specific issues.

SUMMARY FINDINGS: DEMONSTRATION PROJECT

The Ontario Perception of Care Chapter Group (one of the four PPR Standing Committee Chapter Groups) completed a demonstration project aimed at testing out the administration of the OPOC tool to children, youth and families within the CYMH system across fourteen service areas in Ontario. The Ontario Perception of Care Chapter Group partnered with the Centre for Addiction and Mental Health (CAMH) to support the demonstration project.

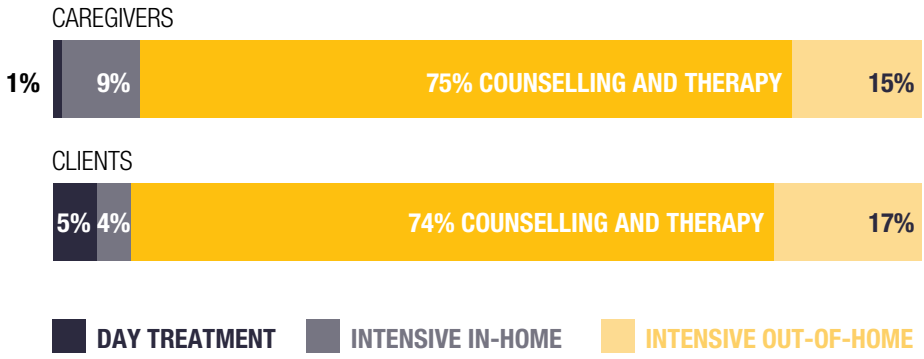
A coordinated OPOC blitz took place in February 2019 among agencies who have volunteered to participate in the OPOC demonstration project. The OPOC demonstration project surveyed clients receiving services in (1) counselling & therapy or, (2) intensive services.

SAMPLE:

During the consortium's pilot in February 2019, we surveyed 410 clients and 485 caregivers across 13 Lead Agencies.

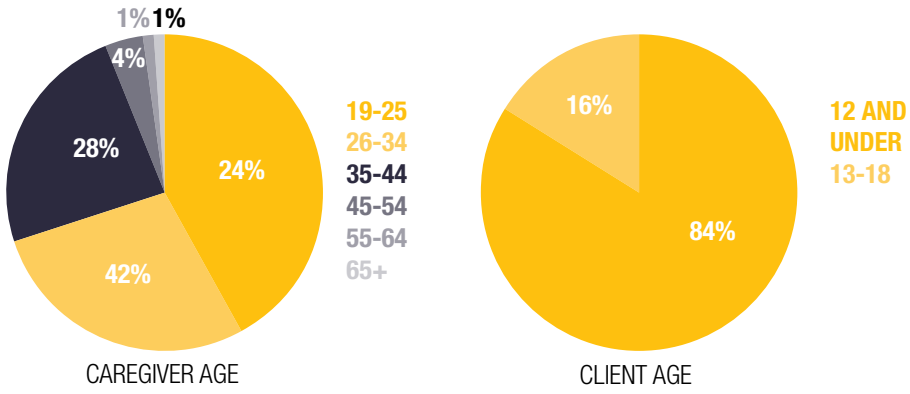
SERVICE TYPE

Three quarters of all responses were for clients in Counselling and Therapy. There were similar service type breakdowns between clients and caregivers, with caregivers responding less frequently for intensive out-of-home (residential) services and slightly more frequently for intensive in-home services.

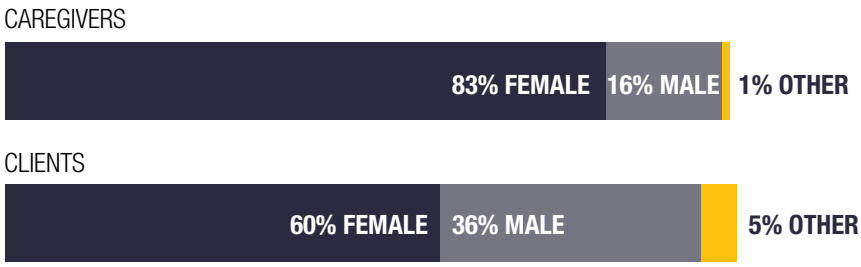


DEMOGRAPHICS

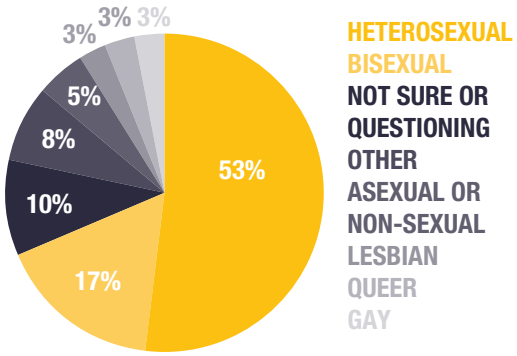
Age: Caregiver age was variable and not surprisingly the majority being between 26 and 54 years of age, most commonly in the middle of this range (35-44). The majority of client's (84%) who completed the survey were aged 13 or older (note the survey is validated for 12 and up). Caregiver surveys were more commonly completed for children 12 and under (72%). There would be value in adding more age categories or collecting year of birth to the OPOC.



Gender: Females were more commonly the respondents for both caregivers and clients, making up 83% and 60% of all respondents, respectfully. We noted that more than 90% of caregiver respondents were the parent of the client. As such, it is probable that clients' mothers are the parent who is more involved in their child's care, at least in our sample. It is not surprising that the client sample was more commonly female , we noted above the client sample was largely clients 13-18 years of age, female in service tend to be older and present with more internalizing issues, as these tend to have a later onset.

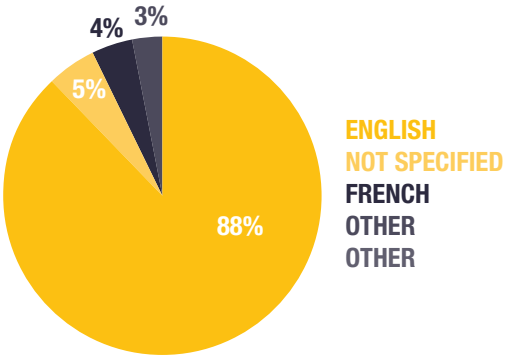


Sexual Orientation: Only just over half of the sample were heterosexual, with the remaining clients identifying on other parts of the LGBTQ continuum. This result is a surprising one. One would expect there be a larger proportion on the continuum than in the general population but not to this extent. This result should be investigated further to better understand the responses to this question item. It is noteworthy that the Facilitator Perception Survey indicated that this particular question item (client sexual orientation) was the question item for which the greatest number of clarifications were asked.



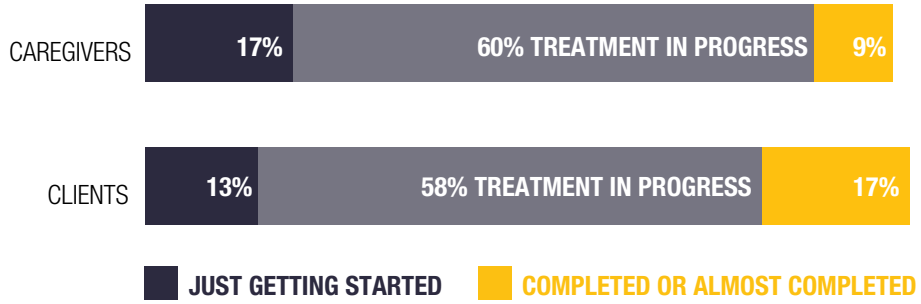
CLIENT SEXUAL ORIENTATION

Mother Tongue: The sample was almost exclusively English, with only 2% of clients reporting French as their mother tongue and 9% either not specifying or choosing "other". Given the importance of language in the mental health recovery process, further investigation to better understand this particular sub-sample of client data could be considered. Demographic question item #5 (language of preference) may further inform this question.



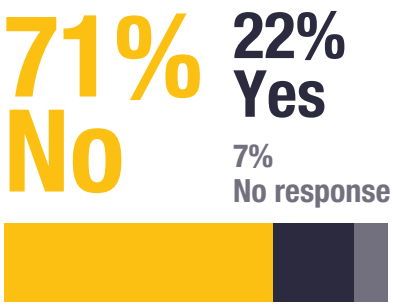
CLIENT MOTHER TONGUE

Timing of OPOC Completion: Approximately 60% of those completing the client OPOC were currently in treatment/ service, 17% had completed or almost completed service and 13% were just getting started. Responses were similar with caregiver survey with 60% reporting their loved one was currently in services, 9% had completed and 17% were just getting started.

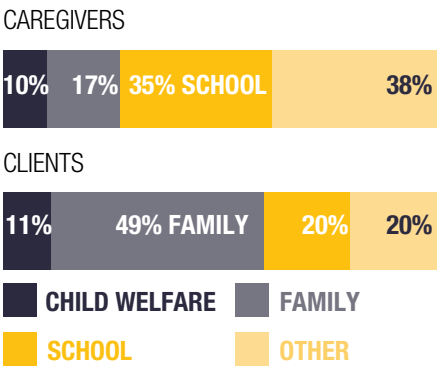


Required, Mandated or Pressured to Attend Treatment Services and Supports: Almost a third of clients (30%) and a quarter (22%) of caregivers reported that they / their loved one was required, mandated or pressured to attend treatment. Of those who responded that they were required, mandated or pressured to attend, clients rated families (49%) highest as the source of this pressure whereas caregivers identified condition/ pressure from school (38%) as the highest. Despite this high proportion of children and youth who reported that they are pressured or mandated to participate in treatment, a total of 87% of all youth surveyed Agreed or Strongly Agreed that "the services I have received have helped me deal more effectively with my life's challenges." This may reflect on the strong abilities of the CYMH agency staff to engage with youth.

CAREGIVER'S PERCEPTION OF PRESSURE TO ATTEND TREATMENT SERVICES

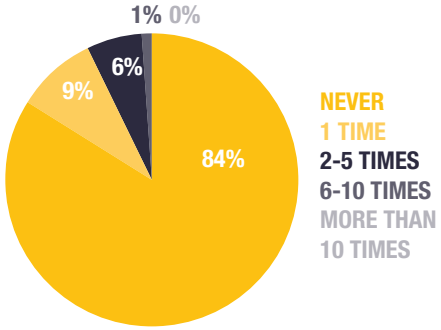


SOURCE OF PRESSURE TO ATTEND TREATMENT SERVICES AND SUPPORTS



Inpatient Hospitalization for Mental Illness: Caregivers were asked how many times their loved one had been hospitalized as an inpatient for mental illness. Approximately 80% of caregivers responded that their loved one had never been hospitalized as an inpatient, 8% responded one time, 6% 2-5 times and 1% responded 6-10 times.

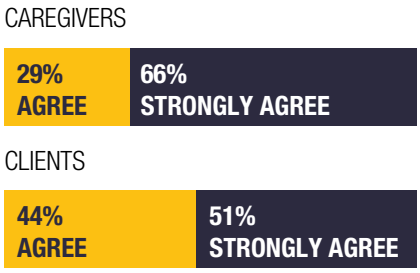
OF TIMES LOVED ONE HOSPITALIZED AS INPATIENT



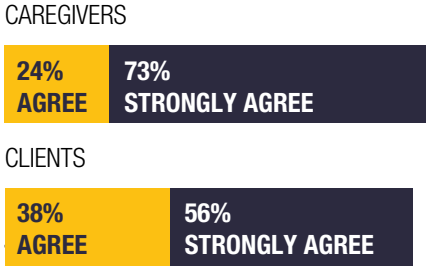
FINDINGS

Overall Client and Caregiver Experience: Across "Counselling and Therapy" and "Intensive Services" both client and caregivers consistently reported positive experiences with the services their families received. In fact, about 95% of clients and caregivers report that the services they receive are of high quality, and more than 90% would recommend to a friend with similar needs.

I THINK THE SERVICES PROVIDED HERE ARE OF HIGH QUALITY



IF A FRIEND WERE IN NEED OF SIMILAR HELP I WOULD RECOMMEND THIS SERVICE



Results were also positive when clients and caregivers were asked about whether the services they or their loved one received helped them to deal with their/their loved one's life's challenges

SERVICES RECEIVED HAVE HELPED ME/ MY LOVED ONE DEAL MORE EFFECTIVELY WITH MY/THEIR LIFE'S CHALLENGES

Because of the sample size, it is challenging to have reliable data for intensive services individually, as such, data from day treatment, in-home intensive and out-of-home intensive (residential) services were pooled and reviewed against data from counselling/therapy clients. Interestingly, caregiver feedback was consistent for both service types. For intensive services, clients were less likely to report services were of high quality, to recommend a friend and to report the services helped them to deal with their life's challenges. (It is important to note, results were consistently high even for clients in intensive services in the mid-high 80s range).

COUNSELLING AND THERAPY SERVICES

I THINK THE SERVICES PROVIDED HERE ARE OF HIGH QUALITY

CAREGIVERS

CLIENTS

IF A FRIEND WERE IN NEED OF SIMILAR HELP I WOULD RECOMMEND THIS SERVICE

CAREGIVERS

CLIENTS

SERVICES RECEIVED HAVE HELPED DEAL LIFE'S CHALLENGES

CAREGIVERS

CLIENTS

INTENSIVE SERVICES

I THINK THE SERVICES PROVIDED HERE ARE OF HIGH QUALITY

CAREGIVERS

CLIENTS

IF A FRIEND WERE IN NEED OF SIMILAR HELP I WOULD RECOMMEND THIS SERVICE

CAREGIVERS

CLIENTS

SERVICES RECEIVED HAVE HELPED DEAL LIFE'S CHALLENGES

CAREGIVERS

CLIENTS

AREAS OF EXCELLENCE

There were a number of areas where clients and caregivers perceive our services as doing exceptionally well. While there was some similarity between clients and caregivers there were some interesting differences as well.

CLIENT SURVEY	% AGREE OR STRONGLY AGREE	CAREGIVER SURVEY	% AGREE OR STRONGLY AGREE
I was treated with respect by program staff.	99%	Staff treated my loved one with respect.	99%
Staff believed I could change and grow.	98%	I felt welcome from the start.	98%
I was assured my personal information was kept confidential.	98%	I felt I was a valued member of the care team for my loved one.	97%
Overall I found the program space clean and well maintained.	98%	Overall I found the program space clean and well maintained.	99%
I was given private space when discussing personal issues with staff.	98%	I felt the facility was safe.	99%
		I was included in decisions made about my loved one's treatment	97%

- **The Therapists, Support Workers/ Staff:** An area where clients' and caregivers' perception of care was exceptionally great was with our staff. This domain had very high ratings on item, including how our staff and organizations respect our clients, demonstrate a belief that clients, were knowledgeable and competent and responsive to the clients' concerns and needs, including cultural needs.
- **Confidentiality:** Clients felting assured that their personal information was kept confidential, with 98% of clients agreeing or strongly agreeing.
- **Environment:** Environment was another domain that received many exceptionally high rating from clients and caregivers. More specifically, approximately 98% of clients reported that they were given private space when discussing personal issues with staff and caregivers felt the facilities providing treatment for their loved ones were safe. Both clients and caregivers found the program space clean and well maintained.
- **Caregiver Involvement and Engagement:** Caregivers reported feeling welcomed from the start, that they were a valued member of the care team and included in decisions made about their loved one's treatment

AREAS OF OPPORTUNITY

There were a number of areas where there is opportunity to make improvements in the services we provide to our clients and their families. While there was some similarity between clients and caregivers there were some interesting differences as well.

CLIENT SURVEY	% AGREE OR STRONGLY AGREE	CAREGIVER SURVEY	% AGREE OR STRONGLY AGREE
There were enough activities of interest to me during free time. (out-of-home)	65%	The wait time for services was reasonable for my loved one.	67%
If I had a serious concern, I would know how to make a formal complaint to this organization.	72%	If I had a serious concern, I would know how to make a formal complaint to the organization.	79%
I have a plan that will meet my needs after I finish the program/treatment.	77%		
Staff helped me identify where to get support after I finished the program/treatment.	79%		
The layout of the facility was suitable for visits with my family and friends (e.g., privacy, comfort level). (out-of-home)	80%		

- **Wait times:** Caregivers had the biggest concern with one third finding the wait times for service to be not reasonable. This is an issue that the system is well aware of, there have been significant increases in the demand for child and youth mental health services while capacity has remained consistent, this has contributed to long wait for service.
- **Out-of-home intensive:** Two of the most significant areas for improvement identified by clients included aspects of out-of-home intensive (residential) treatment. More than a third of these clients reported a lack of interesting activities during free time and one in five reported challenges related to connecting with family, specifically, related to the facility's layout.
- **Making a Complaint:** more than 20% of caregivers and nearly 30% of clients reported they didn't know how to make a complaint if they had a serious concern. This is surprising as clients and caregivers reported positive experiences with regards to inclusion and engagement in treatment.
- **Seeking Support:** Both clients and caregivers identified opportunities for improvement with regards to help in seeking support. More than 20% of clients reported they have a plan to meet their needs after the program and didn't receive help in findings support after their treatment. The majority of clients were still in the course of treatment, so this may have an impact on these results. Caregivers were less likely to report they were given information about supports for themselves and that they were able to access supports for them.

LEARNINGS FOR BROADER IMPLEMENTATION: DEMONSTRATION PROJECT

RESOURCE NEEDS:

- Utilize the Resource Tracker generated by the demonstration project to identify / put in place resources
- Utilize electronic tool rather than paper tool to decrease resource requirements (may require upfront purchases such as iPads)
- Dedicated space / room for OPOC completion
- The majority of youth between the ages of 12-16 years were able to complete the OPOC survey on their own with either no or minimal supports from staff: the average time youth required to complete the survey was 16 minutes, however a small percentage (10%) required 30 minutes or more to complete the OPOC survey.
- Organizations repeatedly identified the importance of utilizing incentives such as provision of snacks or gift cards to engage youth in completion

SUCCESS FACTORS:

- Establish local coaches / implementation specialists for agencies to access
- Utilizing youth peer support workers as facilitators
- Pre-plan ahead of the data collection period: create implementation team within agency, establish social media and other promotional campaigns, engage students and trained volunteers, ensure logistical and administrative processes are in place
- Conduct a testing phase
- Identify agency leaders and champions to drive communications

THE OPOC AND YOUTH AGED 12-16

One important consideration for the Consortium at the outset of the OPOC Demonstration Project was "How much support might youth require to complete an OPOC survey?" While the OPOC has been successfully demonstrated with the adult mental health & addictions service population across Ontario, there was limited understanding and experience in administrating the OPOC with a youth population between the ages of 12 to 16 years old.

The Child & Youth Lead Agency Consortium's February 2019 OPOC blitz campaign presented an opportunity to gather structured observations on the intensity and frequency of assistance that youth between the 12 – 16 years of age might require in order to be able to complete the OPOC survey.

Two Child & Youth Lead agencies within the Consortium agreed to participate to gather observations with this age group during their local OPOC campaigns. These agencies included, Kinark Child & Family Services and the Youth Services Bureau of Ottawa.

A survey tool was then developed in consultation with Consortium members and CAMH (see Appendix A). The survey was designed to capture both quantitative and qualitative information regarding the frequency of supports that youth might require from staff or volunteers during a typical OPOC campaign.

As staff from these two agencies administered the OPOC with their youth participants, they also monitored and recorded the youth's frequency of "asking for help" (ex. not understanding a question or vocabulary on the OPOC). The survey also invited staff to rate their own perceptions of how much support each individual youth required while they were completing the OPOC survey.

A total of 15 staff (across the 2 agencies) recorded their observations. In total, 90 Facilitator Surveys of youth (between 12-16 years) were collected during the February 2019 OPOC blitz. The age distribution for the youth OPOC participants that were observed was: 12 years (10 %), 13 yrs (20 %), 14 yrs(24 %), 15 yrs (24 %) and, 16 yrs (22 %).

READABILITY AND UNDERSTANDABILITY OF THE OPOC OBSERVED AMONG THESE YOUTH PARTICIPANTS

HOW OFTEN DID YOUTH ASK FOR OPOC QUESTION ITEMS TO BE CLARIFIED AS THEY COMPLETED THE OPOC SURVEY?

The majority of youth (12-16 years old) from these two agencies required no assistance from staff to complete the OPOC survey. 70 out of the 90 youth observed (78 %) asked for no assistance or clarifications while they completed the OPOC survey on their own.

A small number of youth (N=5), were observed to ask for more intensive supports from staff (i.e. 6 or more clarifications). These youth tended to be among the younger OPOC participants in both of the OPOC campaigns.

As the youth participants completed the OPOC survey and asked staff for assistance in clarifying specific question items, the **frequency of requests for clarifications** was recorded.

Fifteen youth (17%) asked anywhere from 1 to 5 questions from staff while they completed the OPOC survey.

Only a small number, (5 youth), were observed to ask for more intensive supports from staff (i.e. 6 or more clarifications). These youth tended to be among the younger of the OPOC participants in both of campaigns. Three youth (age 13 to 14) asked for staff clarifications between 6 to 9 times. Two 12-year old youth participants asked staff for clarifications 10 or more times in order to complete the OPOC.

In contrast, among the participants in the 14-16 age range (i.e. 70 % of all youth completing an OPOC survey) only 2 youth from across this age group asked staff for clarifications 6 or more times (see Figure 2).

In these two OPOC campaigns, 29 youth were 12 - 13 years of age. Among these, only three requested more intensive clarifications from staff in order to complete the OPOC survey.

In future OPOC campaigns, youth agencies planning to survey very large numbers of 12-14 year old youth should anticipate that most youth should be able to complete the OPOC with minimal supports. However a small percentage may require more intensive support to complete their surveys.

STAFF PERCEPTIONS ON *HOW MUCH SUPPORT YOUTH REQUIRED* TO COMPLETE THE OPOC SURVEY

The Facilitator Survey asked staff to rate their own perception regarding the amount of support each youth required to complete the OPOC survey. Staff were asked to provide a Likhert scale rating of their agreement or disagreement to the statement,

"This youth was able to complete the OPOC questionnaire with *minimal support* from you or others."

Among the 90 youth, staff agreed or strongly agreed that 74 youth (81%) were able to complete the OPOC survey with minimal supports provided. This level of staff agreement to this statement is consistent across each age between 13 to 16. Among the 12 years old participants, staff ratings indicated that 6 out of the 9 participants (67%) were able to complete the OPOC with minimal supports.

STAFF PERCEPTION ON HOW MUCH READING SUPPORTS DID YOUTH REQUIRE?

The Facilitator Survey asked staff to rate their perceptions regarding the amount of **reading support** youth required while they completed the OPOC survey. Staff were asked to provide a Likhert scale rating to their *agreement or disagreement* to the statement,

"Youth required or asked that most of the OPOC questions be read by the facilitator."

Staff disagreed and/or strongly disagreed to the above statement for 78 of the 90 youth participants that completed the OPOC survey. In other words, 87% of youth were able to read the OPOC questionnaire all on their own. A small proportion of youth (11 %) were perceived by staff however as requiring some reading assistance to complete the OPOC.

TIME REQUIRED BY YOUTH PARTICIPANTS TO COMPLETE THE OPOC

The amount of time youth participants required to complete the OPOC was recorded by staff. About 42% of youth were able to complete the OPOC survey in a 10 minute time period, another 43% required 20 minutes, while 10% of youth needed 30 minutes to complete the survey.

STAFF PERCEPTION OF YOUTH ENGAGED IN COMPLETING THE OPOC

Staff were also asked to provide a Likhert scale rating of their agreement and/or strong agreement that youth "appeared to be engaged in responding to the OPOC survey". Staff agreed and/or strongly agreed that 79% of the youth participants appeared engaged when completing the OPOC survey.

SPECIFIC QUESTIONS ITEMS ON THE OPOC WHERE YOUTH SOUGHT CLARIFICATIONS

During this OPOC blitz, youth collectively asked for clarifications on 18 OPOC survey questions and on 4 of the demographic section. The list of all of these questions has been included below.

The question items that were the most frequently identified by youth for clarifications are listed here.

QUESTION ITEMS WHERE YOUTH ASKED FOR THE MOST FREQUENT CLARIFICATIONS	NUMBER OF TIMES CLARIFICATIONS WERE ASKED
What term do you prefer to use to describe your sexual orientation? (demographic section #6)	**6**
The wait time for services was reasonable for me (OPOC #1).	**5**
The location of services was convenient for me (OPOC #3).	**3**
I had a good understanding of my treatment services and support plan (OPOC #7).	**3**
I found staff knowledgeable and competent/qualified (OPOC #17).	**3**
Staff were sensitive to my cultural needs (e.g. religion, language, ethnic background, race) (OPOC #19).	**3**
What is your mother tongue? (demographic section #4).	**3**

Other questions that youth identified for clarifications included the question numbered on the OPOC survey as: 2,6,8,11,12,13,14,15,16,28,29,33 and 34. The other questions items on the demographic section that were identified for clarification included 3 and 7.

SUMMARY OF RESULTS

The majority of youth between the ages of 12-16 years were able to complete the OPOC survey on their own with either no or minimal supports from staff.

The youth population from these two OPOC campaigns only had a small number (6%) of youth who asked for frequent supports from staff (6 times or more) as they completed the OPOC survey. While this is a very small number, these appear to be the youngest of all youth participants (see Figure 2).

FIGURE 2 . FREQUENCY YOUTH PARTICIPANTS ASKED STAFF FOR CLARIFICATIONS IN RELATION TO THEIR AGES Age of Youth (N=90 participants)

FREQUENCY	12 YEARS	13 YEARS	14 YEARS	15 YEARS	16 YEARS	TOTAL
0 times	7	14	14	16	19	**70**
1 to 5 times	0	3	5	6	1	**15**
6 to 9 times	0	1	2	0	0	**3**
10 times or more	2	0	0	0	0	**2**

The average time youth (N=90) required to complete the survey was 16 minutes, however a small percentage (10%) required 30 minutes or more to complete the OPOC survey.

SUPPORTING DOCUMENTATION: COMMON ASSESSMENT

ASSESSMENT TOOLS: CURRENT STATE AND HISTORICAL CONTEXT

MINISTRY OF CHILDREN AND YOUTH SERVICES (MCYS)

In 1999, the Ministry of Children and Youth Services (MCYS) implemented Canada's first systematic screening and outcome measurement plan, training over 100 children's mental health agencies across the province to use two standardized measurement tools: the BCFPI (Cunningham et al., 2009); and the Child and Adolescent Functional Assessment Scale (CAFAS) (Hodges, Doucette-Gates, Liao, 1999). By the plan's fifth year in 2004, 98% of the agencies trained in using these tools had implemented them (Barwick, Boydell, Cunningham, & Ferguson, 2004) and after six years of implementation, 114 agencies were using the BCFPI and 107 were using the CAFAS (Barwick, 2006). MCYS covered the cost of administering these tools which led to additional uptake while also, crucially, enabling data to be aggregated and reported provincially.

The recommendation to implement the BCFPI and CAFAS over other possible tools was made by a group of experts who were convened to determine which measure(s)specific community-based CYMH agencies should adopt in order to ensure consistent data collection across the province of Ontario. The group looked at a range of factors, including the strength of the tool, ease of adoption and cost (both for implementation and ongoing use) and landed on the CAFAS and the BCFPI. The Ministry provided funding to support the use of tools, but this wasn't to agencies directly; rather CMHO received funds to provide licenses to agencies, support training and to house the data for BCFPI, and Sick Kids received funds to do the same for CAFAS. Both CMHO and SickKids rolled up the data and provided individualized reports to each agency. All agencies, as a condition of their funding, were mandated to use one or both of these tools as a way of ensuring consistency and also contributing to a provincial picture of how kids are doing.

With the introduction of the **Working Together for Kids' Mental Health** initiative (2010-2012), a number of challenges were surfaced with these mandated tools. First, in some instances, neither tool was useful for the agency and the population served. Second, without a real sense of what the data were being collected/used for, agency leaders had a hard time ensuring that staff were actually collecting information and that this was yielding high quality data. Third, there were a number of newer tools that

were coming out that were less like intake tools or checklists, and were actually useful for treatment planning (e.g., the CANS) and philosophically more aligned to the goals of service providers (i.e., more strengths-based than oriented to deficits).

In 2015, as part of the **Draft Child and Youth Mental Health Service Framework** (Government of Ontario, 2013), BCFPI and CAFAS funding was discontinued and use of standardized intake, assessment and outcome tools was no longer required (O'Hara, 2014). The reasons for these decisions were not clear in public policy documents such as the **Draft Child and Youth Mental Health Service Framework** (Government of Ontario, 2013) or the **Community-based child and youth mental health – Program guidelines and requirements #01: Core services and key processes** (Government of Ontario, 2015b). However, possible reasons may include: ongoing practitioner resistance to using the BCFPI and CAFAS; challenges stemming from organizational readiness for change, technological literacy and infrastructure; and lack of understanding and articulation of the potential clinical benefits for children (Barwick et al., 2004).

Currently, there is growing support for the use of a common assessment tool across child and youth mental health service providing agencies. For example, MCYS has funded the Child and Parent Resource Centre (CPRI) to further develop the InterRAI, a new potential tool for assessing child mental health (Hirdes et al., 2011). As well, service providing agencies understand the value in a common tool that provides benchmarks towards which they can work. There is at present, however, no tool that has been formally endorsed or mandated by the current Ministry.

MINISTRY OF HEALTH AND LONG TERM CARE (MOHLTC)

Currently only adult mental health and addictions (mostly inpatient) services complete a mandatory common assessment tool – RAI-MH. The Ontario Mental Health Reporting System (OMHRS) analyzes and reports on information submitted to CIHI about all individuals receiving adult mental health services in Ontario, as well as some individuals receiving services in youth inpatient beds and selected facilities in other provinces. OMHRS includes information about mental and physical health, social supports and service use, as well as care planning, outcome measurement, quality improvement and case-mix funding applications.

OMHRS comprehensive data is collected using the Resident Assessment Instrument — Mental Health (RAI-MH©) version 2.0, a standardized clinical instrument used to regularly assess those receiving inpatient mental health care. The RAI-MH gathers information on where individuals are admitted from and why, where they are discharged to and why, and, potentially, information at other points in time during a hospital stay.

The tool was developed by interRAI , Ontario's Ministry of Health and Long-Term Care and the Ontario Hospital Association. It includes the following:

- The Minimum Data Set for Mental Health (MDS-MH)©, with approximately 300 data elements
- 20 Mental Health Clinical Assessment Protocols (MH CAPs)© for care planning
- 5 Quality Indicators for Mental Health (QIMH)
- 7 outcome measures based on clinical scales
- The System for Classification of In-Patient Psychiatry (SCIPP) case-mix methodology

Assessments are completed at admission, at discharge, every 3 months during service and whenever there is a significant, unexpected change in a patient's clinical status.

Building on the consistency of the RAI-MH data for inpatient resources, The Ontario Common Assessment of Need (O.C.A.N) was selected by the community mental health sector in 2007. The tool is based on the Camberwell Assessment of Need. Additional elements were included to reflect Ontario's community mental health sector. OCAN was implemented in 200 health service provider (HSP) organizations between 2010 and 2013.

The Ontario Common Assessment of Need (OCAN) is a standardized assessment tool that gathers information on 24 domains and:

- Includes a self-assessment portion that supports a client-centred approach to service delivery;
- Supports conversations with consumers about their needs, strengths, and actions;
- Provides aggregate data to inform organizational, regional, and provincial level planning and decision making that is consistent with a recovery approach; and
- Facilitates inter-agency communication through common data standards.

There are continued efforts within the Health sector to look at Common Assessment Tools and how best to position those tools for use with system planning and development. To date, there is not a consistent tool utilized for child/youth inpatient or outpatient/community based services within Ontario. The GAIN suite of tools has been introduced by several LHIN's across Ontario, although uptake of the full suite is not consistent. In speaking directly with CAMH regarding the GAIN, they felt it was not the most appropriate tool for child/youth CYMH assessment needs.

CHILD WELFARE SECTOR (MCYS)

The use of assessment tools in child welfare has been a current practice since 2000. The first iteration was the Ontario Risk Assessment Model (ORAM) used to inform decision-making in child welfare. This model contained a screening tool known as the eligibility spectrum, a safety assessment instrument and risk assessment instrument. The tools included in ORAM derived from an older system developed in New York and were not statistically driven, but consensus-based or experts driven and not validated.

The University of Toronto lead a research project in early 2000, on the feasibility and utility of a number of risk assessment and contextual assessment tools in comparison to the tools contained in the ORAM. Ninety-five child welfare professionals took part in this research and tested eight tools including four contextual tools and four clinical assessment tools.

The Ministry of Children and Youth services concluded that the California Structured Decision-Making System developed by the Children's Research Centre of Wisconsin was the best risk assessment instrument. This instrument was validated and able to predict maltreatment at levels that appear to be useful clinically. The implementation of the California Family Strengths and Needs assessment was also recommended.

From that study, the Ontario child protection decision-making model was adopted. This model is based on the structured decision-making model developed by the Children's Research Centre of Wisconsin and employed a research-based process relying on actuarial risk assessment to identify the likelihood of future harm and clinical assessment to ascertain the strengths and needs of children and their families.

In 2007, the child welfare sector adopted the Differential Response Model that offered differential approaches to service delivery based on the type and severity of child maltreatment customized to provide what each child and family requires. A series of tools are used in the differential response model by child welfare professionals in Ontario to assist them in their assessment and screening of situations in which a child is alleged to be in need of protection.

These tools support decision-making of child protection workers by helping them review each child protection decision-point in an objective, systematic, strengths-based and comprehensive manner. The use of these tools combined with a sound clinical judgment, including culturally sensitive practice strengthens child safety and assessment. They include a safety assessment, a family risk assessment, a family and child strengths and needs assessment, family reunification reassessment and a reunification assessment tools. These tools are still utilized by child welfare professionals in the 41 CASs in Ontario and were mandated by the Ministry. Some common data elements (16) composed the quality improvement plan that every CAS in the province has to report on. Individuals' progress of each agency and provincial trends are compiled to track provincial trends.

MINISTRY OF EDUCATION (MOE)

At this time there is not a consistent measure/assessment being completed within Education to screen/assess health or mental health concerns. Many school communities are utilizing the Ontario Child Health Study and its sub-measure, The School Mental Health Study to plan services and interventions. The Ontario Student Drug Use and Mental Health Survey (OSDUHS) which is supported through CAMH is being administered to secondary level students (self-report tool). However, results are mixed and the reliability of data is questionable given the self-report nature.

Individual school communities utilize different tools like the MASC, CDI, BCFPI and in some cases the InterRAI. "There is interest and openness to a common/consistent assessment tool if it maps onto what the community based children's mental health sector's assessment tool, as this would provide a foundation to begin to define client profiles, treatment plans and outcomes for all of Ontario's children and youth who require access to mental health treatment whether they seek it through the school or community-based setting"

LITERATURE REVIEW

1. SUPPORTING EVIDENCE BASED ASSESSMENT

C. Hunsley, J., Mash, Eric. (2010). The Role of Assessment in Evidence Based Practice. In Handbook of Assessment and Treatment Planning for Psychological

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D. Pranckeviciene, A., Bunevicius, A. (2015). Evidence based assessment: Do we have it? Do we need it?, Vol.17. (pp.13-18). Kaunas, Lithuanian: Lithuanian University of

– Health Sciences, Neuroscience Institute, Laboratory of Clinical Research.

E. Jensen-Doss, A., Hawley, K. (2010). Understanding barriers to evidence-based assessment: Clinician attitudes toward standardized assessment tools., Vol. 39 (pp.885-896).

– Journal Clinical Child Adolescent Psychology.

2. SUPPORTING COMMON ASSESSMENT FOR SECTOR/SERVICES

A. Shlonsky, A., Lambert, L. (2007). The Perceived Utility of Child Maltreatment Risk Assessment and Clinical Assessment Tools. University of Toronto, ONT: Bell Canada
   – Child Welfare Centre

B. Valenstein, M., et al. (2009). Implementing Standardized Assessments in Clinical Care: Now's the Time., Vol. 60 (pp.1372-1375). Ps.psychiatryonline.org.

3. SUPPORTING PROVINCIAL AND SERVICE AREA SPECIFIC WORK TO DATE:

A. Centre for Excellence in Children's Mental Health, Ottawa: Summary of selected tools for assessing mental health needs of children and youth. Updated August 2018

B. Youth Services Bureau, Ottawa: Screening and Assessment Working Group – Summary of Activities and Recommendations. April, 2016

C. East Metro Youth Services, Toronto: Comparison of Clinical Evaluation Tools: Selecting a Short List of Candidate Tools. December 2015

COMMON ASSESSMENT TOOL EVALUATION

CANS MH (John Lyons, Praed Foundation – Key Informant Interview Monday November 5th, 2018)

- multi-purpose tool developed for children's services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services
- developed from a communication perspective so as to facilitate the linkage between the assessment process and the design of individualized service plans including the application of evidence based practices
- primary purpose is to allow system to remain focused on the shared vision of serving children and families
- Six key components of the CANS:
  1. Items are selected based on relevance to planning.
  2. Action levels for all items
  3. Consider culture and development before establishing the action level
  4. Agnostic as to etiology – descriptive, no cause and effect
  5. About the child, not about the service. Rate needs when masked by interventions
  6. Specific ratings window (e.g. 30 days) can be over-ridden based on action levels

InterRAI ChYMH (Ian Kerr, CPRI – Key Informant Interview October 25th, 2018)

- standardized assessment tool designed for clinical use
- 387 items
- 45-90 mins depending on case complexity
- provides summary of needs to complement more exhaustive, in depth diagnostic assessment
- additional supplements where appropriate

- All tools in the InterRAI system use consistent items and language to identify mental health needs in children and youth across settings, and as they age.
- part of suite of assessment tools for vulnerable populations including developmental disabilities, education and youth justice custodial facilities
- Collaborative Action Plans (CAPs) are part of ChYMH – 29 CAPs that flag children and youth with potential problems in need of clinical review

GAIN SS (Brian Rush, CAMH – Key Informant Interview October 11, 2018)

- The GAIN Short Screener (GAIN-SS) is designed to identify clients who may have one or more behavioral health disorders (e.g., internalizing or externalizing psychiatric disorders, substance use disorders, or crime/violence problems)
- 3-5 mins to administer if self-report
- 5-10 mins to administer if interview

****While the GAIN SS was originally in the list of the top 3 tools, the tool's creator, Dr. Brian Rush has not recommended it for use with our population. Instead, he suggests working together to create an adaptation of the GAIN SS, which is not something the group was prepared to pursue at this time.**

CURRENT UTILIZATION CYMH	CANS MH	GAIN SS	INTERRAI	OTHER
Lead Agency (33)	15%	0	66%	19%
Core Service Providers (148)	0.9%	0.9%	48%	34%

AVAILABILITY

KEY CONCEPT	CANS MH	GAIN SUITE	INTER RAI
Digital Health (application settings)	None available through developer COE web enabled the CANs – pockets/ reservoir of data Individual organizations have built into their systems – for individual and internal use – no data sharing – COP for CANS	Online entry, scoring and report generation available for purchase through developer	Online data entry, scoring and report generation available - no cost currently
Workforce Rostering (Skillset/Disciplines that can administer)	Administered by a paraprofessional when trained Train the trainer model Recommended annual refresher	Administered by a paraprofessional when trained	Administered by a paraprofessional when trained (degree or diploma in a related field)

QUALITY KPI: POSITIVE OUTCOMES FOR CHILD/YOUTH/FAMILY

KEY CONCEPT	CANS MH	GAIN SUITE	INTER RAI
Recommended Age Groups (0-18) (0-6 sensitivity?) (18+ sensitivity)	Full Age Range to 18 years Life span tool – add on categories for specific ages or issues Very sensitive to build a story to build the plan Good validity	12 Years Plus for the full suite of tools- The screener (GAIN SS) can be used for 10 years and above	Full Age Range to 18 years Semi – structure interview tool can be applied outside of the range – preschool, school age and adult – most comfortable with school age kids
Full Functionality (screener, assessment, outcome measurement, risk identification)	Items individually validated – allows for customization Good validation and reliability Risk not identified – built off strengths – issues can be assessed	The first stage screener, Global Appraisal of Individual Needs – Short Screener (GAIN-SS), quickly identifies possible mental health and substance use issues requiring further exploration. If the responses to the GAIN-SS raise concerns about potential mental health issues, the second stage screeners are used to gather more information. The screeners is the Problem Oriented Screening Instrument for Teens (POSIT) for those 17 and under. The Global Appraisal of Individual Need Quick3 Motivational Interviewing Ontario (GAIN Q3 MI ONT) is a comprehensive assessment allowing the client to share their life circumstances across a broad range of areas, with a particular focus on substance use. This assessment and the auto-generated clinical reports provide a sound foundation for treatment planning and referral decisions. The Assessment is a semi-structured interview tool.	Intention behind the screener is risk identification and immediate service planning to longer term planning Currently piloting a crisis screener within Chatham- Kent service area Have the opportunity to get needs met with the information collected – put cut offs onto scales – that would consistently provide thresholds for outcomes and to track stages of wellness – this work is almost completed – just waiting for approvals from international experts Algorithm for Risk, Service Urgency Framework to support consistency in decision making – partnership with CIHI is helping to support this development to completion for service standards and guidelines to support the tool.
Marginalized Populations (indigenous, new immigrant, etc..)	Telling the story of the individual and very culturally sensitive – an indigenous adaptation		

KEY CONCEPT	CANS MH	GAIN SUITE	INTER RAI
Assessing Vulnerabilities (social determinants of health, child welfare, justice, addictions)	Four levels of each item with anchored definitions – definitions are designed to translate into action levels For Needs: a. no evidence; b. watchful waiting/ prevention; c. action; d. immediate/ intense action For Strengths: 1. Centerpiece strength; 2. Strengths that you can use in planning; 3. Identified strength - must be built; 4. No strength identified Subscales: - Problem presentation - Risk behavior - Functioning - Child safety - Caregiver needs and strengths - Strengths - Not a diagnostic tool - Direction more so of individual story telling	The GAIN SS has 20 items (four five-item subscales) **Identifies:** - internalizing disorders - externalizing disorders - substance use disorders - crime/violence **Reports for GAIN SS** - GAIN-SS Full Report - GAIN-SS Summary Report - Aggregate Report The GAIN-Q3 is a brief screener used to identify and address a wide range of problems in clinical and general populations. It is designed for use by personnel in diverse settings (i.e. student assistance programs, health clinics, juvenile justice). **Domains** - Problems and service utilization - Substance use - Mental health (internalizing and externalizing problems) - Crime and violence - Stress - Physical health - School and work Quality of life **Reports for Q3** - Q3 Individual Clinical Profile (Q3ICP) - Q3 Recommendation and Referral Summary (Q3RRS) - Personalized Feedback Report (Q3PFR) - Validity Report (Q3VR)	**Domains: Built on the Social Determinants of Health** - Identification information - Intake and initial history - Mental state indicators - Substance use or excessive behavior - Harm to self and others - Strengths and resilience - Cognition and executive functioning - Independence in daily activities - Communication and vision - Health conditions - Family and social relations - Stress and trauma - Medications - Prevention, service utilization, treatments - Nutritional status - Education - Environmental assessment - Diagnostic & other health information - Service termination - Discharge
Available Languages (french, other)	Available in English and French (used internationally – several languages)	Available in English and French	Available in English and French

AFFORDABILITY KPI: COST PER UNIT (P13A: VALUE FOR INVESTMENT)

KEY CONCEPT	CANS MH	GAIN SUITE	INTER RAI
Consolidation (Licensing and resourcing)	Free in public domain (does not require permission from the author).	There is a licensing fee of approximately $100 for unlimited use over five years. One license can cover multiple agencies and end users.	Royalty-free licenses available. Cost for manual and vendor software solutions – need an electronic solution to operate fully. Working with CIHI to set the standards for vendors At the moment looks different in different systems Missing – is the clinical outputs – have specs to provide to agency to build in

KEY CONCEPT	CANS MH	GAIN SUITE	INTER RAI
Workforce Optimization (training and supervision)	A minimum of a bachelor's degree with some training or experience with mental health. Training is required to administer the CANS. Training Time – full day – annual refresher	No special qualifications required to administer GAIN-SS Training-Training is provided in a self-paced online course. The course is available 24/7 and there are no set-times for attendance. The course covers GAIN-SS administration, scoring, and interpretation, and takes approximately 60 minutes to complete. It can be purchased agency-wide with unlimited number of people at your agency or as a per-person training session. **GAIN-Q3 Training** **Online Coursework** Training is provided via online learning. Trainees will complete the online coursework and quiz at their own pace during a specified two-week timeframe. This course takes approximately seven hours to complete and does not need to be completed in one sitting. **Administration Certification** Once a trainee has completed the coursework, they go on to submit recorded interviews to the GCC. We will review the interview, provide written feedback and outline next steps towards certification. This process continues for up to three months until the interviewer demonstrates the ability to maintain or add to the validity of the information collected during an interview with a real client. On average it takes three to five submissions to reach certification. We recommend that candidates who pursue this level of certification are those who will often be conducting GAIN interviews at their agency or will go on to become Local Trainer certified. **Local Trainer Certification** Once administration certification is achieved, a trainee is eligible to continue on to Local Trainer Certification. This is an additional three-month process that provides training to learn to write formal feedback and determine readiness for certification of other GAIN users at their agency. This can be a time consuming process (between 45-50 hours), so it is recommended that only candidates who will be actively training other GAIN users pursue this level. Once someone is certified as a GAIN Local Trainer, they are eligible to train and recommend staff from their agency for GAIN Site Interviewer Certification.	Assessors must have a degree or diploma in a mental health program with two years' experience in the field, as well as complete standardized interRAI training. Training Time – initial training of approximately 1 day – to sustain the practice ongoing supervision and training boosters on an annual basis is recommended – as well as competency testing Train the Trainer model is available to assist organizations to be able to maintain practice Sector has the freedom to determine the sector wide training and sustainability standards

KEY CONCEPT	CANS MH	GAIN SUITE	INTER RAI
Process Optimization (direct and indirect service hours)	Direct Service Hours: Not completed in one session 2 to 3 hours based on needs identified in intake Indirect Service Hours Scoring is done manually. Each item of the measure is translated into a specification level by the Likert scale anchors. Items are based on the past 30 days before administration.	Direct Service Hours Indirect Service Hours Scoring can be done manually or using a web-based computer application (for purchase from the Lighthouse Institute).	Direct Service Hours Screener – 20 to 40 mins CHYME – 60 mins on average (learning curve) Indirect Service Hours Scoring can be completed using web based software. Scales scores use algorithms based on differential risk pathways to derive measures of status or functioning rather than calculating global scores through a simple summation of individual item scores. Certain items within the ChYMH serve as "triggers" to activate specific Collaborative Action Plans (CAPS) to assist with individualized, evidence-informed care-planning.
Back Office Efficiencies (data (base/ analysis/ reporting)	No connected database or software scoring – individual organizations have created their own capacity COE web enabled is not currently playing the role of CIHI or CPRI – just individual organizational capacity at this time to pull from the web tool Not suggest parceling out indicators for comparable across organization outside of demographics	Database limited Software scoring available	Partnership with CIHI Database in place Software scoring available

ACCEPTABILITY

PCMH Consult	• Want a standardized/evidence based tool that identified the needs of children/youth and families • Want a consistent practice across the province that engages families and shows value add with respect to supporting the right service at the right time • Want to enable trust amongst providers for assessment information to be shared – preventing duplication of processes • Want providers to think about the amount of assessments being done and the impact on families – question what is the value add? How do you explain the value add or engage with the families
COE Advisory	• See the value in a standardized/evidence based measure • Want a consistent tool and process across province that could be shared from service area to service area • Want to assist sector in developing process/practice to ensure it works for youth

BACKGROUND REFERENCES

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VII. Centre for Excellence in Children's Mental Health, Ottawa: Summary of selected tools for assessing mental health needs of children and youth. Updated August 2018

VIII. Youth Services Bureau, Ottawa: Screening and Assessment Working Group – Summary of Activities and Recommendations. April, 2016

IX. East Metro Youth Services, Toronto: Comparison of Clinical Evaluation Tools: Selecting a Short List of Candidate Tools. December 2015

X. Key Informant Questionnaire

XI. SOAR Assessment

SUPPORTING DOCUMENTATION: ACCESS

CURRENT STATE: AVAILABILITY, AFFORDABILITY AND ACCEPTABILITY

Availability: One measure of availability that is frequently used to assess the level of access to the children and youth mental health system is **wait times**. Wait times can be broadly defined as the amount of time between the point at which a service is request and receiving that service.[23] Defined in the Child and youth mental health data dictionary as the number of days from initial contact to service start, wait times can be affected by a number of factors, including system capacity, the number of patients, and the number of emergency or urgent cases.[24] The Auditor General Report (2016) highlights significant wait times for some services, lack of updating to families on wait list times while they're waiting, and inconsistent prioritization processes. More young people than older people show up on the ED without prior contact for mental illness or addiction (42.7% for people aged 16-24 v. 29.8% for people aged 25 and above). HQO Taking Stock Special Report 2015

The CMHO 2016 Report Card showed that between 2006-07 and 2015-16, among children and youth (ages 5- 24):

- ED visits for mental disorders rose by 63% in Ontario
- Hospitalizations for mental health disorders rose 67% in Ontario
- Hospitalizations for all other conditions fell18% across Canada.

Wait lists for treatment in the community continue to grow – over 6,500 children and youth are waiting over a year for treatment. There is wide geographic variation in mental health needs, as well as in how children and youth access physician- and hospital-based mental health care and the quality of care they receive. For example, among Local Health Integration Networks, the North West LHIN had the highest rates of neonatal abstinence syndrome (48.1 per 1,000 live births compared to the provincial rate of 5.5), ED visits for deliberate self-harm (92.8 per 10,000 population compared to 30.0 provincially) and deaths by suicide (33.0 per 100,000 population compared to 5.9 for Ontario).

IMPORTANT CONSIDERATIONS IN AVAILABILITY:

Available services are part of an integrated service delivery approach (that reflect a LEAN approach). Available services should also be able to demonstrate the needs they are meeting (evidence-informed).

23 Centre of Excellence for Children and Youth Mental Health (August 2015). Evidence In-Sight:

24 Haddorn (2000).

- Service delivery models across the province should be offered in a consistent way while still addressing specific local community needs
- The issues of availability need to consider the unique issues in each area such as geography of north
- In many communities, there are specific costs related to travel (both the distance and the time) that is directly related to access and availability, coupled with a lack of access to transportation. There is less availability of a range of services, and specifically often less access to more specialized services, including intensive services close to home.

Affordability: Affordability needs to consider the WHOLE cost of the encounter (not just the cost of service that the government pays for through funding to agencies, OR through an employer provided benefits program for the small percentage of the population that has one). The cost of the total encounter includes a consideration to value the client/customer/consumer's time in accessing the service, their travel time and time away from work (either by public transit or personal vehicle), as well as the staff travel time when providing outreach to off-site locations or home visits. An effective treatment model for mental health needs to consider the costs for medication (now covered by pharmacy government program). Any model of affordability needs to consider travel time as one of the system costs.

Not currently measured in the sector however, the CMYH Data dictionary includes a place holder for a future performance indicator called Value for Investment. How this will be calculated has not yet been determined.

Compared to children and youth in the wealthiest neighborhoods, those in the poorest ones had higher rates of unscheduled return visits to the ED within 30 days of an initial visit for a mental health or addictions– related condition (respectively, 9.0 and 10.0 revisits per 100 children and youth with an incident ED visit), and they had higher rates of readmission within 30 days of discharge from hospital (8.8 and 9.7 readmissions per 100 children and youth with an incident hospitalization). ICES 2017

IMPORTANT CONSIDERATIONS IN AFFORDABILITY

There is a need to address the lack of clinical capacity in the work force with a high rate of turnover of staff. There is an issue of equalization of pay rates between community based mental health workers and those in hospitals and child welfare. The high rate of turnover has an impact on families in building on-going trusting relationships with their treatment providers

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The increased use of digital health – could this address affordability: The expansion of telepsychiatry and other innovative models into more rural and remote communities will be an important step in improving access to care. ICES 2017

Acceptability: Among children and youth who presented to the ED for a mental health and addictions-related condition, 51.7% of refugees, 48.9% of immigrants and 42.1% of non-immigrants had never received physician care for their illness. However, follow-up with a physician within 7 days of discharge for a mental health and addictions-related hospitalization was marginally higher among refugees (35.2 %) and immigrants (36.8%) compared with non-immigrants (32.4 %). These findings suggest that immigrants and refugees may be more likely than non-immigrants to face barriers in accessing outpatient care, but once connected to care, they have better outcome measures of accessibility and quality of care[25].

25 ICES 2017

Many studies confirm that one of the cumulative outcomes of social inequities, systemic racial discrimination, sexism, poverty and marginalization of Aboriginal peoples and members of racialized groups (including immigrants and refugees) is the debilitating impact on the mental health prospects for members of these communities, including the multidimensional impact of intersections of poverty, race, gender and sexual orientation (Across Boundaries: 1997; Surgeon General's Report: 1999; Report of the Canadian Task Force, 1988;Report of the Royal Commission on Aboriginal People: 1999, Krieger: 199l). … Although racialized groups and members of Aboriginal communities have mental health needs and issues that are extremely serious and warrant significant attention, few psychiatric services respond specifically with research, clinical support, programming, organizational change, health promotion or community collaboration that indicate cultural competence, understanding or awareness in a systemic manner. Recent conferences on mental health and racialized communities (Kafele: 2003; Hong Fook: 2000) as well as a major community-based study (Building Bridges, Breaking Barriers: 2003) detail concerns regarding the lack of access, poor culturally appropriate access to services and low commitment to meaningful organizational change within the sector:

- 33% of LGBTQ youth have attempted suicide in comparison to 7% of youth in general (Saewyc 2007).
- Over half of LGBTQ students (47% of males and 73% of females) have thought about suicide (Eisenberg & Resnick, 2006).
- In 2010, 47% of trans youth in Ontario had thought about suicide and 19% had attempted suicide in the preceding year (Scanlon, Travers, Coleman, Bauer, & Boyce, 2010).
- LGBTQ youth are 4 times more likely to attempt suicide than their heterosexual peers (Massachusetts Department of Education, 2009).
- Adolescent youth who have been rejected by their families for being LGB are over 8 times more likely to attempt suicide than their heterosexual peers (Ryan, Huebner, Diaz, & Sanchez, 2009).

IMPORTANT CONSIDERATIONS IN ACCEPTABILITY

The fit between the clinician and the client is critical For example it is inappropriate for a Muslim woman to have only the option of access to a male clinician.

Acceptability must address the cultural and linguistic needs of a client.

While the implementation of OPOC will provide a standardized assessment of perceptions of care for all those who receive services, it does not reach individuals who did not access services because they did not find them to be acceptable. We do not fully understand why some individuals are not accessing the services.

There is a critical importance for youth and family engagement is service design and planning to respond to the issue of acceptability

There is a need to reconcile the unique needs of First Nation, Inuit and Metis populations and their experiences of mental health and of receiving services. There has been a real lack of resources available for this population.

It is critical that there are good links to primary care, hospitals and universities and colleges where young people are accessing services.

STRATEGIC FOCUS AREAS AND PROMISING PRACTICES TO IMPROVE ACCESS: A LITERATURE REVIEW

DIGITAL HEALTH

TELEMENTAL HEALTH (TMH)

Definition/link to availability

- "broad term referring to the provision of mental health care at a distance" (Myers et al., 2017 p.91)
- increasing access and availability of mental health services to children and youth is often the rationale for implementing telemedicine programs (Myers et al., 2017)
- "TMH makes care accessible in areas with limited or no professional mental health resources, especially psychiatrists" (Bashshur, Shannon, Bashshur & Yellowlees, 2015)
- allows a link to patients with unique needs including the young, minority populations and the elderly (Bashshur et al., 2015)

General evidence

- Evidence base is increasing specific to young people (Myers et al., 2017)
- As there is generally more familiarity with technology now (e.g. mobile phones, video conferencing software) this enhances the use of the technology for clinical applications (Myers et al., 2017)
- TMH has been used in mental health assessment, treatment, patient education, monitoring and collaboration between professionals (Bashshur et al., 2015)
- Recent extensive review of telemental health (TMH) across the lifespan showed strong and consistent evidence of its feasibility and acceptability from providers and clients (Bashshur, et al., 2015)
- Telemental health research needs to expand increasing the focus on rural and diverse populations, use improved methodology (control groups that are receiving other treatments), include therapist effects and process variables, and evaluate different treatment models (focus on CBT or motivational interviewing in current youth literature) (Sloane, Reese & McClellan, 2012).
- "The Canadian Senate and the Canadian Academy of Child and Adolescent Psychiatry have approved telepsychiatry for consultation, education and training. However, there is limited research on telepsychiatry in children and adolescents, mostly consisting of case reports and project descriptions." (Roberts, Hu, Axas & Repetti, 2017 p. 842)
- One Ontario-based study found high patient and ED physician satisfaction with emergency consults through telepsychiatry with no significant differences found for patient outcome for face-to-face appointments or through telepsychiatry (but small sample size, interpret with caution) (Roberts et al., 2017)

Strengths

- Can be used to bridge the gap between supply and demand, in rural and other underserved communities (Myers et al., 2017)
- Good fit with youth given their propensity with and frequent use of technology (Myers et al., 2017)
- Point of delivery of TMH services can be varied. Can be delivered to primary care clinics, community mental health centres, physician offices, outpatient clinics, schools, correctional facilities, group homes, day cares, etc. (Myers et al., 2017). This is a strength and opportunity for collaboration between different settings (e.g. when held in schools can include school personnel in treatment planning)
- Can also be used for specialists to provide consultation to therapist in distant communities (Myers et al., 2017)
- TMH offers collaboration opportunities with pediatricians to help them improve their skills in diagnosing and managing common mental health problems with young people (Myers et al., 2017)
- Policy paper exists outlining guidelines for the practice of TMH with youth (American) – (Myers et al., 2017)
- Cost savings by the ability to reduce travel – if the workload exceeds a certain number of clients (adult studies) (Bashshur et al., 2016)

Weaknesses

- Not much research regarding its use with children so lessons are often drawn from adult populations (Myers et al., 2017) – only preliminary supporting evidence about videoconferencing effectiveness with youth as most studies have been descriptive. Evidence supporting telemedicine in children and youth has been found though.
- Majority of studies (adult/young people) focus on depression and anxiety – a need to expand beyond this (Bashshur et al., 2016)

WEB AND APP-BASED SERVICES

Definition/link to availability

- Using computer or mobile phone applications to increase access to services
- There are different types of these services – vary on dimensions of:
  - Interface (CD-ROM, web-based, smartphone based)
  - Therapist involvement (no input, supported by clinician) - there is no consensus on what degree of support is required for a program to be effective (adult literature)
  - Use for treatment versus prevention
  - Modes and media: mostly text or multimedia materials delivered on a stand-alone computer, or online with interactive feature, in the future could expand to virtual reality (Stasiak, Fleming, Luccassen, Shepherd, Whittaker & Merry 2016)
- Increase in interest in recent years, as there is attention being paid to alternative models of treatment, aimed at overcoming barriers such as access for children, youth and adults (Donavon, Spence & March, 2017; Reyes-Portillo, Mufson, Greenhill, Gould, Fisher, Tarlow & Rynn, 2014; Stasiak et al., 2016)

General evidence

- Evidence is limited, particularly as it relates to children and youth (Arnbert, Linton, Hultcrantz, Heintz & Jonsson, 2014; Reyes-Portillo et al., 2014)
- An extensive study published by the National Collaborating Centre for Mental Health (2014), noted there was insufficient data to support the recommendation of individual products but when data is combined it is more robust and demonstrated what they termed proof of concept" or "proof of principle" of web-based services
- Programs with evidence of being efficacious have been based on CBT (Stasiak et al., 2017).

Strengths

- Using web-based and mobile based treatment has the potential to increase access to care (Stasiak et al., 2016; Donavon et al., 2017) and decrease number of in-person sessions required (Gipson et al., 2017)
- These modalities are flexible, can reach greater proportions of the population, offer a sense of anonymity and have the potential to be cost-effective (Donavon et al., 2017)
- One recent study investigating long-term outcomes for web-based CBT for children with anxiety disorders found treatment gains were sustained over a 12-month period, but the study was methodologically limited (small sample size, missing data) and conclusions should be drawn very cautiously (Vigerland, Serlachius, Thulin, Andersson, Larsson & Ljotsson, 2017)
- Review from National Collaborating Centre for Mental Health (2014), noted that from focus group discussions young people want e-therapies to be part of the help they are offered but not a replacement for face-to face therapies.

Weaknesses

- Much of the research done in this area suffers from poor methodology or small sample sizes (both web-based and mobile based) (National Collaborating Centre for Mental Health, 2014), can't draw conclusions about long-term effects, non-inferiority to proven treatments, adverse effects, cost effectiveness or efficacy when used with children and youth (Arnbert et al., 2014)
- "High volume but low-quality publications lead to high noise to signal ratio." From their review, it was clear that many studies were of low and very low quality (National Collaborating Centre for Mental Health, 2014).
- Some barriers to implementation such as data security and privacy. Those developing applications need to be transparent about what exactly is collected; concerns about data saved on mobile devices in the event the device is stolen (Gipson et al., 2017)
- Little guidance on the use of mobile devices from professional associations or the legal system (Gipson et al., 2017)

TASK SHIFTING

Definition/link to availability

- "Task-shifting is a method of strengthening and expanding the healthcare workforce by redistributing the tasks of delivering services to a broad range of individuals with less training and fewer qualifications than traditional health care workers" (Kazdin & Rabbitt, 2013, p.173)
- "Task shifting entails the shifting of tasks, typically from more to less highly trained individuals to make efficient use of these resources, allowing all providers to work at the top of their scope of practice" (Hoeft, Fortney, Patel & Unützer, 2017 p.49)

General evidence

- While a model used in developing and developed countries, it appears most research is done in the health context or if it is mental health related mostly in developing countries and with a focus on adults (Kazdin & Rabbitt, 2013). What is known in middle and low-income may not apply in high-income countries as there are difference in infrastructure (Hoeft et al., 2018).
- In a study looking at perceptions of training for community mental health workers in Ghana, it was found that the core training they receive was adequate for the role they are supposed to play but not the role they actually play (e.g. prescribing medication), they don't receive enough supervision. This raises suspicion about the quality of care they can provide (Agyapong, Osei, Mcloughlin & McAuliffe, 2015). Task-shifting may blur the lines of clinical competency and shifts in tasks would need to be clearly defined and still within the scope of practice for the individual.
- Task-sharing may be a more accurate term as it describes that care must be shared within a team of providers (Hoeft et al., 2018). This may be more of a collaborative care model, or telepsychiatry model (Hoeft et al., 2018) as outlined under the affordability below.

Strengths

- Studies have shown that lay counsellors can provide effective mental health treatment for some mental health disorders (Kazdin & Rabbitt, 2013; Matsuzaka et al., 2017)

Weaknesses

- More challenges with implementation in developed countries where there are set rules from government, and professional organizations to work around (Kazdin & Rabbitt, 2013)
- New area with many directions for future research including that the new model of care is safe, effective and scalable (Hoeft et al., 2018).

PROVIDING CARE IN NON-TRADITIONAL SETTINGS

Definition/link to availability

- Expanding care beyond traditional locations for services (e.g. clinics) and into everyday settings where people are spending their time (e.g. schools, workplaces, homes, neighborhoods, churches, hair salons) (Kazdin & Rabbitt, 2013)
- May open opportunities to meet the needs of people otherwise not serviced (Kazdin & Rabbitt, 2013)

General evidence

- Most research has been done in health (e.g. stroke education program in beauty salons where stylists were trained to talk to their clients about stroke risks and signs.)
- One study suggested to locate nurses in rural communities to places of convenient access for young people including police stations, schools and community organizations to promote the early engagement of young rural people into appropriate mental health care, but this was only based on a surveys and interviews about gaining help for young people within a rural community (Wilson & Usher, 2015). Others have also recommended this approach, but specifically psychiatric nurses as they are more likely to live in rural areas than psychiatrist sand have the potential to increase access to quality mental health care in these regions (Kolko et al., 2010).
- Studies have found that school-based programs with youth-friendly professionals greatly improves the child or youth's access to care, and integrate multiple community partners to collaborate on treatments (Clayton, Chin, Blackburn, & Echeverria, 2010; Soleimanpour, Geierstanger & Kaller, 2010)

Strengths

- Use of school as an alternative location for prevention is already common (Kazdin & Rabbitt, 2013)

Weaknesses

- Not a lot of research outside of health for other unique locations.

AFTER-HOURS SERVICES

Definition/link to availability

- Services provided outside of traditional hours
- This is often mentioned as a strategy for making services more youth and family friendly, by improving the ability to attend appointments and develop therapeutic relationships (Cox, 2017)

General evidence

- Little literature on this topic exists specific to child and youth mental health (Cox, 2017) (verified by Centre search)
- Came across one study where stakeholders deemed an extended-hours service to be effective but there was too much ambiguity in service purpose making it hard to draw conclusions. The authors recommended that anyone looking to develop an after-hours service do a comprehensive needs analysis that would include a full description of the target population and their needs to ensure the right resources are in place during the required time periods (Erksine, Baumgartner & Patterson, 2015)

Strengths

- Not enough research to ascertain strengths of this model.

Weaknesses

- Not enough research to ascertain weaknesses of this model.

CENTRALIZED INTAKE

Definition/link to availability

- Centralized intake model uses one entry point where people are assessed to determine the best resources for their specific needs (Building Changes, 2015)
- The entry point typically employed those with expertise in triage, assessment, and referrals and typically does not offer counselling or treatment services (Building Changes, 2015)
- The key is to build a hub for young people and families and the need for a central location to access services (Building Changes, 2015)

General evidence

- Duncombe (2008) concluded that the model of the intake system is not as important as its ability to deliver good intake practice. Since good intake practices will differ depending on context, a showcase of different models should provide better insight. For more information on different intake models please refer to the Centre's evidence in-sight paper on this topic. It can be found here.
- Evaluation of Contact Brant found that the service helps families navigate service better and get to the right program, and therefore reduces unnecessary wait times or demand for partnering services. Client surveys found that most families found the service helpful but were unclear as to the role Contact Brant had after intake.

Strengths

- Early Childhood Iowa highlighted the following benefits of centralized intake:
  - Allows maximum usage of services
  - Focuses on a single point of entry
  - Assures that children, youth and families will be linked to the most appropriate services available to them based on their needs
  - Allows for uniform screening and mechanism for follow-up
  - Promotes collaboration between programs
  - Eliminates duplication by creating a single point of entry for families

Weaknesses

- Building Changes (2015) highlighted the following challenges:
  - High volume of calls and assessments for intake agency staff
  - One physical location may not be easily accessible for all clients if a county covers a wide geographic area or has a rural population
  - A virtual location may not be accessible to all due to a lack of telephone or internet access
  - Partner agencies need to release control of their entry and assessment procedures

WORKFORCE OPTIMIZATION

MULTI-DISCIPLINARY TEAMS

Definition/link to affordability

- "Multi-disciplinary teams" means using different people with different skill sets to tackle a problem. This can be either through a mix of different types of professionals (e.g. psychiatrists, psychologists, mental health nurses, social workers, counsellors, etc.) either working in the same or in different industries (e.g. education, health, mental health, addictions, judicial) (Addiction and Mental Health Collaborative Project Steering Committee, 2014; Victoria State government, 2016)

General evidence

- Flexible Assertive Community Treatment consists of a team of 11 to 12 full-time staff who monitor 200 clients. 20% of the individuals in the "client pool" are under care of the Assertive Community Team, the remaining 80% are those who require less intensive treatment (Morrison & Peterson, 2017)
- The benefits of Collaborative Chronic Care Models (CCMs) are robust across populations, settings, and outcome domains, achieving effects at little or no net treatment costs.
  - CCMs provide a framework of broad applicability for management of a variety of mental health conditions across a wide range of treatment settings, as they do for chronic medical illnesses (Woltmann, et al, 2012).
- Under the Choice and partnership approach (CAPA), a client is offered a choice appointment that acts similarly to an assessment found in most centralized intake programs. The Choice appointment aims to assess the client's severity of symptoms, risk and history while aiming to ease access, standardize assessment and reduce wait-times (Choice and Partnership Approach, 2015).

Strengths

- FACT care generates benefits from having those with serious mental illness fall under the care of a team and by providing access to those with less severe mental illness (Morrison & Peterson, 2017)
- Uses a flexible switching system where those requiring the most intensive care are discussed daily whereas those requiring less intensive care are provided with case management and multidisciplinary supports (Morrison & Peterson, 2017)
- Collaborative care approaches are effective in treating mental conditions in primary care settings and extending the reach of psychiatrists by allowing them to focus on the most complex patients (Walker et al, 2015)

Weaknesses

- Undefined roles present a problem for workers outside of the core team in the CAPA model (Robotham & James, 2009)
- Total health care costs did not differ between CCMs and comparison models. A systematic review largely confirmed and extended these findings across conditions and outcome domains (Woltmann, et al, 2012)

FULL-TIME: PART-TIME & PERMANENT: CONTRACT

Definition/link to affordability

- In privately operated substance abuse clinics, the proportion of revenue spent on wages has decreased over the past 5-years; driven, in part, by increased hiring of part-time, lower-wage workers (Ismailanju, 2017)

General evidence

- Including mental health in our provincial health coverage would reduce wait times as we are underutilizing a large portion of mental health specialists in the private sector because of limits on Ontario Health Insurance Plan coverage (Cappelli & Leon, 2017).
- Community mental Health Centres in Georgia (Walker et al, 2015) developed various staffing models with combinations of full and part-time positions, and salaried and contracted positions.

Strengths

- Not enough research to ascertain strengths of this model.

Weaknesses

- Community mental Health Centres (CMHC) administrators described difficulties offering competitive salaries and filling positions that were not full-time with benefits; additionally, retention was low among part-time psychiatrists. Rural CMHCs reported trouble in hiring qualified psychiatrists. Once psychiatrists were hired, high case-loads, patients' complex psychosocial needs, and required guidelines often limited psychiatrists' ability to acculturate to the new settings and hampered retention efforts. Recruiting psychiatrists for ACT teams, which require intensive community-based services, was especially challenging (Walker et al, 2015).

PROCESS OPTIMIZATION

CONSISTENCY/LEVEL OF CARE*

Definition/link to affordability

- Training the workforce to be comfortable working in cooperative teams and at the interfaces of health care, behavioural interventions and social sciences is critical to expand the proportion of the population in good health (Lipstein et al, 2016).

General evidence

- Collaborative chronic care models provide a framework of broad applicability for management of a variety of mental health conditions across a wide range of treatment settings, as they do for chronic medical illnesses (Woltmann, Grogan-Kaylor, Perron, Georges, Kilbourne & Bauer, 2012).
- Standardized tools can support primary care providers in identifying children and adolescents who might need a more comprehensive mental health assessment (Cappelli & Leon, 2017)

Strengths

- The stepped-care approach promotes the delivery of the most effective, yet least resource-intensive treatment. More expensive and complex interventions are only implemented after simpler, less costly interventions have been unsuccessful (Capelli & Leon, 2017)

- Integrated care has been shown to: Increase client access to services, reduce readmission rates to hospitals, improve patient outcomes, increase productivity and employee and satisfaction, and decrease system costs (O'Donnell, Williams & Kilbourne, 2013).

Weaknesses

- A New Brunswick review found that, although various studies and initiatives designed to integrate mental health services existed internationally, no model approached the proposed scope of the Integrated Service Delivery (ISD) model, which included the integration of all child and youth services across four provincial ministries, and the delivery of services in the school, home and community contexts
- Few mental health providers clearly understand how primary care providers need to operate, what information primary care providers need to coordinate physical and mental health services or how their own practice fits within the health care system (Capelli & Leon, 2017)

*too much overlap between consistency and level of care was found to clearly delineate the two

BACK-OFFICE EFFICIENCIES

TECHNOLOGY ENHANCEMENTS

Definition/link to affordability

- Examples include electronic health records and automated electronic workflows

General evidence

- Successful efforts have 4 common changes: (1) installing electronic health records, (2) using this information for more intensive interactions between patients, caregivers, and staff, (3) reducing use of specialists, and (4) providing services not traditionally covered by fee-for-service reimbursement (Emanuel, 2017).

Strengths

- As the use of electronic medical records is more widely adopted, IT programs that can integrate client records and the services provided to clients will prove valuable to operators for client care as well as service provider productivity (Ismailanju, 2017)

Weaknesses

- Mental health and substance abuse clinics/centres currently spend $0.04 on machinery, equipment and other capital expenses for every $1.00 spent on labour. This leaves the industry heavily reliant on human capital and is missing an opportunity to leverage technological enhancements as a means of bolstering labour productivity (Ismailanju, 2017).

CONSOLIDATION

Definition/link to affordability

- No industry specific literature addressing consolidation of transfer payments has been found

General evidence

- No industry specific literature addressing consolidation of transfer payments has been found to date.

Strengths

- No industry specific literature addressing consolidation of transfer payments has been found

Weaknesses

- No industry specific literature addressing consolidation of transfer payments has been found

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APPROACHES TO MEASURING ACCESS AND CURRENT INDICATORS

MCYS – SERVICE DESCRIPTION SCHEDULE MAY 2018 (DEFINITIONS)

TERM	DEFINITION
Initial Contact	The date the child/youth and/or family contact the agency for service/ treatment.
Start Date	The date of first contact between the worker/therapist delivering the service and the child/youth/family member to focus on the goals identified for treatment.
End Date	The date of last contact between the worker/therapist delivering a service and the child/youth, and/or the date when a service is determined to have ended based on client preference, goal attainment, or change in eligibility.
Coordinated Access	Coordinated access is a collaborative, community-based approach to streamline access to mental health services and other types of supports. It helps children, youth and families access appropriate services and supports quickly and easily.
Number of Individuals Served	Number of individuals for whom a record has been created and who were recipients of the approved service(s) at some point during the fiscal year.
Number of Days Children/ Youth Waited for Service	The number of days between the initial contact date and the start date for service provided to the child/youth in n the reporting period. Both dates required.

ONTARIO HEALTH REPORTING STANDARDS (OHRS) – CHAPTER 7 (DEFINITIONS)

TERM	DEFINITION
Functional Centre	Functional Centres are subdivisions of an organization for the purpose of recording revenues, expenses, and statistics pertaining to the function or activity being carried out. They are used to capture the costs of labour, supplies and equipment required to perform specific functions.
Community Mental Health and Addictions	Community Mental Health and Addictions funded programs is the responsibility of the Local Health Integration Networks (LHINs) and includes the following programs: • Community Mental Health Program (MH), • Children's Mental Health (CMH), • Substance Abuse (SA) • Problem Gambling (PG) • Psychiatric Outpatient Medical Salaries (POMS)
Community Mental Health and Addictions Functional Centres	CMH&A service recipient functional centres have been created based on CMH&A program types, that is, Mental Health, Substance Abuse, Problem Gambling and Supportive Housing. In some cases there is only an Addictions functional centre available, where Addictions includes both Substance Abuse and Problem Gambling.
Children's Mental Health Functional Centre	Reporting for the Children's Mental Health program is not associated with a specific functional centre as it depends on the service provided. It is important that organizations select functional centres based on the definitions that match, as closely as possible, to the services provided. Refer to section 7.6 for definitions of all functional centres.
Age Categories	The age is reported as the age of the client on the date the service is provided. The age ranges for each category are as follows: Elderly — over 65 years Adult — 18 – 65 years Pediatric — 17 years and under Age Not Known - — Client age data unavailable (Used in selected accounts only)

CYMH KEY PERFORMANCE INDICATORS

P5A – SERVICE UTILIZATION (PER CORE SERVICE)

Proportion of children/youth by each core service, as a percentage of all children/youth served during the reporting period.

Numerator = Number of (unique) children/youth by each core service served during the reporting period. Denominator = Number of (unique) children/youth served during the reporting period

P6A – SERVICE DURATION (PER CORE SERVICE)

The average length of time between service start date and service end date, by service.

Numerator = The length of time between service start date and service end date, by service. The service end date must be during reporting period. Denominator = Number of (unique) children/youth, by service, that ends the service in the reporting period

P11A - AVERAGE SERVICE LATENCY

Average length of time that children/youth waited to start services during reporting period.

Numerator: total numbers of calendar days children/youth have been waiting (i.e., from initial contact date to service start date) for each service that started during the reporting period (exit cohort from waiting list)

Denominator = Number of (unique) children/youth waiting for specific treatment services during the reporting period

P11B - AVERAGE CHILDREN/YOUTH TIME ON SERVICE WAITLISTS

The average amount of time that clients were on waitlists, for services that started during the reporting period.

Numerator: total numbers of calendar days children/youth have been on the waitlist (i.e., from waitlist in date to waitlist out date) for each service that started during the reporting period;

Denominator: Number of (unique) children/youth that were on the waitlist and started to be served during the reporting period

P11C - LENGTH OF WAIT-LIST

The unique number of children/youth on a service wait list during reporting period

The unique number of children/youth on a service wait list during reporting period.

P12B - PROPORTION OF CHILDREN/YOUTH REQUIRING TRANSITIONS

The proportion of children/youth discharged during the reporting period and transitioning to other service providers by Transition Service Provider Type.

Numerator = unique number of children/youth discharged during the reporting period and transitioning to other service provider by Transition Service Provider Type.

Denominator = unique number of children/youth discharged during the reporting period and transitioning to another service provider

P1A – PROPORTION OF CHILDREN/YOUTH POPULATION SERVED

Number of unique children/youth served during the reporting period as a proportion of children/youth population, by community.

OHRS – PERFORMANCE MEASURES

S.406 99 10 INDIVIDUALS CURRENTLY WAITING FOR ASSESSMENT

The number of individuals referred to the organization and currently **waiting for initial assessment** (i.e. they have an application/referral date but do not yet have an assessment complete date). This reflects the number on the waiting list on the last day of reporting period. This is a snapshot at a specific point in time as at September 30 (Q2), December 31 (Q3), March 31 (Year End). It is not a cumulative number at Year End.

S.406 ** 20 INDIVIDUALS CURRENTLY WAITING FOR SERVICE INITIATION

The number of individuals **waiting for service** from a specific functional centre after assessment. These individuals have had their assessment and have been referred or booked for a service but have not yet had their first visit and are still waiting for service. This statistic is recorded in the client/service functional centre (not in case management functional centre). This reflects the number on the waiting list on the last day of reporting period. Service Recipient Category required. This is a snapshot at a specific point in time as at September 30 (Q2), December 31 (Q3), March 31 (Year End). It is not a cumulative number at Year End.

S.407 99 10 DAYS WAITING FOR ASSESSMENT

The number of days a client waited from the date of application/referral to the assessment complete date by the organization. This statistic is a cumulative figure and can only be recorded after the initial assessment for the client has been completed. This statistic is used to produce the average wait time for client assessments.

S.407 ** 20 DAYS WAITING FOR SERVICE INITIATION

The number of days waited from service referral date/assessment complete date to service initiation date (date of actual first visit by service). These days can only be counted after the service has started and the client is no longer waiting. This statistic is recorded from the date that the client is deemed eligible for service rather than from the date the case manager or coordinator orders/books a service. This statistic is a cumulative figure number, year-to-date value and is recorded in the service delivery functional centre (not in case management functional centre). Service Recipient Category required.

S.455 ** *0 INDIVIDUALS SERVED BY FUNCTIONAL CENTRE

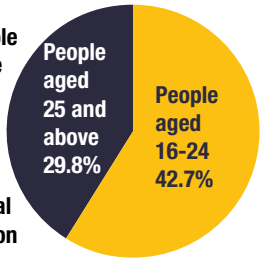
Note: that the definition has been revised to clarify the reporting of this account.

This statistical account is a year-to-date count of the number of individuals served by the functional centre in a reporting period and identified by a unique identifier. Individuals are counted only once within the functional centre within a fiscal year, regardless of how many different services they have received or the number of times they were admitted and discharged within the reporting period. This account is reported in the functional centre where the service was received. An individual may receive services from several functional centres during the same reporting period. This count cannot be summed for a "total" for the whole organization to report S.855** Total Individuals Served by the Organization. Service recipient category is required. Reporting is **not** valid with age category – unknown, S.455** 90.

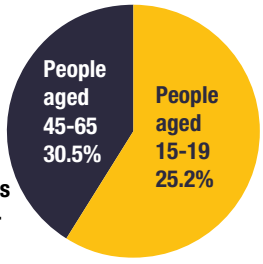
OHRS TO MCYS: COMPARING ACCESS RELATED MEASURES

CONCEPT	OHRS – CHAPTER 7	CYMH DATA DICTIONARY
Number of individuals served by service group	S.455 ** *0 Individuals Served by Functional centre	P5a – Service Utilization (per core service)

More young people than older people show up in the emergency department without prior contact for mental illness or addiction



Young peope access services less than older people. They are less likely to receive a follow-up visit within seven days after hospitaliza-tion for mental illness or addition



CONCEPT	OHRS – CHAPTER 7	CYMH DATA DICTIONARY
Length of time waiting to start services	S.407 ** 20 Days Waiting for Service Initiation * cumulative	P11a - Average service latency *average P11b - Average children/youth time on service waitlists
Number of individuals on a service wait list	S.406 ** 20 Individuals Currently waiting for Service Initiation	P11c - Length of wait-list
Number of individuals that require transition to another service provider		P12b - Proportion of children/ youth requiring transitions
Number of individuals waiting for assessment	S.406 99 10 Individuals Currently waiting for Assessment	
Cumulative number of days waiting for assessment	S.407 99 10 Days Waiting for Assessment	
Number of individuals in service	S.501 ** *0 Admissions to Community Services * count OR S506 ** *0 Individuals Received First Service	P1A – Proportion of children/ youth population served * proportion

CONCEPT	OHRS – CHAPTER 7	CYMH DATA DICTIONARY
Number of days in residential service	S. 403 45 *0 Resident Days (for residential only)	P5a - Service Utilization by Core Service
Number of days between start of service and end of service		P6a – Service Duration (per core service)

HEALTH QUALITY ONTARIO – TAKING STOCK: MENTAL HEALTH AND ADDICTIONS SPECIAL REPORT 2015

The rate of first contact in the emergency department for a mental illness or addiction is lower among children and youth in Ontario (up to age 24), varying by condition, from less than 2% (16.0 per 1,000 people) for schizophrenia and other psychotic disorders to just under 25% (233.4 per 1,000 people) for anxiety disorders (Figure 3.6).

FIGURE 3.8

ACCREDITATION CANADA: COMMUNITY BASED MENTAL HEALTH SERVICES & SUPPORTS 2019 SURVEY

TASKS	DIMENSION
2.0 Access to services for current and potential clients, families, teams, and referring organizations is provided in a timely and coordinated manner	
2.1 There is a process to respond to requests for services in a timely way.	Accessibility
2.2 Hours of operation are flexible and address the needs of the clients and families it serves.	Accessibility
2.3 Services are provided in clients' and families' choice of locations wherever possible.	Client-centered services
2.4 Clients and/or families are informed on how to access 24-hour emergency or crisis services.	Accessibility
2.5 Information about the client is gathered as part of the intake process and as required.	Accessibility
2.6 Defined criteria are used to determine when to initiate services with clients.	Accessibility
2.7 To the extent allowed by legislation, clients and/or their families have the right to refuse care, treatment, or services.	Client-centered services
2.8 When the team is unable to meet the needs of a potential client, access to other services is facilitated.	Accessibility
2.9 Clients and families are supported to navigate the health care system.	Continuity of Service
2.10 Clients and families are made aware of the team member who is responsible for coordinating their service, and how to reach that person.	Accessibility
2.11 There are processes to follow up with high-risk clients and/or families who do not appear for scheduled appointments.	Appropriateness

EXAMPLES OF INNOVATIONS IN ACCESS

SERVICE AREA	GREY/BRUCE
Name	Phil Dodd
Phone	(519) 371-4773 ext. 156
Email	phildodd@keystonebrucegrey.com
Problem Identified	Wait times of 8 weeks average
Actions Taken	Keystone restructured our service delivery model and trained all clinical staff in Brief Service Walk In model provided through Karen Young at ROCK.
Result/Impact	Since the training and restructuring over a year ago, Keystone has maintained a wait time of two weeks average for the past year.
SERVICE AREA	**TORONTO**
Name	David Willis
Phone	416-438-3697 x21117
Email	dwillis@emys.on.ca
Problem Identified	Wait times and waitlists for community-based services in Toronto Region for ages 0-18 and additional focus on transitional age youth
Actions Taken	Toronto expanded our What's UP Walk-in to six organizations across the city representing different geographies and age groups. Sought additional private funding for transitional age youth
Result/Impact	Saw 3000 young people 2017/18, a 57% increase from the year prior. Most young people receive same day services and only require 1-2 sessions (brief services). Those who require additional services/support are referred to appropriate services in the community and within the agency based on a comprehensive understanding of the young person's needs. The impact is improved access, reduction in wait times, more appropriate service referrals. We leveraged corporate/private dollars to ensure services for transitional age youth and to do marketing and branding. Developed a youth engagement program to improve service delivery. Data shows: • average # of visits across system 1.5 • Average wait time 16-20 min • 22% of young people report they would have gone to health care (hospital/MD) for care if they didn't have access to Walk IN
SERVICE AREA	**OTTAWA**
Name	Monica Armstrong
Phone	613-729-0577 ext 1231
Email	marmstrong@ysb.ca
Problem Identified	Problem Identified: - unable to meet growing demand for CYMH services and increase wait times for services - lack of clarity and consistency in matching needs and services - Lack of consistent approach in service delivery - Lack of clarity about quality of service available or provided - skill base not necessarily keeping up with needs of clients - increasing emergency criteria - youth and families reporting that access to care is confusing, complicated and frustration and that there is a lack of coordination of services and sustained and meaningful interventions. In addition, youth and families stated they wanted to be active contributors in the therapeutic process and that they were often not clear what was involved in the service they were being offered
Actions Taken	Implementation of Choice and Partnership Approach (CAPA), a continuous service improvement model to deliver CYMH services that combines collaborative and participatory practice with clients to enhance effectiveness, efficiency, skills modelling and demand and capacity management by improving client flow and quality of care.
Result/Impact	- significant reduction in wait time for children and youth to access CYMH services - focus on continuous improvement to identify and eliminate of waste in client flow through intake, treatment and discharge to improve efficiency and quality of service - improvement in treatment matching - identification of strengths and gaps in clinical skills and knowledge across CYMH system in Ottawa resulting in targeted training initiatives

SERVICE AREA	FRONTENAC/LENNOX AND ADDINGTON
Name	Amber McCart
Phone	613-849-7320
Email	amccart@maltbycentre.ca
Problem Identified	Wait times to access child and youth mental health services, even brief mental health consultation, were too long.
Actions Taken	Development of new walk in mental health access model that serves as brief mental health (complete) service or gateway to further services (scheduled immediately) as appropriate.
Result/Impact	In this first month of service: - 4x more new referrals were seen face to face, than in the same month the previous year. Overall a 30% increase in total number of new referrals for child and youth mental health services. Because children and youth had faster access, issues were resolved with less overall intervention needed, with 60 percent resolving through clinic access only.
SERVICE AREA	**CHATHAM-KENT**
Name	JoDee Anderson
Phone	519 358-4550
Email	jodee.anderson@ckcs.on.ca
Problem Identified	1) Emergency Hospital visits on the rise - youth and families not access local crisis services 2) Timely access to service to reduce rising wait list
Actions Taken	submitted a proposal to provide mental health assessment in the Emergency Department 2) launched Brief in 3 - booked appointments at the time of intake -3 sessions in 6 weeks
Result/Impact	Emergency visits are stable- current protocols in place with school boards around who and when to send to emergency departments. 2) waitlists dropped in 4 months from 180 days to 70 days
SERVICE AREA	**SIMCOE**
Name	Glen Newby, CEO
Phone	705-733-2654 x 2227
Email	gnewby@newpath.ca
Problem Identified	Complexity of five core service providers, two being housed in Child Welfare and CMHA.
Actions Taken	Intentional discussions with Child Welfare and CMHA to consider consolidating their core services into the Lead Agency core services.
Result/Impact	Reduced core service providers from 5 to 3. More effective coordination of system resources. Less administrative resources required to manage contracts with MCYS (now MHLTC).
SERVICE AREA	**HALTON**
Name	Joanna Matthews
Phone	905-638-4972
Email	joannam@rockonline.ca
Problem Identified	Community Services Plan: Increase inclusive services provision
Actions Taken	Indigenous Youth and Families 1) Provided targeted training for Halton service staff to increase knowledge and awareness of cultural safety requirements to support Indigenous youth and families 2) Hosting one .75 FTE Youth Outreach Worker to work specifically with Indigenous Youth in Halton • Newcomer Families - Created specific online resources (rockonlearn.ca) that are culturally and linguistically appropriate for newcomers • French Language Services - Completed mapping of available services in Halton Area with recommendations to build culturally and linguistically specific pathways for families (I can send report if you want to see it)

Result/Impact	Traditionally marginalized communities have increased access to core services
SERVICE AREA	**HALTON**
Name	Joanna Matthews
Phone	905-638-4972
Email	joannam@rockonline.ca
Problem Identified	Equitable Access to Services in North Area (Halton Hills)
Actions Taken	Implemented two walk-in clinics in North Halton. Clinics are running one day a week in Acton and Georgetown in existing Senior's Activity Centres
Result/Impact	For our initial Lead Agency Investment 2016 we have had provided 708 brief services to 461 unique clients in North Halton.
SERVICE AREA	**BRANT**
Name	Flora Ennis
Phone	519 752 5308 ext 105
Email	fennis@woodview.ca
Problem Identified	Recent research has shown that children's mental health services that are created in partnership with youth are more effective, better utilized and produce better outcomes for youth. Currently, our programs are designed with only the agencies input, it is important to move to a model where programs are co-developed with youth.
Actions Taken	We have hired youth advocates to work with our youth coordinator to serve as a co-leader and co-developers of youth engagement. As a team they travel to where the youth already gather to collect data on youth's view of services in our community and how we can improve services. From information received, if was evident that the at-risk youth where not accessing counselling services. We created a non-traditional brief outreach position to assist at-risk youth by going to established youth drop-in centers. The youth can access in the moment counselling and this created a new pathway for disconnected youth. This provided our youth with the right service, at the right time, delivered in the right way.
Result/Impact	This new non-traditional Brief Outreach service sees between 50-65 youth per night at Why Not Youth Centre. Due to the nature of the programming and centre many of these youth may be different each night, providing us the opportunity to reach a large variety of disconnected youth every month. Many, if not most of these youth have not and will not access services using traditional pathways and require a trusted adult to guide them in system navigation through strong rapport, and warm transfers. This is based on direct input from the youth and years of experience from the Why Not staff who have served the disconnected youth of Brantford for over a decade. It is important to note that the gap between disconnected youth is narrowing through the use of this new service and will help to bridge the gap between unreachable youth and the services they need. In order to track the work that we do, the counsellor tracks the number of counselling sessions in our client database. We are utilizing a target prevention approach that is less intrusive then a formal counselling session. Once rapport is built, individuals may access one-to-one sessions more freely. Ongoing impact will also be observed and obtained through consultation with the youth, staff, and leaders in training at Why Not. Their input and co-development of this new service is key to bridging the gap between at-risk youth and clinical services. Currently, we are attending Why Not on a weekly basis, this would have greater impact if we could attend more frequently.

SUPPORTING DOCUMENTATION: LIVE-IN TREATMENT SERVICES

CURRENT CAPACITY

We have attempted to quantify how much of this capacity is currently being funded by MCCSS by using the MCCSS detail code A353 which MCCSS describes as "to provide treatment to children and youth affected by mental health problems…and who require an intensive level of intervention in an external setting". A quick survey of lead agencies yielded the information in the chart below and also highlighted some challenges with this approach. **For example, it is difficult to establish what percentage of the overall child and youth mental health budget in Ontario is spent on live-in treatment services.** Some highlights and learnings from this survey process include:

AVAILABILITY OF LITS BY REGION:

Central: 6/6 service areas (100%)

East: 4/9 service areas (44%)

North: 3/6 service areas (50%)

Toronto: 1/1 service areas (100%)

West: 7/11 service areas (64%)

TOTAL: 21/33 service areas (64%)

\AVAILABILITY OF LITS FOR CHILDREN UNDER THE AGE OF 12: NONE AVAILABLE IN EAST OR TORONTO REGIONS

Most LITS are not gender-specific

Recommendation for next steps: More thorough review of live-in treatment services that are funded under A353 to get an accurate current state picture.

When the then Ontario Ministry of Children and Youth Services (MCYS) established the seven child and youth mental health core services, funding was allocated to agencies by core service type, not individual programs or services. For example, an agency that provides live-in treatment services, a day treatment program and in home intensive services receives one lump sum from the Ministry for all these services. Not all agencies are readily able to separate out the budget amount spent on each program. In addition, in some service areas, funding for the "treatment" portion of live-in treatment services (i.e. salaries for clinicians) is not included in the intensive services detail code but funded separately under the counselling and therapy detail code.

Also, trying to estimate capacity by asking for the number of beds available in each live-in treatment service proves problematic. As previously mentioned, CYMH funding has not kept pace with inflation and it is anecdotally understood that many of these programs operate at a deficit. Consequently, agencies with live-in treatment services cannot afford to operate a full capacity and beds are left vacant to manage cost over-runs.

CONSISTENCY IN LANGUAGE AND UNDERSTANDING

The current lack of a clear and consistent definition of live-in treatment services complicates efforts to build and strengthen system capacity, to provide the right services at the right time to the people who will most benefit and to improve outcomes for those children and youth who receive the services. It challenges progress towards the establishment of a system by providers, funders and policy-makers or even being able to consistently quantify the capacity of what currently exists.

In the adult mental health and addiction sector there are no fully comparable services. Historically, children's services have used a 24-7 residential milieu model with treatment integrated into the "residential" program, whereas adult's services have typically used a "residential" housing model with the adult accessing treatment services outside of the residential supports.

Children and youth have some unique requirements in their treatment that are not present in adult services. These include the need to accommodate for children's developmental stages; to effectively involve the family or caregivers as legal guardians; to ensure clients' participation in mandatory education; and to appropriately address the presence or absence of addiction, given that addiction may be less likely to be present in younger children. Consequently, live-in treatment services tend to be more integrated with assessment, counselling and therapy, case management, education and family supports merged into the residence/home where the children are living.

With adults, on the other hand, intensive supportive living services tend to be separated and less integrated across specific services. For example, case management, mental health treatments, longer term addiction treatment are accessed ancillary and often addressed separate from one's housing and stabilization needs.

SYSTEMIC CONTEXT

Live-in treatment services in the CYMH sector exist within a broader health system, which includes primary care, acute care, and specialty mental health and addictions programs. For a range of historical reasons, these sectors—and the service providers and institutions within them—have been organized and operated in silos. As a result, service providers have varying understandings of their respective roles and responsibilities in the provision of CYMH services. For children, youth, and families, the consequence has been having to travel through disjointed and confusing care pathways, as their challenges intensify—often without having their needs met.

When families of children and youth with acute and complex care needs do not have available services at the community or primary care level, they turn to the hospital emergency department for help.

As a result of these disjointed and confusing care pathways, a disproportionate number of children, youth and their families seek mental health help at their local emergency department, regardless of the hospital's ability to appropriately meet the intensity of their needs. This results in children and youth receiving treatment and care at inappropriately higher levels of intensity than is warranted by their level of need. Additionally, the lack of community-based intensive services for children and youth with acute and complex needs contributes to inefficiencies in accessing care and delivering effective treatment that is responsive to the level of need.

Recent studies have demonstrated an alarming increase in hospital utilization for mental health and substance-use issues among children and youth. Since 2006, there has been a 72% increase in the number of young people making emergency department (ED) visits and a 79% increase in rates of hospitalization for mental health and substance-use issues.[i] This is during a period in which, across Canada, hospitalizations among children and youth for other conditions has dropped by 22%. The percentage of clients with three or more ED visits for mental disorders was 38% compared to 15% for other conditions; for three or more hospitalizations, these numbers are 9% and 4% respectively. The median stay in hospital for mental disorders was six days, compared to two days for other conditions. These trends speak to a significant lack of child and youth mental health services at the community level as well as issues of access.

Though there are a wide range of reasons why young people are removed from their homes by CASs, most of which are not specifically related to a young person's mental health, many of these children and youth are struggling with mental health issues—sometimes quite significant mental illnesses.[1] When young people are removed from their homes, CASs must make placement decisions on a fairly immediate basis and waiting for an available intensive treatment bed in a CYMH agency—even if it is the most appropriate service destination—is not an option. (Based on work from the Residential Services Working Group, convened by some of Ontario's CASs, it is estimated that in some areas of the province, upwards of 40% of youth in the care of group homes should actually be in the care of a CYMH agency. [2]) As result, CASs are often forced to place young people with significant mental health issues into OPRs, which are consistently unable to meet their needs although their costs are frequently higher.

The value and efficiency of 'the right services at the right time by the right provider' is a well-understood principle in healthcare. There are several factors that confound this approach in child and youth mental health, including the lack of well-defined clinical pathways. Child and youth mental health core services do exist on a continuum of intensity and all too often intensive services, including live-in services, are reserved as an 'the end of the line' intervention, to be used only when all other options

have been exhausted. Children and youth with complex needs benefit when intensive services are a well-established component of a comprehensive system of care, reserved for young people who face significant mental health issues and, for any number of reasons, cannot safely and successfully live with their family for some period. As any other component in the health care system, live-in treatment services must function in relation to, and in coordination with, other services—for example, serving to divert or step-down young people leaving a period of hospital-based care.

As a highly intensive intervention, live-in treatment services should be reserved for those who present with highly complex needs and will benefit from this intensity of treatment. However, children and youth are placed in live-in treatment services for a number of reasons. Some placements are the result of challenging home environments and compromised parental capacity, while others are the consequence of a child or youth's significant emotional and behavioural dysregulation that put others at risk. Rather than providing these children and youth with the right live-in treatment at the right time, all too often live-in treatment is viewed by the service system as a "placement of last resort" after all other services are exhausted rather than an effective and valuable treatment tool as part of a comprehensive treatment plan.

ELIGIBILITY CRITERIA

In Ontario, there is an absence of consistent and clear-cut diagnostic and profile indicators for live-in treatment placement. Without clear eligibility and suitability criteria, it is not possible to consistently determine (a) whether an individual will benefit from live-in treatment, (b) the most appropriate treatment approach, (c) the appropriate safety plan, or (d) the impact that child or youth may have on other clients and staff within a program. Common assessment tools and program guidelines are not in place to assist clinicians to determine when live-in treatment is appropriate. Without standardized assessment tools and related criteria that define and designate a child or youth as "complex," it is very difficult to ensure consistency across the sector and ensure that similar types of children and youth are being referred to, and are accessing, live-in treatment.

In place of common assessment and screening processes, MCYS established residential access committees across the province. Every referral made by a provider to a live-in treatment service must be presented to and approved by these local access committees. The committees are intended to identify appropriate referrals and prioritize admissions. Currently each committee has its own process for determining appropriateness and prioritization and they differ greatly. There are no standardized processes or tools to determine suitability or risk and need.

EVIDENCE-BASED PRACTICES

Child and youth live-in treatment has been under scrutiny for its limited evidence to indicate that this highly intrusive, intensive, and expensive resource consistently and reliably contributes to improved outcomes for children and youth. There are no randomized control trials (RCTs) from which to draw strong conclusions as live-in treatment services are incredibly heterogeneous and lack standardized expectations. In addition, there is an emergence of a growing number of less intrusive, less costly family- and home-based treatment options, which do have the ability to demonstrate positive outcomes.

Many live-in treatment services do not subscribe to the use of evidence-based practices in the milieu and the research on the implementation and effectiveness of evidence-based practices in

live-in treatment is scant. James, Alemi, and Zepeda (2013) reviewed research on individually-based interventions used in live-in treatment care and found only 13 eligible studies that reported on 10 interventions. The interventions varied with respect to treatment approaches and, overall, the studies reported significant improvements in such areas as program completion, trauma, depression, aggression, substance abuse, and family functioning. However, due to "considerable bias," significant "methodological weakness" and "lack of methodological clarity," results are considered by James to be preliminary at best.

James' (2011) review of milieu-based interventions yielded no better results. Despite using stringent inclusionary criteria and identifying five live-in treatment models developed specifically for youth, James' review "indicated a painfully small knowledge base considering the decades that some models have been in existence" (James et. al., 2015, p. 151). He concluded that the research is far too weak to make a recommendation for any one milieu treatment model.

Despite being much in demand and consuming a significant amount of provincial child and youth mental health funding, live-in treatment is generally not able to document positive outcomes for children and youth, particularly outcomes that last beyond discharge or an efficient approach to program utilization across the province.

Although the effectiveness of live-in treatment over other forms of treatment or alternative models of live-in treatment has not been clearly demonstrated, **there is agreement within the literature that live-in treatment is required as a component of a continuum of mental health programs for children and youth with significant and complex needs who require of 24-hour care and treatment. Although live-in treatment is more expensive, intrusive and restrictive than other community-based alternatives, these services strengthen the mental health system by providing services to children and youth who are either too challenging to treat at home or who have not benefited from inpatient or community treatment services** (Lyons, Woltman, Martinovich, & Hancock, 2009) (Kott, 2010). However, determining effectiveness of live-in treatment services is difficult until a mutual understanding and core definition of live-in treatment is established (Kott, 2010).

Although live-in treatment services are likely the most expensive and intrusive community child and youth mental health services provided in Ontario, they have developed (or not) in a fragmented and opportunistic manner in the absence of any provincial assessment of need, strategic direction, plan for distribution of programs across the province. Providers, whether they are not for profit transfer-payment agencies, government directly operated or private non-profit or for-profit per diem entities, typically design and develop programs based on their own skills, philosophies and priorities, informed by local demand at the time.

The resulting services are likely not comparable in terms of program design, types of therapeutic services and professional disciplines involved, clinical profiles, staff-to-client ratios, characteristics of the living environment, lengths of stay, age requirements, geographical boundaries, and bed availability. Furthermore, they have limited capability to adapt as local needs evolve. In addition, as access to mental health services is not mandated, providers are not required to develop programs for children and youth whose needs are not well met by existing programs, meaning that providers may accept or decline referrals based on agency capacity rather than acuity of need.

FUNDING APPROACH

The present funding model has not kept pace with inflation in costs of "bricks and mortar" and staffing. Capacity in Ontario has largely been determined by the funding by the government rather than need (Auditor General's Report, 2008). Budgets have typically been based on, at best, expenditures rather than the cost of the program. Anecdotally, we understand that many government-funded child and youth live-in treatment services operate at a deficit, drawing on funds earmarked for other less expensive programs, private fundraising, and bed vacancy management to manage cost over-runs. As CYMH funding has not kept pace with inflation, we are seeing an increase in closures of live-in treatment services for financial reasons, including the lack of funding for the required clinical supports to treat complex clients safely and effectively. Closures are occurring in the absence of a coordinated provincial, or in some cases local, service plan, based on "one off" provider agency decisions driven by fiscal pressures.

In this unplanned and largely undifferentiated set of programs, children and youth must fit into the program that individual providers build and government funds (or families/caregivers can afford) rather than have access a program that is most likely to able to address their unique treatment needs.

ACCESS CHALLENGES

As is the case across the CYMH service continuum, availability of live-in mental health treatment is not equitable across Ontario or across child and youth populations. There are significant populations in Ontario that either do not access services or who are poorly served by the available services including: socio-economically marginalized groups, Indigenous peoples, racialized peoples, individuals who identify as LGBTQI2S+, medically complex clients, newcomers, immigrants, Francophones and people living in remote and rural areas including northern Ontario.

There is a substantial body of research that documents the heightened mental health risks of being a member of a marginalized group yet almost no formalized response to their diverse needs. Services designed for the 'mainstream' may be unable to effectively meet their needs and support positive outcomes.

Ontario's geography also contributes to issues with equitable access to appropriate services. Children and youth with complex mental health issues are frequently required to leave the north to access services, for month and sometimes for years. This means that most northern children and youth who require live-in treatment are separated from their families and communities at a time when they are most vulnerable, and the communities they do eventually return to are not well equipped to support continued community treatment. This can create a cycle of hospital admissions, child welfare involvement, further out-of-home placements, family trauma and in the worst situations death by suicide.

The needs of children and youth who require live-in treatment are not homogeneous – either in terms of their diagnoses or their degree of functional impairment. The treatment responses they require from the CYMH system needs to be similarly differentiated. Consistent with learnings from healthcare more generally, we know that when a program tries to do everything well, we inevitably end up over treating some and under treating others. Currently in Ontario there is no ability to differentiate among community-based live-in treatment programs although anecdotally we know that they have very different clinical capacity, different programming and different physical plants. A relatively small number

of children and youth in Ontario will require highly specialized treatment in programs, perhaps with a provincial catchment, that have 24/7 clinical teams and a treatment environment that mitigates physical risk. A somewhat larger group may benefit from regionalized programs, where there is sufficient prevalence to justify this approach. The largest group of children and youth may have their needs met through more 'local' programs that provide a therapeutic living environment with access to consulting clinicians. Clinical best practice and fiscal accountability would dictate that we should seek to differentiate our resources as set out in Figure 2, Chapter 4.

ACCOUNTABILITY AND QUALITY

The current 'quality assurance' processes for live-in treatment are licensing and to some degree compliance with funding guidelines. They apply differentially to providers funded directly by the government and others, including private providers.

Ontario's residential licensing regime for child and youth residences was recently updated in the new **Child, Youth and Family Services Act** and sets out legislative and regulatory requirements for all residential licensees. Provincial licensing standards and practices provide a minimum threshold rather than a true measure of quality. While this serves to ensure that basic rights and safety measures are in place for children and youth in care, it does not address issues related to treatment effectiveness and the ability to appropriately address unique needs. Adult programs are not licensed.

With the introduction of core services, including intensive services, in 2014 MCYS introduced **Program Requirements and Guidelines #01: Core Services and Key Processes** (PGR#01). These minimum expectations apply to MCYS-funded mental health providers of live-in treatment only, not on other providers of live-in treatment.

Most government-funded providers have pursued accreditation by a qualified entity such as Canadian Centre for Accreditation or Accreditation Canada for all their services, including live-in treatment services, although it is not mandatory.

Some provider organizations have innovated within their own scope to attempt to improve the quality of the intensive services they provide to the children and youth with most complex needs. Continuous quality improvement is not a funded activity within CYMH budgets and so there is considerable variability among providers as to how much capacity they can put to undertaking work on their own in the areas of data analytics, performance measurement, staff training etc. Several interesting examples include:

- Kinark Child and Family Services produced a policy paper entitled **Strengthening CYMH Residential treatment through Evidence and Experience** in 2015. This paper summarizes the last 30 years of international research in this area, examines experience in its own residential treatment programs, identifies nine critical success factors for live-in CYMH treatment and provides some recommendations for system change. Kinark has now developed a tool (the Scoring Tool for Assessing Residential Treatment [START]) to assess programs against those success factors that has been validated in partnership with other providers.
- A collaboration between Windsor Regional Hospital, Hotel Dieu Grace Healthcare – Regional Children's Centre (RCC), Maryvale Adolescent and Family Services, and Windsor-Essex Board of Education (Section 23 classroom at Maryvale) has focused on quality through developing a continuum of care model. If a child or youth at the ED is suspected of experiencing a mental health

crisis by the triage nurse, a crisis worker from RCC is contacted. The crisis worker conducts a mental health assessment and if the child is deemed eligible, they are admitted to a Schedule One bed at Maryvale. A child or youth who is suspected of experiencing a mental health crisis but is not admitted, is referred to services at the RCC walk-in clinic.

WORKFORCE

Like the CYMH sector more generally, live-in treatment providers face a constellation of workforce-related challenges. Frontline and clinical work in these settings is arguably the most difficult and demanding work in the CYMH sector: it is shift-based, working with highly complex clients who present a high degree of risk. The limited research in this area confirms that staff who are consistently subjected to challenging behaviour are quicker to experience burnout and medical challenges, as they often feel unsupported, agitated, and overwhelmed (Van Oorsouw, Embregts, Bosman, and Jahoda, 2010). Furthermore, Willems and his colleagues (2010) found that, over time, live-in treatment staff can exhibit signs of depression, hopelessness, and indifference.

While frontline live-in treatment workers—typically child and youth care practitioners (CYCPs)—are trained to help children, youth, and families better cope with personal and daily living challenges, the training they receive is limited relative to the complexity of the work. Indeed, there are no consistent or mandatory standards for the pre-service educational qualifications. Given these more limited qualifications—though, despite the difficulty of the work—frontline workers are the lowest paid staff within the CYMH sector who are engaged in the delivery of treatment; and even looking outside of the CYMH sector, CYCPs are paid notably more in the education and hospital sectors.

CASE EXAMPLES

"Safe with Intervention", the report from the Expert Panel on the Deaths of Children and Youth in Residential Placements established by the Ontario Office of the Chief Coroner found that the limitations of our current approach are leading us to place young people in very expensive settings that are not only unable to meet their needs but are increasing the risk they face—with tragic consequences.

Several case examples illustrate the complexity of the needs of some of our children and youth placed in settings unequipped to address their treatment needs.

Omar is an 11 year old boy admitted to a residential and day treatment program. He received counselling/therapy prior to admission. His living arrangement with his caregiver broke down due to his increasingly high risk and unsafe behaviour, particularly suicidal ideation, threats to self-harm (e.g. running into traffic, drinking gasoline), and attempts to run away. He was taken into CAS care. He had three group home placements prior to admission. Omar was removed from his biological parents at 3 months of age, then placed with grandparents, and at least 3 subsequent placement. He has been exposed to issues related to adult mental health, substance use, and violence. Omar began displaying challenging behaviour as a toddler, and he has received several diagnoses including Learning Disabilities, Attention Deficit Hyperactivity Disorder- Combined Presentation (Severe), Attachment Disorder, and Oppositional Defiant Disorder. He becomes behaviourally dysregulated, which often results in aggressive behaviours directed at residential staff (e.g., hitting, kicking, punching) and destruction of property. He has suicidal thoughts and

self-harming behaviours. Omar often requires one-to-one supervision. His lack of trust and feelings of hopelessness and related behaviours have made it difficult for him to engage in treatment. Slowly he has begun to progress in his individual sessions and has also experienced successes with the structure and support of the day treatment classroom.

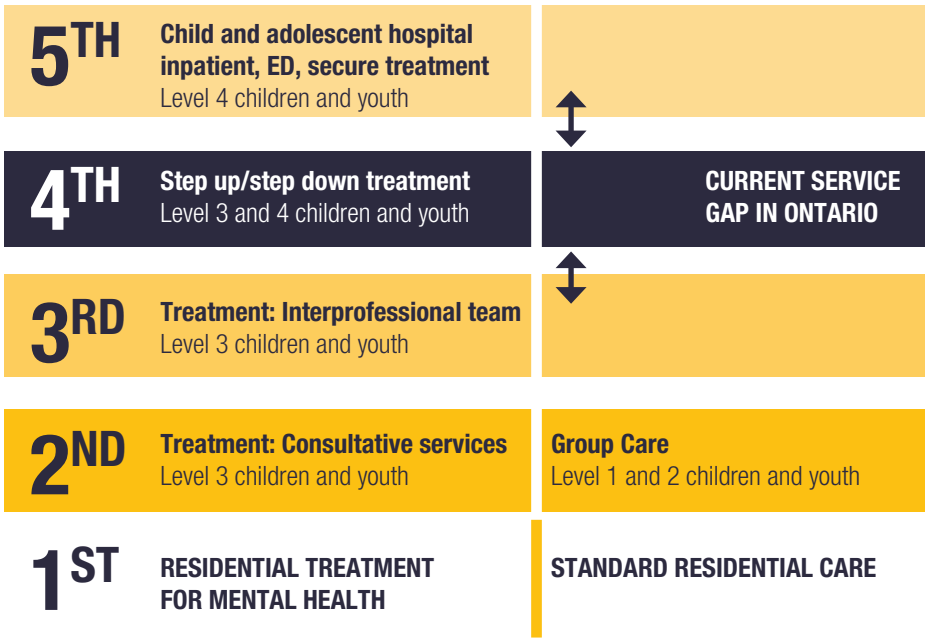
Jolene is a 15 year old Indigenous youth from a fly-in northern community attending school in Thunder Bay. She has been in Thunder Bay for almost two months and has been receiving support for substance use, depression, anxiety and self-harm from both her school and the local Indigenous service provider. Jolene has a long history of trauma including sexual assault. Although she has never been in care, both her younger siblings have been in and out of care with child welfare. One is currently placed with family in Kenora, the other is with his grandparents in her home community. Jolene is worried that her brother's and sister's needs are not being met; that was her job. Jolene's family has a long history with residential schools with all of her grandparents being forced to attend. Currently, her father is serving time in Manitoba for aggravated assault, and her mother is 1 year sober living in Thunder Bay to attend school and trying to get her family back together. Jolene has been terribly home sick; the NP at school is treating her for major depression. Jolene has had 2 recent suicide attempts, with the last one an intentional drug overdose while intoxicated. Jolene is now in the regional hospital adolescent unit awaiting residential placement. She has reluctantly agreed to go but there are no beds in Thunder Bay. The family, despite the trauma they have experienced is very close to their community and culture. They want services closer to home with access to Elders and traditional healing supports. Recently, Jolene with the help of her grandmother and Elder in her community has been reconnecting with her culture and has started to learn the language.

PROPOSED MULTI-TIERED DESIGN

Children and youth struggling with the most significant and complex mental health issues, for whom living at home is not an option for some period, need timely, high-quality treatment services; that are close to home and matched to their specific needs; which offer a positive experience and generate positive outcomes; and which support and facilitate returning home as soon as is appropriate and possible.

To succeed in meeting these needs, Ontario's CYMH live-in treatment services need to be organized in a tiered system, which distinguishes "care" from "treatment", and which categorizes services based on a provider's ability to meet escalating levels of need and complexity. These services must be planned provincially, with the most specialized (and most expensive / least utilized) services offered at the regional and provincial levels. And all of these services must operate within the context of the broader CYMH sector and the health care system—for example, with live-in treatment being used as a step-down from hospital inpatient services as appropriate.

The current group of live-in treatment providers are attempting to meet all the needs of all the children and youth referred to their programs – with differential resources and clinical capacity. A system of tiered services allows for matching the right services to each client —promoting better outcomes and more efficient effective services. Although some CYMH agencies are contracted as live in treatment providers, their capacity is better suited to delivering other types of intensive, but less expensive, interventions. As most non-residential interventions will also be less expensive, this allows more children and youth to be served more effectively with the same or less funding.



- Tier One is live-in group care for children and youth who require an out-of-home placement but do not have mental health issues. Tiers Two – Five provide mental health treatment at increasing levels of intensity and complexity. Tier 5 represents hospital-based or secure treatment services. Tier 2 and Tier 3 are live-in treatment settings with access to inter-professional teams, with clients with differing risk profiles.
- Tier 4 is a "step up/step down" program that supports clients moving from Tier Five transition between a higher tier programs (Tier 5) or a less intensive program (Tier 3 or community-based programs). Currently there are only a few programs in the province that successfully treat these children and youth who are high risk and have very significant and complex mental health needs. Many young people have had very poor outcomes in community-based settings when their behaviours and needs exceed the capacity of their program. Often at that point hospitals have been the only option.
- This design will include a Tier Four, a very specialized intensive program to stabilize and comprehensively assess young people and target specific mental health needs that are having a detrimental impact on the youth and family functioning. The service will have a robust and comprehensive community (non-residential) component, as well as targeted out of home capacity. This service will work closely with both Tier Five and less intensive community services, to ensure high risk and complex needs young people are supported to sustainably function effectively in the community.
- Tier Four services are largely missing in Ontario, resulting in an under-response for youth who are transitioning out of hospital-based services, as well as an over-response for youth who are inappropriately accessing hospital EDs for non-acute mental health needs. To provide an effective response for youth who present with significant and/or severe mental health needs, diverting them away from expensive hospital-based services as well as offering a step-down service, a community-based specialized intensive service is required.

A redesigned CYMH live-in treatment system, that focuses on keeping families together and better matching client needs to appropriate, high-quality services at the right time to optimize treatment outcomes will significantly reduce the extent to which we are removing young people from their homes.

In some service areas, the demand for live-in treatment beds far exceeds availability and every year, at shocking expense, young people in underserved areas such as northern Ontario are sent across the province for placement because no sufficient capacity exists in their geography. Typically they are placed with private for profit facilities that are unable to provide treatment. In other service areas, maintaining occupancy rates becomes a pressure that leads programs to admit clients for whom they do not have an appropriate program. Frequently, vacancies in these programs are arising not because there is an over-supply of treatment beds, but because the highly complex needs of some children and youth exceeds the providers' capacity to safely and effectively address. Current standards of training and resource allocations have simply not kept pace with the current service requirements. For much less cost, these children and youth could be served through a well-organized and equitably distributed system of tiered programs, delivering significantly better outcomes for young people.

To ensure that these live-in intensive treatment interventions are effective and given that the purpose of live-in treatment is to achieve positive and sustainable outcomes for children and youth (Dougherty, Strod, Fisher, Broderick, and Lieberman 2014), implementing a performance measurement system that captures short- and long-term functional outcomes is crucial. Live-in treatment services that measure long-term outcomes "are better prepared to assess how changes in their own practices can improve outcomes post-discharge. They are also better positioned to articulate their value in a system of care and respond to changes in the health- care and youth and family servicing systems" (Dougherty et al., 2014, p. 183).

It is also imperative that service providers are supported to measure program performance. Within the US mental health care sector, performance measurement systems are used to gauge the efficacy and effectiveness of programs and services, as well as the extent to which best practices and supports are in place to facilitate treatment efforts (American Association of Children's Residential Centers [AACRC], 2014). However, there is no such system in Ontario or nationally. This is area of significant future opportunity.

Importantly, providers must also measure families' experience of care, as we understand how inextricably linked it is to better client outcomes. Our leadership in the Ontario Perception of Care demonstration project for children and youth, referenced in detail in Chapter 1, positions us well to incorporate this feature into an overarching performance measurement framework for live-in treatment services.

The government is focused on helping families, making services more efficient, and ensuring better outcomes for clients. We believe that is an opportunity for Ontario to become a leader in delivering efficient and effective live-in CYMH treatment. There is general agreement that the use of intrusive and expensive live-in treatment should be reserved for children and youth assessed as having the most complex needs when they cannot be served by other less intrusive interventions. This is not the same as seeing these services as 'the end of the [treatment] road', as discussed earlier. These youth require a range of evidence-based intensive, **non-residential** treatment programs that effectively address the complex needs of children and youth while supporting them in their family or care settings.