



**An Ideal Model for Children's Mental Health  
Services in South West Region  
Year 2 Implementation**

**Children's Mental Health  
Core Services and Supports**



**Submitted to:**  
South West Region Children's  
Mental Health Steering Committee

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SWR

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# **IN MEMORIAM**

*Dr. Dan Offord*

*As we pursued our work on the “Ideal Model” for the children’s mental health services system we, time and time again, relied on the body of work of Dr. Dan Offord, eminent Child Psychiatrist, who passed away on Saturday, April 10, 2004.*

*The Offord Centre at McMaster University is an important institute that was born out of his work with children at risk. One of his key themes was the need for outcome measures that would allow for assessment of the quality of early child development in communities. The breadth and depth of his work on behalf of children is truly inspiring.*

*Ultimately, an Ideal Model for Children’s Mental Health is about people in relationship with each other for the sake of children, youth and families. It is in this spirit that we mark the passing of a most extraordinary person who was at the vanguard of respecting and appreciating the wonder of children, youth and families.*



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# EXECUTIVE SUMMARY

This document is part of the continuing work of the implementation of the Ideal Model for Children's Mental Health Services in the South West Region. It deals with the largest and foundational part of the Ideal Children's Mental Service Model; that is, Children's Mental Health Core Services and Supports.

The child or youth and their family must be the centre of our service system concerns and energies. Further, our concern must take into account the whole child or youth in context and not focus solely on the problem. Services need to be available, responsive, effective and efficient, and consistent with the **South West Region Children's Mental Health Services Project Vision:**

***A high quality system of children's mental health services that is accountable to the child and family, easily accessible and integrated with other supports for children.***

## **Definition of Core Services and Supports:**

Children's Mental Health Core Services and Supports are those provided to children, youth and their families with children's mental health service needs. These services are First-line and may be Intensive. The needs responded to may be complex, and may be met locally, in collaboration with Children's Mental Health Highly Specialized Services and Supports.

Children's Mental Health Core Services and Supports are those that include a range of ESSENTIAL community and home-based supports and services. These services and supports MUST BE located in each community, close to consumers and responsive to the community's needs. This shall include a balanced continuum of services and supports, extending from prevention and early intervention to treatment and practical supports.

## **A Continuum of Services**

A continuum of services was developed and each service was defined. It is anticipated that this common language would support a collaborative system of services for children, youth, and families.

## **Major Themes:**

- ✓ The most frequently cited comment was that there was the need for a balanced system of children's mental health services within a broader system of children's services. If a child or youth has a mental health concern its impact is usually not limited to one domain of the child or youth's life. Further, the corollary follows that

the relative functioning in other domains of the child or youth's life has an impact upon the child or youth's mental health. Consequently it is critical that children's mental health services work in collaboration with the broader children's services system in responding to needs.

- ✓ An Ideal Model and balanced system of services for children's mental health would take into account the mental health needs of **all** children, youth, and their families in the South West Region. The children's mental health system would have the over-arching responsibility to guide, support, and promote services that would promote the mental health of all children and youth.
- ✓ The role of the children's mental health system is to work in **collaboration** with children, youth, families and others to build upon their strengths and build **resiliency** within children, youth and families, so as to withstand and overcome current and future challenges within their lives. Beyond the obvious need for the children's mental health services system to engage and respect their relationship with children, youth and families, another **fundamental relationship required is that with the education system.**
- ✓ A balanced system of children's mental health services must include **a range of service from prevention and early intervention services to the most intensive therapeutic interventions.**
- ✓ The development of capacity in a community needs to consider:
  - the support and promotion of resiliency in all children, youth and families
  - the prevalence rates of "at risk" children
  - the persistence and severity of mental health problems within the community,
  - the reality of co-morbidity and consequent service linkages required, and
  - the service capacity to respond in an efficacious manner.
- ✓ The Ideal Model and subsequent work is based upon literature regarding **systems of care** and elements required for success of such systems.

*"a multi-faceted approach is required that includes universal programs to promote health for all children, targeted programs for children at risk, and clinical services for children with severe disorders."*

Offord, D., Kraemer, H., Kazdin, A., Jensen, R., (1998).





# 1 INTRODUCTION

The Ministry of Community and Social Services (MCSS) South West Region, in collaboration with the Ministry of Health and Long Term Care and the Ministry of Education, conducted a review and mapping of the children's mental health services system in 2000. Community and service provider profiles were completed. This review led to a three-phased project.

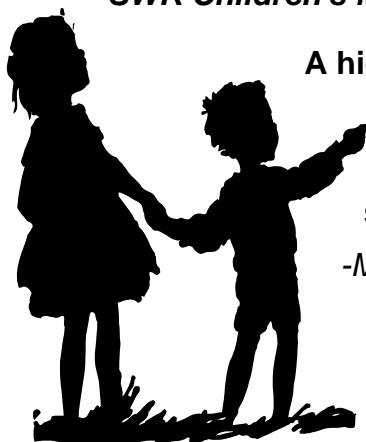
Data from Phase 1 (Review and Mapping) provided helpful information about service access, flexibility and responsiveness. A vision for children's mental health services, First Principles and "Givens" were also created.

Phase 2 (Development of the "Ideal Model") of the project determined the "Ideal" MCSS - Children's Mental Health Services Model for the South West Region so that existing services and future potential resources could be allocated effectively within the South West Region. Additionally, a working draft definition of children's mental health and definitions for children's mental health services were developed. Phase 2 also provided the foundation for a future implementation of the "Ideal Model".

Phase 3 (Implementation of the Ideal Model) of the project will:

- ◆ develop a Multi-Year Implementation Plan to operationalize the MCSS MCYS South West Region Children's Mental Health Services "Ideal" Model;
- ◆ support the implementation of activities that can be operationalized immediately, consistent with the "Ideal" Model and the overall vision for children's mental health services, within the MCSS MCYS South West Region (e.g. Early Years Initiative).

## ***SWR Children's Mental Health Services Project VISION:***



**A high quality system of children's mental health services that is accountable to children and their families, easily accessible and integrated with other supports for children.**

*-May 2000*

The Ministry of Community and Social Services Ministry of Children and Youth Services (MCSS MCYS) South West Region has developed a three-year plan that will systematically consider all the components of the "Ideal Model" and its implications for children, families, service providers, the children's services system, and other stakeholders. Although we do not expect that the "Ideal Model" will be fully implemented in three years, we do expect that substantial progress towards the ideal can be achieved. Furthermore, whatever changes are possible within existing resources will be implemented.

*First Principles:*

1. The project approach will focus on re-thinking current services and patterns of activity to create a service system.
2. In the allocation of scarce resources, we will strategically invest in the most complete range of service/program options along the promotion/prevention – amelioration/treatment continuum, while allocating resources to those in greatest need.

*Givens:*

1. For purposes of this project, the child will be defined according to the Child and Family Services Act (CFSA), that is, 0-18 years of age.
2. Demand for services challenges the availability of resources and therefore priority setting is required (see First Principle #2 re: resource allocation).
3. Resources may shift.
4. While divestment is not an option for Child and Parent Resource Institute (CPRI), services and resources may be re-aligned.
5. The Ministry, as the service system manager responsible for children's mental health, in conjunction with its partners, represents the purchaser and can therefore determine the range of services to be purchased, recognizing that children have a wide variety of needs.
6. Respecting the history and experience of local communities, we will continue to build on their capacity to deliver children's mental health services through the development of a regional service delivery model.
7. We will move toward equitable access to appropriate services and develop a strategy to achieve equitable access.
8. While services will be provided as close to home as possible, there are not enough resources to do this for all services.

9. This exercise should not be expected to result in additional new dollars.
10. New federal, provincial and municipal initiatives and policies are being developed as this project is being implemented; these will need to be taken into account as appropriate.
11. The Ministries of Education, Health and Long Term Care, and the Ministry of Community and Social Services and the new Ministry of Children and Youth Services working together signals their intent to be as creative and innovative as possible and recognizes the need to break down silos.
12. Our work will serve to inform provincial policy.
13. Stakeholder involvement is essential to this process and guiding principles with respect to their involvement will be developed.

### ***Looking at the Model***

It may be difficult to understand the pictorial version of the Ideal Model on the next page at first glance, without all the accompanying explanation provided in the document *An Ideal Model for Children's Mental Health Services in the South West Region - Final Report (September 2001)*

We have come to learn that the natural tendency is to view the picture as an access path describing how a client might go from "A" to "B" and obtain a particular service. The picture is not a road map for navigating through the children's mental health service system.

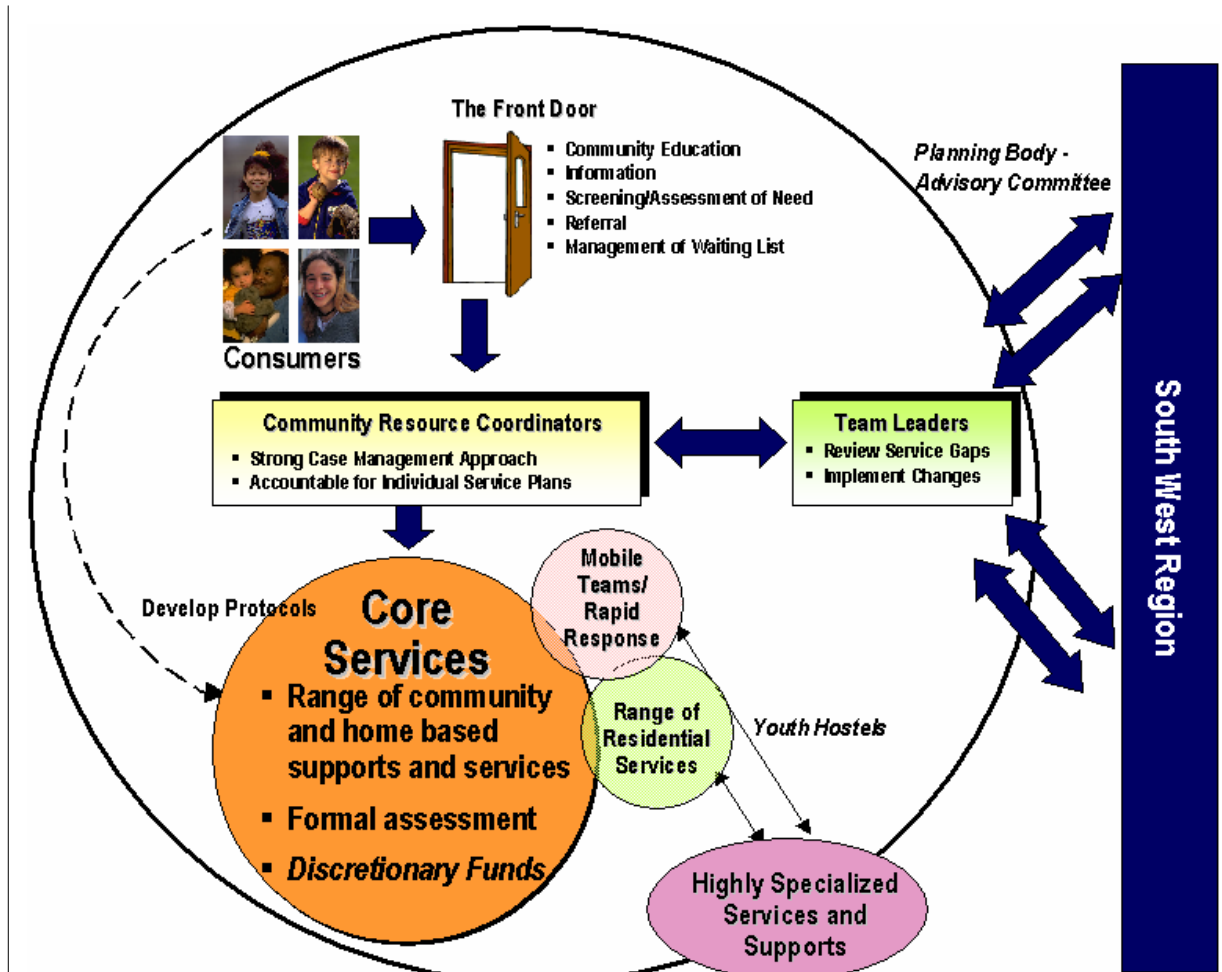
Rather, it may be helpful to remember that the picture represents a system, as it would exist in the local community. The Ideal Model is multi-dimensional, and the picture depicts the components of the system and their relationship to each other. A useful analogy for viewing the model is to think of it as a set of carved Russian dolls - one component sitting inside another but all part of the same system.

Highly Specialized Services and Supports are positioned on the outer circle of the diagram to connote that they have a role and responsibility in supporting the whole of the children's mental health system. Just how Highly Specialized Services and Supports is intermeshed with the whole of the children's mental health service system and how children, adolescents and their families needing such specialized help access these services was the subject of the report *An Ideal Model for Children's Mental Health Services in the South West Region - Year I Implementation - Highly Specialized Services and Supports (November 2003)*.

**Core Services is the largest single component of the Ideal Model.** This is in keeping with the principle that children should be supported in their local community to the greatest extent possible. Core services are the foundation and backbone of the system of services.

**The subject of this report is Core Services and Supports and how it is intermeshed with the whole of the children's mental health service system.**

## Service Delivery Model for "Each" Community

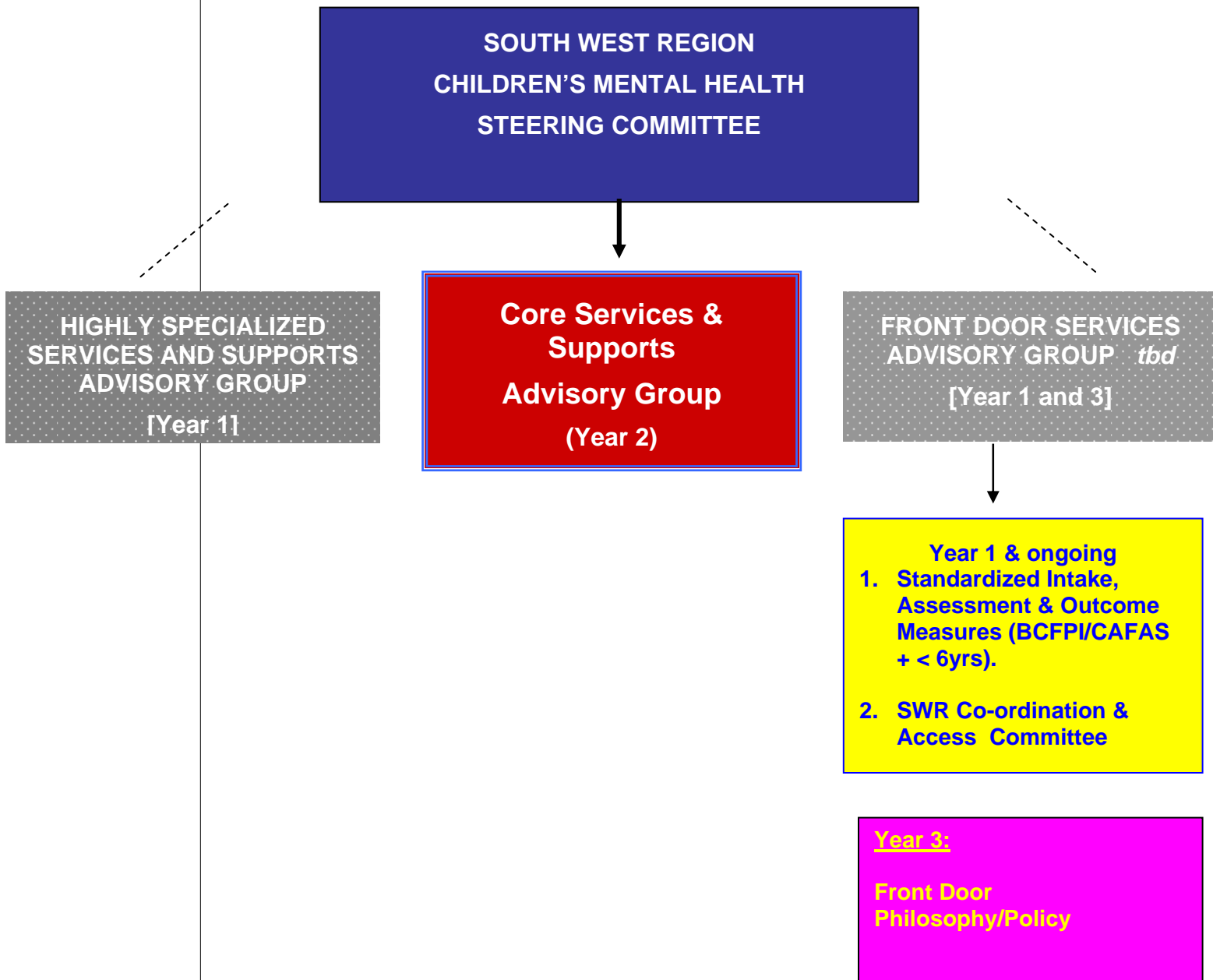


We have divided the implementation plan for the "Ideal Model" into three components for focused discussions over three years. The three components are:

- i. Children's Mental Health Highly Specialized Services and Supports (Year 1)
- ii. Children's Mental Health Front Door Services (Year 1 & Year 3)
- iii. Children's Mental Health Core Services and Supports (Year 2)

Of course, any and all implementation will be done within the context of the "Ideal Model" as a whole. It is likely that certain conclusions early in our implementation journey might have to be re-visited in light of new information and knowledge gained throughout the process.

To assist us in this process we have sought the consultation of stakeholders and their participation on Advisory and Working Groups. The following represents the organizational structure for the implementation of the Ideal Model **up to this point**.



## 2. BACK TO THE FUTURE -THE SOUTH WEST REGION CHILDREN'S MENTAL HEALTH PROJECT THUS FAR...

On June 26, 2001, a "Town Hall" meeting was convened and over 120 people met to review and discuss the Ideal Model. This meeting involved parents and consumers, children's mental health service providers, representatives from three Ministries as well as planning bodies from across the South West Region and beyond. The combined feedback from this day and from the 27 focus groups held to develop the Ideal Model was brought together in the document *An Ideal Model for Children's Mental Health in the South West Region - Final Report (September 2001)*. This document was subsequently released for public distribution.

*"The strongest piece of feedback received at the Town Hall meeting was that the number one priority for the ideal delivery model had to reflect the need for more Core Services. While there was some support for other aspects of the model, people had a difficult time endorsing these other aspects because it was felt that there had to be a primary focus on increasing the amount of Core Services in order to address the escalating need of consumers. Addressing Core Service had to occur first if successful progress on the ideal model was to be achieved." (Ideal Model Final Report -Sept. 2001, page 6).*

Ideally, we would have begun the implementation process for the "Ideal Model" with Core Services and built upon that foundation. However, circumstances in the Region required that we begin our implementation journey from a different point: Highly Specialized Services and Supports. These circumstances were as follows: the need to address the strategic direction of CPRI as soon as possible; and the need to determine whether or not the Adolescent Unit (AU) currently sited with the Regional Mental Health Care (RMHC) in London should be part of the new centre to be erected by St. Joseph's Health Services by 2007.

Regardless, the project has now reached the point at which the fundamental issues related to Core Services can be explored. Naively, perhaps, there was some hope that this work had already been done in another forum, and the Core Services and Supports Advisory Group would focus on synthesizing and fleshing out the Core Services area of the Ideal Model. Unfortunately, it was not as simple as that. The work of the Core Services and Support Advisory Group was built on the practice and experience of the membership, their collective wisdom, and guided by research. The work contained within this report promotes and supports the best of what we would want in a service system for children and youth that have mental health problems.

## *THE PROJECT GOING FORWARD - A NEW UNDERSTANDING...*

The work of the Project has been an iterative process and one group of people built upon the work of those involved before. New understandings and perspectives evolved regarding the implementation, as a result of the tremendous time, energy, and thoughtful discourse of the many people involved in the many aspects of the work.

The approach of the project thus far has been to carve certain large components of the model and delve into issues and concerns related to that particular component of the Ideal Model. With the work of the Core Services and Supports Advisory Group, a new understanding has arisen. That is, the various parts of the Ideal Model Children's Mental Health Services System are inter-dependent one with the other and it is critical that implementation of the Ideal Model reflect that inter-dependence of one part on another.

One of the recommendations from the Highly Specialized Services and Supports Advisory Group was the following:

It is recommended that the Highly Specialized Services and Supports Advisory Group meet twice a year to review issues and concerns related to the service delivery of the programs and their progress regarding recommendations within this document.

However, with this submission of this Final Report on Core Services and Supports the work of the Core Services and Supports Advisory Group comes to a close. And, this group also saw the need for continued involvement, much like the Highly Specialized Services and Support Advisory Group did in the above noted recommendation.

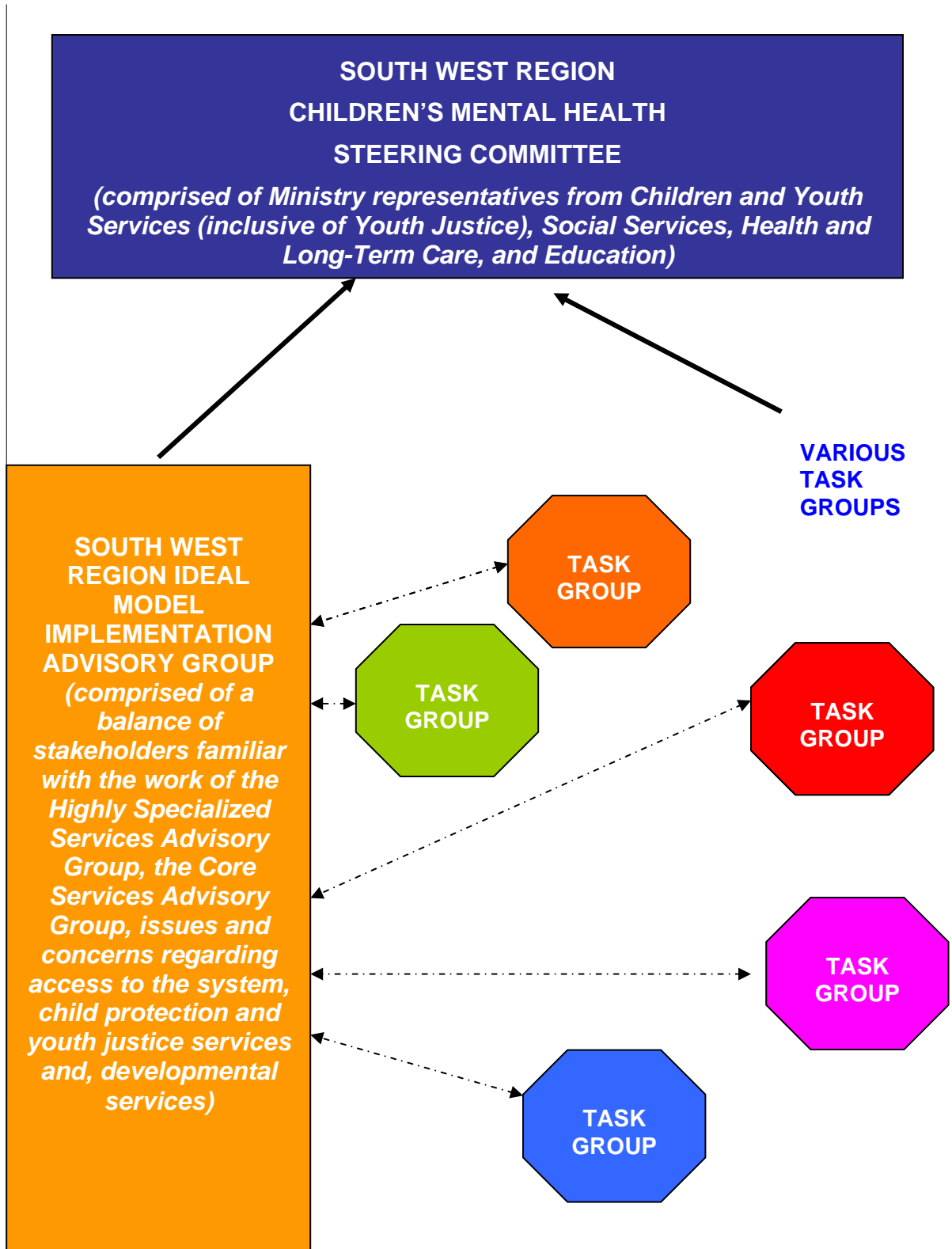
However, the new understanding that evolved within both groups was the need to work at the implementation of the Ideal Model from a comprehensive approach in order to ensure the establishment of a complete and inter-dependent system of care that would appear seamless to the children, youth and families it serves.

Consequently the following recommendation was developed:

It is recommended that a balance of stakeholders familiar with the work of the Highly Specialized and the Core Services Advisory Groups, as well a child protection, youth justice services and, developmental services meet twice a year to review issues and concerns related to the service delivery of the programs and their progress regarding recommendations within this document and the ongoing implementation of the Ideal Model.

The new understanding for going forward is represented in the following diagram.

*THE PROJECT GOING FORWARD - A NEW UNDERSTANDING...*



## 3. CHILDREN'S MENTAL HEALTH CORE SERVICES AND SUPPORTS ADVISORY GROUP\*

### 3.1 Purpose

The SWR CHILDREN'S MENTAL HEALTH Children's Mental Health Core Services and Supports Advisory Group (CS&S Advisory Group) was appointed October 2003:

- ◆ To determine the role and the range of core and residential services and supports within the South West Region MCSS MCYS Ideal Model
- ◆ To develop protocols, processes and accountabilities for integrating these core and residential services and supports into the South West Region MCSS MCYS Children's Mental Health Service System, so as to ensure provider linkages, collaboration and co-ordinated provision of services across the South West Region
- ◆ To define the transitional plan and resources required

*\*(During the course of deliberations of this Advisory Group a decision was made to change the name of the group from the Core and Residential Services and Supports Advisory Group to the Children's Mental Health Core Services and Supports Advisory Group (CSS Advisory Group). While residential services are seen as a critical part of the Ideal Model and modality of service; they are nevertheless part of the continuum of mental health services. Simply providing a place to live is not the purpose of children's mental health services; that is; it is the treatment and care surrounding the place to live that is the fundamental role of a children's mental health service system. Consequently, the word "Residential" was removed from the Advisory Group name.)*

### 3.2 Choosing the Membership

The South West Region Children's Mental Health Co-leads determined that, due to the nature of the tasks, a mix of representatives was required. The decision was made to include expertise from each element of the ideal continuum of services at the table while, at the same time, ensuring the advisory group represented a geographic balance from across the South West Region. Membership was sought through an "expression of interest" process, and placement on the advisory group was based on the criteria cited within the terms of reference for all Advisory Groups. The criteria included being:

- ◆ knowledgeable about and/or experienced with the current system;
- ◆ open to new ideas and change;
- ◆ able to communicate effectively, and
- ◆ able to contribute to consensus building.

All individuals selected for membership were advised that they were not on the advisory group to represent any given agency or community but to speak to the continuum of services from their respective experience, knowledge and expertise.

### 3.3 The Membership

<b>Prevention</b>	Ms. Anne MacDougall	Mr. Peter Aharan
<b>Early Intervention</b>	Mr. David Wright	
<b>Assessment Services</b>	Ms. Anna Woodson	Mr. Alan Goyette
<b>Out Patient Treatment</b>	Ms. Monique Pressé	Ms. Terri Sparling
<b>Home Based/School based Serv.</b>	Ms. Sandra Fieber	Dr. Mark Skovron
<b>Respite Services</b>	Ms. Melodie Smith	
<b>Day Treatment</b>	Mr. Mark Donlon	
<b>Emergency Crisis Service</b>	Dr. Wayne Richardson	
<b>Local Acute Care Hospitalization</b>	Ms. Pat Edwards	
<b>Parent Model Support</b>	Ms. Betty Bedard-Bidwell	
<b>Therapeutic Group Care</b>	Mr. Ken Akers	Ms. Brenda Hall
<b>Therapeutic Camp</b>	Ms. Janet Kelly	
<b>Independent Living Services</b>	Ms. Brenda Hall	
<b>Residential Treatment Services</b>	Mr. Alan Goyette	
<b>Crisis Residential Supports</b>	Ms. Pat Peloso	
<b>District Health Council Liaison</b>	Ms. Linda Hebel	
<b>Co-Chair, Project Manager</b>	Mr. Bryan Chambers	
<b>Co-Chair, Project Manager</b>	Ms. Helen M. Lowe	

### 3.4 Timelines, Outcomes, and Structure

The Core Services and Supports Advisory Group (CSS Advisory Group) was originally convened in October 2003 to December 2004 with full-day meetings held approximately every two weeks from October 2003 to May 2004. Changes in the staffing supporting the South West Region Children's Mental Health Project and work on public consultation for the Children and Youth Mental Health Fund delayed the original timelines. Consequently, the members of the CSS Advisory Group were reconvened in December 2004 to complete the work on the Final Report following the summer of 2004 consultation process.

The CSS Advisory Group was to provide, by March 2004, a written draft report with recommendations on:

- ◆ The role and range of core and residential services within the South West Region Ideal Model, detailing the service(s) that should be provided in each community for the South West Region.
- ◆ Protocols, processes and accountabilities for integrating this role into the South West Region Children's Mental Health Service System; specifically with regards to defining a mechanism for equitable access to service, with protocols developed to ensure a equitable process with all Central Access Mechanisms in the South West Region.
- ◆ To outline considerations and issues related to implementation and resource allocation that can be implemented over time within existing and new resources

The Children's Mental Health Core Services and Supports Advisory Group met October 21, November 6, 20, December 4, 18, 2003 and January 8, 22, February 5, 19, March 4, 18, April 1, 29, May 6, 13, and reconvened December 15, 2004, January 12, 26, February 9, and March 30, 2005. All meetings were held in London and were generally convened from 10:00 AM to 3:00 PM.

### **3.5 Consultation with Stakeholders:**

The Advisory Group was presented with the first draft of the Core Services and Support Advisory Group Discussion Paper on April 1, 2004 for review and discussion at the meeting April 29, 2004. Subsequent revised drafts of the Discussion Paper for public consultation were reviewed on May 6 and 13, 2004.

Please note that the definitions for the services within the continuum of services were tested with 36 service providers in the South West Region in March 2004. This "test" was conducted by means of a template that surveyed how service providers would categorize their current services in light of the revised definitions.

The draft report entitled Discussion Paper was reviewed by the Highly Specialized Services and Supports Advisory Group for comment in May 2004 and subsequently released for public consultation in August 2004. Consultation Forums took place as follows:

May 10, 2004 - Highly Specialized Services and Supports Advisory Group

September 21, 2004 - Windsor

September 28, 2004 – London

September 30, 2004 - Owen Sound

Jan. 26, 2005 - Highly Specialized Services and Supports Advisory Group

Feedback from these sessions in combination with other responses received were reviewed by the Core Services Advisory Group and considered for incorporation in the Final Report. The Final Report will be then forwarded to the Children's Mental Health Steering Committee and finally to the South West Region MCSS-MCYS Regional Director for approval and release. The public distribution of the Final Report on Core Services and Supports is anticipated to be Spring 2005.

### **3.6 Process**

The Advisory Group members upheld their commitment to bring their perspective, expertise, and experience to discussions as opposed to lobbying for a particular agency or geography.

The work of this Advisory Group was done in plenary sessions with all members of the Advisory Group as opposed to separate and or smaller task groups reporting back to the full Advisory Group. The Advisory Group built upon the previous work captured in the Ideal Model Final Report (September 2001) and the Highly Specialized Services and Supports Advisory Group Final Report (November 2003).

The Children's Mental Health Core Services and Supports Advisory Group emphatically concurred with the statement of the Highly Specialized Services and Supports Advisory Group that there were simply not enough resources within the children's mental health services system and, given this reality, it was a difficult task to speak to an "Ideal". Nevertheless, Advisory Group members actively participated in discussions about many issues and consensus was reached on the majority of matters presented in this report.

A significant portion of the Advisory Group discussion involved the development of the definitions for the services in the continuum of services of an Ideal Model. This was tedious but necessary work, and it is hoped that it can be a beginning framework for a common language and understanding throughout the children's mental health service system. It bears repeating, that the children's mental health service system has a variety of funding sources and legislative requirements and, in this regard, it is hoped that a common language and understanding of services would be proactive in the achievement of the South West Region Children's Mental Health Project Vision:

***A high quality system of children's mental health services  
that is accountable to the child and family,  
easily accessible and integrated with other supports for children.***

The Advisory Group developed a definition of Core Services in a relatively quick manner following the many hours of work involved in the development of the service definitions. Discussion as to the relative position and importance of Core Services within the Ideal Model and, in particular, in relation to Highly Specialized Services and Supports was dynamic and animated but nevertheless unanimous in its conclusion.

Undoubtedly, the work regarding the capacity of the Ideal Model is likely to be the most debatable section of this report. However, it is presented in order to enliven the understanding and role of children's mental health services within the broader children's services system. Each of the statements in this section, as with the whole report, is founded on the work of well-known and respected researchers and clinicians within the children's mental health services system.

## 4. MAJOR THEMES AND UNDERLYING PRINCIPLES

The Children's Mental Health Core Services and Supports Advisory Group worked diligently on their tasks. However, an underlying theme of the work was that the viability of the current children mental health system was under threat due to lack of resources. Time and time again, the Advisory Group noted the need for additional resources for the current system to survive over the next year.

Relative to the Ideal Model and the discussion of Core Services and Supports Advisory Group, the most frequently cited comment was that there was the need for a balanced system of children's mental health services within a broader system of children services.

The work of Dr. Dan Offord and the findings of the Ontario Child Health Study, as well as the work of Dr. Robert Friedman and Beth Stroul on Systems of Care heavily influenced the work and perspective of the Core Services and Supports Advisory Group.

Beginning with the premise that there is a communal responsibility to support the wellbeing of children, youth, and families, the Advisory Group developed a perspective regarding the role of children's mental health services within the broader system of children's services. The consensus of the Advisory Group was that an Ideal Model and balanced system of services for children's mental health would take into account the mental health needs of **all** children, youth, and their families in the South West Region. That is to say, the children's mental health system would have the over-arching responsibility to guide, support, and endorse services that would promote the mental health of all children and youth. There may be some services that do not need to be provided exclusively by traditional mental health service providers, but the services they provide relative to children's mental health would be in concert with the goals and aims of the traditional or recognized or possibly "mandated" children's mental health system providers.

The Core Services and Supports Advisory Group was also inclusive in considering who was or was not part of the children's mental health system and therefore recognizes that the children's mental health service system is not exclusively only the publicly funded system. This group understands that the children's mental health system would also include those services that may be privately or alternatively funded and that also contribute to the children's mental health services system.

The role of the children's mental health system is to work in collaboration with children, youth, families and others to build upon their strengths and build **resiliency** within children, youth and families, so as to withstand and overcome current and future challenges within their lives. Beyond the obvious need for the children's mental health services system to engage and respect their relationship with children, youth and families, another fundamental relationship required is that with the education system. The children's mental health system must work with the child and youth within the context of their lives and, as such, strong connections with their

home and school are fundamental to reaching good outcomes for children and youth dealing with mental health issues.

Consequently, a balanced system of children's mental health services must include a range of services from prevention and early intervention services to the most intensive therapeutic interventions.

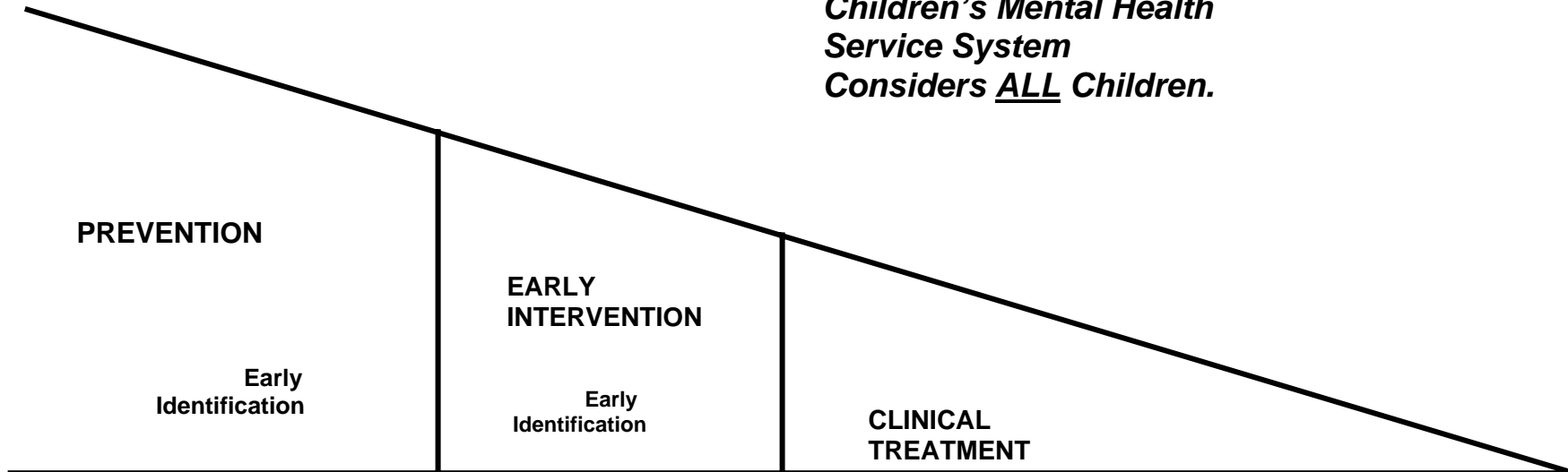
### **Principles for an Ideal Model**

The Children's Mental Health Core Services and Supports Advisory Group emphasized that it was critical that any discussion of an Ideal Model must be predicated on a principled foundation of what was best for children, youth, and families using any service within the continuum. The Core Services and Supports Advisory Group further emphasized that any and all services within the continuum of services must be child, youth, and family focused as well as fundamentally respectful of the strengths of the child, youth and family who use the service.

Considering the initial work in the "Ideal Model" Final Report (September 2001) (page 7) the (Core Services and Supports) Advisory Group determined that the "Ideal Model" for Children's Mental Health would include the following underlying principles:

- Ensure easy, equitable and timely access for all consumers;
- Provide access to a balanced range of services that are family focused, located in their communities, close to their homes;
- Keep children in their homes through the use of the least intrusive, most effective service deemed appropriate, and minimize the use of residential services;
- Create individual service plans and ensure that services are co-ordinated and remain accountable to the child, youth and families;
- Require integration of services, collaboration, use of multi-disciplinary strategies across the entire spectrum of child, youth, adult and family service systems;
- Ensure system co-ordination within local and regional communities;
- Respond to the uniqueness of each community and build on existing services, initiatives and strengths therein;
- Ensure that Highly Specialized Services and Supports execute their role in full partnership with the local service system in order to meet the needs of children, youth and families.

**A Balanced  
Children's Mental Health  
Service System  
Considers ALL Children.**



Healthy Community Initiatives (Civic Vitality)	Universal Programs	Targeted Programs	Clinical/Consultation Service
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Social networks.

The communities' commitment to care for its children.

Family does not seek help.

No known risks.

Family does not seek help but children identified not because they have problem/disorder but are at risk for developing one.

- a) characteristics outside child e.g. Socio-economic conditions, parental depression.
- b) characteristics lie within child eg. prematurity.

Family/or other professional seeks help for a specific issue/problem.

1. References: "a multi-faceted approach is required that includes universal programs to promote health for all children, targeted programs for children at risk, and clinical services for children with severe disorders. Offord, D., Kraemer, A., Jensen, R., (1998). Lowering the burden of suffering from child psychiatric disorders: trade-offs among clinical, targeted, and universal interventions. Journal of the American Academy of child and Adolescent Psychiatry 37: 7 p.p. 686-694
2. Guy, K.A., Our Promise to Children. Ottawa: Canadian Institute of Child Health(1997)
3. Examples provided by Susan Ralyea M.S.W, London Middlesex Health Unit for Healthy Babies-Healthy Children Program

## 5. CAPACITY AND THE IDEAL MODEL

The Core Services and Supports Advisory Group determined, early in their discussions, that existing capacity is far less than the ideal. This compromises the system's ability to not only respond to children, youth and their families, but also impedes positioning for system change to further the development of the "Ideal Model." To move the system forward, significant attention and resources would be required to stabilize, and then, revitalize the system in a manner that supports the development of the "Ideal Model".

It was also understood, early in the deliberations that development of the "Ideal Model" capacity, as outlined later in this document, would need to occur in a strategic manner, over time. Dramatic, quick change is not recommended given the fragility of the current system and the pressures upon it. That is to say, that development and substantive progress towards the Ideal Model should be evolutionary, not revolutionary. Future investment should occur in a manner that supports development in a planned, thoughtful and strategic way. In spite of these cautions, the concern for the viability of the current system compels the need for an immediate and sustained course of action regarding the children's mental health system.

### **The Ideal Model = A System of Care**

The Ideal Model is a comprehensive system of care, which includes a continuum of services, and it is designed to respond to all children and youth with mental health needs. These services may be provided at a Highly Specialized level where the mental health needs are complex and unable to be dealt with at the core or local level, or be provided at a Core or local level for the majority of children or youth needing a response to a mental health need(s).

Twenty years following from the work of Stroul and Friedman (1986, 1996), the system of care has been shown to be a viable program model.

"In the landmark report on the mental health of the nation by the Surgeon General (US Department of Health and Human Services, 1999), the section on children's mental health recommended the continued development of systems of care. The report concluded, "The multiple problems associated with 'serious emotional disturbance' in children and adolescents are best addressed with a 'systems' approach in which multiple service sectors work in an organized collective way" (p. 193). More recently, a report on the recommendations from special commissions created by states to examine mental health services issues proposed, as the first recommendation, that there be a continued focus on the value and principles of systems of care for children (Friedman, 2002). Ref.:Epstein, Kutash, Duchnowski (2004) Outcomes for Children and Youth with Emotional and Behavioral Disorders

## **Basis for Assumptions on Capacity**

The work of the following persons was used to inform the discussion and assumptions in this section regarding: Whom Should We Serve?; Prevalence; Persistence and Severity; Utilization; Co-morbidity; Flow-through: A Function of Capacity; Developing Capacity.

- ◆ Cunningham, C., Pettingill, P., Boyle, M. Brief Child and Family Phone Interview, Toronto, BCFPI. Inc.
- ◆ Fontaine, J.L., Archer, R.P., Elkins, D.E., Johansen, J.(2001) The Effects of MMPI-A T-Score Elevation on Classification Accuracy for Normal and Clinical Adolescent Samples. *Journal of Personality Assessment*, 76(20, 264-281).
- ◆ Friedman, R. M., (August 1987), Service Capacity in a Balanced System of Services for Seriously Emotionally Disturbed Children.
- ◆ Offord, D. R.(1989), Issues in the Delivery of Mental Health and Social Services in Ontario: Findings and Their Implications from the Ontario Child Health Study, presentation at the conference entitled "Towards Improved Consultation and Integration in Children's Services", Bayview-Wildwood Resort Hotel, Sparrow Lake, Ontario, November 1<sup>st</sup> to 4<sup>th</sup>, 1989
- ◆ Offord et al (1991), Ontario Child Health Study: Summary of Initial Findings, Queen's Printer for Ontario
- ◆ Offord et al (1991), Ontario Child Health Study: Children at Risk; Queen's Printer for Ontario
- ◆ Steinhauer, P. D. (1999), What Do We Know That Works in Children's Mental Health Services? - Panel Presentation to the Annual Meeting of the Ontario Association of Children's Mental Health Centres, May 31, 1999
- ◆ Waddell, Charlotte, Shepherd, Cody (October 2002), Prevalence of Mental Disorders in Children and Youth A research Update Prepared for the British Columbia Ministry of Children and Family Development;— Mental Health Evaluation & Community Consultation Unit, Department of Psychiatry, Faculty of Medicine, The University of British Columbia



### ***Whom Should We Serve?***

The Ideal Children's Mental Health Service System needs to consider the mental health needs of **all** children and youth in the community, particularly in the provision of Prevention and Early Intervention Children's Mental Health Services. With effective Prevention and Early Intervention Services, it is believed that 85% of children and youth in the community have sufficient resiliency and would not need any direct mental health service intervention.

The balance of 15% of children and youth in the population will require a significant number of targeted resources to support their resiliency to cope with current and future mental health challenges.

**All** children would therefore include those children with mental health needs who may also be served by Child Welfare Services, Youth Justice Services, Developmental Services and/or the Education System. This contention thus integrates the response to children with mental health needs and highlights the needs for an adequately resourced system of services. Our current inadequately resourced system of children's mental health service has by default, contributed to the development of parallel systems of children's mental health services particularly within the education, child welfare, and youth justice systems. It is the position of the Core Services and Supports Advisory Group that policy and funding decisions are needed in order to challenge the continuation of these parallel systems. (See discussion page 32, *A Matter of Balance*)

"After almost two decades of development, a comprehensive and integrated system of care for children who have serious emotional disturbances and their families has been shown to result in an increase access to and use of services. Families report more satisfaction with services received through a system of care, restrictive inpatient hospitalization is reduced, and better follow-up care is available when hospitalization does occur. While the question of the cost of the system compared to traditional services is not clear, there is mounting evidence that systems of care, under specific

operating conditions (see Chapter 10 by Foster and Connor), do not cost more. **\*Furthermore, agencies other than the mental health system may experience significant cost avoidance for children served through a valid system of mental health services.** *\*[emphasis added]*

Ref.:Epstein, M.H., Kutash, K., Duchnowski, A.J. (2004) Outcomes for Children and Youth with Emotional and Behavioral Disorders and Their Families: Program and Evaluation Best Practices, Second Edition, p.17

## ***Prevalence***

In our deliberations we reviewed a number of current sources of compelling research. That research revealed the following

"The burden of suffering for any health problem may be characterized by its frequency, morbidity, and associated human and fiscal costs (Offord, Kraemer, Kazdin, Jensen, & Harrington, 1998). According to these criteria, child and youth mental disorders cause a large burden of suffering. In terms of frequency, studies over the past 20 years have indicated that approximately 20% of children and youth may experience mental disorders at any given time (Costello, 1989; Angold and Costello, 1995; Bredenburg, Friedman, & Solver, 1990; Roberts, Attkisson, & Rosenblatt, 1998). Recently, significant progress has been made in incorporating impairment into the thresholds for defining clinically important mental disorders, which has led to somewhat lower overall prevalence rates. The findings of this research update indicate that 15% of children and youth have clinically important mental disorders if measures of impairment are included."  
(Prevalence of Mental Disorders in Children and Youth MHECCU, UBC, October 2002) p.3 (See chart next page.)

Emergent literature indicates that the number of 15% cited as the prevalence rate of children and youth that have clinically important mental disorders might be a conservative estimate. At the recent Ontario Children and Youth Summit held in Toronto on November 25,2005, Dr. Neal Halfon stated in his keynote address regarding young children at risk that an estimated 30% display some form of a behavioural, mental health or learning problem.

**Prevalence of Mental Disorders in Children and Youth**

<b>Disorder</b>	<b>Prevalence (%)</b>	<b>Approximate Number in BC*</b>
Any anxiety disorder	6.5	60,900
Conduct disorder	3.3	30,900
Attention-deficit/hyperactivity disorder	3.3	30,900
Any depressive disorder	2.1	19,700
Substance abuse	0.8	7,500
Pervasive developmental disorder	0.3	2,800
Obsessive-compulsive disorder	0.2	1,900
Schizophrenia	0.1	900
Tourette's disorder	0.1	900
Any eating disorder	0.1	900
Bipolar disorder	<0.1	<900
Any disorder	15	140,500

\*The approximate number who may be affected is based on a population estimate of 936,500 children and youth in BC (MCFD, 2002)

The above table shows that the average overall community prevalence rate for mental disorders in children and youth is 15%. Anxiety, conduct, attention, and depressive disorders are the most common. It is important to note that these prevalence rates refer to the clinically important disorders that cause *both* significant symptoms *and* significant impairment. This means that in BC, approximately 140,000 children and youth experience mental disorders causing significant distress and impairing their functioning at home, at school, with peers, or in the community.

Ref.: a Research Update prepared for the British Columbia Ministry of Children and Family Development (October 2002) entitled *Prevalence of Mental Disorders in Children and Youth*,

"It should be kept in mind that the leading group of conditions that lower life quality and reduce life chances of Canadian children and youth, 1 to 19 years of age, are emotional and behavioural problems and early learning difficulties"

Offord, D.R. (2000), "The Mental Health of Children and Youth" in The Health of Canada's Children (Third Edition) by Canadian Institute of Child Health, p.225

## ***Persistence and Severity***

It is unlikely that sufficient services would be available in the near future to respond to the 15 % of the child and adolescent population who have "clinically important mental disorders".

"The number of children with clinically important emotional and behavioural problems is so large that clinical services alone can never deal adequately with the problem. A combination of universal, targeted and clinical interventions are needed, all carried out against the background of a civic community." Offord, D.R. (2000)

There is currently a standardized intake instrument implemented in Ontario known as BCFPI or Brief Child and Family Phone Interview that compares standardized scores for the child and family's mental health and functioning to average scores from a large community sample. This shows which aspects of mental health seem to be in the normal range, and the degree to which others are elevated. For example, a high score on this instrument would be a good indication that further clinical assessment is warranted. This tool also provides indicators of the most efficacious intervention for the various presenting issues.

Traditionally, clinically significant scores were set at 2 standard deviations above the mean, that is, a Tscore of 70 representing about 2% of the population as with BCFPI. However, this cut off is seen as too restrictive. Other research has demonstrated that "Classification accuracy analyses revealed that although the clinical base rate (for occurrence of psychopathology) did affect the accurate classification of cases, a T-score cut-off of 65 resulted in higher levels of accurate classification overall while minimizing the miscalculation of both clinical and normal (adolescent) cases". Fontaine, J.L., Archer, R.P., Elkins, D.E., Johansen, J.(2001). A T-score of 65 correlates to 1.5 standard deviations above the mean and equal to or greater than 91% of the population. That is, research regarding adolescents is indicating that the clinical base rate for the occurrence of psychopathology is about 9% of the population. The Advisory Group did not review research relative to a younger population, however, the experience present within the group would contend that the children's mental health treatment services system capacity required would be in the range of 7-9% across the entire age spectrum.

## ***Who Should Provide What Service?***

At the outset of this paper the Core Services and Supports declared that the Ideal Model for children's mental health should respond to all children and youth in the South West Region. Furthermore, it was asserted that more than just the traditional or current children's mental health service providers should be engaged in providing the continuum of children's mental health services under the guidance of recognized children's mental health providers. Service providers who might be engaged in targeted and/or universal children's mental health services could include education, medical, and broader social services.

Certain services within the continuum of services are natural points of interface and integration to service providers in the broader social services system. For example, \*Prevention and possibly Early Intervention Services at one end of the continuum and Supported Independent Living and Continuing Care at the other end of the continuum are likely points of integration with the broader social services system. (See definitions in Section 8 of this report)

It is important to note that the role of the children's mental health system is to work in collaboration with children, youth and families and others to build upon strengths and enhance resiliency\* within children, youth and families, so as to withstand and overcome current and future challenges within their lives. (\*See Glossary). Children, youth, and families often have networks of family, friends, neighbours, and associates who are willing to provide support, guidance, example, assistance, and encouragement to help build upon strengths and promote resiliency. This informal system often gets overlooked in the development of treatment plans and interventions to the detriment of success for the child, youth and family. Involvement of family members in a strength-based assessment and treatment process can lead to better outcomes. (Ref.: Harniss, M and Epstein, M. "Strength-Based Assessment in Children's Mental Health", in Epstein, M., Kutash, K., Duchnowski, A., (2004) Outcomes for Children and Youth with Emotional and Behavioral Disorders and Their Families: Program and Evaluation Best Practices (Second Edition), p.139)

In spite of the inclusiveness of the helping system, there are arenas of service that should be reserved exclusively for recognized and skilled children's mental health staff and agencies and they are:

- ◆ Children's Mental Health Assessments
- ◆ Children's Mental Health Emergency Services
- ◆ Non-residential Treatment Services
- ◆ Residential Treatment Services

The challenge of lack of sufficient capacity within these arenas remains constant. Nevertheless, there is a duty to provide the best possible children's mental health service to children, youth and families.

### ***Utilization***

A number of factors significantly affect utilization of services. These include but are not limited to:

- distance;
- availability;
- cost of transportation;
- general accessibility;
- availability and awareness of the service; and
- willingness to seek help.

The Ontario Child Health Study revealed that the parent's perception of the child's mental health issues was the key to the child having a mental health service or social services contact.

Regardless, the Core Services and Support Advisory Group would contend that in the best of circumstances, the demand for children's mental health treatment services would continue to outweigh the supply of services in the near future. Nevertheless, it is the responsibility of the children's mental health service system in the broadest sense to determine to whom children's mental health resources could most efficaciously and compassionately be directed.

### ***Co-morbidity***

The results of the Ontario Child Health Study note: "Not only do psychiatric disorders co-occur in the individual child, but children with a psychiatric disorder are at increased risk for other morbidities, such as poor school performance, chronic health problems, and substance use. The major implications are that treatment services for children must be comprehensive"(Offord, 1989).

"Many youngsters may require more than one mental health service at a time.... It is estimated that from one-third to one half of all youngsters will require multiple services at any point in time". (Friedman, 1987)

### ***Flow-through: a Function of Capacity***

"The number of youngsters that can be served in a system during a year depends not only upon the capacity of each service component at any point in time but the rate at which youngsters move through each system component." (Friedman, 1987) That is, the length of time any given "youngster" is in a program obviously impacts on the program's capacity to respond to additional youngsters. The number of youngsters who can be served in the system is also dependent upon the number of components of service accessed by each youngster.

Lack of balance in the continuum of services may impinge on the effectiveness of certain services and significantly impacts flow-through due to:

- the inability to intervene at the most efficacious time frame for that service
- and/or the inability of a service to discharge or transfer a child, youth and family at the optimum time to another service in the continuum.

## ***Developing Capacity***

Again, it is recognized that development of the system will need to occur in a planned and strategic manner, over time. This needs to be executed respecting the history, experience and local demographic of each community, engaging stakeholders in the individual community plans that will ensure that at least some components of each of the major service types are available in every community.

In summary, the development of capacity in a community needs to consider:

- the support and promotion of resiliency in all children, youth and families,
- the prevalence rates of "at risk" children,
- the persistence and severity of mental health problems within the community,
- the reality of co-morbidity and consequent service linkages required,
- the service capacity to respond in an efficacious manner.

## 6 DEFINITION: CHILDREN'S MENTAL HEALTH CORE SERVICES AND SUPPORTS

*Children's Mental Health Core Services and Supports are those provided to children, youth and their families with children's mental health service needs. These services are First-line and may be Intensive. The needs responded to may be complex, and may be met locally, in collaboration with Children's Mental Health Highly Specialized Services and Supports.*



*Children's Mental Health Core Services and Supports are those that include a range of ESSENTIAL community and home-based supports and services, that MUST BE located in each community, close to consumers and responsive to the community's needs. This shall include a balanced continuum of services and supports, extending from prevention and early intervention to treatment and practical supports.*

# *DELIBERATIONS ON THE DEFINITION OF CHILDREN'S MENTAL HEALTH CORE SERVICES AND SUPPORTS*

## *Building on Previous Efforts*

In the document, *An Ideal Model for Children's Mental Health Services in the South West Region - Final Report (September 2001)*, core services were described as follows:

"[Core Services are those] that include a wide range of community and home-based supports and services, that provide a broad range of services that are located in each community, close to consumers and responsive to the community's needs. This should include a continuum of services and supports that range from prevention and early intervention to treatment and practical supports along with formal assessments. (Ideal Model Final Report, page 8)

## *The Refined Definition*

The Core Services and Supports Advisory Group refined these statements into the following definition for Children's Mental Health Core Services and Supports:

Children's Mental Health Core Services and Supports are those that include a range of **essential** community and home-based supports and services that **must be** located in each community, close to consumers and responsive to the community's needs. This shall include a balanced continuum of services and supports, extending from prevention and early intervention to treatment and practical supports along with formal assessments.

There was significant debate within the Core Services and Supports Advisory Group as to whether the definition should refer to Core Children's Mental Health Services as *essential* or *mandatory*. There was the desire to emphasize that core mental health services are critical for children at risk so as to mitigate against further progression into serious impairments to healthy and productive functioning. Nevertheless, it was understood that, ultimately, involvement in the children's mental health system is the choice of the child, youth and family. That is, one does not have a choice as to whether or not to be involved with Child Welfare Services or youth justice services if one has exceeded certain legislative thresholds. However, one can be suffering from a serious mental health problem and the option to seek help remains with the child, youth and/or their family in spite of the fact such help is essential to their wellbeing and functioning. While essential, children's mental health services are neither mandated nor mandatory.

## The Vision

The Core Services and Supports Advisory Group made every attempt to consider all aspects of core children's mental health services and supports within the South West Region. The context for their deliberations was the South West Region Children's Mental Health Services Project Vision:

***A high quality system of children's mental health services that is accountable to the child and family, easily accessible, and integrated with other supports to children.***

## The Community

For the purposes of this project, "community" is commonly defined as the upper tier municipality or county. "Community" cannot be redefined in a manner that would diminish access to core services and supports. For the purposes of the Ideal Model continuum of services, it is recognized that consideration must be afforded to the sustainability of programs in rural, remote and lower populated areas. Therefore, we must consider demographics, geography and prevalence as we determine community. There is not necessarily a sustainable critical mass of children/youth in some counties to responsibly provide a full range of services. This may mean a collaborative partnership among some neighbouring communities to affect a sustainable continuum. In these cases the community may be redefined to be incorporated neighbouring communities.

While understanding the pragmatics of critical mass and sustainability, there was some concern expressed that the definition of community might be changed to correspond to the level of resources available and thus negatively impact upon the efficacy of the service provided. This does not mean that services are centralized but does address infrastructure to support viability. However, critical mass should not override accessibility to core services. For example; if a child needs intensive prolonged service on a daily basis it must be available within a reasonable distance in order to be accessible and effective.

## What's at the Core of "Core"?

Children, youth and their families are at the core of "Core". Consistent with the Ideal Model, it is confirmed that most children's mental health services would be provided by Children's Mental Health Core Services within the community of the child, youth and family. However, the service response may also include other children's services within that community.

Core Services and Supports are the backbone of the System. They are the First-line Services\* and may be Intensive Services\*. (\*See Glossary) The needs responded to might be complex, and met locally, in collaboration with Children's Mental Health

Highly Specialized Services and Supports. Almost all children's mental health service responses would be at the Core Services and Supports level. Core Services are the largest component of the Ideal Model.

It is tempting to look to the medical model and adult mental health system as an analogue for the development of the children's mental health system. For example, one might proffer that so many kidney dialysis centres are necessary for a certain population. However, this analogy breaks down with children and youth that are facing mental health problems due to the fact that so many of the efficacious interventions include others than the "identified" patient, as well as direct interventions and consultations with other family members, caregivers, educators etc. Thus the matter of distance to the service becomes significant to effective service.

In this regard, it is critical that we recognize the need for expert and skilled children's mental health staff who can credibly assist the whole of the children's service system to understand and respond to the mental health needs of children, youth and families. Children are not "short adults" and, as such, responses to their needs must be specifically understood and directed by persons who have the professional understanding of the most efficacious interventions required to assist the children, youth and families who come before them.

### *Core vis-à-vis Highly Specialized Children's Mental Health Services and Supports*

Highly Specialized Services and Supports are those provided to Children's Mental Health Core Services and Supports in order to help children, youth and their families with the highest needs within their respective catchment area. These needs are complex and determined to be refractory to first-line (primary) and intensive (secondary) care. Highly Specialized Children's Mental Health Services and Supports may, on occasion, be provided directly to the child, youth, and family and only in concert with the Core Children's Mental Health Services and Supports of the child, youth, and/or family's community.

### *The Door to Core*

The Core Services and Supports Advisory Group was attentive to the fact that their focus was children's mental health services as opposed to the entire children's service system. Access to children's mental health services would first involve some form of accountable intake, assessment, and outcome process focused on children's mental health concerns. Whether the concern can be addressed through prevention, early intervention or more intensive treatment services, the first order of business would be to assess the nature of the children's mental health concern to be addressed in order to ensure an efficacious response.

### A Matter of Time

In an "Ideal Model" there are no waiting lists. The thrust of the discussion was to promote a system that responds in a "timely" manner. Sometimes it seems as if the current system puts the client in some form of "deep freeze" hoping that all has remained static and thereby ignoring the reality that children, youth and families are dynamic and ever changing beings. A child, youth, and family dealing with mental health problems need the right type of service at the right time.

Timely service is dependant upon the capacity of the system to respond with skilled and trained staff. Staff also need the time and the opportunity to work within the system and appreciate their respective role in the lives of the children, youth, and families in order to provide timely and efficacious service within the system of care.

### A Matter of Capacity

In addition to timeliness of response, another significant element of successful intervention is the quantity and quality of service.

The children's mental health system must ensure that there is a common standard of service quality throughout the South West Region, so that there can be an appropriate matching of need with intervention. It is recognized that the development of this standard for each service in the continuum will take time. In the meantime, children, youth and families may need to be served via less efficacious services. It is important that we can analyse the gaps in services and identify children and youth who are not getting what they need but only the best of what we have to offer at the time. It is also important to note that this evaluation of a match of the child or youth's needs to the service is not to be a "ready excuse" for a failure of the system, but rather, a marker for areas of development in service capacity relative to volume, availability, intensity, staff development and training, expert recruitment and retention.

Recognizing that Core Services and Supports will serve most of the children and youth that require some form of mental health treatment, it is critical that there is sufficient service capacity at the local level. Determining how much of each Core and Highly Specialized service each community requires is an important step that needs to be taken to further the work towards the Ideal Model. Sufficient capacity at a Core Services and Supports level will mitigate service bottlenecks in Highly Specialized Services and Supports. Furthermore, the corrective action required for each community to reach the Ideal Model capacity will be different for each community.

No discussion of capacity would be complete without significant attention to the issue of staff recruitment and retention. In the 2000 report by the Canadian Institute of Child Health entitled The Health of Canada's Children, mental illness was termed "*the new morbidity*" for children. The need to ensure quality and experienced staff to

respond to this disconcerting new morbidity can not be overstated. Service capacity at a local level is significantly affected by the local service system's capacity to recruit and retain a consistent and skilled body of staff. The synergy of a consistent and skilled workforce that develops into a community of practice is critical to enabling the achievement of an Ideal system of children's mental health care. The ability of the children's mental service system to do so warrants the attention of those seeking to improve the current system. A significant issue that warrants attention related to recruitment and retention is compensation.

### *A Matter of Distance*

Distance and transportation are major barriers to access service. Core Services need to be accessible to children, youth and families and to those who surround them. Further, services need to be available within a reasonable distance. Alternatively, a portable version of the service needs to go to the child, youth and/or family when clinically warranted. Children need to be seen in their family and community context.

The development of Core Services within each of the local communities, as defined in this report, would mitigate the distance barrier that is currently creating inequitable access to service in the South West Region. As always, the development of an Ideal Model is not predicated on a single factor such as distance. A matrix of factors must be taken into consideration to warrant and sustain a credible calibre of a particular service such as: critical mass of population, distance, socio-economic level, affordable public transportation, and so on.

### *A Matter of Measure*

In *Celebrating Success: A Self-Regulating Service Delivery System for Children and Youth*, a discussion paper prepared for the Federal/Provincial/Territorial Group on the Mental Health and Well-Being of Children and Youth (2000)(p.25-26) it is asserted that "a number of problems of present service delivery in this area could be addressed by concentrating efforts on;

- *developing and selecting mental health indicators that would service children and youth who are receiving services and for those in the general population , but who may be at risk;*
- *developing a feedback process that is valued , effective, and produced at regular intervals;*
- *developing strongly reinforcing incentives attached to the most desired indicators; and*
- *creating, or facilitating the development of, an entity that can influence all mental health treatment, prevention and promoting services for children and youth. This "entity" is best described by its purpose than by its form. That is, its singular purpose is to improve the mental health of young people, but it might be a person, board or inter-agency group, and it could be appointed by edict, selected*

*via competition, or elected. It might function by facilitation, leverage and/or decree. Regardless of its form, it will be judged in terms of progress toward achievement of its mission."*

A fundamental element of an Ideal Model is the need for the development of program evaluation and outcome measures.

The children's mental health system has the responsibility to pursue the best practices and processes required promoting optimum mental health for children, youth and families. To meet this responsibility successfully, the children's mental health system has to have highly skilled and educated staff that practices in an accountable manner. This responsibility to pursue and implement best practices must not preclude the development of creative and innovative approaches to service delivery.

### *A Matter of Balance*

The Ideal Model of Children's Mental Health Services presents a balanced continuum of children's mental health services. It cannot be emphasized strongly enough that the success of the children's mental health service system is a direct function of a balanced system of services within the broader children's services system.

*"a multi-faceted approach is required that includes universal programs to promote health for all children, targeted programs for children at risk, and clinical services for children with severe disorders."*

Offord, D., Kraemer, H., Kazdin, A., Jensen, R., (1998).

The overarching goal of the children's mental health system is the promotion of positive mental health functioning, working in concert with the whole of the children's service system including education, health, recreation, and broader social services.

It is the conviction of the Core Services and Supports Advisory Group that the current imbalance in the children's service system and consequent lack of children's mental health services is a contributing factor to the ever-increasing numbers of children coming into the care of Child Welfare Services. Parallel systems are developing in Child Welfare Services due to lack of capacity in children's mental health services. Further, the youth justice system is developing services to respond to the increasing complexity of youth needs.

### *A Matter of Connection*

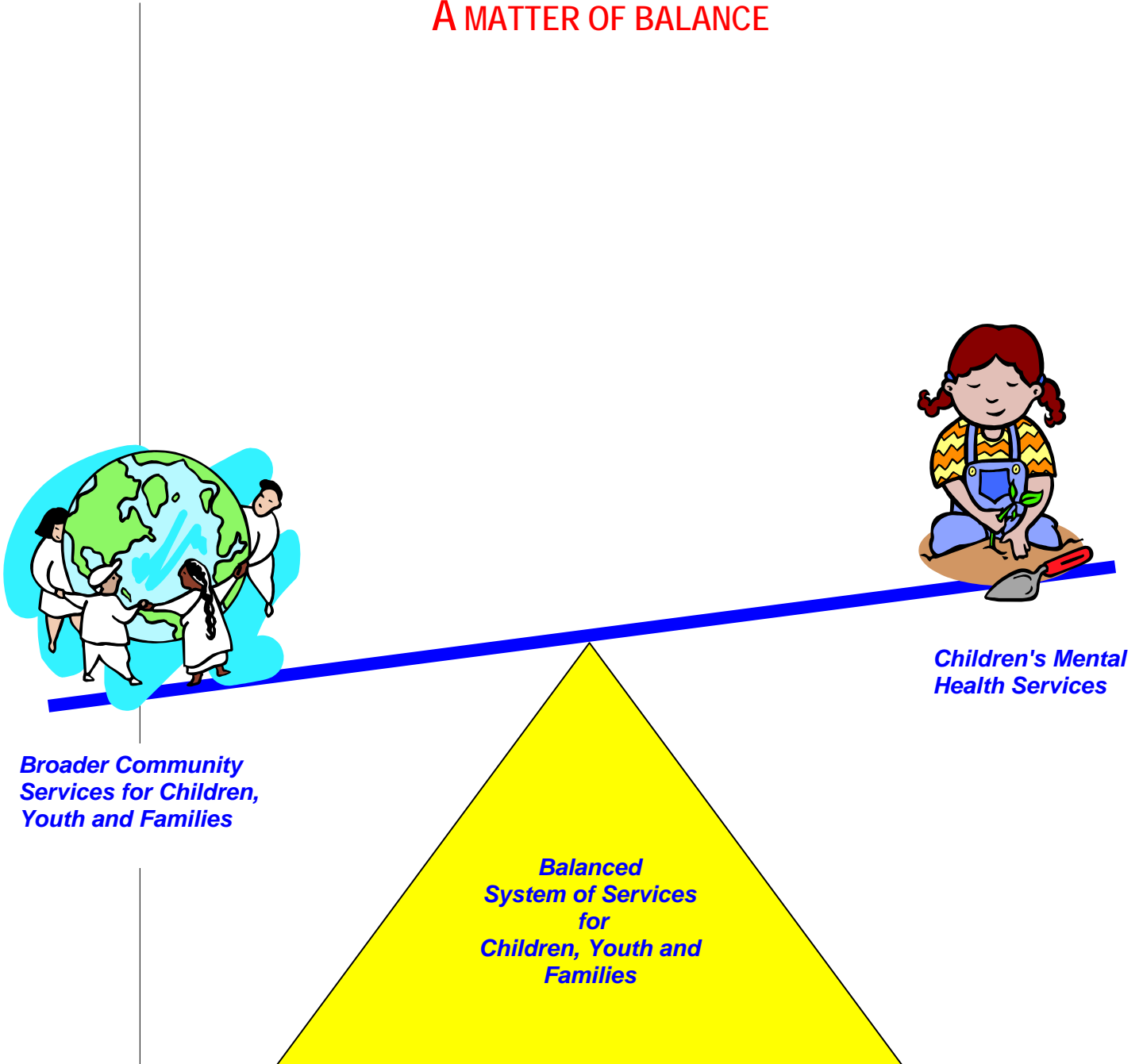
It is important to note the need for "bridges" between societal responsibility and the children's mental health system, with respect to areas of common or shared responsibility such as prevention, early intervention and intensive treatment services

etc. Although the Core Services and Supports Advisory Group consciously focused on children's mental health, there is a recognition that there are many elements of the continuum of mental health services that are appropriately shared domains of concern and integration with the broader children's and adult service systems.

Findings from the Ontario Child Health Study, as seen below, also reinforce the need for "service bridges" to be built between other service components within the continuum of services.

*Clinical services must be designed to recognize the strong relationships among the outcomes in the study. For example, a service to help children with psychiatric disorder that excludes the possibility of interventions for academic difficulties would be incomplete since it would be expected that about 1 in 4 children with psychiatric disorder would have poor school performance. The fact that a child with one poor outcome or problem is at increased risk for other difficulties suggests that provincial ministries concerned with children must work together to launch coordinated diagnostic and intervention programs. Children tend not to have only a Ministry-specific problem or deficit. Provincial ministries concerned with children must overcome their jurisdictional and funding boundaries and sort out their overlapping responsibilities. (OCHS:Summary of Initial Findings (1991), page 8)*

# CHILDREN'S MENTAL HEALTH SERVICES A MATTER OF BALANCE



## 7. THE CONTINUUM OF CHILDREN'S MENTAL HEALTH SERVICES WITHIN AN IDEAL SYSTEM:

### ***A Common Language***

One of the first tasks undertaken by the Children's Mental Health Core Services and Supports Advisory Group was the tedious challenge of developing and refining definitions for each of the services within the Continuum of Services of the Ideal Model. The Highly Specialized Services and Supports Advisory Group had built upon the Ideal Model Final Report (September 2001) and described the nature and role of Highly Specialized Services and Support Services. However, it did not refine the actual definitions and limits of each of the services within the original listing of the continuum of services. Consequently, it became the task of the Children's Mental Health Core Services and Supports Advisory Group to undertake this very difficult task.

The development of a common set of definitions for services will enable the system to communicate more effectively regarding the nature and amount of services needed and/or offered to a particular child, youth, and family. In spite of the significant expertise present on the Core Services and Supports Advisory Group, there was an initial thought that perhaps these definitions had already been well-developed somewhere else, and that we merely needed to locate this work. It became apparent early on that there was no "ready made" set of definitions developed within an Ontario context and that, in fact, there existed significant differences in interpretation as to what was meant by a certain service type.

The graphic on the next page depicts the continuum of services as discussed and defined by the Core Service and Supports Advisory Group. Not all of these services were subsequently determined to be Core Services and Supports.

### ***Assessment***

Any and all of children's mental health services must be provided in an accountable and efficacious manner. In this regard, some form of assessment must take place. The assessment may be very short and informal or lengthy, comprehensive and intensive. Thus, the ideal children's mental health system consists of skilled staff that can perform credible assessments and demonstrate why a particular path of intervention would ultimately promote mental health and optimal functioning for the child, youth and family.

Assessment is an ongoing responsibility of the children's mental health service provider. Vigilance is required to ensure that the best of what is needed for the child, youth and family at the time is being provided and that, as needs change, so do the interventions, if warranted.

# Continuum of Services

ASSESSMENTS\*  
\*also an inherent part of all service components

PREVENTION

EARLY INTERVENTION

RESPIRE SERVICES

EMERGENCY SERVICE

- EMERGENCY CRISIS SERVICE
- LOCAL ACUTE CARE HOSPITALIZATION
- CRISIS RESIDENTIAL

NON-RESIDENTIAL TREATMENT SERVICES:

- OUTPATIENT TREATMENT
- HOME BASED TREATMENT
- SCHOOL BASED TREATMENT
- DAY TREATMENT

RESIDENTIAL SERVICES

TREATMENT

- THERAPEUTIC PARENT MODEL
- RESIDENTIAL TREATMENT
- THERAPEUTIC CAMP

CARE

- SUPPORTED INDEPENDENT LIVING
- CONTINUING CARE\*

REQUIRED SUPPORTING FUNCTIONS WITHIN CONTINUUM OF SERVICES\*

- ◆ SERVICE COORDINATION SERVICES
- ◆ CASE MANAGEMENT SERVICES
- ◆ CONSULTATION

\* also an inherent part of many services in the continuum of services

## ***Prevention and Early Intervention***

It is recognized that the traditional children's mental health service system may not be the exclusive provider of prevention and early intervention services. It is critical however, that these services are included as components within a balanced system.

An accountable and informed Prevention and/or Early Intervention Service supported by recognized and skilled children's mental health professionals is fundamental to the achievement of positive outcomes. It is anticipated that most children in the general population will receive only Prevention and/or Early Intervention Services. Nevertheless, an understanding of the mental health needs of all children helps to inform how best to respond to those at risk. Children's Mental Health Prevention and Early Intervention Services can provide excellent opportunities for cross-sector collaboration.

Children's Mental Health Prevention Services should, for example, work in collaboration with the school system and others in a universal public education approach related to the identification of early warning signs for depression in adolescents. Examples of other more targeted interventions may be the early identification of children and youth whose parents suffer from mental illness.

## ***Respite***

Respite service is an area that has been largely ignored in the past. It is critical that in a balanced system of children's mental health services, the capacity exists to provide "breathing space and time" for those children, youth and families who are struggling with mental health problems. An adequate level of respite can promote and support resiliency and mitigate the breakdown of relationships that are critical to the wellbeing of children, youth, and families.

## ***Emergency Services***

Timely response in an Emergency/Crisis situation can offset the progression toward more severe problems. Children, youth and families might experience a mental health crisis that can be resolved by quick and short-term intervention that may include a brief hospital stay. Access to this timely response could mitigate the loss of resilience and functioning in other domains of the child, youth and families' life.

Emergency Services provides an excellent opportunity for integration of services traditionally funded by two different ministries, namely MCSS-MCYS and MOH-LTC. A co-ordinated emergency response to children, youth and families with mental health problems requires the close co-operation between the local hospital and other community based mental health services for children, youth and families. However, caution must be exercised to ensure that Emergency Services does not become the automatic admission path into limited mental health resources.

### ***Non-residential Treatment Services:***

Everything that can be done to keep a child or youth within their home and regular school needs to be done hence the bulk of children's mental health treatment services must be community-based and non-residential.

It is significant that these services are not entitled simply "community-based mental health services" or "non-residential mental health services", but rather, "non-residential *treatment* services". The emphasis is that the child remains within their regular home setting and school and yet can still receive "treatment" to bring about a return to and/or enhancement of resiliency to cope with the problems occurring in their lives

Determining and establishing the right amount of Non-residential Treatment Service in a community will require significant time, effort and expertise. Determining the appropriate balance of service will be an equally challenging task. Consideration should be given to ensuring that there are adequate resources in non-residential treatment services in order to address the goal that most children with mental health problems will receive community-based, non-residential treatment services.

### ***Residential Treatment Services:***

Children's Mental Health Service is for clinical treatment purposes and is not to be construed as a means of providing a place to live for a child or youth.

The defining difference between children's mental health residential treatment and child welfare residential placement is that the primary purpose of children's mental health intervention is not to subsume the role of an absent, neglectful, or abusive parent or guardian, but to work with the parent and/or guardian to respond to the mental health needs of the child or youth.

Within the parlance of children's mental health, we have come to refer to the capacity of forms of residential children's mental health services as "beds". A "bed" is not treatment. Following on the principle and disclaimer that *children's mental health services are for clinical treatment purposes and are not to be construed as a means of providing a place for a child or youth to live*, it is important that we consider very seriously any treatment choice that would separate a child or youth from their home. Our decision must consider whether positive results are dependent upon a separation of the child from his or her normal place of residence and community.

Generally, anytime a child or youth could not be maintained in their regular home and, as a result, may stay "overnight" at another site, the service was classified as "residential".

As noted in the Final Report on "An Ideal Model for Children's Mental Health Services in the South West Region" (September 2001), residential services are part of a comprehensive continuum of children's mental health services which begins with supporting the child or youth in his or her own home and community. Consumers and service providers have indicated that they believe effective and timely treatment offered during a person's initial involvement with the system will reduce the need for more intensive, costly and intrusive placement services. They point out that, wherever possible, a child's own family and community must be seen as the preferred option and environment for support and treatment. However, for some children and youth, residential care and out-of home placement is necessary. (See glossary for definition of "home").

The Core Services and Support Advisory Group reiterate the comments from the report "An Ideal Model for Children's Mental Health Services in the South West Region" (September 2001):

"Supported by evidenced-based research, a number of concepts underlie the delivery of residential services for children's mental health. Residential care should:

- ◆ Be flexible, adaptive and include **individualized plans of care** so that the complete mental health needs of the child and youth, including physical, emotional, social and educational needs are addressed;
- ◆ Provide the most **normative environment** that is clinically appropriate and provide treatment that recognizes the unique needs and potentials of each child; this includes sensitivity to cultural, racial, disabilities and other unique differences;
- ◆ Occur in a **least restrictive manner**, minimizing the lengths of stay, maximizing all opportunities to maintain continuity of relationships including the family and key professionals who were involved prior to placement and may need to be involved upon re-integration and emphasizing rapid re-integration (this includes planning for and implementation of an intensive support system for the child and family, prior to and upon discharge);
- ◆ Remain **family focused**; while the distinct and unique needs of each child need to be addressed in an individualized and flexible manner, residential services must provide optimum opportunity to involve parents, family and other key people in the child's life, as full partners in all aspects of planning and treatment including providing the capacity to involve wraparound approaches;
- ◆ Use of **multidisciplinary, interagency teams** to do assessments, review complex plans of care/treatment planning and discharge planning;
- ◆ Be **community based**, located as close as possible to the child's home or within reasonable travel time, so that important relationships remain intact , key people remain involved and rapid re-integration back into the child's community and home is possible (use case management and services co-ordination for planning and monitoring of placement progress and establish the linkages with community agencies); and

- ◆ Recognize that **highly specialized, residential or institutional treatment** will be required for some children and youth with the most challenging difficulties.

Residential care extends the range of treatment options for children and youth with the most complex difficulties. Residential care must provide a balanced range of services that include respite, least restrictive and normative placements such as therapeutic foster care homes, longer-term residential treatment such as group care and crisis beds that provide stabilization services."

### ***Residential Care***

There was an understanding on the part of the Advisory Group that some children and youth have long-standing, chronic mental health problems and a lack of capacity or resiliency to function in an unsupported home or school situation. As a result, the Advisory Group developed a service category named "Continuing Care". The primary purpose for admission to this service would be the need for a long-term maturational, therapeutic setting due to a persistent mental health problem.

### ***Service Co-ordination, Case Management, Consultation***

The critical functions of Service Co-ordination, Case Management, and Consultation help to make the system of care presented in the Ideal Model hold together. These functions are inherent in virtually all the services within the continuum of services.

## 8 THE SERVICE DEFINITIONS IN AN IDEAL CONTINUUM OF CHILDREN'S MENTAL HEALTH SERVICES

### Process Used by the Core Services and Supports Advisory Group for Developing Service Definitions

Name the Service

Review Ideal Model Definition

Review definition in Stroul and Friedman (1986)

Review comments on service within CMHO benchmarks/operational standards.

Review any other comments by lead person on the service.

Develop the definition:

- ◆ State/List the essential nature of service including:
  - ✓ the “spirit” of the service,
  - ✓ timing,
  - ✓ intensity,
  - ✓ accessibility (e.g. hours of services, location), and
  - ✓ inter-connectedness with other services in continuum of services
- ◆ State boundaries or limits
- ◆ Note references used

The following subsections capture-general discussion points related to each service, providing context and background for each definition. At the end of each section is a box containing the definition and parameters related to that specific service.

Individual best practices are not noted because our work was confined to the system of care. Preliminary performance measures are mentioned in order to prompt thinking about how outcome measures need to be fully researched

## 8.1 Assessment Service

Assessment is referred to as an evaluation and/or diagnostic process facilitated by one or more professionals. Assessment occurs in collaboration with the child, youth, family as well as other relevant and appropriate parties. Information on an individual and/or family's strengths, needs, and resources is collected and recommendations are made for treatment and related services. Within most treatment models in children's mental health, assessment is an ongoing and fluid process on a formal or informal basis.

Assessment also occurs not only to determine what interventions might be brought to deal with a problem on an individual basis, but also, to determine on a broader social and/or community basis, what broad-based interventions might be brought to bear to improve a service system. **Assessment is a fundamental action prior to an intervention on a specific, individual, family, community, system, universal, or targeted basis.**

Assessment may involve a wide range of tools and/or procedures that may differ dependent upon the goal of the assessment and/or the profession providing the assessment. Assessment may be undertaken to identify issues at any point within an individual or larger system to the child, youth, and/or family and may result in a diagnosis. (See glossary) **All determinations for an individual or for systems development are founded on an assessment. Hence it is listed first in the continuum.**

### ASSESSMENT SERVICE

Assessment is an evaluation and/or diagnostic process facilitated by one or more recognized and skilled children's mental health staff. Assessment occurs in collaboration with the child, youth, family as well as other relevant and appropriate parties. Information on an individual and/or family's strengths, needs, challenges and resources is collected and recommendations are made for treatment and related services.

Timing	Intensity	Accessibility (Location and Time)	Staffing Supports	Eligibility
Timely	Range from 1 hour or less, to as intense as needed	Variable: broader community e.g. home, school, agency, hospital, etc. Assessment Service may be offered at variable times dependent on the type and may be ongoing.	Recognized & skilled CMH staff	Identified child/youth &/or family

## 8.2 Prevention Service

Prevention is a planned, community-based activity and/or service of a multi-disciplinary and integrated nature that will develop resiliency skills in children/youth and families. Prevention can be universal or targeted to specific populations.

Prevention is:

- Promotion of positive mental health and competencies using program and curricula to strengthen a sense of identity and self-esteem and to teach specific skill, particularly problem solving.
- Increasing self-help groups and support systems. Individuals with strong and intimate relationships are better able to handle crisis and stresses.
- Systems change, making modifications within the system to increase the likelihood that individuals will encounter favourable outcomes with intervention at stressful periods in the lives of children/youth in order to avert the development of serious emotional disorders.

This support and/or service is specially designed for designated groups of children and youth who are **at risk** of poor outcomes which will require long-term or intrusive services, but these children and youth are not exhibiting specific behaviours or symptoms. Risk factors are characteristics of the child or youth (such as physical health and coping skills), or characteristics of their environment (such as poverty or family violence) that research has shown puts these children and youth at greater risk of poor outcomes (such as poor school performance, mental disorders, child abuse, anti-social behaviour, low birth weight, substance abuse). (Notes from Ideal Model)

The "Ideal Model" report under Section 5.1 coupled prevention and early intervention and stated that they often lead to interventions that are targeted and that strive to keep the number of children with severe mental health problems as small as possible. This section also stated that schools should play a major role in prevention and early intervention.

Stroul and Friedman spoke of prevention service as follows:

*The basic goal of prevention within a mental health system of care is to reduce the incidence of emotional problems in children. As used here, the concept is equivalent to the public health concept of primary prevention. It refers to interventions directed at individuals and/or families who have not yet been identified as having emotional problems, especially those children who by virtue of genetic, family or situational factors are at the highest risk of developing severe emotional disturbances.*

There seems to be some confusion in the literature between prevention in its purest sense and early intervention. Prevention in its purest sense is described as community-based activities and services of a multi-disciplinary and integrated nature:

- a) for all persons regardless of risk (all citizens);
- b) to general populations perceived to be at a higher risk. E.g. High school students;
- c) to specific populations within the higher risk category;
- d) to identified individuals and/or families within the high risk population

In the literature, there is a variance between attempting to “prevent” or to “stop” something from happening which is deficit-based language versus “to be in readiness for” which is asset-based, empowering and supportive of the concept of resiliency. Resiliency appears to be noted in the current literature as the preferred state.

Based on this definition, the paper reviews biological, psychological, familial and social factors related to disadvantage that undermine the development of the precursors of resiliency, and lists factors that protect the potential for resiliency in each of these areas.

Several protective factors foster resilience:

- personal characteristics, including social competence, problem-solving skills, autonomy, perseverance and an optimistic outlook
- families that have the strength to cope and endure despite chronic stress and repeated crisis
- families and schools that provide care and support, high but achievable expectations, and opportunities for children to participate and contribute
- caring communities and nations that support the family and see children as a shared and precious resource.

## PREVENTION

Prevention is a planned community based activity(ies) and/or service(s), of a multi-disciplinary and integrated nature, to develop resiliency skills in children, youth and/or families. Prevention can be universal or for specific population(s).

Timing	Intensity	Accessibility (Location and Time)	Staffing Supports	Eligibility
Ongoing & variable	Variable	Variable: broader community e.g. home, school, agency, hospital, etc. ongoing	Skilled staff &/or volunteers	Universal or specific populations

### 8.3 Early Intervention Service

Early Intervention Service applies to children and youth and/or their families who exhibit behaviours or symptoms that indicate the beginning signs of a mental health challenge. Early intervention service is provided to mitigate the anticipated long-term effects of mental health problems.

Early intervention supports and/or services apply to children who personally exhibit behaviours or symptoms indicating they are just starting on a course that could require expensive, intrusive or long-term services. Early intervention supports/services are provided early to prevent the anticipated long-term deviations from health development. (Notes from Ideal Model)

The National Mental Health Information Center (US) describes early intervention as:

A process used to recognize signs for mental health problems and to take early action against factors that put individuals at risk. *Early intervention* can help children get better in less time and can prevent problems from becoming worse.

Provincial policy documents such as *Making Services Work for People* noted:

Local systems of services must result in earlier supports, so that individuals and families can rely on their own strengths, receive services before problems worsen, remain intact within the family unit and rely less on services in the future.

Much of the work and thinking respecting early intervention over the past several years has operated under the assumption that intervening *early* in the onset of a mental health problem necessarily implies that such service/supports be exclusively focused on younger children, generally under the age of six. Some of the more recent initiatives (e.g. Children's Mental Health Services for Children 0-6 years) were directed to this population. **The above definitions do not, however, make any explicit or implicit reference to the age of children to be served. The "early" in early intervention should make reference to the stage of onset of a particular difficulty, not to the age of the child or youth.**

Many different kinds of services can be considered as early interventions, if they are delivered in the early stages of problem onset.

## EARLY INTERVENTION SERVICE

Early Intervention Service applies to children and youth and/or their families who exhibit behaviours or symptoms which indicate the beginning signs of a mental health challenge. Early intervention services are provided to mitigate the anticipated long-term effects of mental health problems.

Timing	Intensity	Accessibility (Location and Time)	Staffing Supports	Eligibility
Variable	Variable	Variable: broader community e.g. home, school, agency, hospital, etc. Variable: up to 24 hours per day, 7 days per week, 365 days per year	Skilled staff &/or volunteers	Identified individuals &/or specific populations

## 8.4 Respite Service

Respite Service is care and/or supervision accessed on a planned basis or in urgent situations, and is provided for a specified period of time to children/youth who have a mental health problem and who are already linked to the children's mental health system in some way. Typically, respite provides the primary caregiver a break from their care-giving role, to help preserve the family/caregiver unit and prevent or postpone the need for long-term placement.

Respite Service can be provided in the child's home or in a variety of out of home settings. It can range from a couple of hours to 24-hour care over a period of several months, depending on the needs of the child and their caregiver(s).

Typically, respite (located in each community):

- ◆ Provides stabilization, and the length of stay may range overnight to 2-3 days
- ◆ The setting could be the child's home, a foster, group home or residential treatment setting, and
- ◆ It should be used when the family is unable to manage the child in the home even with in-home supports. (p.21 "Ideal Model")

### RESPITE SERVICE

Respite Service is care and supervision accessed on a planned, timely basis, and is provided for a specified period(s) of time to children/youth with a mental health problem and/or families. Typically, respite provides the primary caregiver a break from their care-giving role, to help preserve the family/caregiver unit and prevent or postpone the need for long term placement.

Timing	Intensity	Accessibility (Location and Time)	Staffing Supports	Eligibility
Planned and timely	Can range from a few hours to 24-hour care, for a specified period(s) & may be intermittent	In child's home or in a variety of out-of-home settings 24 hours/day /365 days/year	Recognized & skilled CMH staff and/or skilled caregivers with linkages to multi-disciplinary clinical supports	Identified and assessed child/youth &/or family

## 8.5 Emergency Crisis Service

Emergency Crisis Service is a non-residential, children's mental health service provided in crisis situations where a "crisis" is defined as a situation in which:

- a child/youth's behaviour poses an imminent physical threat to the child or to someone else, and /or;
- a family does not have the ability/capacity/resources to manage adverse events, leading to significantly negative effects on the child/youth's ability to function. (E.g. parent diagnosed with serious illness and the child/youth is reacting to all of this and not able to manage in a number of areas) and/or;
- a child/youth can not be safely stabilized by the caregivers leading to significant risk to the well being and functioning of self and/or others (E.g. even if the child is not suicidal or homicidal, the risk is significant enough that quick action should be taken).

Emergency Crisis Service:

- Is aimed at assessing and stabilizing a mental health crisis in the most normal setting that is appropriate for the child, and initiating a plan for the child to resume his normal place of residence and school;
- Is available immediately and triaged for life-threatening crisis, and within 5 working days for other urgent situations;
- Is provided by a qualified mental health worker experienced in crisis intervention and supported by multi-disciplinary team, which has access to a psychiatrist, for advice and assessment;
- Is available 24 hours per day, 365 days per year;
- May include a limited number of crisis follow-up sessions;
- Involves parent(s)/caregivers where appropriate;
- Has access to a range of residential and non-residential services to further assess and stabilize the situation, and plan for ongoing intervention;
- Is community-based and designed to avert hospitalization
- Has access to the nearest Schedule 1 hospital.
- The Advisory Group did not make any determinations as to the location of the emergency/crisis service provider relative to distance that might need to be travelled and /or demographics.

## **EMERGENCY CRISIS SERVICE**

Emergency Crisis Service is non-residential service that is aimed at assessing and stabilizing a mental health crisis.

<b>Timing</b>	<b>Intensity</b>	<b>Accessibility (Location and Time)</b>	<b>Staffing Supports</b>	<b>Eligibility</b>
Immediate	As intense as needed	Variable: broader community e.g. home, school, agency, hospital, etc. Access to nearest Schedule 1 hospital Access to a range of residential & non-residential services 24 hours/day/365 days/year	Recognized & skilled CMH staff, in conjunction with multi-disciplinary team with access to medical staff & psychiatrist	Triaged & identified child/youth

## 8.6 Local Acute Care Hospitalization

Local Acute Care Hospitalization provides inpatient services for children/youth with serious acute disturbances/distress or are in imminent danger to self or others and who cannot be managed in the community. Children/youth are admitted by a physician, voluntarily or involuntarily, to the nearest designated medical facility to which they have access.

Medical staff is on site in the facility, which is governed by the Public Hospitals Act. The facility may or may not have mental health designated beds and there are defined linkages to clinical and community supports.

### LOCAL ACUTE CARE HOSPITALIZATION

Local Acute Care Hospitalization provides inpatient services for children/youth with serious acute crisis who cannot be maintained safely in the community. Children/youth are admitted, voluntarily or involuntarily, by a physician.

Timing	Intensity	Accessibility (Location and Time)	Staffing Supports	Eligibility
Immediate	As intense as needed to manage acute phase	Nearest hospital to which family has access 24 hours per day 365 days per year	Medical staff with access to multi-disciplinary clinical supports	Triaged & identified child/youth

## 8.7 Crisis Residential Service

Crisis Residential Service is a component of the crisis intervention continuum, as depicted at the introduction to this section of the report. It serves children/youth that are in such acute distress that they require immediate, twenty-four hour support to meet their needs. The purpose of Crisis Residential Service is to immediately reduce the level of acute distress for the child/youth and family, and to attempt to stabilize the situation to a pre-crisis state which will allow the youth to be discharged to a less intrusive setting, preferably their own home.

This service may vary in form from a parent model home supported by professional staff, to a crisis stabilization unit offering close supervision and intensive intervention by a multi-disciplinary team with access to medical/psychiatric consultation.

Crisis Residential Service has the following characteristics:

- Non-hospital, community based;
- Short-term (1 to 30 days);
- Active involvement of the parent or guardian, where appropriate;
- Active case management which facilitates a timely discharge plan including appropriate follow-up services;
- Strong linkages/protocols with the community service providers who will be delivering follow up intervention.

### CRISIS RESIDENTIAL SERVICE

Crisis Residential Service is a component of the crisis intervention continuum. The purpose of Crisis Residential Service is to immediately reduce the level of acute distress for the child/youth and family, and to attempt to stabilize the situation to a pre-crisis state which will allow the youth to be discharged to a less intrusive setting, preferably their own home.

Timing	Intensity	Accessibility (Location and Time)	Staffing Supports	Eligibility
Immediate	Short-term (1-30 days) to provide stabilization	Non-hospital, community-based 24 hours per day, 365 days/year	Variable: Parent or staff model home supported by recognized and skilled staff up to a crisis stabilization unit offering close supervision & intensive intervention by a multi-disciplinary team with access to medical/psychiatric consultation.	Voluntary child/youth in acute distress

## 8.8 Outpatient Treatment Services

Outpatient Treatment is a primary (first-line) response that includes assessment and treatment services for a broad range of mental health concerns. Outpatient Treatment is a formalized response that may involve a variety of therapeutic approaches, alone or in conjunction with other modalities. Treatment may be provided for a client in transition to more or less intensive services in the continuum of care, with defined linkages to other services.

In the general sense, Outpatient Treatment is flexible with:

- ◆ a system of triage (immediate response – waiting list),
- ◆ a range of intensity (infrequent up to less than 3 hours/day) and,
- ◆ access in a range of time and locations (office, home, school, satellite outreach etc).

*It is important to note that, for the purposes of definition, the Advisory Group limited this specific service to that which would take place at an agency or hospital where the child was not in residence.* These limits were put in place more to highlight the significance of the place of treatment and attendant variables as important factors in services to children, youth and their families.

Thus, typically, a child, youth or family would travel to an appointment with a clinician at the children's mental health agency or hospital in their community.

### OUTPATIENT TREATMENT

Outpatient Treatment is a formalized response that may involve a variety of therapeutic approaches, alone or in conjunction, with other modalities. Treatment may be provided for a client in transition to more or less intensive services in the continuum of care, with defined linkages to other services

Timing	Intensity	Accessibility (Location)	Accessibility (Time)	Staffing Supports	Eligibility
Timely: based on assessed need	Range of intensity: typically less than 3 hours per day	Primarily agency or hospital-based	Days &/or evenings	Recognized & skilled CMH staff	Identified child/youth &/or family

## 8.9 Home-based Treatment Service

Home-based Treatment Service is provided on an outreach basis in the home of the child or youth. It encompasses a variety of service delivery approaches and degrees of immediacy, intensity and duration of services predicated on the achievement of the following goals:

- a) preserving family integrity and preventing unnecessary out-of-home placement,
- b) linking child/family with other appropriate professional &/or community supports, and
- c) strengthening the family's coping and parenting skills and related capacity to function effectively in the community.

Geared to keeping the child where he or she is living, home-based service provides needed supports that help manage children and youth in their natural settings. A range of practical and instrumental supports are included such as child management, parenting skills, social skill building, in-home respite and lay intervention approaches such as home visitors, parent mentors and peer mentors.

### HOME-BASED TREATMENT SERVICE

Home-based treatment service is a formalized response that may involve a variety of therapeutic approaches, alone or in conjunction with other modalities, with defined linkages to other services, primarily in the home.

Timing	Intensity	Accessibility (Location and Time)	Staffing Supports	Eligibility
Timely: Planned admission Based on assessed need	Variable, dependent upon modality	Primarily in the home  Flexible, depending on family schedule and need	Recognized & skilled CMH staff	Identified child/youth &/or family

## 8.10 School-based Treatment Service

School-based Treatment Service is delivered to the child/youth primarily in the child's community school. It encompasses a variety of service delivery approaches and degrees of immediacy, intensity and duration of services predicated on the achievement of the following goals:

- a) maintaining the child/youth within the child's home school
- b) complementing the efforts of parents, other professionals, and community supports, to facilitate the child/youth to achieve satisfactorily in various aspects of his/her educational experience;
- c) contributing to decisions around the need for a variety of specialized and possibly more intrusive, interventions, supports and/or placements.

School-based treatment service is a formalized response that may involve a variety of therapeutic approaches, alone or in conjunction with other modalities, with defined linkages to other services, primarily in the child's community school, pre-school or day-care centre. Similar support may be necessary in the school to keep a child in the classroom and minimize the use of "Section 20" segregated classrooms. More clinical services may need to be included such as individual counselling, family counselling, wraparound and family preservation models.

### SCHOOL-BASED TREATMENT SERVICE

School-based treatment service is a formalized response that may involve a variety of therapeutic approaches, alone or in conjunction with other modalities, with defined linkages to other services, primarily in the child's community school.

Timing	Intensity	Accessibility (Location and Time)	Staffing Supports	Eligibility
Timely: planned admission based on assessed need	Range of intensity, typically less than 3 hours per day	Primarily in the child's community school During community school hours	Recognized & skilled CMH staff	Identified child/youth &/or family

## 8.11 Day Treatment

Day Treatment is an intensive, child-focused, therapeutic milieu service provided in a variety of settings wherein service is provided for 3 hours or more a day on a regularly scheduled basis, excluding overnight services.

Children/youth requiring day treatment service experience serious mental health difficulties of a social, emotional, psychological and/or behavioural nature within their family, school, and/or community environments.

Service is multi-disciplinary, requires the involvement of the family unit as appropriate, and is offered in collaboration with community service providers.

Day Treatment requires an operational agreement between an agency and school board, if an educational service is provided in a care and treatment facility. Therefore, it is not the existence of a Section 20 classroom that denotes Day Treatment. It is the need for Day Treatment that compels the use of a Section 20 classroom.

### DAY TREATMENT

Day Treatment is an intensive therapeutic milieu service provided in a variety of settings. Service is multi-disciplinary and is offered in collaboration with community service providers.

Timing	Intensity	Accessibility (Location and Time)	Staffing Supports	Eligibility
Planned admission based on assessed need	3 hours or more/day on a regularly scheduled (typically daily) basis, excluding overnight services.	Agency, hospital, school Days &/or evenings	Recognized & skilled CMH staff, qualified teacher (as required)	Identified child/youth &/or family

## 8.12 Therapeutic Parent Model Care

This service component of children's mental health services provides a family environment for up to four children with special needs. Treatment parents are regarded as primary agents of treatment for the child. Program staff provides frequent consultation, supervision and support to treatment parents. Program staff has low caseloads to permit them to work actively and intensively with the treatment family, child and natural family.

Therapeutic Parent Model Care is licensed residential care for up to 4 unrelated children/youth with mental health problems, provided within a change-oriented family milieu with parents as the pivotal component of the treatment team.

The foundation of this model is a family treatment modality that creates and supports change by working with a developed clear individualized plan of care that the addresses the needs of the child/youth.

Therapeutic Parent Care (ref. pp 21 Ideal Model):

- Provides a family style, "normalized" setting;
- Allows a child to maintain connections with their own community, school, friends and family;
- Has enriched, ongoing training and specialized foster home support workers;
- Provides regular and frequent relief and respite as part of the program;
- Ensures that regular professional consultation is available and in place;
- Has access to child care/behavioural, social work, psychological and psychiatric assessments;
- Allows a maximum number of children per home ;
- Has available homes in every community, providing both short and longer term care;
- Can be managed centrally by an existing service provider.

### **THERAPEUTIC PARENT MODEL CARE**

Therapeutic Parent Care is licensed residential care for up to 4 unrelated children/youth with mental health problems, provided within a change-oriented family milieu with parents as the pivotal component of the treatment team.

<b>Timing</b>	<b>Intensity</b>	<b>Accessibility (Location and Time)</b>	<b>Staffing Supports</b>	<b>Eligibility</b>
Planned admission	As intense as needed	CFSA licensed setting in local community 24 hours per day	Foster Parent/Caregiver, sometimes staff-assisted, with access to multi-disciplinary clinical supports	Identified & assessed child/youth

## 8.12 Residential Treatment Service

Residential Treatment is the part of the continuum of services that is considered the most intensive, intrusive, and costly intervention strategy. Assessment and treatment service is provided on a 24-hour basis. Residential treatment requires the ability to provide service 24 hours per day up to 365 treatment days per year to children and youth. It is typically housed on a single campus and can provide a complete school program. Treatment is multi-disciplinary in nature and can address psychiatric, psychological, psychosocial, clinical, medical, recreational, and educational needs for severely emotionally and/or behaviourally disturbed children/youth and their families.

Residential treatment provides both assessment and treatment strategies at a high level of intensity and is usually reserved for the most severely challenged children and youth. Residential treatment should be considered as one piece of a larger continuum of services and not as a stand-alone service. It is not intended to meet the on-going maturational needs of a child.

### RESIDENTIAL TREATMENT SERVICE

Residential Treatment is the part of the continuum of services that is considered the most intensive, intrusive, and costly intervention strategy. It can provide a complete school program. Treatment is multi-disciplinary in nature and can address psychiatric, psychological, psychosocial, clinical, medical, recreational, and educational needs for severely emotionally and/or behaviourally disturbed children/youth and their families.

Residential treatment provides both assessment and treatment strategies at a high level of intensity and is usually reserved for the most severely challenged children and youth. Residential treatment should be considered as one piece of a larger continuum of services and not as a stand-alone service. It is not intended to meet the on-going maturational needs of a child.

Timing	Intensity	Accessibility (Location and Time)	Staffing Supports	Eligibility
Planned admission	The most intensive, intrusive intervention strategy	Regionally or sub-regionally; typically housed on a single campus 24 hours per day 365 days per year	Recognized/skilled staff who are part of a multi-disciplinary clinical team	Child/youth with severe, complex mental health problems

### 8.13 Therapeutic Camp \*

Therapeutic Camp is a short term, intense, multidisciplinary camping experience that provides unique opportunities for children, youth and, in some instances, families to engage in activities that affect values, attitudes and emotional, cognitive and physical development.

Therapeutic Camp occurs in a variety of settings, from wilderness settings to city based agency sites and may be residential or day camps.

Therapeutic Camp can initiate, accelerate and solidify the process of change that traditional non-therapeutic programs cannot duplicate and, when offered conjointly with other programs, enhance intervention strategies based on a treatment plan. Camps can be used for assessment and/or consolidation and integration of skills, may provide respite and are designed to provide children/youth with a fun experience.

*Note:*

*Following a review of the Continuum of Services the Advisory Group determined that Therapeutic Camp was neither a Core nor Highly Specialized Service. Nevertheless, it was determined to be an efficacious service that should be developed once core services were established.*

#### THERAPEUTIC CAMP

Therapeutic Camp provides unique opportunities for children, youth with mental health problems and in some instances families, to engage in change-oriented camping activities that affect values, attitudes and emotional, cognitive and physical development.

Timing	Intensity	Accessibility (Location and Time)	Staffing Supports	Eligibility
Planned admission	Not less than 3 hours per day per week, for a specified number of weeks	Variety of settings: wilderness to city-based Variable: seasonal; residential/day	Recognized/skilled staff with access to multi-disciplinary clinical supports	Identified child/youth &/or family

## 8.14 Supported Independent Living

This type of service is typically for transitional aged youth (16-24 years), with a broad range of mental health problems, and is designed to promote independence. The spectrum of care includes therapeutic group care and concludes with the youth living independently in an apartment with no formal supervision. This service has an explicit focus on the information and skills required for individuals to successfully live on their own. Such skills are needed to manage financial, medical, housing, transportation, social/recreational and other daily living needs.

Given the nature of the service, the issues presenting and the small numbers, exploration of shared domain with other sectors should occur to provide the optimum service in any community.

### SUPPORTED INDEPENDENT LIVING

This service is for transitional aged youth (16-24 years), with a broad range of mental health problems, and is designed to promote independence.

This service has an explicit focus on the information and skills required for individuals to successfully live on their own. Such skills are needed to manage financial, medical, housing, transportation, social/recreational and other daily living needs.

Timing	Intensity	Accessibility (Location and Time)	Staffing Supports	Eligibility
Planned admission	As intense as needed	Broader local community Variable	Skilled staff with linkages to multi-disciplinary clinical supports	Transitional aged youth with mental health problems

## 8.15 Continuing Care

Continuing Care is a licensed children's residential environment providing services for children and youth with serious and persistent emotional and behavioural problems, designed to meet their ongoing maturational needs.

Interventions may include individual and group therapy, and family therapy where appropriate. Social work, psychological, recreational and educational modalities, as well as self-esteem building and appropriate role modelling may be included in the intervention.

### CONTINUING CARE

Continuing Care is a licensed residential environment for children and youth with serious and persistent emotional and behavioural needs that cannot be met within a less intrusive environment.

In addition, Continuing Care is designed to respond to ongoing maturational needs.

Timing	Intensity	Accessibility (Location and Time)	Staffing Supports	Eligibility
Planned admission	As intense as needed	CFSA licensed group care setting in local community 24 hours per day	Recognized/skilled staff with access to multi-disciplinary clinical supports; low child/staff ratios	Identified & assessed child/youth

## CONTINUUM OF SERVICE CHART

### Continuum of Services

SERVICE TYPE	Timing	Intensity	Accessibility (Location and Time)	Staffing Supports	Eligibility
<b>Assessment</b>	Timely	Range from 1 hour or less, to as intense as needed	Variable locations within the broader community e.g. home, school, agency, hospital, etc. Assessment Service may be offered at variable times dependent on the type and may be ongoing.	Recognized & skilled CMH staff	Identified child/youth &/or family
<b>Prevention</b>	Ongoing & variable	Variable	Variable locations within the broader community e.g. home, school agency, hospital, etc. Prevention is an ongoing service	Skilled staff &/or volunteers	Universal or specific populations
<b>Early Intervention</b>	Variable	Variable	Variable locations within the broader community e.g. home, school agency, hospital, etc. Services may be offered at any time.	Skilled staff &/or volunteers	Identified individuals &/or specific populations
<b>Respite Service</b>	Planned and timely	Can range from a few hours to 24-hour care, for a specified period(s) and may be intermittent.	Respite services may be offered in child's home or in a variety of out-of-home settings and may be offered at any time.	Recognized & skilled CMH staff and/or skilled caregivers with linkages to multi-disciplinary clinical supports	Identified and assessed child/youth &/or family

## Continuum of Services - Emergency Services

SERVICE TYPE	Timing	Intensity	Accessibility (Location and Time)	Staffing Supports	Eligibility
<b>Emergency/ Crisis Service</b>	Immediate	As intense as needed	Variable locations within the broader community e.g. home, school, agency, hospital, etc.  Access to nearest Schedule 1 hospital  Access to a range of residential & non-residential services 24 hours/day, 365 days/year	Recognized & skilled CMH staff, in conjunction with a multi-disciplinary team with access to a psychiatrist and medical staff	Triaged & identified child/youth
<b>Local Acute Care Hospitalization</b>	Immediate	As intense as needed to manage acute phase	Nearest hospital to which family has access, 24 hours per day, 365 days per year	Medical staff with access to multi-disciplinary clinical supports	Triaged & identified child/youth
<b>Crisis Residential Service</b>	Immediate	Short-term (1-30 days) to provide stabilization	Non-hospital, community-based 24 hours/day/365/ year	Variable: Parent or staff model home supported by recognized and skilled staff up to a crisis stabilization unit offering close supervision & intensive intervention by a multi-disciplinary team with access to medical/psychiatric consultation.	Voluntary child/youth in acute distress

## Continuum of Services - Non-residential Treatment Services

SERVICE TYPE	Timing	Intensity	Accessibility (Location and Time)	Staffing Supports	Eligibility
<b>Outpatient Treatment</b>	Timely: based on assessed need	Range of intensity: typically less than 3 hours per day	Primarily agency or hospital-based Days &/or evenings	Recognized & skilled CMH staff	Identified child/youth &/or family
<b>Home-based Treatment</b>	Timely: based on assessed need	Variable, dependent upon modality	Primarily in the home  Flexible, depending on family schedule and need	Recognized & skilled CMH staff	Identified child/youth &/or family
<b>School-based Treatment</b>	Timely: based on assessed need	Range of intensity, typically less than 3 hours per day	Primarily in the child's community school During community school hours	Recognized & skilled CMH staff	Identified child/youth &/or family
<b>Day Treatment</b>	Planned admission based on assessed need	3 hours or more/day on a regularly scheduled (typically daily) basis, excluding overnight services.	Agency, hospital, school Days &/or evenings	Recognized & skilled CMH staff, qualified teacher (as required)	Identified child/youth &/or family

## Continuum of Services - Residential Services

### TREATMENT

SERVICE TYPE	Timing	Intensity	Accessibility (Location and Time)	Staffing Supports	Eligibility
<b>Therapeutic Parent Model Care</b>	Planned admission	<b>As intense as needed*</b>	CFSA licensed setting in local community 24 hours per day	Foster Parent/ Caregiver, sometimes staff-assisted, with access to multi-disciplinary clinical supports	Identified & assessed child/youth
<b>Residential Treatment Service</b>	Planned admission	The most intensive, intrusive intervention strategy	Regionally or sub-regionally; typically housed on a single campus 24 hours per day 365 days per year	Recognized/skilled staff who are part of a multi-disciplinary clinical team	Child/youth with severe, complex mental health problems

### CARE

<b>Supported Independent Living Services</b>	Planned admission	<b>As intense as needed</b>	Broader local community Variable	Skilled staff with linkages to multi-disciplinary clinical supports	Transitional aged youth with mental health problems
<b>Continuing Care</b>	Planned admission	<b>As intense as needed*</b>	CFSA licensed group care setting in local community 24 hours per day	Recognized/skilled staff with access to multi-disciplinary clinical supports; low child/staff ratios	Identified & assessed child/youth

## 9. THE WHOLE CHILDREN'S MENTAL HEALTH SYSTEM:

- ◆ CORE SERVICES AND SUPPORTS
- ◆ HIGHLY SPECIALIZED SERVICES AND SUPPORTS
- ◆ FRONT DOOR SERVICES
- ◆ ESSENTIAL COMPONENTS AND SUPPORTING FUNCTIONS

The Core Services and Supports Advisory Group built upon the previous work of the South West Region Children's Mental Health Project and reflected upon the work of recognized experts in the field. Along with the dynamic interchange and vast experience of persons on the Advisory Group the perspective on the Ideal Model evolved.

### **Core Services and Supports is:**

- the largest component of the Ideal Model and as such deals with the vast majority of the children, youth and families who have children's mental health issues;
- the face of the children's mental health system to the broader public and other service sectors;
- the integration point to all other parts of the Ideal Model and the broader social service system;
- not a single entity, but a co-ordinated, integrated system of mental health care at a community level;
- ranges from prevention to intensive residential services and responds to acute as well as serious and persistent children's mental health problems;
- the foundation and bedrock from which the children's mental health system should be built.

## Highly Specialized Services and Supports

Highly Specialized Services and Supports are those that address the most severe and complex needs of children and youth via consultation, assessment and treatment as well as providing mechanisms for research, education, and training. These services may be located in the community or, regionally, depending on the size of the population and the critical mass needed to provide the services in an economical fashion.

- ◆ Highly Specialized Services and Supports are defined according to the complexity of needs and not the intensity of needs, nor the scarcity of resources nor geographic location.
- ◆ Highly Specialized Services and Supports are to be equitably accessible to children/youth and their families throughout the South West Region and may be provided via a centralized or outreach service delivery model.
- ◆ It is expected that Highly Specialized Services and Supports and Core Services [first line and intensive care] co-ordinate and link to ensure continuity of care that is responsive to ongoing needs.
- ◆ Highly Specialized Services and Supports are to be accessed on a planned basis and not as part of a first response mental health service.
- ◆ Highly Specialized Services and Supports may be located in the community or regionally depending on the size of the population and the critical mass needed to provide the services in an economical and effective fashion
- ◆ Access to Highly Specialized Services and Supports is for clinical treatment purposes and is not to be construed as a means of providing a place to live for a child or youth. Moreover, Highly Specialized Services and Supports shall be equal partners [*with other service providers*] in the delivery of a plan of service for a child and has a key role in discharge and transitional planning.

## Front Door Services

A fuller exploration of Front Door Services is yet to occur. The following are excerpts from the South West Region Children's Mental Health Project, (September 2001) An Ideal Model for Children's Mental Health Services in the South West Region (Final Report) related to Front Door Services. Much of this work was based on the book edited of Beth Stroul in 1996 entitled Children's Mental Health: Creating Systems of Care in a Changing Society.

The current Co-ordinated Access Mechanisms throughout the South West Region represent the state of the art thus far regarding what is meant by Front Door Services. "The functions generally include gathering and giving information to consumers, providers and other professionals. Front Door Services may also provide initial screening; initial assessment and understanding of the need presented and then offers referrals so that people are directed to the right place and service. In

response to consumer input about multiple waiting lists, the Front Door may also manage a common waiting list for certain services.

Front Door services would also provide case planning and service co-ordination functions that may include:

- A consumer-focused role that is neutral, unique, and separate from the role of services providers;
- Accountability for a comprehensive individual service plan including informal and non-traditional supports;
- Information, referral and advocacy assistance to parents and children to facilitate their access to the various service providers;
- Service coordination that provides continuity (i.e. stays with the client) as the client moves through the system and as the client needs change;
- Monitoring the quality and quantity of services and supports and revises service plans at regular intervals; and
- Resource development within the local community to locate or design additional needed supports.

According to Stroul (1996) "case management or service coordination has been referred to in the literature as "the 'backbone' or the 'glue' that holds the system together for consumers, and the key to systemic success of a system of care".

### **Essential Components and Supporting Functions:**

In describing the whole system the Core Services and Supports Advisory Group:

- ✓ specified which services should be part of the Core Services and Supports,
- ✓ indicated which service(s) in the Continuum of Service should be considered an Essential Component and/or Supporting Function and
- ✓ indicated which service they believed should be considered Highly Specialized.

There are also characteristics of the whole system, which are required to hold the disparate parts of the system together. Some of these characteristics are encompassed in the capacity building role of Highly Specialized Services and Supports and others are asserted here to emphasize their importance in an Ideal Model. These characteristics should be viewed as the lifeblood of the model and critical to its sustained viability. Essential components of an Ideal Model include:

- ✓ Strategic System Capacity Building: to develop strategies to oversee and promote the development and capacity of the children's mental health services system,

- ✓ **Clinical Consultation:** service at a local level can be optimized if access to expert clinical consultation is available. *"We know that the use of the mental health consultation model works." Dr. Paul Steinhauer (1999) What Do We Know That Works in Children's Mental Health Services?*
- ✓ **Ongoing Training and Education:** the system cannot respond if it does not know how. Ongoing training and education are essential to the viability of an accountable children's mental health system. Thus, the ideal children's mental health system comprises skilled staff that can provide credible treatment and demonstrate why a particular path of intervention would ultimately promote mental health and optimal functioning for the child, youth and family.
- ✓ **Research and Evaluation:** It is essential to an Ideal Model that we measure what we are doing and explore how better to provide the most efficacious children's mental health services on a specific and systemic level.

### **Interface of Core and Highly Specialized Services and Supports**

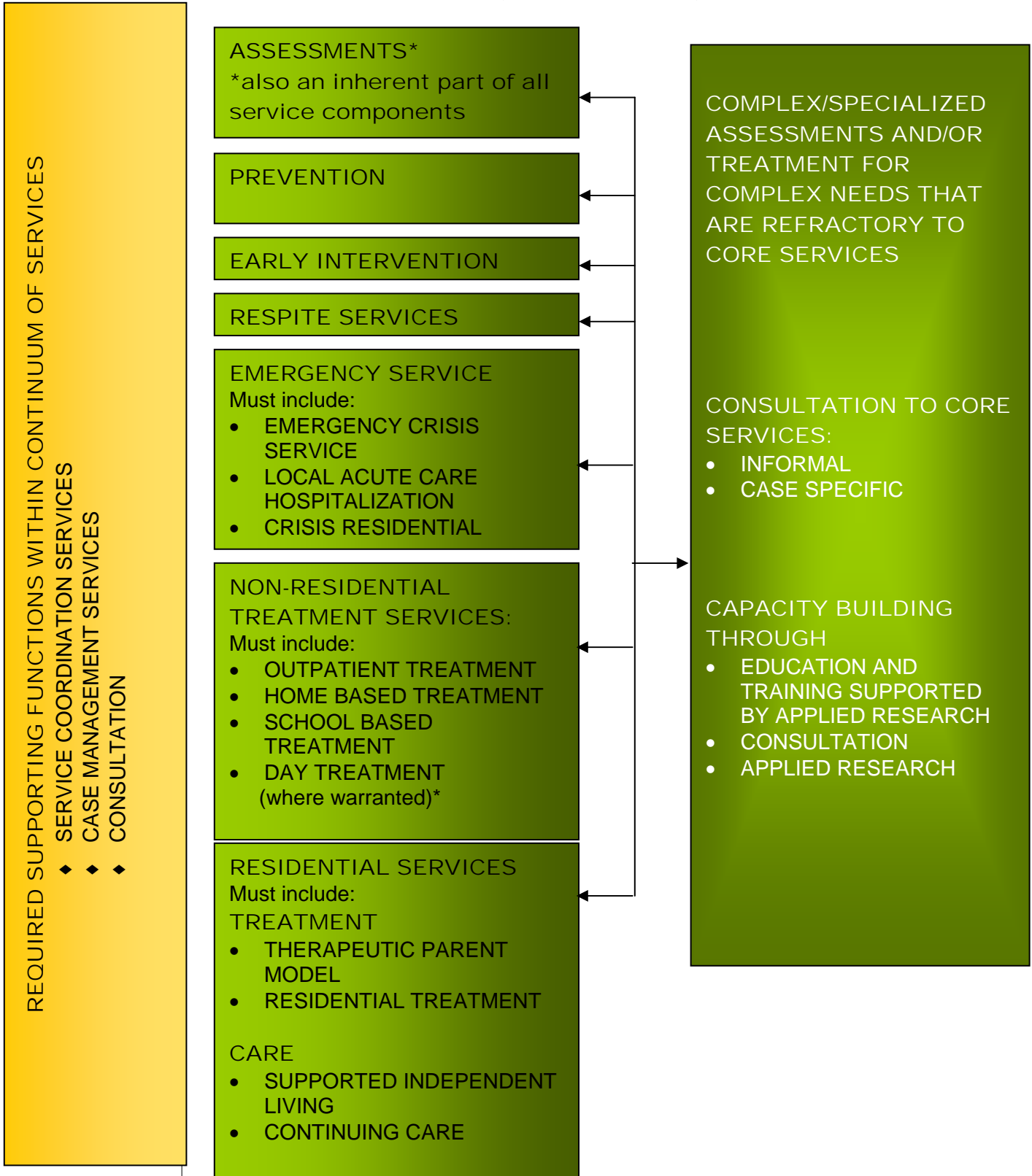
The chart on the following page depicts the composite views expressed by the Children's Mental Health Core Services and Supports Advisory Group. It is a visual representation of services deemed to be Core Services and Supports demonstrating their relationship to Highly Specialized Services and Supports.

Each of the major category headings under CORE, on the right side of the chart indicates the type of services that must be present in every community. In Non-residential Treatment Services and Residential Treatment Services, it is understood that the composition of specific services may vary from community to community based on the demographics of the community and presenting needs of the population. However, every community should have some of the components listed within these categories of service.

**CORE SERVICES COMPONENTS**



**HIGHLY SPECIALIZED SERVICES & SUPPORTS INTERFACE**



## 10. RECOMMENDATIONS AND TRANSITION PLAN

The Children's Mental Health Core Services and Supports Advisory Group was convened to provide advice regarding the role and range of core children's mental health services and supports within the South West Region Children's Mental Health Ideal Model. It is recognized that further consultation with other relevant parties is required as the implementation moves forward. The following represents the considered opinion and conclusions of the members of the South West Region Children's Mental Health Core Services and Supports Advisory Group:

An overriding concern of the Advisory Group is the viability of the current children's mental health system. The system requires urgent attention and fundamental issues of policy and resourcing must be addressed. Ontario's children's mental health system must be publicly and adequately funded, and provide equitable access to all children, youth and families.

The following recommendations and related actions are proffered with the presumption of acceptance and approval of recommendations by appropriate authorities and most particularly the Regional Director, South West Region, Ministry of Children and Youth Services;

### ***Defining the System:***

**10.1 That the South West Region adopt the Continuum of Services, related definitions and recommendations as described herein with a view towards demonstrating its success.**

**Action:** The MCYS Regional Director issue a directive in Fall 2005 for implementation of the Continuum of Services, related definitions and recommendations as described herein on a pilot basis starting April 1, 2006.

### ***From Barriers to Balance***

**10.2 That jurisdictional barriers to an integrated system be examined and resolved through Inter and Intra ministerial collaboration. The following service sectors are to be included in this collaboration:**

- **Children and Youth Mental Health Services (MCYS & MOH-LTC)**
- **Developmental Services**
- **Child Welfare Services**
- **Youth Justice Services**
- **Education Services**
- **Community Support Services**
- **Social Services**
- **Health Services**

**Action:** The South West Region Children's Mental Health Project Steering Committee issue an inter and intra ministerial directive to work together on an ongoing basis to promote and support opportunities to establish an integrated system of services for children, youth and families.

Decisions about funding related to children's mental health issues, in all sectors; require an inter-ministerial community planning process.

**10.3 That inter-ministerial effort is made to harmonize and/or eliminate service barriers between sectors regarding the mandates and age restrictions related to children's mental health services.**

**Action:** The SWR Children's Mental Health Steering Committee consider the question and develop a discussion paper by March 31, 2006 on the issue for action and resolution within their respective ministries.

**10.4 That in accordance with this document ideal capacity is ascertained and operationalized, reflecting a balanced continuum of core services within each community.**

**Action:** The South West Region convenes a panel of experts in the field of epidemiology and children's mental health to determine how much of each service should exist in each community. The resulting 'service capacity template' would be the operational definition of "balanced continuum" to be achieved by December 31, 2005.

**Action:** The South West Region work with Community Planning Tables to complete a mapping of services vis-à-vis the Ideal Model and related documents beginning April 1, 2006

**10.5 That a new group comprised of various system representatives be developed to support implementation of the Ideal Model**

**Action:** The South West Region convene a group by Fall 2005 comprised of a balance of stakeholders familiar with the work of the Highly Specialized Services Advisory Group, the Core Services Advisory Group, issues and concerns regarding access to the system, child protection and youth justice services and, developmental services to meet at minimum twice a year to review issues and concerns related to the service delivery of the programs and their progress regarding recommendations within this document and the ongoing implementation of the Ideal Model.

## ***Stewardship and Accountability***

**10.6 That a plan to address the problem of retention and recruitment of staff resources be developed with stakeholders to create a system of excellence. This should include equitable compensation, training, education and ongoing professional development opportunities.**

**Action:** The South West Region convene a regional task group to develop a plan to address the system capacity for retention and recruitment of staff resources by April 1, 2006

**Action:** The South West Region convene a regional task group to develop a plan to address the system capacity for training, education and ongoing professional development of staff by April 1, 2006

**10.7 That the South West Region strike a task group whose membership is comprised of representatives with expertise in each of the services in the continuum, supported by experts in evaluation, to examine and establish appropriate outcomes and their indicators for each component of the continuum.**

**Action:** The South West Region convene a task group whose membership is comprised of representatives with expertise in each of the services in the continuum, supported by experts in evaluation, to examine and establish appropriate outcomes and their indicators for each component of the continuum by April 1, 2006

**10.8 That the capacity of technological infrastructure needs be examined and provision made for the ongoing support and advancement of technology to advance service capacity.**

**Action:** This recommendation will be referred to the SWR Technology Task Group currently underway.

**10.9 That once the operational ideal level of service is determined, a strategic plan be developed to put the continuum place over a period of five to ten years. This strategic plan needs to recognize the diverse levels of service currently available in communities and allow for local flexibility to meet the goals.**

**Action:** The South West Region will convene and facilitate local planning tables to implement this recommendation.

# GLOSSARY OF TERMS

## **Best Practices**

Best practices are documented strategies that serve as system benchmarks for the most current, innovative and advanced practices relative to the delivery of children's mental health services.

Best practices evolve from:

- The analysis of current trends and emerging issues;
- Networking with the people and organizations involved in the delivery of children's mental health services;
- Matching community and regional needs with the demand for proven expertise and experience.

Best practices demonstrate practical ways in which public, private and civil society sectors are working together to improve upon the children's mental health service system.

## **BCFPI**

Brief Child and Family Phone Interview (**BCFPI**) is the **standardized intake/triage instrument** that is currently being implemented on a pilot project basis in 125 children's mental health sector (both MCSS and MOH-LTC funded) across Ontario. This was part of the MCSS Four Point Plan announced in May 2000 that included:

- ◆ Standardized Intake, Assessment and Outcomes Measurements
- ◆ Intensive Child and Family Services
- ◆ Mobile Crisis Services
- ◆ Tele-medicine

The Centre for the Study of Children at Risk at Hamilton Health Sciences developed the Brief Child and Family Phone Interview instrument with the support of Children's Mental Health Ontario.

## **CAFAS**

The Child and Adolescent Functional Assessment Scale (**CAFAS**) is the **standardized outcome assessment instrument** that is currently being implemented on a pilot project basis in 125 children's mental health sector (both MCSS and MOH-LTC funded) across Ontario. This was part of the MCSS Four Point Plan announced in May 2000 that included:

- ◆ Standardized Intake, Assessment and Outcomes Measurements
- ◆ Intensive Child and Family Services
- ◆ Mobile Crisis Services
- ◆ Tele-medicine

The CAFAS is widely used in the United States and was brought to Ontario by the Hospital for Sick Children.

### **Children's Mental Health Service Provider**

For the purposes of this report, a children's mental health service provider includes:

- ◆ a children's mental health centre,
- ◆ a Schedule 1 Hospital and/or local hospitals and Ministry of Health and Long Term Care funded services that serve children and adolescents with mental health problems,
- ◆ a physician,
- ◆ co-ordinated access services within the South West Region including the counties of Waterloo and Wellington in the case of the RMHC-AU, and including the counties of Waterloo, Wellington, Brant, Hamilton, Niagara, Haldimand, Norfolk in the case of CPRI Highly Specialized Services and Supports.

### **Children's Mental Health Service Sector**

When the term "Children's Mental Health Service System" is used, it includes the entire system, regardless of funding body. Thus, local or "Core" level services include MCFCS funded services, and also Schedule 1 hospitals and/or local hospitals and Ministry of Health and Long Term Care funded services that serve children and adolescents with mental health problems.

### **Clinical Services**

Clinical services include medical, diagnostic or therapeutic services provided by designated professionals.

Clinical services relate to the assessment and treatment of children, youth and families within children's mental health services.

### **Community**

For the purposes of this project, community is commonly defined as the upper tier municipality or county. For purposes of the Ideal Model continuum of services, it is recognized that consideration must be afforded to the sustainability of programs in rural, remote and lower populated areas. Therefore, we must consider demographics, geographic and prevalence as we determine community. There is not necessarily a sustainable critical mass of children/youth in some counties to responsibly provide a full range of services. This may mean a collaborative partnership among some neighbouring communities to effect a sustainable continuum. In these cases the community is redefined to be those neighbouring communities.

### **Comorbidity**

The term "comorbidity" refers to the presence of any two or more illnesses/disorders in the same person. These illnesses/disorders can be medical or psychiatric conditions. Comorbid illnesses/disorders may occur simultaneously or sequentially.

The fact that two illnesses/disorders are comorbid, however, does not necessarily imply that one is the cause of the other.

### **Co-ordinated Access Committee (Mechanism)**

For the purposes of this report, a co-ordinated access committee means:

- ◆ Community Services Coordination Network (CSCN) for the counties of Elgin, Oxford, Huron, Perth, Middlesex;
- ◆ Coordinated Access for Bruce-Grey,
- ◆ Help Link for Essex county,
- ◆ Starting Point for Lambton county,
- ◆ Kent Inter-Disciplinary Support (KIDS) Team in Chatham -Kent,
- ◆ SPARC (single-point access to residential care) in Waterloo/Wellington, and
- ◆ CONTACT in the Region of Hamilton-Niagara.

### **CPRI**

Child and Parent Resource Institute

### **First Line (or Primary) Services**

Service is accessible to all children/youth and their families who have mental health problems. First Line Services refers to prevention, assessment and treatment by frontline mental health care providers such as the local children's mental health centre, the family doctor, or the hospital emergency room. First Line Services include: Information and referral, Crisis telephone lines, Mobile crisis teams, Schedule 1 hospital emergency services, Holding/safe beds, Primary Care physicians, Mental Health counselling, Community health centres, Children/youth service organizations. (Adapted from Ministry of Health and Long Term Care - Making It Happen: Implementation Plan for the Reformed Mental Health System)

### **Highly Specialized Service and Support Provider**

For the purposes of this report there are 4 Highly Specialized Services and Support Providers, they are: SWR Eating Disorders Program, SWR Autism Program for Pre-schoolers, RMHC-AU, and CPRI Highly Specialized Services and Supports.

### **Individual Service Plan**

A treatment plan especially designed for each child and family, based on the individual's strengths, needs, age and stage of development. The service provider develop(s) the service plan with input from the family. The plan establishes goals and details appropriate supports, treatment and clinical intervention to meet the specific mental health needs of a child and his/her family. A service could be provided only one time or repeated over a course of time, as determined by the child, youth, family and service provider.

### **Intensive (or Secondary) Services**

Intensive Services refers to mental health assessment, treatment and support services provided in the community or local hospital and/or residential care settings. Intensive services provide on-going and continuous clinical input/support service to children/youth and their families with serious mental health problems. (Adapted from Ministry of Health and Long Term Care -Making It Happen: Implementation Plan for the Reformed Mental Health System)

### **MCSS**

Ministry of Community and Social Services

### **MCYS**

Ministry of Children and Youth Services

### **Milieu Therapy**

Milieu refers to the people and all other social, physical factors in the environment with which the child, youth and family interacts.

Milieu therapy:

- ◆ offers opportunities to acquire adaptive coping skills (teaches more effective or new ways to deal with problems) and lets the individual test these new coping skills in a secure, comfortable setting
- ◆ provides recreational, occupational, social, psychiatric, medical and/or nursing therapies
- ◆ protects and shelters the individual from: perceived pain, terrifying stressors, their own or others maladaptive behaviour
- ◆ provides an environment wherein all involved parties must work together to provide a caring, healing environment
- ◆ provides individual treatment plans
- ◆ promotes self-governance and progressive levels of responsibility, a variety of activities, links with family and community and effective interaction among the children's mental health team.

Components/objectives of a "total milieu":

- ◆ correct or redefine perception of stressors
- ◆ correct maladaptive behaviour
- ◆ develop adaptive coping
- ◆ acquire interpersonal & stress-management skills
- ◆ apply all of this in a social context

### **Multi-disciplinary Team**

Professionals and providers from different specialities who work together with a common goal of providing children's mental services to children, youth and families. The integration of disciplines, experience and expertise in combination with defined

common goals, allows for the efficient sharing of information and eliminates duplication of efforts.

**MRP (Most Responsible Physician)**

The physician who has final responsibility and is accountable for the medical care of a patient.

**MOH-LTC**

Ministry of Health and Long Term Care

**OPI**

Commonly used acronym particularly in the Child Welfare Sector to refer to Outside Paid Institution. OPI's are generally licensed privately operated (non-government funded) group and/or foster care residential care facilities for children.

**Refractory**

Resistant to treatment or cure; unresponsive to stimulus.

**Resiliency**

The human capacity and ability to face, overcome, and be strengthened by and even transformed by experiences of adversity. Also defined as the "unusually good adaptation in the face of severe stress, and/or an ability of the stressed person to rebound to the pre-stress level of adaptation". (Sparrow Lake Alliance)

Child's demonstrated capacity to maintain or resume development in the face of normal challenges or following extraordinary challenges.

**RMHC-AU**

Regional Mental Health Care -Adolescent Unit

**Schedule 1 hospital**

A facility named in the first list of psychiatric facilities that appears in the regulations to the Mental Health Act, and is designated as such by the Minister. It is a facility/hospital for the observation, care and treatment of persons suffering from mental illness. The regulations and schedules determine the provision of the following essential services:

1. Inpatient services
2. Outpatient services
3. Day-Care services
4. Emergency services
5. Consultative and Educational Services

**Section 20 Classroom**

Ministry of Education Policy and Program Memorandum #85 (1986) outlines the ministry policy for the development of suitable educational programs which recognize **the primacy of the care, custody and/or treatment needs of the children/youth who have been admitted to facilities.** The Student Focused Funding: Legislative Grants Regulation (section 20) provides the regulatory basis for funding educational programs provided by school boards **at the request of the facilities** for children/youth who are admitted to such government-approved facilities.

**Serious Emotional Disturbance**

"Serious Emotional Disturbance" is not defined in law in Canada as it is in the U.S. The U.S. Federal Register (1993) states children with "serious emotional disturbance are defined as persons aged from birth to 18 years who currently or at any time during the past year have had a diagnosable mental, behavioural or emotional disorder of sufficient duration to meet the diagnostic criteria specified in DSM -IV (or comparable criteria) that resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school or community activities". NB: a level of complexity of need that may be characterized by co-morbidity, concurrent disorder, dual diagnosis or the involvement of more than one sector: mental health, child protection, youth justice and

**Skilled and Recognized Children's Mental Health Staff**

Staff working in the children's mental health continuum of services, whose skill set is applicable and necessary to the services they provide and, by virtue of the services they provide, they are recognized as critical facilitators in the provision of children's mental health services. Skilled and recognized children's mental health staff have formal designations relative to the children's mental health sector, although the range of designations may be variable as well as cross-sectoral in nature.

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## **WORKING DEFINITION OF CHILDREN'S MENTAL HEALTH (IDEALMODEL)** *Developed in 2001*

### **CONTEXT:**

Mentally healthy children have the ability to realize their full potential and become competent, productive human beings. Factors which influence a child's mental health begin during the pre-natal period and continue until adulthood. A broad definition of children's mental health encompasses the emotional well-being of children or adolescents and their families. Many important factors are involved in the development of a child's mental well-being. These factors also interact with one another to impact on the child's development and on subsequent adult well-being. These include:

- individual factors such as temperament, physical health, intelligence;
- family factors such as family history of mental illness or physical illness, parents' childhood background (which contributes to their ability to parent), family functioning, siblings' physical and mental health; and
- social factors such as income, school environment, community involvement and peer relationships.

In order to optimize children's mental health, risk factors need to be decreased, children's abilities to cope need to be strengthened and supportive factors have to be built within the family and society. When these factors are not optimized, complex and often concurrent mental health problems begin to emerge which can severely affect the child's ability to function.

The definition of children's mental health is intended to be comprehensive and reflect the broad range of elements that include:

- the concept that "mental health" spans a continuum between wellness and severe dysfunction;
- the inclusion of environmental, genetic and biological factors in the etiology of children's mental health;
- an age range of 0-18;
- the concept of severity and functional impairment;
- the need for diagnostic classification; and
- the inclusion of behaviours.

### **DEFINITION:**

Children with a mental health problem are persons from birth up to age 18 who currently have a diagnosable mental, behavioural or emotional disorder of sufficient duration to meet diagnostic criteria, that resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school or community activities. These mental health disorders can be described using various

classification systems (e.g., DSM-IV, ICD-9, SCIS). Regardless of which classification system is used, children's mental disorders can generally be described in the following categories: conduct; oppositional; attention deficit hyperactivity disorder; anxiety; depression; and other serious mental illnesses.

Functional impairment is defined as limiting a child or adolescent from achieving or maintaining one or more developmentally or culturally appropriate social, behavioural, cognitive, communicative or adaptive skills. Functional impairments of episodic, recurrent and continuous duration are included unless they are temporary and expected responses to stressful events in the environment. Children who would have exhibited functional impairment without the benefit of treatment or other support services are included in this definition.

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