KPMG Consulting

An Ideal Model for Children's Mental Health Services in South West Region

Final Report

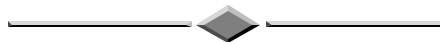
Submitted to:
South West Region Children's Mental Health Services Project Steering Committee

Submitted By:
KPMG Consulting LP

September 2001

Table of Contents

1. **Introduction** 1
   - 1.1 Purpose 2
2. **Project Activities** 3
   - 2.1 Literature Overview 3
   - 2.2 Round One Focus Groups 3
   - 2.3 Round Two Focus Groups 4
   - 2.4 Reference Groups 4
   - 2.5 Town Hall Meeting 4
3. **An Ideal Service Delivery Model for Children's Mental Health Services in the South West Region** 7
4. **Front Door** 11
   - 4.1 Community Resource Coordinators 12
   - 4.2 The Role of System Planning 14
   - 4.3 Implementation Issues/Further Areas to Explore 14
5. **Core and Specialized Services** 16
   - 5.1 Prevention and Early Intervention 17
   - 5.2 Home Based/School Based Services 17
   - 5.3 Clinical Services Including Assessment 18
   - 5.4 Mobile Services 18
   - 5.5 Highly Specialized Services and Supports 18
   - 5.6 Implementation Issues/Further Areas to Explore 19
6. **Residential Services** 20
   - 6.1 Implementation Issues/Further Areas to Explore 22
7. **Summary and Conclusions** 24



Appendix A: Detailed Project Activities
Appendix B: Literature Overview
Appendix C: Children's Mental Health Definition
Appendix D: Service Definitions

Bibliography

1. Introduction

The Ministry of Community and Social Services (MCSS) South West (SW) Region undertook a review of the children's mental health services system. This began in 2000 and continued under the auspices of the South West Region Children's Mental Health Services Project Steering Committee, consisting of representatives from MCSS, in collaboration with the Ministries of Education and Health and Long Term Care.

The SW Region includes the counties of Bruce, Elgin, Essex, Grey, Huron, Kent, Lambton, Middlesex, Oxford and Perth. The population of the SW Region is approximately 1.5 million people of which about 26% or 390,000 are children or youth under the age of 18 residing in both urban and rural environments. Over 125 distinct children's service providers including children's mental health centres serve this population.

The first phase of the review was completed in November of 2000. It involved mapping the service system at the local, community and regional levels. This information provided an understanding of the existing service system. Community and service provider profiles were also completed. Together with a literature review, trend analysis and service linkages, data from the first phase provided important information about equitable access, service flexibility and responsiveness. A Vision for children's mental health services and First Principles were also created.

The second phase of the review began in February 2001, culminating in June with the submission of this report — An Ideal Model for Children's Mental Health Services in South West Region. The second phase was intended to develop a model for the delivery of children's mental health services throughout the SW Region.

The development of the model makes use of the service mapping data as well as evidenced-based research about "systems of care".[1] Most importantly, significant input from numerous focus groups and reference groups throughout the region that included consumers, service providers and Ministry representatives was obtained. This input substantially influenced both the underlying principles that evolved during model development and the major features and functions of the model.

---

[1] Stroul, B. A., (Ed.). (1996). *Children's Mental Health: Creating Systems of Care in a Changing Society.* Baltimore: Paul H. Brookes Publishing Co., Chapter 1.

1.1 Purpose

The purpose of the second phase of the children's mental health services project is to determine the "ideal" children's mental health services model for the SW Region so that existing services and future potential resources will be allocated most effectively. Working with major stakeholders including consumers, service providers and representatives of the three Regional and District offices of the three Ministries, a single, integrated approach to an ideal model for children's mental health services was developed. The ideal model needed to address issues of access for consumers, service flexibility so that a range of options are available and responsive so that services are provided promptly.

2. Project Activities

The project included a number of activities involving focus groups, workshops, reference groups and a town hall meeting of all stakeholders. The project also involved regular, monthly meetings with the South West Region Children's Mental Health Services Project Steering Committee. These activities were intended to create a balance between broadly-based stakeholder participation and consultation and more in-depth consideration and analysis of specific elements and issues of a new service model.

The project provided a unique opportunity for individuals and organizations to plan and develop an innovative and enhanced service system for meeting the future mental health needs of children and youth in the South West Region of Ontario. The project involved extensive community participation in model development.

The next sections briefly explain each of the major project activities (focus groups, reference groups and the town hall meeting). Appendix A provides a more detailed list of activities and lists the members of the Steering Committee.

2.1 Literature Overview

An overview of published literature was conducted. The overview considered strengths, issues and barriers for various key features in a system of care for children and families. Three features of a system of care were emphasized in the literature. These included: (a) developing community-based services and systems; (b) accountability and responsibility for managing and coordinating individual plans of service; and (c) integration of services and the need for collaboration amongst professionals and providers. The need for interventions that take place in the child's most normative environments was also emphasized. Finally, the literature recognized the importance of local prevention and early intervention programs which should diminish the need for more intrusive and costly residential and specialized mental health services.

Appendix B summarizes the literature overview in a matrix table that links references in the literature with the key elements and features of the "ideal" model.

2.2 Round One Focus Groups

The project involved extensive consultation and elicited good representation from consumers and providers throughout the entire Region. During the first round of focus groups, input was sought concerning the key features and characteristics of an ideal model of services. A total of nine consumer groups, involving 46 participants, and three provider groups with 117 participants, were conducted in different communities across the Region. Additionally, a focus group with 18 participants including representatives from the Regional and District offices of the three Ministries (MCSS, MOHLTC, MOE also sought input about the model.

2.3 Round Two Focus Groups

Feedback on and validation of a proposed model occurred during the second round. During the second round of focus groups, consumer and service providers were presented with the results from *Round One* and input was sought to validate the features of the "ideal model". A total of eight consumer groups, involving 51 participants, and three provider groups with 72 participants, were conducted in different communities across the Region. Additionally, a focus group involving representatives from the Regional and District offices of the three Ministries (MCSS, MOHLTC, MOE)" also sought input about the model.

2.4 Reference Groups

The project also sought expert, in-depth opinion from knowledgeable consumers and providers who were invited to participate in four different Reference Groups. Representatives from MCSS, MOE and MOHLTC also participated. These groups met to deal with specific issues and elements of the model that required further exploration. The reference groups included:

- Role of Education in the Children's Mental Health Services System & the Role of children's mental health in the Education System;
- Residential Services & Supports (within a System of Care);
- Front-Door & Role of Community Resource Coordinators & System Planners (within a System of Care); and
- Core and Specialized Services (within a System of Care).

2.5 Town Hall Meeting

A Town Hall meeting was held on June 26th in London. Over 120 people attended from across the region including consumers, providers and representatives from the Regional and District offices of the three Ministries (MCSS, MOHLTC, MOE). The meeting provided a forum for presenting feedback from the reference groups, reviewing the definition of children's mental health, discussing the proposed model and offering the next steps in the process.

Reference Groups — Participants were generally quite pleased with the outcomes of the Reference Groups, particularly with the broad spectrum of representatives who participated in each of the groups, as well as the informative and useful discussions that took place at each Reference Group. Because of the success of these groups, it was recommended that a similar forum or mechanism be used in the future, as this project moves on to its next phase.

Definition of Children's Mental Health — A Draft Working Definition for Children's Mental Health was presented at the Town Hall Meeting. The Steering Committee had reviewed the draft once and decided to provide a broader distribution by sharing it with consumers and service providers at the June 26th Town Hall Meeting.

The Draft Working Definition originally came from a previous consulting project involving representatives of the Ministries of Health and Community and Social Services. That project looked at the various types of data that were being collected by both Ministries in relation to children's mental health. The definition that emerged from that previous project was adapted to fit the parameters of this current project. It was first presented to the South West Region Children's Mental Health Services Project Steering Committee on May 25, 2001. Some revisions were made so that a Draft Working Definition could be presented at the Town Hall Meeting.

At the Town Hall, there was strong reaction to the terminology included in the definition, particularly to the word "diagnosable". For many people, this represented too much of a medical model and raised a number of concerns. In general, many participants at the Town Hall felt strongly that the working definition should not be "diagnosis-driven".

Part of the feedback provided at the Town Hall included the feeling that the definition was too broad. Some people were not sure if the definition was intended to cover children's services in general or whether its intention was to focus primarily on children's mental health.

Some of the discussion at the Town Hall revolved around the definition needing to focus on the healthy aspects, and not necessarily the dysfunctional features of children's mental health. These comments echoed a similar discussion that had previously occurred at the Steering Committee. At the end of that previous Steering Committee meeting it was felt that the issue had been dealt with appropriately by placing a "Context" section at the start of the Working Definition. This "Context" section dealt with the many-faceted approach to building toward "healthy" mental health. However, at the Town Hall, it appeared that participants focused on the "Definition" section and perhaps overlooked the "Context" section.

Participants also commented on the lack of attention in the definition to early identification and early intervention. While this perception is correct, the working definition was intended to only focus on the contextual factors influencing mental health and then providing a definition of children's mental health. It was not intended to address the "service" or "treatment" aspects that could be implemented to deal with children's mental health difficulties. The Steering Committee's efforts at developing definitions for services aspects are included in the next section of the report.

Finally, a number of participants pointed out that Children's Mental Health Ontario (CMHO), a provincial association had already developed definitions similar to the effort provided during this project and that we should consult with them about the directions that they had forged in this particular area.

Service Definitions — The Steering Committee had also worked on developing a series of definitions that would give a common language and understanding to the service aspects that were used to address the range of children's mental health difficulties. These service definitions are included in Appendix D of this report.

Additional Feedback — During the Town Hall meeting, a lot of feedback about the ideal service delivery model was discussed. Two major points that were highlighted throughout the discussion focused on two main themes:

- *The Front Door to What?* — This point reflected on the overwhelming need that people were experiencing in relation to a lack of service throughout the various communities of the South West Region. While there was support for the concept of an easy-to-reach Front Door that could connect people to the appropriate service, people were concerned that a well-functioning Front Door was simply a faster route to finding out that an appropriate service package was not available because of the overwhelming demand.
- *A Focus on Core Services* — The strongest piece of feedback received at the Town Hall meeting was that the number one priority for the ideal service 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 needs of consumers. Addressing Core Services had to occur *first* if successful progress on the ideal model was to be achieved.

3. An Ideal Service Delivery Model for Children's Mental Health Services in the South West Region

The development of an "ideal" service delivery model for children's mental health in the South West (SW) Region used the service mapping data from Phase I of the review. The service mapping revealed important information about equitable access, service flexibility and responsiveness. Model development was also informed by evidenced-based research about "systems of care". Stroul and Friedman define a system of care as "a comprehensive spectrum of mental health and other necessary services that are organized into a coordinated network to meet the multiple needs of children and adolescents with serious emotional disorders and their families"[2] They describe a number of values and principles in an ideal system of care that include comprehensiveness, individualization of services, least restrictive services, family orientation, service integration, strong case management, the need for early intervention, and smooth transitions to other systems.

Using this as a beginning context, input from consumers and providers substantially influenced both the underlying principles that evolved during model development and the major features and functions of the model. Through a substantial amount of feedback, we heard that an ideal service delivery model for children's mental health in the South West Region must:

- have easy and equitable access for all consumers;
- provide access to a balanced range of services that are family focused and which are located in their communities and closer to their homes;
- strive to keep children in their home and minimize the use of residential services;
- provide a 'guide' or 'supporter' for consumers who will help them navigate through the system, create individual service plans and ensure that services are coordinated and remain accountable to the child, youth and families;
- emphasize integration of services, collaboration, use of multi-disciplinary teams and system coordination;
- recognize the unique needs and rights of children, youth and families and deliver services equitably and with sensitivity to race, ethnicity, religion, national origin, disabilities or other characteristics; and
- recognize the uniqueness of each community and build on existing services, initiatives and strengths in each community.

---

[2] Stroul, B. A., (Ed.). (1996). *Children's Mental Health: Creating Systems of Care in a Changing Society*. Baltimore: Paul H. Brookes Publishing Co., Chapter 1.

In light of these principles however, please note that consumers and providers were unanimous during this study in advocating for a system that provides a comprehensive range of non-residential and residential services in each community *first*, before instituting a Front Door, Community Resource Coordinators and a system planning function.

These principles reflect a system that would be consumer-focused and community-based with an emphasis on collaboration and movement toward full-integration of services. In the ideal model, a fully integrated system would allow consumers easy and smooth access to a broad array of services, whether they are provided by a single agency, several agencies or even if they are provided by organizations funded by different ministries.

An important principle underlying the model would be to provide the least restrictive and most normative services possible. Finally, service planning, coordination and accountability would be central characteristics of the model.

The "ideal" service delivery model also embodies the vision for children's mental health developed by the SWR CMH steering committee:

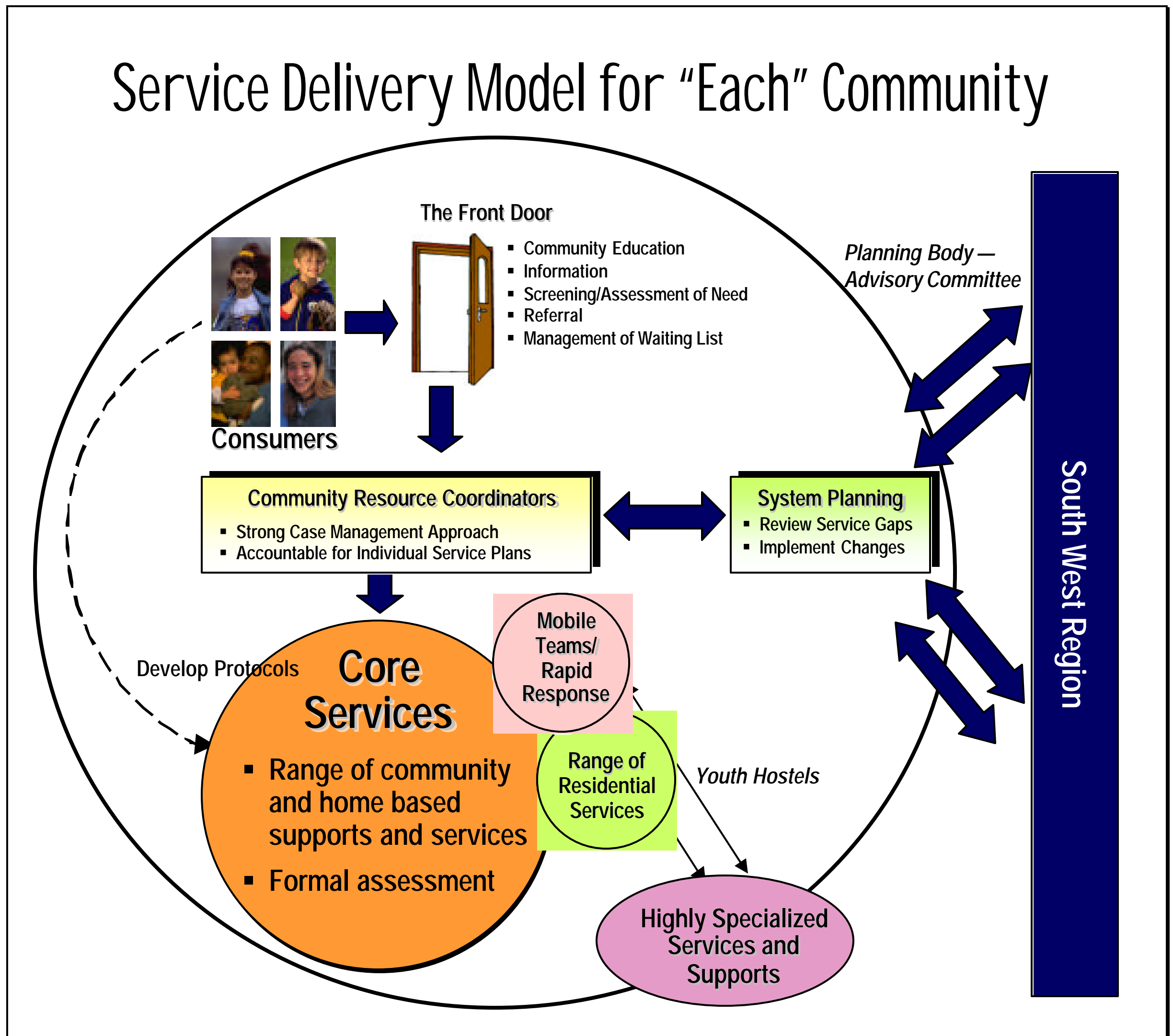
> *A high quality system of children's mental health services that is accountable to the child and family, easily accessible and integrated with other supports for children.*

The features of this "ideal model" include the following elements:

- **The Front Door** — is a "single point of entry" in each community that provides community education and information about the system, screening and initial assessment of need, referrals and management of a single waiting list for appropriate services.
- **Community Resource Coordinators** — who are part of the Front Door function, act as resource developers, provide service coordination through a strong case management approach and, who help empower families and are accountable for each individual service plan.
- **A System Planning Function** — may or may not be an actual position but its function is associated with the Front Door, as a function to act as "community developers" at the local level to identify service/resource gaps and provides system planning.
- **Core Services** — 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.

- **Mobile Services** — that provide a rapid and an immediate response to crisis situations. A rapid response team, located in each community, would mobilize to provide appropriate and timely support and intervention. Workers from within this team would be available on an on-call basis. Psychiatric consultation would also be available.
- **Residential Services** — that provide a range of services located as close as possible to a child's home and community. Residential services should be part of a comprehensive continuum of children's mental health services which begins with supporting the child in his or her own home and community.
- **Highly Specialized Services and Supports** — that address the most severe and complex needs of children as well as providing mechanisms for research and training. These more specialized 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. Specialized services include 24-hour psychiatric telephone support and consultation, local acute-care hospitalization where indicated and treatment for high risk behaviours.

This model is depicted in the following graphic, while the next section of this report describes each of these features in detail.


Service Delivery Model for "Each" Community
The Front Door
Community Education
Information
Screening/Assessment of Need
Referral
Management of Waiting List
Consumers
Planning Body — Advisory Committee
Community Resource Coordinators
Strong Case Management Approach
Accountable for Individual Service Plans
System Planning
Review Service Gaps
Implement Changes
South West Region
Develop Protocols
Core Services
Range of community and home based supports and services
Formal assessment
Mobile Teams/ Rapid Response
Range of Residential Services
Youth Hostels
Highly Specialized Services and Supports

4. Front Door

Provincial and local planning initiatives have identified the need for consumers to have clear and easy access to services. This need was also identified in the Phase I service mapping exercise and was clearly and consistently raised by both focus groups and reference groups during this project. Centralized and "single point of entry" access for a variety of children's services are being implemented across the region but they vary in their scope, structure and stage of development.

While consumers supported these efforts, they identified the need for a more comprehensive and consistent approach to access for immediate screening and assessment of need, along with an immediate response and provision of supports when they were needed.

The proposed "Front Door" is the entry or "single point of contact" for consumers and others in the community. It is where a variety of activities occur which contribute to people getting the help and supports they need when and where they need it, in the way that best serves them. A request may be made in a variety of ways; in person, by telephone, by letter, or electronically over the internet. "Front Door" services are offered with sensitivity to disabilities such as hearing impaired and other characteristics.

The function includes gathering and giving information to consumers, providers, and other professionals. It provides initial screening, initial assessment and understanding of need and then offers referrals so that people are directed to the right place and service.[3] In response to consumer input about multiple waiting lists, the "Front Door" also involves managing a single waiting list for certain services, such as residential services. These activities would be offered across the region 24 hours a day and seven days a week in a consistent and equitable manner.

The following functions are provided by the "Front Door":

- **Community education** so that consumers, providers and other professional are well informed about children's mental health and available resources.
- **In-depth information** about children's mental health, the services available locally and regionally; suggestions, strategies and tools for parents and professionals; and information about children's and parents' rights.
- **Screening and assessment of need:**
    - initial and immediate screening to identify needs and the appropriate services to meet them;

[3] Stroul, B. A., (Ed.). (1996). *Children's Mental Health: Creating Systems of Care in a Changing Society.* Baltimore: Paul H. Brookes Publishing Co., Chapter 23.

- intake processes to gather core information needed by all providers in a manner that facilitates sharing of information with consent; and
- assessment to determine the best course of action to address the child and family's needs using a common assessment tool or protocol (e.g. Child and Adolescent Functional Assessment Scale — CAFAS and the Brief Child and Family Phone Interview — BCFPI).

- **Referral** to core services in the community such as clinical assessments, clinical services, peer & professional support groups for parents, siblings and children, crisis response services and referral protocols that:
  - ensure timely referral and follow-up;
  - address the most urgent cases first;
  - ensure clients are prepared with accurate information; and
  - ensure the smooth transfer of information.
- **Centralized waiting list** maintained for certain services such as residential placements together with an approach that includes a fair and equitable way to set priorities for receiving services.

The intake process at the Front Door includes a technology infrastructure that will support a consistent approach to data collection and the common assessment tools.[4] This will enable key data links between and amongst service providers and the Front Door so that information moves with the client and individuals will "tell their story only once". A technology infrastructure is a key support to providing the data necessary for monitoring of both client and system progress, tracking success to be able to demonstrate or provide proof of what works and the identification of service gaps.

The "Front Door" can be utilized to provide appropriate supports throughout the entire time that a consumer is involved in the system. This includes case management and service coordination by Community Resource Coordinators.

4.1 Community Resource Coordinators

Although many communities have engaged in "wraparound" approaches for some children, accountability for the child and family is still somewhat fragmented. Each agency is essentially accountable for the particular service or services that they have agreed to provide. No one agency is responsible to plan or coordinate a system of services or provide consistent case management for families who require a variety of services from multiple providers.

[4] Stroul, B. A., (Ed.). (1996). *Children's Mental Health: Creating Systems of Care in a Changing Society*. Baltimore: Paul H. Brookes Publishing Co., Chapter 13.

Community Resource Coordinators (CRC) should be the link between multiple providers and between mental health and other systems such as education, health, child welfare and juvenile justice.[5] Consumers from across the region were consistent in looking for an approach that provided a strong, accountable case planning and service coordination function. Consumers, in particular, preferred advocates who would work with them to help them navigate the system, coordinate an array of services for them and ensure that they received the services they needed in a timely fashion and over time as their needs change. In this model, Community Resource Coordinators employ a high level of expertise to help consumers navigate the system and ensure that an appropriate array of services are in place for the child, youth and/or family. The importance of maintaining autonomy and independence in the role of the Community Resource Coordinators was promoted by consumers throughout the project.

The case planning and service coordination function includes:

- a consumer-focused role that is neutral, unique, and separate from the role of service 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 client needs change;
- monitoring 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.

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".[6]

While capacity or availability of an adequate range of services remains a critical challenge, the central role of a Community Resource Coordinator, connected with the Front Door as a unique and neutral function, is key. Given their client-focus, Community Resource Coordinators are able to support the consumer without competing priorities, i.e. they will not have clinical or service provision responsibilities. They are the "client and service experts", who have an in-depth understanding and knowledge of

---

[5] *ibid*, Chapter 14.

[6] *ibid*, Chapter 14.

the community, its resources and are able to manage often difficult and complex situations, to access services and ensure that clients receive what they need in a supportive, effective and timely manner.

4.2 The Role of System Planning

System Planning is currently undertaken, to various degrees, by different players in the social services and health systems. Certain functions are carried out by Program Consultants in the Ministry of Health and Long-Term Care, by Program Supervisors in the Ministry of Community and Social Services and by District Health Councils, for example. Work with stakeholders in local communities needs to take place to monitor and adjust the service system as changes occur over time. Service gaps should be identified and work with the community should be undertaken to establish local priorities and develop plans that will lead to these gaps being filled.

The System Planning role entails a thorough understanding of the local community and the services system. The function involves considerable research on needs, evaluation of outcomes and the development of programs and services. Information gathered at the Front Door during the intake function and over time by Community Resources Coordinators provides an important baseline for understanding service trends and changing needs. System Planning ensures that services match consumer needs at a community level. Some of these functions include:

- working with stakeholders to monitor how the service system is working;
- identifying gaps in service and exploring options to fill those gaps;
- coordinating community activity to fill those gaps;
- working with local planning bodies, advisory committees, the three Ministries and other funders providing regular reports, on the performance of the service system, and on resource needs;
- identifying best practices and staff training needs;
- connecting with other System Planners throughout SW Region;
- building partnerships to address a whole range of needs; and
- ensuring collaboration involving multi-disciplinary teams and the family as much as possible.

4.3 Implementation Issues/Further Areas to Explore

In each section of the report, there is an identification of Implementation Issues & Further Areas to Explore in relation to each major feature of the model. It should be noted that *any implementation that occurs* will be completed over a period of time. It is also important to recognize that it was strongly suggested that a demographic analysis be completed as an implementation task to determine the level of resources required in each community and that this analysis should be compared with a template of the suggested model. There also needs to be acknowledgement that any progress made in

the implementation of an "ideal" model will be difficult to achieve because like any large-scale change management project, this one will have many challenges to overcome to be successful.

As implementation of the model begins in relation to the Front Door, Community Resource Coordinators and System Planning, a number of issues will require further exploration. These include:

- definitions for children's mental health and who should be served (eligibility) are needed;
- a better understanding of case management and service coordination, authority and autonomy of Community Resource Coordinators (the extent to which case managers have authority to prioritize and access services and resources may determine their effectiveness);
- sorting out the various roles and responsibilities in relation to System Planning among Ministry of Community and Social Services' program supervisors & Ministry of Health and Long-Term Care' consultants;
- protocols will be required to deal with linkages and standardize processes between Front Door and service providers;
- the best way to build on local initiatives and capitalize on existing or local "single point of access" services;
- how best to harmonize waiting lists as not all service offerings lend themselves to a waiting list;
- role of 'private sector' and Employee Assistance Programs (EAP); and
- changing roles of major regional providers.

Perhaps the most significant question will deal with "where to begin implementation". Consumers and providers were unanimous in advocating for a system that provides a comprehensive range of non-residential and residential services in each community. The next sections of this report will describe these services in the context of an ideal model beginning with Core Services.

5. Core and Specialized Services

An ideal system of children's mental health service delivery must provide a broad range of services that are located in each community, close to consumers and responsive to the community's needs. The system must be characterized by a local presence that is real and meaningful. The ideal model provides a continuum of services and supports that range from prevention and early intervention to treatment and practical supports.

These services must not only be available close to home, they must also be offered in a timely manner. They must be flexible and adaptive, depending on the individualized needs of the child or youth. They must be responsive and mobile, and linked or integrated with existing resources so that the complete needs of the child are addressed. To be effective, core services must be:

- located in the community, close to home, family-focussed and community-based (services based in the home, school and community wherever possible);
- easily and equitably accessible by all consumers in each community across the region;
- respectful of consumers regarding them as partners in the development and implementation of individualized service plans;
- part of a balanced continuum of services in each community;
- integrated so as to address the complete mental health needs of children, youth and families and emphasize collaboration and the use of multi-disciplinary teams (protocols to support service providers in working together); and
- built on existing services, initiatives and strengths in each community.

Consumers emphasized the need for practical or instrumental services such as in-home supports, in-home respite, support services including child management, parenting skills, social skill building and lay intervention approaches such as home visitors, parent mentors and peer mentors. Research suggests that these kinds of instrumental, community-based services can be cost effective and produce equal or better outcomes than residential treatment.[7]

Clinical services, such as counselling, psychiatric consultations, and assessments must also be community-based and easily accessible. Focus groups also suggested that each community have access to discretionary funds to deal with unique situations.

---

[7] Schmitz, Cathryne L. and Lewayne D. Gilchrist. (1991) Developing a Community-Based Care System for Seriously Emotionally Disabled Children and Youth. Child and Adolescent Social Work, 8, 417-429.

In summary, core services provide a range of supports involving prevention & early intervention, home-based and school-based services, assessment and clinical services, respite, day treatment and emergency services. These are reviewed in the following sections.

5.1 Prevention and Early Intervention

Prevention and early identification 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. Focus groups suggested linkages with programs such as child care, the Healthy Babies, Healthy Children initiative and early school registrations programs at age three to provide a method for early detection. School-based screening for early-age children has been mentioned frequently in the literature.[8] Clearly, these programs require many partnerships created early on in the process of treatment. Collaboration must occur at the service system and community levels and also at the higher Ministry and government levels where policy can be framed to support efforts to provide integrated services.

Schools should play a major role in prevention and early intervention. However, an increased understanding of children's mental health needs is required by teachers. The service system needs to provide local, informal multi-disciplinary teams who can work in partnership with schools, providing training, consultation, sharing of expertise and other consultative initiatives to improve understanding of issues and support teachers in managing children with mental health problems within regular classrooms. Child care centres and early childhood educators should play a similar role in prevention and early identification.

5.2 Home Based/School Based Services

Geared to keeping the child where he or she is living, home-based and school-based services provide needed supports that help manage children and youth in their natural settings.[9] 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. Similar support may be necessary in the school to keep a child in the regular classroom and minimize the use of "Section 19" segregated classrooms. More clinical services also need to be included such as individual counselling, family counselling, wraparound and family preservation models.

---

[8] Wu, P., Hoven, C. W., Bird, H., Moore, R. E., Cohen, P., Alegria, M., Dulcan, M. K., Goodman, S. H., Horwitz, S. M. Lightman, J. H., Narrow, W. E., Rae, D. S., Regier, D. A., Roper, M. T. (1999). Depressive and Disruptive Disorders and Mental Health Service Utilization in Children and Adolescents. American Academy of Child and Adolescent Psychiatry, 38, 1081-1090.

[9] Schmitz, Cathryne L. and Lewayne D. Gilchrist. (1991) Developing a Community-Based Care System for Seriously Emotionally Disabled Children and Youth. Child and Adolescent Social Work, 8, 417-429.

5.3 Clinical Services Including Assessment

Clinical services are community-based and strive to keep the child in their own home. These include individual, group and family counselling, psychiatric intervention and back-up supports including assessment and diagnosis, consultation and education for families and for other service providers. Assessments need to be standardized using common tools such as the Child and Adolescent Functional Assessment Scale – CAFAS and the Brief Child and Family Phone Interview - BCFPI that are tied to services in the system and respected by service providers. Finally, these services are integrated, supported through multi-disciplinary teams of professionals collaborating to deliver services.

5.4 Mobile Services

A mobile, rapid response to a crisis strengthens the family's ability to support children and youth in their own homes or school and avert long-term or recurring situations.[10] In times of crisis, a rapid response team, located in each community, would mobilize to provide appropriate and timely support and intervention. Workers from within this team would be available on an on-call basis. Psychiatric consultation would also be available to provide immediate telephone support for the team and assist in determining the need for local stabilization or, in more serious situations, hospitalization or admission to a local or regional crisis service. Linkages and protocols would be needed involving the role of the local police, hospitals and clinics to ensure back-up supports are in place.

5.5 Highly Specialized Services and Supports

Options for specialized services are necessary in more difficult situations, for the most severe and complex needs. These more specialized 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 and effective fashion. Specialized services include 24-hour psychiatric telephone support and consultation, local acute-care hospitalization where indicated and treatment for high risk behaviours. A recurring theme in focus groups concerned the lack of, or difficulty with, transportation. Consumers stressed the need for assistance to offset costs or provide assistance in helping to transport a child in crisis. Specialized services must also provide a vital research role, examining best practices and developing and delivering staff training across the region.[11]

---

[10] Stroul, B. A., (Ed.). (1996). Children's Mental Health: Creating Systems of Care in a Changing Society. Baltimore: Paul H. Brookes Publishing Co., Chapter 8.

[11] *ibid*, Chapter 15.

5.6 Implementation Issues/Further Areas to Explore

A number of issues were raised during focus groups and reference groups that will require further exploration as the implementation of the model moves forward. These include:

- more "evidenced based" research is required to demonstrate which interventions are most effective;
- transitional resources may be required so that the service system doesn't implement something at the expense of something else;
- assuming limited resources, more clarity is need about identification of priorities;
- clarity is needed about how local teams/protocols will be established and how training will be delivered equitably across the SW Region;
- collaboration and management of multi-disciplinary teams or establishing protocols across professions and ministries will be a challenge; and
- policy, protocols, accountability and governance issues and structures that deal with provider linkages, collaboration and coordinated provision of services across Regional and District offices of the three Ministries need to be formalized.

6. Residential Services

Residential services are part of a comprehensive continuum of children's mental health services which begins with supporting the child in his or her own home and community. Both consumers and providers indicated that 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, the 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.

Supported by evidenced-based research, a number of concepts underlie the delivery of residential services for children's mental health.[12] 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 length 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 focussed**; 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 service coordination for planning and monitoring of placement progress and establish the linkages with community agencies); and

---

[12] Stroul, B. A., (Ed.). (1996). *Children's Mental Health: Creating Systems of Care in a Changing Society.* Baltimore: Paul H. Brookes Publishing Co., Chapter 1, Chapter 24.

- 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 or 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 homes, longer term residential treatment such as group care and crises beds that provide stabilization services.

The range of residential options are described below:

- **Respite (located in each community)**
  - provides stabilization, and the length of stay may range from overnight to 2-3 days[13];
  - the setting could be 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.

- **Associate family or parent model residential resources (located in each community)**
  - provides a family style, "normalized" setting;
  - allows child to maintain connections with their own community, school, friends and family;
  - this type of foster home should have enriched, ongoing training and specialized foster home support workers;[14]
  - regular and frequent relief and respite should be part of the program;
  - availability of regular professional consultation should be in place;
  - should have access to child care/behavioural, social work, psychological and psychiatric assessments;
  - should have a maximum number of children per home (two to three children);
  - homes available in every community, provides both short and longer term care;
  - program can be managed centrally by an existing service provider; and
  - as program becomes operational, it should be preferred option to other alternatives.

---

[13] All time parameters related to length of stay used in this section of the report were compiled from various sources, including literature as well as from Focus Groups and Reference Groups.

[14] Stroul, B. A., (Ed.). (1996). *Children's Mental Health: Creating Systems of Care in a Changing Society.* Baltimore: Paul H. Brookes Publishing Co., Chapter 24.

- **Group Care and Residential Treatment (located in each community or regionally)**
  - provides structure and limits with moderate professional supports for assessments, counselling, guidance, support and coping strategies;
  - should make use of community resources as part of the treatment milieu;
  - services can be geared for more intransigent and challenging kinds of difficulties;
  - length of stay generally varies from three to 12 months;
  - supported by multi-disciplinary team while providing a full range of clinical services including assessments, counselling, group therapy, etc; and
  - depending on age, also provides life skills and transition to adulthood.
- **Crisis and Stabilization (located in community or regionally)**
  - provides stabilization and short-term treatment with an average length of stay from four days to three weeks;
  - supported by and access to multi-disciplinary team for advice, assessment; and
  - used when the child is in crisis, the family is unable to manage the child in the home and respite is not sufficient to manage the crisis.
- **Specialized Services (located regionally or sub-regionally)**
  - provides longer term, more intensive and specialized service than available in a community, e.g. Schizophrenia, Bipolar Disorder, Eating Disorder;
  - length of stay may be up to six months; and
  - supported by various medical specialties and a multi-disciplinary team; provides differential diagnosis, neurological investigation, and specialized structured treatment.

6.1 Implementation Issues/Further Areas to Explore

Several implementation or transitional issues related to service delivery and location (or distribution of service within the region) are noted below. These include:

- Further clarity is needed with respect to what defines a community (county, city, town) and a sub-region (combination of counties, Health Planning District, etc.).
- Further clarity is needed with respect to the supports and infrastructure required to implement and operate an associate family or parent model of residential services.
- What is the role of hostels for youth, as an alternative to residential care?

- What services are needed to prepare youth for independent living and/or ease the transition into the adult system?
- What are the infrastructure requirements (i.e. recruitment, training, ongoing support, access to assessment, etc.) required for associate family or parent model residential resources?
- What is the mix of residential services that should be offered locally and which can be offered regionally?

7. Summary and Conclusions

The children's mental health services system in the South West Region has been addressing issues of equitable access, service flexibility and responsiveness over the past few years. At the same time, there has been a shift within the Ministry of Community and Social Services to match the planning boundaries of the Ministry of Health and Long Term Care. Along with this, there has been a move from having Area Offices to Regional Offices, and therefore new ways of thinking about regional and local services have been occurring. These trends have led this project to develop a single, integrated approach to a system of care for children's mental health services within the broader range of supports for children and families in the SW Region.

The project involved two rounds of focus groups with good representation from both consumers and providers from across the entire Region. Extensive input was sought concerning the key features and characteristics of an ideal model of services during the first round. Feedback on and validation of a proposed model occurred during the second round. The project also sought expert, in-depth opinion from both consumers and providers in four different Reference Groups. These groups met to deal with specific issues and elements of the model that required further exploration.

While the development of the ideal model made use of the service mapping data from Phase I of the project and was informed by evidenced-based research about "systems of care", input from consumers and providers substantially influenced both the underlying principles that evolved during model development and the major features and functions of the model. Although there was not total agreement, a number of consistent themes emerged. These ideas describe a system that is characterized by the following features:

- easily and equitably accessible by all consumers, providing access to a range of services located close to home;
- delivers services that are family-focused and community-based;
- provides a balanced array of services that includes prevention, practical supports, clinical treatment, short and long-term placements and highly specialized services;
- delivers services that are integrated so as to address the complete mental health needs of children, youth and families and emphasizes collaboration and the use of multi-disciplinary teams;
- provides a 'guide' or 'supporter' for consumers who will help them navigate through the service system;
- ensures that services are accountable to the child, youth and family;
- provides ongoing coordination of a package of services to each individual as well as system-level monitoring and coordination;
- maximizes the efforts to keep children in their home and minimizes the use of residential services;

- recognizes the needs and rights of children, youth and families and delivers services equitably and with sensitivity to race, ethnicity, religion, national origin, disabilities or other characteristics; and
- recognizes the uniqueness of each community and builds on existing services, initiatives and strengths in each community.

These principles reflect a system that would be consumer-focused and community-based. The system would be well-understood by consumers and easily accessed by them. There would be an emphasis on collaboration amongst various service providers and a move toward a full-integration of services. An important feature would be the provision of a balanced array of services located in major communities that share a common goal to provide the least restrictive and most normative services possible. Service planning, coordination and accountability are central characteristics of the model. Most importantly, the ideal service model strives to a create a balanced range of services in each community that is easily accessible, accountable and integrated with other supports for children.

Appendix A: Detailed Project Activities

Appendix A: Detailed Project Activities

Round One Focus Groups

- Conducted 12 focus groups with providers and consumers, sought input about key features of a new service model for CMH in South West Region, during the weeks of February 19th to March 5th
    - three provider focus groups (Listowel, London, Windsor), total of 117 participants; and
    - nine consumer focus groups (Owen Sound, Mitchell, London, Tilsonburg, Windsor, Essex, Sarnia, Chatham, Strathroy), total of 46 participants.
- Conducted one focus group with representatives from the Regional and District offices of the three Ministries (MCSS, MOHLTC, MOE) in London, 18 participants.

Round Two Focus Groups

- Conducted 11 focus groups with consumers and providers, presented the elements and key features of a "proposed model" and sought input to validate the model, during the weeks of April 30th to May 10th
    - three provider focus groups (Listowel, London, Windsor), total of 72 participants; and
    - eight consumer focus groups (Owen Sound, Goderich, London, Woodstock, Windsor, Essex, Sarnia, Chatham), total of 51 participants.
- Conducted one meeting with representatives from the Regional and District offices of the three Ministries (MCSS, MOHLTC, MOE) in London, 15 participants.

Reference Groups

- Four reference groups were conducted, comprised of representatives from providers, consumers, and the Regional and District offices of the three Ministries (MCSS, MOHLTC and MOE), during the week of June 4th to June 8th, explored key issues, in relation to the major elements of the model in more detail:
    - *Role of Education in the Children's Mental Health Services System & the Role of children's mental health in the Education System, in London;*
    - *Residential Services & Supports (within a System of Care), in Windsor;*
    - *Front-Door & Role of Community Resource, Coordinators & System Planners (within a System of Care), in Sarnia; and*
    - *Core and Specialized Services (within a System of Care), in London.*

Town Hall Meeting

A Town Hall meeting was held on June 28th in London with over 120 people attending from across the region, including service providers, consumers and representatives from the three ministries (MCSS, MOHLTC, MOE). The meeting provided a forum for presenting feedback from the reference groups, reviewing the definition of children's mental health, discussing the proposed model and offered next steps.

Steering Committee

Comprised of staff from the Ministry of Community and Social Services, Ministry of Education and the Ministry of Health and Long Term Care, this group met monthly to provide advice and insights to the consulting team on all aspects of the project. It worked with the consulting team to plan the consultations and considered various service continuum options. Membership included:

- Peter Steckenreiter, Regional Director (Ex-officio), MCSS.
- Christopher Payne, Community Services Manager, MCSS.
- Ronna Warsh, Community Services Manager, MCSS.
- Helen Lowe, Regional CMH Services Project Co-Lead, Program Supervisor, MCSS.
- Jenny Iserman, Regional CMH Services Project Co-Lead, Program Supervisor, MCSS.
- Bud Carter, Program Supervisor, MCSS.
- Michelle Burd, Program Supervisor, MCSS.
- Debbie Cercone, Program Supervisor, MCSS.
- Anita Jackson, Program Supervisor, MCSS.
- Keith Quigg, Education Officer, MOE.
- Rosanne Perron, Mental Health Consultant, MOHLTC.

Appendix B: Literature Overview

Appendix B: Literature Overview

*Note: **Financial constraints** and **limited human resources** are mentioned throughout the literature as potential barriers to the implementation of many of these features.*

Features of the Model	Strengths	Issues and Implications	Linkages with other Sectors	Barriers
Front Door (Single Point of Access)				
Access Mechanisms	▪ The first essential component of any system of care is the ability to identify and bring into the system all who need care. There are various ways to do this: developing community awareness, directed outreach efforts, and "child find" efforts. ▪ Anyone should be able to call with a concern about a child and be directed to appropriate services. (Stroul, 1996, ch.30)	▪ Children with internalizing problems (e.g., anxiety, depression, etc) are often under-identified or under-referred. Children with "externalizing disorders" (e.g., ADHD, etc) are more likely to be referred and to use mental health services. (Wu et al., 1999)	▪ Schools can provide a single point of access to services in a non-threatening atmosphere, thus reducing the barriers for children who need help. ▪ School based services are the most widely used and the easiest to access. (Wu et al., 1999) ▪ A school that acts as the hub for service delivery has been referred to as the "one-stop" or "full-service" school. (Stroul, 1996, ch.10) ▪ Other services children should have access to in a system of care are: – Social, Educational, Health, Substance Abuse, Vocational, Recreational, and Operational (e.g., case mgmt, self-help groups, advocacy, etc.). (Stroul, 1996, ch.1)	
Screening and Assessment	▪ It is important for initial screening/assessment to have an 'ecological' perspective (i.e., examining the environment in which the child functions and not personality characteristics and deficits). ▪ Assessment leads to a specific, individualized treatment plan that meets the needs of the child and family. (Stroul, 1996, ch.23)	▪ Providing an accurate assessment is difficult and often things are overlooked. There needs to be effective supervision to ensure that assessments are accurate and that referrals are being made. (Leon, 2000) ▪ The primary goal should be to keep child in the community. Residential treatment should be the last option considered. (Stroul, 1996, ch.17)	▪ There is a need for school-based screening and assessment. This will help identify children with psychiatric disorders at an early stage, thus allowing the family to access services. (Wu et al., 1999)	▪ There is a lack of clarity and agreement regarding the criteria and definition of serious emotional disorders. Population is varied in terms of needs, level of functioning, diagnosis, family issues, past services, etc. (Stroul, ch.1 & 4) ▪ Inadequate supervision regarding the process of screening and referrals. (Leon, 2000)

Features of the Model	Strengths	Issues and Implications	Linkages with other Sectors	Barriers
Case Management (“Community Resource Coordinators”)	▪ A case manager can be involved with therapeutic interventions (sometimes referred to as a therapeutic case advocate). (Young, 1990) ▪ Case managers are considered “systems agents” or “brokers”. ▪ They are responsible for mobilizing, coordinating, and maintaining an array of services and resources to meet the needs of children and families over time. ▪ They may also be responsible for monitoring and evaluating service, advocacy, clinical services and financial management. ▪ Case management teams are composed of a group of case managers who share responsibility for a caseload of children. This team can serve to enhance continuity of care, facilitate 24-hour on-call availability, flexible management of crises, accommodate staff turnover, etc. (Stroul, ch.14)	▪ Managing the financial component of care can put case managers in a difficult position. There is an inherent tension between advocating for the best services of the client versus finding the most cost-effective means of service delivery. ▪ Also, there have been issues raised with case managers who are providing clinical services. There is a belief that they are less able to view the client’s progress objectively and independently. (Stroul, 1996, ch.14)	▪ Case management can be the link between mental health and services from other systems (e.g., education, child welfare, juvenile justice, etc.). ▪ The case manager may choose to assemble a multidisciplinary or multi-agency team to assist in the planning and overseeing of services. In this case the case manager would play a facilitative leadership role and work with the group to develop a comprehensive, individualized service plan for the child. (Stroul, 1996, ch.14)	▪ A case manager’s caseload may be too heavy. They may be unable to provide adequate attention to each individual case. ▪ A lack of cooperation between agencies and/or systems. (Stroul, 1996, ch.14)
Core Community-Based Services (Non-Residential)				
Promotion and Prevention	▪ Community-based service is more cost effective and more beneficial to the child’s health and well-being. (Schmitz & Gilchrist, 1991) ▪ From the child welfare literature, research suggests that community-based services provide equal or better outcomes compared with residential treatment. (Leon, 2000)	▪ Many children are not identified as needing preventative supports, particularly in the educational system. In these cases, the children cannot access services, putting a tremendous strain on the child, the family, the teacher and the system in general. (Eber & Nelson, 1997)	▪ Integrated networks of services can help bridge the gap separating the different sectors. (Stroul, 1996, ch.1)	▪ Identification of children with serious emotional disorders. (Eber & Nelson, 1997) ▪ Current funding and policy emphasis is on residential care not community-based services. (Schmitz & Gilchrist, 1991)

Features of the Model	Strengths	Issues and Implications	Linkages with other Sectors	Barriers
Early Identification	▪ Children and their families are able to access services as early as possible. ▪ Early identification avoids long-term, high-cost interventions for a large a pool of children. (Stroul, 1996, ch.10)	▪ Need to develop more early, comprehensive, intensive, and evaluated interventions. ▪ Important to build on knowledge of risk factors, particularly those factors that predispose children to conduct disorders (for example, parenting styles, family stress, social skills training, academic tutoring, classroom interventions). (Stroul, 1996, ch.10)	▪ The school plays an important role in the early identification process, particularly school health clinics. (Stroul, 1996, ch.10)	
Support Services (For example, wraparound and respite services)	▪ Recognition that children and their families need a network of support in service delivery. ▪ Services need to meet the unique needs of children and their families. ▪ Wraparound services are both traditional and non-traditional. They are services specifically designed for individual children and families to enable them to achieve the goals specified in a customized service plan. (Stroul, 1996, ch.23) ▪ Respite services are provided both in the child's home and in out-of-home settings by trained staff. Families are given a much needed break from the physical and emotional demands of care-giving. (Stroul, 1996, ch.8)	▪ Often children with serious emotional disorders are not identified and thus cannot receive support services. This adds a tremendous amount of strain to the system. (Eber & Nelson, 1997)	▪ Supports within and between different systems are essential for children to receive the care they need. (Schmitz & Gilchrist, 1991) ▪ School-based wraparound services allow the child to be able to function in the educational system and for teachers to be able to manage the classroom. ▪ Schools do not often coordinate their own wraparound services. (Eber & Nelson, 1997)	▪ A lack of support for the system of care philosophy (which emphasizes a network of support services, integrated care, etc.). ▪ A lack of resources (financial, time, commitment, etc) that prevent effective wraparound care from being provided and maintained. (Eber & Nelson, 1997)

Features of the Model	Strengths	Issues and Implications	Linkages with other Sectors	Barriers
Crisis Response	▪ Must have 24-hour response capability. (Schmitz & Gilchrist, 1991) ▪ Must also have mobile outreach crisis services available for families. (Stroul, 1996, ch.8) ▪ The goals of crisis-oriented programs include stabilizing the family situation, reducing the risk of out-of-home placement, teaching the family new coping skills, and connecting the family with appropriate community resources for ongoing service needs. (Stroul, 1996, ch.24)	▪ Crisis intervention is usually short-term, however in some cases it needs to be provided on a longer term basis. ▪ If a community has limited services, then brief, time-limited approaches may be insufficient to meet the needs of many families who have children with emotional disorders. ▪ One of the most challenging issues is linking families with appropriate follow-up resources and services. (Stroul, 1996, ch.24)		
Clinical Services	▪ Clinical services such as training in daily living skills, crisis intervention, medication management, supportive counselling, and individual and family therapy, are important both for the child and family. ▪ These services can be coordinated or provided by the case manager. (Stroul, 1996, 14)	▪ As mentioned above in the case management section, there is disagreement over whether or not the case manager should provide clinical services or simply coordinate the various services. (Stroul, 1996, ch.14)		
Residential Services				
Short Term Stabilization	▪ It is important to see the child as quickly as possible to assess the level of care that is needed. ▪ A multidisciplinary team of professionals is one approach to providing comprehensive care for children who are at risk for multiple and complex physical, developmental, and mental health problems. (Example in article includes a paediatrician, nurses, a developmental specialists, a psychologist, and a liaison with the department of social services). (Blatt et al., 1997)	▪ Use of hospital-based or residential programs for the stabilization phase of treatment should depend on the severity of the problems. Hospitalization or residential care should not necessarily be a prerequisite to treatment or the only option available. (Stroul, 1996, 26)		

Features of the Model	Strengths	Issues and Implications	Linkages with other Se ctors	Barriers
Long Term Therapeutic	▪ Residential Treatment Centres (RTC) provide schooling and medical services, allowing children's behaviour and functioning deficits to emerge and be addressed consistently across multiple contexts. (Leon, 2000) ▪ Some children with severe mental health issues may not be able to have their needs met in a less restrictive setting. Intensive non-residential services may not meet the therapeutic needs of the child and family, and it may not be in the interest of the child to remain with the family. (Stroul, 1996, ch.1)	▪ Residential services should be located as close to the child's home as possible in order to cause the least disruption of the child's links to family, friends, agencies, school, and community. This also maximizes the possibility of family involvement in the treatment process and is more likely to prepare the child for successful reintegration into the natural environment. (Stroul, 1996, ch.1)		
Therapeutic Foster Care	▪ This is considered the least restrictive option among the range of residential services. ▪ This approach creates a therapeutic environment in the context of a nurturing family home by providing specialized treatment interventions in a home-based setting. This is different from regular foster care in that it provides a treatment environment not just a substitute family environment. (Stroul, 1996, ch.24)	▪ Therapeutic foster care costs more than regular foster care services but less than residential or hospital services. (Stroul, 1996, ch.24)	▪ Therapeutic foster care programs maintain active linkages with a variety of community agencies, particularly the school system. (Stroul, 1996, ch.24)	▪ The lack of available service options and financial support for the child and foster family. (Stroul, 1996, ch.24)

Features of the Model	Strengths	Issues and Implications	Linkages with other Se ctors	Barriers
Other Components				
Rural Service Delivery		▪ Mental health services are typically concentrated in urban areas. In many rural settings there is a smaller spectrum of services available, requiring patients to travel long distances to receive specialty services. ▪ Families need to have immediate access to crisis intervention and emergency services, which is more difficult in rural areas. ▪ Generally, children see a primary care physician as opposed to a specialist. The general provider may not always be able to recognize mental health problems. (Yuen et al., 1996)		▪ The lack of service resources and mental health specialists. (Yuen et al., 1996)
Human Resources	▪ Human resources allow the system to function, both in terms of providing the necessary services but also in providing support for parents and children. (Stroul, 1996, ch.15)	▪ There is a high level of concern over array of workforce issues such as: ability to recruit appropriately trained staff, staff retention, in-service training, sufficient numbers, racial, ethnic, and cultural diversity, and finally geographic distribution of staff. ▪ There is not a human resource development office that focuses on the child and adolescent system. (Stroul, 1996, ch.15)	▪ It is important that specialized staff be recruited and trained to work in all sectors that children with serious emotional disorders come into contact with (e.g., education, child welfare, juvenile justice, etc.). (Stroul, 1996, ch.15)	▪ Insufficient funding, salaries are too low, too few who are trained are entering the public system, caseloads are too heavy, bureaucracy is frustrating, staff feel ineffective with clients because of lack of access to resources. (Stroul, 1996, ch.15) ▪ Lack of trust, shared vision and commitment between staff within and between agencies/systems. (Schmitz & Gilchrist, 1991) ▪ “System reactivity” where children are refused care or ejected from the system (e.g., juvenile justice, education, etc.). (Nugent & Glisson, 1999)
Information Technology	▪ An integrated data-management system would have the capacity to combine information about children service systems so that families do not have to be subjected to multiple intakes and assessments. It also would track services received by children and families over time. (Stroul, 1996, ch. 13)	▪ A comprehensive database system would allow for the elimination (or at least limitation) of paperwork barriers. (Stroul, 1996, 30)	▪ Information from all sectors would be integrated into one data-management system. (Stroul, 1996, ch. 13)	

Appendix C: Definition of Children's Mental Health

Draft
Working Definition of Children's Mental Health

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.

Appendix D: Service Definitions

Definitions for the Continuum of Services

Prevention

These supports and/or services are 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 or coping skills), or characteristics of their environment (such as poverty or family violence) and 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).

Early Intervention

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 healthy development.

Assessment Services

Assessment is referred to as evaluation or diagnostic services conducted by a professional. Information on an individual's or family's strengths, needs and resources is collected and recommendations are made for treatment and related services.

Out Patient Treatment

Out patient treatment is provided in a variety of settings and typically consists of individual, family or group therapy.

Home-Based/ School-Based Services

Home-based / School-based services are provided on an outreach basis in the home/school of the child or youth. Typically, this type of children's mental health services are family-centred, intensive and immediate.

Respite Services

Based on the belief that quality respite services promote healthy families, respite can be provided in a number of ways: out of a child's home in a residential setting; working with various community agencies to expand the range of respite services available to families in their own homes, and the creation of respite drop-in sites.

Day Treatment

Day treatment services are offered for a longer period of time. Day treatment integrates educational, counselling and family interventions and child/youth participate on a daily basis.

Emergency Services/Crisis Services

Emergency or crisis services are community-based and designed to avert hospitalization, and stabilize the situation. Emergency services are available 24 hours a day, seven days a week on a short-term basis. Emergency services are short term and provide evaluation, assessment, crisis intervention, stabilization and follow up planning.

Local Acute Care Hospitalization

In extreme situations children and/or youth with serious acute disturbances/distress in imminent danger to self or others are admitted to hospital. Medical staff are on site and there is a defined linkage to clinical supports.

Associate Family or Parent Model

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

Therapeutic Group Care

Therapeutic group care is provided in homes which support groups of five to ten children and/or youth. A range of therapeutic interventions is available for children and/or youth with mental health difficulties.

Therapeutic Camp

Therapeutic Camp generally represents a summer experience for children and/or youth with mental health difficulties. It is provided in a camp-setting and offers camping experiences along with a range of therapeutic interventions.

Independent Living Services

This type of children's mental health residential service is typically for transitional aged youth and is designed to promote independence.

Residential Treatment Services

Children and/or youth with serious mental health disturbances are supported by a multi-disciplinary clinical/treatment staff on site. There is a high staff/child ratio and an on site school available. Typically there is a well defined linkage to clinical support and community children's mental health service providers.

Crisis Residential Services

These services are non-hospital, short term, community-based and designed to provide a level of stabilization and resolve the crisis. There is a strong linkage to clinical supports.

Bibliography

Bibliography

Blatt, S. D., Saletsky, R. D., Meguid, V., Critz Church, C., O'Hara, M. T., Haller-Peck, S. M., Anderson, J. M. (1997) A Comprehensive, Multidisciplinary Approach to Providing Health Care for Children in Out-of Home Care. *Child Welfare*, 76, 331-47

Eber, L., Nelson, C. M. (1997) School-based Wraparound Planning: Integrating Services for Students With Emotional and Behavioral Needs. *American Journal of Orthopsychiatry*, 67, 385-396

Leon, S. C., Lyons, S., Uziel-Miller, N. D., Rawal, P., Tracey, P., Williams, J. (2000). Evaluating the Use of Psychiatric Hospitalization by Residential Treatment Centers. *American Academy of Child and Adolescent Psychiatry*, 39, 1496-1501

Nugent, W. R., Glisson, C. (1999) Reactivity and Responsiveness in Children's Service Systems. *Journal of Social Science Research*, 25, 41-60

Rivard, J. C., Johnsen, M. C., Morrissey, J. P., Starrett, B. E., (1999) The Dynamics of Interagency Collaboration: How Linkages Develop for Child Welfare and Juvenile Justice Sectors in a System of Care Demonstration. *Journal of Social Science Research*, 25, 61-82

Schmitz, Cathryne L. and Lewayne D. Gilchrist. (1991) Developing a Community-Based Care System for Seriously Emotionally Disabled Children and Youth. *Child and Adolescent Social Work*, 8, 417-429

Stroul, B. A., (Ed.). (1996). *Children's Mental Health: Creating Systems of Care in a Changing Society*. Baltimore: Paul H. Brookes Publishing Co.
Ch. 1: The System of Care Concept and Philosophy (Stroul & Friedman)
Ch. 4: The Population of Concern: Defining the Issues (Friedman, Kutash & Duchnowski)
Ch. 10: The Role of Education in Systems of Care (Knitzer)
Ch. 14: Service Coordination in Systems of Care (Stroul)
Ch. 15: Human Resource Development (Pires)
Ch. 17: Measuring Outcomes in a System of Care (Stroul, McCormack, & Zaro)
Ch. 23: Individualized Services in a System of Care (Lourie, Katz-Leavy, & Stroul)
Ch. 24: Community-Based Service Approaches: Home-Based Services and Therapeutic Foster Care (Stroul & Goldman)
Ch. 30: Systems of Care for Children with Special Health Needs (Bronheim, Keefe, Morgan, & Magrab)

Yeun, E. J., Gerdes, J. L., & Gonzales, J. J. (1996). Patterns of Rural Mental Health Care: An Exploratory Study. *General Hospital Psychiatry*, 18, 14-21

Young, Thomas M. (1990) Therapeutic Case Advocacy: A Model for Interagency Collaboration in Serving Emotionally Disturbed Children and Their Families. American Journal of Orthopsychiatry, 60, 118-124

Wu, P., Hoven, C. W., Bird, H., Moore, R. E., Cohen, P., Alegria, M., Dulcan, M. K., Goodman, S. H., Horwitz, S. M. Lightman, J. H., Narrow, W. E., Rae, D. S., Regier, D. A., Roper, M. T. (1999). Depressive and Disruptive Disorders and Mental Health Service Utilization in Children and Adolescents. *American Academy of Child and Adolescent Psychiatry*, 38, 1081-1090