7-12 LATENCY AGE WORKING GROUP

Final Report

July 2017

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MESSAGE FROM THE CHAIR

The middle years are profoundly important in child development, especially through a mental health lens. In particular emotional regulation, self-control and social skills are developed during this time and the importance of these skills are now recognized as key to social and educational development. Also, the impact of adverse early childhood experiences often manifest during these middle years and intervention is required or else the risks are high for accelerated trajectory. Not surprisingly, prevalence studies show that the highest prevalence of children's mental health profile clusters during these years are children with disruptive behaviour and children with significant anxiety disorder. With growing public awareness, our agencies face increasing demand for service without any funding support. Notwithstanding this dilemma, we are compelled to look for, and act on, improvement opportunities and how we can work together as a system to do the best for Toronto's children.

As Chair of this working group, I had the pleasure to work with outstanding colleagues from Toronto's latency age serving agencies and I would like to thank them for their clinical acuity and commitment to our work. As we worked together, we connected more, began to see increasingly through a common perspective and at a higher altitude beyond our individual agencies to a system perspective. While wanting to improve services, we came to appreciate the challenge of not having the data to do this reasonably, and accordingly have made a strong recommendation about this. We did make a start at cataloguing the existing children's mental health services that will be required not only for planning but also for the central-point-of-access (CPA).

We see opportunity and interest to continuous improvement in particular, by elevating services using best evidence for the needs and issues we are addressing. If we successfully act on this, we can improve not only the client experience but also improve outcomes. While most of the services we offer deal with Level 3 need, as a system we also provide for Level 2 and 4. We saw gaps and pressures particularly in the intensive services available to Toronto's children and families. Particularly for this age group, all members felt that this balanced range of offerings was appropriate. We discussed and agreed for latency agencies to cover clinical need in their area but also to specialize and increase focus in some areas and modalities and to give parents choice to travel for this specialization.

Finally, we saw many opportunities for continuing improvement by collaborating on training opportunities and other work including looking at providing common planned programming. These opportunities can be realized if the LAWG continues to meet to bring these ideas to life. There is a saying, 'we didn't come this far, only to come this far'. If we continue to meet and continue our systems perspective, we can achieve ongoing progress and improvement.

Tony Diniz
Chief Executive Officer
Child Development Institute

INTRODUCTION

Moving on Mental Health (MOMH) is an important part of Ontario's Comprehensive Mental Health and Addictions Strategy. The plan ensures children, youth and families can get mental health services in their communities that are accessible, responsive and based on the experiences of the children and youth who need help. The goal of MOMH is to ensure all children, youth and families in Ontario have easy access to:

- Mental health services in their communities, and
- Mental health services and supports that meet their needs

Strengthening the community-based system for delivering mental health services will bring people and organizations closer together locally and benefit everyone.

East Metro, Toronto Lead Agency

As the lead agency for Toronto, East Metro Youth Services (EMYS) is tasked with leading the implementation of the MOMH action plan in Toronto. Once fully implemented, MOMH will transform the experience of Toronto's infants, children, youth and families living with mental health challenges.

Working in collaboration with the other service agencies and through extensive, meaningful engagement of youth and families, EMYS is working to facilitate system-wide changes to better improve access, experience and mental health outcomes for infants, children, youth and families who need and rely on the Children and youth mental health system in Toronto. EMYS also participates in province-wide lead agency discussions, sharing lessons and insights and informing a province-wide approach to the MOMH action plan.

Collective Impact – A Collaborative Approach

Collective Impact Framework is based on the belief that no single organization can tackle or solve the increasingly complex social problems we face as a society. The framework based on the premise that multiple organizations need to work together toward a common agenda.

John Kania & Mark Kramer first wrote about collective impact in the *Stanford Social Innovation Review* in 2011 and identified five key elements for Collective Impact to succeed. EMYS has adopted these elements to guide and shape our work in leading the transformation of the community-based child and youth mental health sector in this city.

1. **A common agenda**
   Coming together to define a problem and create a share vision to solve it
2. **Shared measurement**
   Agreeing to track progress in the same way, which allows for continuous improvement
3. **Mutually re-inforcing activities**
   Co-ordinating collective efforts to maximize the end result
4. **Continuous communications**
   Building trust and relationships among all participants
5. **Backbone support – East Metro Youth Services**
   Dedicated staff to coordinate, support and facilitate key activities and processes

Role of Working Groups
The sheer number of organizations both inside and outside the community-based child mental health sector requires a more intentional focus on relationship building and coordinating opportunities to simply engage and build a spirit of collaboration. These time intensive activities are foundational to building a sustainable system change.

To help lay the foundations for Toronto's system transformation, working groups were established to leverage the expertise of the core service providers (CSPs). In addition to providing the invaluable research, analysis and recommendations which help to inform the development and ongoing adaptation of the Core Services Delivery Plan and Community Mental Health Plan, nearly all agencies providing core services participated as working group members, contributing greatly to the spirit of collective impact and forming emerging relationships across agencies. The analysis, recommendations and research results provided by the working groups will continue to be incorporated into the larger analysis and planning process as we move forward.

7-12 WORKING GROUP MANDATE

The goal of the Year 2 working groups was to continue the foundation of work completed in Year 1 by the lead agency and Year 1 working groups to identify the current landscape for MCYS core services. Harnessing the expertise and experience of its members, working groups provided analysis and recommendations assessing where we currently are as a sector and what is needed to "move the needle". Understanding the service landscape is a critical component of planning for service delivery. The specific mandate of the 7-12 Working Group was to expand the system profile as it relates to both the specific age focus as well as the broader Toronto context. (See **Appendix 1** for Mandate Letter)

METHOLODY

Working group meetings (See **Appendix 2** for membership list)
Membership of the 7-12 Working Group represented a selection of agencies providing treatment within the core services funding portfolio to latency aged children in Toronto including those offering services in French and Toronto's only agency with a residential treatment program for latency aged children. Many of the agencies represented also provide services that cross into the early years (0-6) and adolescent (13-18) age groups and offered insight into the challenges of transitions in and out of latency programs. Additionally, membership in the working group included representation from clinical and program directors and executive director/CEOs of the agencies.

Meeting on regular basis, the Chair led the working group through discussion and analysis of key issues, challenges and opportunities brought forward from members' professional experience, as well as from the working group's investigative and research activities.

Review of relevant reports (See **Appendix 3**)
As discussed in the analysis and recommendations, there is a significant gap in data and information within Toronto's infant, children and youth mental health sector. This is not to say that we are starting with no information. The working group began its mandate with a review of existing reports and report

summaries to establish a general baseline of the clinical cluster profiles and prevalence for latency age children. This was then brought into a Toronto-focus through discussions of the experience of Toronto's service providers and reconfirmed supplemented through a targeted survey.

Building on the 2015-16 Multi-Sectoral Latency Age Working Group (See **Appendix 4**)
In June 2016, the multi-sectoral Latency Age Working Group finalized a report producing analysis and recommendations to its members (representation included organizations serving latency age children in child and youth mental health agencies, education, child welfare, health/hospitals, crisis services and French language services). Given that the scope of analysis and recommendations was comprehensive and included issues for transitioning in/out of latency age services and the children and youth mental health (CYMH) sector, the report was distributed to all of the Year 2 Working Groups and Tables. The 7-12 Working Group dedicated considerable time to reviewing and analyzing the relevant components as part of their work, building on those areas to inform the SWOT analysis and development and priority setting of the recommendations included in this report.

Survey of CPSs providing services to 7-12 population (See **Appendix 5** for the survey report)
To support the SWOT analysis, the 7-12 Working Group developed a survey that examined current capacity (FTE and educational background) of agencies serving latency age children in Toronto, types of services and evidence-based mental health interventions provided, and the location where these services are made available. The survey was provided to 10 CSPs known to provide core latency age mental health services in Toronto. Hospitals, child welfare and other agencies whose core mandate is not the provision of mental health services to latency children were not surveyed due to time and resource limitations.

Key survey questions included:
- How many CMYH referrals are received by latency age serving organizations?
- What is the clinical FTE available at these organizations to serve latency age clients? What are the professional designation OF these clinical staff?
- Where latency age mental health interventions ARE offered across Toronto?
- Which are the most community used interventions for latency age clients?

Conclusion - Thanks to the 100% participation rate by the agencies, a significant amount of information was received for this survey. Further data mining of this information and data gathering from other CSPs is important to have a more complete picture of prevalence, service availability and access. Mapping of interventions shows that there are many evidence-based interventions being offered throughout the city and many organizations are providing services in areas of Toronto other than their "home base". However, there seems to be some areas where there are gaps. This should also be further studied.

There are a variety of skills and resources available to latency age children throughout Toronto, but it is not known how these resources can be best deployed until there is a comparison and alignment with census and prevalence data. It will also be important to survey the other organizations as a follow up activity. Having a mechanism to gather and share with each other the information that we currently gather would be helpful in beginning to align resources, skills and need.

Consultation with other working groups and tables
One of the key learnings from Year 1 was the need to better facilitate knowledge sharing among the groups established to research, analyze and develop recommendations for the lead agency to consider

in its system planning. To address this, Tony Diniz, Chair of the 7-12 Working Group, attended regular meetings of the Year 2 Chairs where key areas of analysis and draft recommendations were shared and discussed.

Youth and family engagement

Recognizing the size, diversity, and complexity of the Toronto service area the Lead Agency has focused their youth and family engagement work on two fronts: A long-term framework and strategy development involving building capacity within the system to engage families and youth and immediate efforts towards embedding engagement processes and commitments in the operations of organizations and systems. To inform this work and provide a lens to view the working group recommendations, the Lead Agency developed and implemented, in partnership with the working groups, peer-led consultations. In this project youth and family members were trained to lead consultations and took part in forming questions, and interpreting results. 7 consultations were held, and 51 youth and family members participated.

STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS ANALYSIS

Mental health problems begin to emerge and be identifiable during the latency age (7-12) developmental stage of children. In the field of mental health latency is generally identified as being approximately 7-12. It is during this stage that many developmental milestones are achieved and when learning and socialization become major goals. Latency children are still highly dependent on their parent(s) and families, and strong trusting relationships build resiliency for future challenges. Family relationships are the foundation upon which latency age children develop trust and the skills to form new relationships. During the latency period, children are expected to learn, get along with others and develop skills that will prepare them for next stage growth including self-regulation and independence.

2010

The Latency Age Working Group (LAW) had originally been formed in Toronto by MCYS prior to 2010 to address the impact of reduced availability of residential services for latency age children and to consider alternatives to residential care. Child Welfare had indicated a concern about the lack of intensive services available for latency age children and who had as a result, been referred to their organizations.

2015-2016

LAW reconvened in 2015-2016 to conduct an analysis of needs and gaps in the service system for children under 12 and their families. The 2015-2016 LAW group was co-facilitated by Brian O'Hara (Delisle Youth Services) and Cathy Masters (C.A.S.). The 2015-2016 group was comprised of representatives from Child and Youth Mental Health, two school boards, Child Welfare, Hospitals and MCYS (see attached report).

2016-2017

In 2016, the lead agency, convened a latency age group to conduct a SWOT analysis of the service system for this age group. The group was charged to make recommendations regarding priorities. The 2016-2017 LAW was made up of latency age CYMH core service providers serving children across Toronto.

The following represents themes that emerged regarding the strengths, weakness, opportunity and threats of the CYMH service system for latency age children in Toronto. This analysis was based on the aggregated discussions gathered from the 2015-2016 and 2016-2017 LAW groups. In 2016-2017, a survey was disseminated to 10 organizations in Toronto who identify themselves as providing core mental health services to latency age children. However, due to limited resources, this survey was not distributed to those organizations that are recipients of CYMH funding but who do not identify themselves as being core service providers of latency age mental health services (e.g. child welfare, health, crisis providers (e.g. Youthdale) or who have a broader mandate (e.g. JCA)). This could be a follow up task in the future with those organizations.

Strengths

I. Values and principles
- The Toronto CYMH system for latency age children has a strong commitment to strength-based and multi-disciplinary approaches that includes the skills, knowledge and expertise of various professions. Services are not medically oriented nor pathology focused
- Principles of child and family involvement, individualization, continuity of care, normalization, evidence-informed/based practices, and assessment of risk are embedded in clinical practice
- The relationships between existing latency age CYMH centers is strong. This is based on a history of effective working relationships as well as partially due to a manageable number of providers. These relationships allow for knowledge exchange as well as service support for clients (e.g. "warm" transfers) and contributes to effective continuity of care

II. Distribution, range and type
- There is at minimum, one CYMH Centre situated in North, East, South, West and Central Toronto
- Toronto's latency CYMH system is serving children who present with levels "2, 3 and 4"of complexity. (See Survey results). At a general level, the services provided by the CSPs are well aligned to the specific mental health needs of the latency age population (e.g., oppositional defiance disorder, anxiety, learning disabilities, attention deficit, etc.)
- An initial analysis of services (See Survey results), interventions and resources allocated across Toronto shows that community based services are available through the city and these services represent the various MCYS funding data elements (in particular: targeted prevention, brief, family skills building and counselling)
- Walk-in services seemed to have improved access and reduce wait times
- The increased availability of in-home specialized assessment and treatment services (as an alternative to residential programming) is an important service for latency age children who are at levels 3 and 4 of complexity. This aligns with the principle of normalization which seeks to provide the least intrusive measure to achieve positive outcomes

III. Access, coordination and continuity of care
- Location (e.g. home, community) of services in the CYMH sector is flexible
- Services are available Monday through Friday from approximately 8:00 am– 8:00 pm. Intensive in-home services are also available on weekends
- There is a centralized access and referral system (C.A.R.S) for referral of children in need of intensive in-home services and residential services who have intensive/complex needs and high-risk behaviors

- There is some existing funding and support mechanisms/processes to provide some flexibility, urgent and specialized care when needed (e.g., STEPPS Funding; WIT funding to for highly complex latency age children; the Acute Support Unit at Youthdale (differential diagnosis and recommendations); Crisis Mobile Service and Transitional Psychiatric Unit at Youthdale (urgent issues and difficult transitions)

IV. Knowledge and skills
- Organizations have the necessary knowledge, skills and experience to respond to the mental health needs of latency age children and their families (see Survey results)
- An initial analysis of evidence-based practices indicates that EIP/EBP's are available throughout the city. Family therapy continues to be one of the top five strategies used with latency age children. (See Survey Results). This approach is aligned with best practice for this age group, and is normalizing for latency age children. This also reflects the principle of client centered approaches and client as expert in clinical practice

V. Data and information services
- Seven of the ten latency age CYMH providers surveyed use a common data and information system (i.e. CYSIS). (Youthdale although not a part of this survey, is a provider of some services to latency age children, also uses CYSIS)

Weaknesses

I. Branding and awareness
- There is public lack of awareness of CYMH services
- There is a professional (particularly G.P.) lack of awareness regarding CYMH services

II. Legislation and regulations
- Legislation (across ministries), regulations and policy pertaining to the needs and rights of latency age children is inconsistent and contradictory (e.g. consent). This affects service delivery models and confusion regarding child rights, parental rights and agency responsibilities
- Health, mental health and education definitions of latency age children are not aligned with each other. This creates confusion for both professionals and parents, children, youth when seeking, referring and accessing CYMH services. This also contributes to challenges in transitions between organizations who have age range mandates.
  - o MCYS data elements categorize children between the ages of 0-5, 6-14, and 15- 17
  - o The mental health field categorizes developmental stages for infants and toddlers (birth to 3), pre-school (3-5), latency (6-12), and youth (12 and over)
  - o Education categorizes learning stages for children as those children in Primary grades (JK-6; age 4-11), Middle School (Grade 7-8; age 12-13) and High School (Grades 9-12: age 13 -17)
- Toronto District School Board, Toronto Catholic School Board, Francophone School Board districts, LHINS and sub-LHINS, and CYMH boundaries are not aligned with each other. This makes seeking child and youth mental services more difficult for parents and professionals. The lack of consistency also limits collaborations between sectors and providers

III. Distribution, range and type

- There is a need for more intensive type of services for latency age children who are at levels 3 and 4. Child welfare have indicated that it is difficult to find timely and effective treatment (including residential services) for latency age children
- There is a lack of clarity and agreement on protocol and decision making regarding type of intensive services is most appropriate for latency age children. In-home intensive or residential is often considered where the child's symptoms are such that the child cannot be maintained in a community setting or school. However, there is a paucity of information and criteria that helps to inform which children and families are most likely to benefit from in home intensive or residential
- Specialized Consultation: There is a lack of comprehensive framework for specialized consultation services (e.g. psychiatry, psychology, occupational therapy, speech and language, etc). Availability of these services is often based on historical funding or resources. It is unclear how much of this resource is needed across the city
- Residential: There is only one agency (Aisling Discoveries) in Toronto that provides latency age residential treatment and this is situated in East Toronto. This creates challenges in at least two areas a) access is a problem for parents who live in other parts of Toronto, b) There is a greater demand for residential services that is available. Mental health problems for these children are likely to exacerbated and more difficult to treat as they continue to wait. Child Welfare, emergency departments and crisis services may be more frequently called upon or accesses and these are not effective for the long term (revolving door)
- Intensive in Home: There are two organizations that provide in-home, intensive latency age children. Both services are accessed through C.A.R.S which is helpful to coordinate and manage access. However, there are also wait times, and the impacts are similar to residential (as above). Some organizations continue to have historical Intensive Child and Family Services (ICFS) which were intended to provide home based intensive services. Fiscal restraints have reduced the availability of these services
- Day Treatment: There is insufficient availability of day treatment Section 23 type classes for latency age children who present with serious externalizing behavioral challenges. Often WIT needs to be involved or agencies need to go beyond their resources to provide one to one. (Further analysis regarding day treatment services is available through the Section 23 Working Group)
- The Education system has limited educational alternatives for very highly complex latency age children who are not in Section 23 type class but who require more intensive services and/or one-one in order to be maintained in Section 23 programs
- Transitional type services (step up and step down from hospitalization, crisis services, Section 23, etc.) are limited and inconsistent for latency age children who have complex needs. There are few agreed upon protocols in place specifically around step-up and step-down for latency age kids. The lack of transitional type services makes it very difficult for children and families to maintain gains
- Crisis Supports: Crisis supports for latency age children are limited in Toronto and not necessarily geared to that developmental stage (e.g. Youthdale, hospital emergency department, police crisis response units)

- **Respite:** Respite services are not available for parents of latency age children with mental health challenges. Mental health problems in latency age children affects parental stress, relationships, resiliency, employment, job retention, housing, etc.
- Diversity: There is insufficient data regarding the mental health needs of children who come from diverse backgrounds and/or languages. There is also limited capacity to respond to children and families of diverse backgrounds and/or languages, including French language services. Translation costs are very expensive and there is no specific funding allocated for translation

IV.   **Access, service, coordination and continuity of care**
- There are limited latency age mental health services available on weekends. The need for this is an area for exploration
- There is not a common framework for memorandums of understanding between hospitals and CYMH which would support improved access, mental health services and continuity of care for latency age children. Hospital emergency services are not set up for referral of latency age children in mental health crisis. Alternatives to hospital emergency services for latency age children need to be considered
- Longer wait times for ongoing CYMH services such as individual therapy, family therapy, or other ongoing treatment services affect timely access for children with complex needs. Long wait times for these services lead to more deeply embedded mental health problems that are more difficult to address
- There is inconsistency in the definition and practice of service coordination for children and families across all sectors who service latency age children
- Within an environment of continued fiscal restraint and resulting siloed services, there is less availability and access to necessary disciplines which are enabling to effective outcomes (e.g. occupational therapy, speech therapy, psychological assessments, etc.
- When children are experiencing mental health problems in the education sector, school boards are challenged when it comes to providing timely assessments impacting the ability to make good decisions about appropriate classroom recommendations or referrals to mental health services. Latency age children are particularly affected by this as psychological assessments in general are not considered valid until grade 2. This delays children receiving a recommendation for a mental health referral for at least a year
- Currently service coordination and transitions support is as an expected activity for service. However, the delivery of service coordination and transition support for complex latency age children is very labor intensive and impacts service targets and direct service availability
- There are very limited service navigation services for latency age children with complex needs. This becomes a greater need with complex latency age children where there are increasing needs to access other providers within and outside the sector
- Access is often a renewed challenge when children need to move between organizations and change providers due to age limitations set by organizations. These transitions also affect continuity of care

V.   Knowledge and skills

- There is not a common framework for the necessary core clinical knowledge, skills, assessment, treatment, discharge and best clinical approaches/practice for latency age children
- Lack of common documentation for assessment, treatment, discharge and follow up. Common documentation would support continuity of care as well as acceptance of CYMH expertise across sectors
- There are gaps in knowledge and skills and/or resources in serving latency age children with a diagnosis of fetal alcohol spectrum, ASD and dual diagnosis. While these are not considered mental health areas, some features of these diagnoses present similarly to children with mental health problems
- There is a lack of a consistent framework to address child mental health related to high conflict families. There are also gaps in knowledge and resources to address child and youth mental health issues because of high conflict families
- There is a need for a comprehensive, consistent training approach and support for educators and classroom child therapists in effective behavioral management approaches

VI.   Data, information and evaluation

- The lack of alignment between MCYS age categories and the mental health field is problematic as the MCYS data set does not lend itself to be well analyzed for expected outcomes and comparison for this age group
- There is not a mechanism or framework to analyze common data elements, utilization, duplication etc. between providers
- At present, there is no common outcome measurement tool (previously, BCFPI and CAFAS were the most commonly used)
- Current prioritization and risk tools are not well formulated and are not normed for latency age children
- Inconsistency regarding expectations for target caseloads and direct service.
- There is a lack of data and analysis to address the question of geographical equity in relation to age (e.g. 0-6, latency, adolescents) complexity, level of intensity, etc. There is a strong impression in the sector that there is significant inequity with respect to age based services with adolescent services representing a much higher investment relative to population
- Not all latency age child mental health organizations have the necessary Information Services staffing to manage, monitor and maintain information services and data well. There is a lack of standards as what level of staffing and knowledge required for effective information services
- Not all child mental health organizations have evaluation resources to evaluate services and monitor outcomes. Those organizations that do have evaluation capacity use these resources fully. There are limited resources to develop information frameworks, gather common data and establish protocol and mechanisms to evaluate outcomes

Opportunities

- Leverage the relatively small number of latency age CYMH centers to seek opportunities for collaboration, knowledge exchange, standardize common language and develop a framework for best practice

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- Increased focus on data and information should be leveraged to help establish a framework for clinical practices which also align with   most frequen.t presenting clinical clusters (e.g. interventions which focus on oppositional defiance, anxiety)
- Identify those strategies that are effective and can be expanded/replicated
- Make use of existing networks (evaluation group, clinical directors/managers) and seek opportunities to collaborate with other sector groups
- Capacity knowledge and skill building can be strengthened through communities of practice for latency age children
- Seek opportunities to use technology to further knowledge and skills building (e.g. web based learning
- Use of technology to establish branding
- Use of technology to deliver services (e.g. apps, web based, telephone, etc.)
- Limited resources such as psychology, O.T., speech and language could be brought together to provide community based responses. (e.g., Community Consultation & Assessment Service (CCAS) at Blue Hills Child & Family Centre delivers a provincial resource that provides both interdisciplinary consultation when the clinical path is unclear, as well as formal psychiatric, psychological and/or speech and language assessments)
- Increasing evidence in brain neurology may enable further gains in effective treatment modalities
- Collective approaches to development of coordinated, integrated pathways across sectors (Health, Education and Child Welfare) and between age groups can lead to improvements in continuity of care and access
- The common use of CYSIS by seven out of ten latency age CYMH providers can be leveraged to share and analyze data to explore and address questions related to access, duplication, continuity of care, wait times, effectiveness
- While there is no data that tells us about the extent to which latency aged kids are showing up in the Hospital ED's in the city or being served by Youth dale's crisis services data, there is a belief that a significant number of latency aged kids are being served in the Whatever It Takes (WIT) program. This is an area that should be further explored in terms of data collection. It may also offer an opportunity to examine the network of intensive and crisis services and how to better align and coordinate these services. This can be an area for further exploration in cross sectoral discussions
- There is expertise within the system in finding private funding/ non-governmental funding which could be shared

Threats

- The continued lack of sustained focus on the mental health needs of latency age children
- Ongoing lack of a funding model which supports latency age children with complex needs
- Continued stigma and challenges regarding access to mental health constrains parental engagement and advocacy
- Insufficient numbers of, and access to child psychiatrists
- Requirement for primary care referral to psychiatry perpetuates "silo-like" access to services and intervention
- Need for complete psychological assessments is prohibitive for most families and for CYHM centres

- Need for OT, speech and language assessments and treatment are not accessible to most families due to costs
- Private-profit driven and not for profit organizations (e.g. family health care teams) are emerging in the Toronto region where there are transdisciplinary approaches to care under one roof
- Possible increase in demand in the coming years as knowledge of CYMH increases while not having the resources to respond
- High concentration of clients with health issues and/or complex challenges within the single residential program often results in significant reliance on STEPPS funding which can easily be depleted
- With the Hincks Dellcrest merger with Hospital for Sick Children, there may be reduced availability for latency age children in the North

RECOMMENDATIONS

1. **Development of an evidence-informed strategy for service development and delivery**
   a. **Develop a city-wide data and information working group with identified priorities**
      As LAW moved forward to attain a systems point-of-view on the way to systems management work, the single biggest limiter was the lack of data. The LAW recommends as its highest priority the formation of a city-wide working group to give us the tools to advance work. Areas of data/information include:
      - *Alignment with the CPA development, implementation and quality improvement planning* – Priority
        The CPA will need to have data about services to move clients into the system. The data needed for the above referenced systems planning work must align with the framework for data to support the CPA
      - *Develop a common lexicon among CSPs* – Priority
        Through the course of our discussions and analysis, the working group discovered language used by different service providers did not always mean the same thing. Just as we needed a common data book for Ministry reporting, we need to level the language to a common lexicon
      - *Use population data to inform service planning for latency age kids* – Priority
        The data working group needs to develop an underlying population-based mapping capacity. As a sector, we will want to look at geographic equity and/or identifying priority target communities as we move to these critical dimensions of service planning. Anecdotal evidence through our discussions leads us to suspect that there is substantial age inequity of CYMH services with the vast majority assigned to adolescents
      - *Build on existing service mapping work*
        There have been several initiatives which looked at mapping the existing services provided by our service agencies, including the work by the Year 1 Service Mapping Working Group and a preliminary scan of 7-12 services produced by the LAWG that might inform future work. Specific metrics to measure should include: target population, treatment strategy and admission criteria, location of services, wait list, service capacity etc.

b. **Continuous improvement to core services**
We are committed to providing the best possible children's mental health services to Toronto's latency aged children and their families and to committing to a continuous process of improvement to core services to maximize outcomes and the client experience. In our limited time, the working group identified just a small sample of the improvement opportunities. There is substantial opportunity to raise our game with more and continuous focused work. The LAW is committed to this.

- *Identify and continue to move toward best practices* – Priority
  Toronto's latency aged service agencies all clearly have an agenda to move to EB and evidence informed best practices. It is impressive. Having said that, we know we need to continue on this path and work is not done. In particular, we noted the need for more work on intensive services and long-term therapy. We discovered a great web site (practice-wise) as a great first and accessible tool to look at best practices
- *Maintain a balance of core services*
  Toronto's latency aged services are mostly focused on level 3 kids though there are some level 2 and level 1 initiatives. Agencies feel the pressures to continually serve more and more high needs and complex kids. While we work to do this, the LAW recommends a balance of core services and especially for this age group, there is strong value in providing level 2 and some level 1 service that we are effectively preventing more serious issues. The literature supports this
- *Striking the balance between universal and specialization*
  Identify those evidence-based/informed programs that should be "universally" accessible across latency age programs in Toronto
- *Intensive services*
  During the review and analysis of intensive services for latency aged kids, the LAW identified concerns about the adequacy of a system with only one residential facility for latency aged kids. In addition, Toronto does not have any respite services for this age group. LAW also recommends that we centralize or coordinate through C.A.R.S. admission to day treatment programs for latency aged kids
- *Sector wide service initiatives*
  As we have a manageable core group of agencies, LAW recommends that we explore sector wide strategies at the service level that might be best launched this way rather than isolated agency one-off's. For example, could we collaborate on a schedule of PMT workshops at times and locations across the city with common curriculum? And other possible initiatives? This is a first step to not only conceiving services from a sector perspective but also delivering services through such a collaboration

2. **Develop and implement a sector-wide communications marketing and branding strategy**

While agencies will always have the need to communicate their own work, there is also a need for marketing the services of latency age services as a system to parents and first line responders such as physicians and teachers. Such work should be based on focus groups feedback from those stakeholders. Information aimed at parents should include not only agency and service but also under what contexts to seek CYMH service. This will have to be deeply connected to the walk-in network but also to the CPA

3. **System level training and standards**

While agencies have traditionally set their own human resource needs and development, with growing work as a system, it is timely to start to develop aspects of a systems-wide human resources plan. This is not intended to supplant core agency responsibilities but to set system standards and to max opportunities.

    a. **Establish criteria for staffing and caseloads which support the service coordination function as well as guidelines about length of service/session for treatment based on complexity**

    b. **Identify core skill sets for clinical professionals working with latency aged clients**

    c. **Undertake a planned professional development in core practices as an annual collaborative across Toronto's latency age agencies**

4. **Cross-sectoral/interdisciplinary issues and opportunities**

    a. **Advocate for alignment/consistency of key regulations, legislation and policies**

- Review, map and explore options for alignment of relevant legislation, including those between Ministries
- Review, map and explore options for alignment of relevant legislation, regulation and policies for consent among sectors and stakeholders

    b. **Advocate for access to interdisciplinary resource to ensure full continuity of care, service coordination and transitions**

- Develop strategies for improved access to specialist services including psychiatry, psychology, speech and language and occupational therapy
- Develop a strategy for enlisting GP's in the continuum of care as well as to provide CYMH information to clients
- Review inter-sectoral protocols for latency aged children
  - Develop protocols to address rising demands of the education sector for services
  - Develop protocols for inter-sectoral touch points with hospitals and ED services. The LAW was not able to obtain information about the usage of hospital ED services for latency aged kids though we do have the sense that there is activity in this area. It is striking that we are not aware of any step up or step down protocols between agencies and the health and hospitals. There is clearly an opportunity to do better inter-sectoral work here

5. **Facilitate and support a latency-aged network**

The LAW found clear value in coming together as the main CSPs for latency aged children and achieved some momentum in this work. While we have made some progress through this workgroup, there is so much more we could do in advancing children's mental health service delivery across the city. This work could include some of the items we have recommended above.

Before Making Service Work and the Toronto regions plan to have agencies work in geographical quadrant clusters, we used to come together for common training and program development. We have re-discovered the richness of this opportunity and would like to continue as a working group, notably to continue the development of core services for latency aged children. The best scenario would be to do this with the support of the lead agency.

WORKING GROUP MEMBERS

Thank you to our dedicated working group members who made this report possible:

- Tony Diniz, Chief Executive Officer, Child Development Institute (Chair)

- Paul Bessin, Program Director, Adventure Place

- Ewa Deszynski, Executive Director, Etobicoke Children's Centre

- Darren Fisher, Project Manager, East Metro Youth Services (Lead Agency liaison)

- Jonathan Golden, Director, Clinical Service, Jewish Family and Child Services

- Leticia Gracia, Community Clinic Director, The George Hull Centre

- Janet McCrimmon, Executive Director, Aisling Discoveries

- Delhia Smith, Interim Manager for our Day Treatment Centre, Centre francophone de Toronto

- Roxanne Sultan, Vice President Clinical Transformation, Hincks Dellcrest

- (September 2016 – February 2017)

- Katina Watson, Director of Service-Yorktown Child and Family Centre

APPENDIXES

Appendix 1   Mandate Letter

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Appendix 4   Year 1 Multi-sectoral Latency Age Working group Final Report

Appendix 5   Results from the 7-12 Working Group Survey

Appendix 1: Mandate Letter

September 28, 2016

Mr. Tony Diniz
CEO, Earlscourt-Créche Child Development Institute
197 Euclid Ave.
Toronto, ON M6J 2J8

Dear Tony,

Thank you for agreeing to chair the 7 to 12 Aged Working Group. The goal of the Year 2 working groups is to continue the foundation of work completed in Year 1 by the lead agency and Year 1 working groups to identify the current landscape for MCYS core services. Harnessing the expertise and experience of its members, working groups will provide analysis and recommendations assessing where we currently are as a sector and what is needed to "move the needle".

Understanding the service landscape is a critical component of planning for service delivery. The specific mandate of your working group will be to expand the system profile as it relates to both your specific age focus as well as the broader Toronto context. Key areas for review, analysis and recommendations include:

- Translation of the 7 Core Service definitions providing context as they relate to the respective age range of your working group and where possible, clinical clusters (i.e. breakdown of services such as day treatment, targeted prevention etc.)
- Strengths and opportunities that currently exist in our system including evidence-informed/best practices and promising initiatives
- Service gaps and barriers within the system facing infants, children, youth, and families as well as agencies, which are impeding access to effective service delivery as well as improvement and innovation within the sector
- Existing and potential pathways, access and transition points through core services, with other non-core services and with other sectors (e.g. health, education)
- Key trends and possible impact on our work moving forward

Working groups will begin in September 2016 and run until May 31, 2017. The deliverables for the Working Groups will include, through the Chair, regular updates including areas of alignment and other relevant issues, to the other Year 2 working groups, Health and Education Partnership Tables, and Centralized Point of Access initiative. The working groups are further encouraged to identify other opportunities for cross-pollination of working group activities and ideas.

The working group will produce a final report identifying the group's analysis and recommendations which will inform the work of the lead agency as we move into year 3 planning.

Consideration of the unique requirements of Toronto's diverse communities must also inform the recommendations of each working group. The lead agency will provide backbone support, working with your working group to guide and support any community engagement activities including a specific focus on youth and families. Additional backbone support will include: strategic guidance to assist the Chair in monitoring and measuring progress, facilitating literature searches, access to any available reports and data and other relevant information sources; as well as logistical support including the development and dissemination of meeting summaries, assisting in the scheduling and hosting working group meetings and providing the Chair with reporting and presentation templates.

Once again, thank you for agreeing to Chair this working group. We look forward to working with you.

Sincerely,

Claire Fainer

Executive Director

Appendix 2: Membership List

Tony Diniz, Chief Executive Officer, Child Development Institute (Chair)

Paul Bessin, Program Director, Adventure Place

Ewa Deszynski, Executive Director, Etobicoke Children's Centre

Jonathan Golden, Director, Clinical Service, Jewish Family and Child Services

Leticia Gracia, Community Clinic Director, The George Hull Centre

Janet McCrimmon, Executive Director, Aisling Discoveries

Delhia Smith, Interim Manager for our Day Treatment Centre, Centre francophone de Toronto

Roxanne Sultan, Vice President Clinical Transformation, Hincks Dellcrest

(September 2016 – February 2017)

Appendix 3: Listing of reports and presentations reviewed

Listing of reports and presentations reviewed by the 7-12 Working Group

- A Clinical Profile of Children & Youth Accessing Mental Health Services in Ontario: An Interagency Collaborative (Kinark Child & Family Services, The Hincks-Dellcrest Centre Child and Family Centre) Presentation at the 2015 CMHO Conference)
- Client Profile Workbook, Kinark Child & Family Services
- Kinark Client Profile: April 1, 2012 to March 31, 2014 Prepared by Research and Evaluation, October 2015 Update, Kinark Child and Family Services
- Child and Youth Mental Disorders: Prevalence and Evidence-Based Interventions, A Research Report for the British Columbia Ministry of Children and Family Development, June 2014 (Children's Health Policy Centre Faculty of Health Sciences, Simon Fraser University)
- Literature Review – Defining Need – Children and Youth Mental Health
- Mental Health Surveillance Among Children — United States, 2005–2011, *Supplements,* Morbidity and Mortality Weekly Report (*MMWR*) **May 17, 2013 / 62(02);1-35**

Toronto Region

LATENCY AGE WORK GROUP

(L.A.W.)

Summary Report JUNE 2016

Introduction:

Early identification and intervention for latency age children who are at risk for or experiencing mental health problems can prevent problems from becoming entrenched as these children develop. Latency age children undergo a significant amount of development emotionally, socially, cognitively and in their relationships. Latency is a crucial age where, as a result of developmental, increased exposure to and interactions with peers and adults, increased expectations, and other factors, mental health problems become more apparent and prevalent. Key also, in relation to latency age children, is the role of parents, family and community in their development. Providing "the right treatment at the right time" and building resilience is essential to latency age children's success in their future.

Developmental considerations are the foundation of recommendations contained within this document. In considering the current system of care as well as mental health practices, transitions (developmental, service and school) have been identified as needing careful attention, particularly as the system tends to make decisions based on age rather than developmental readiness or need.

The following document is based on the knowledge and experience of providers representing the perspectives of Child and Youth Mental Health, Health, Education and Child Welfare. This group met for a period of one year (September 2015-June 2016) to identify the mental health service needs of latency age children. The work of this group provides a framework for identifying strengths, issues, needs, gaps and barriers in the current system of mental health care for latency age children. Recommendations for improving the system of mental health care for latency age children are also provided.

Strengths

The current mental health system of care in Toronto for latency age children has a number of strengths that will be important to maintain and strengthen. The following represents some of these strengths of the mental health system of care for latency age children

- There is a significant amount of clinical excellence, experience and skills across Toronto community providers who serve latency age children.
- There has been a continuous growth and increase in the use of evidence based/informed practices (e.g. cognitive behavioral, trauma informed, attachment, and neuro-developmental. methodologies).
- Evaluation of outcomes is an increased focus of attention in the delivery of services to latency age children.

- Mental health services are highly individualized and developed for latency age children who present with a range of complex needs.
- Services to latency age children are embedded in values of family and child involvement and this is reflected in child, family and community based interventions/care that exist across Toronto.
- Children who have complex needs, high-risk behaviors and intensive levels of needs are effectively presented and triaged for intensive in home and/or residential placements through CARS. This centralized mechanism is very effective in bringing together possible resources and the community in helping to anticipate and plan for the mental health needs of latency age children with intensive levels of need.
- The Toronto system of mental health care for latency age children has a strong commitment to strength based and multidisciplinary approaches that includes the skills, knowledge and expertise of various professions (e.g. social work, child and youth work, psychology and psychiatry, medicine, occupational therapy, speech and language and nursing (as needed)). The system of care for latency-aged children is not rooted in a medical model of intervention and this is a significant strength of the services provided.
- STEPS funding provides much needed short-term flexible support.
- WIT funds and service provide short-term support to formulate appropriate service plans for high needs complex latency age children.
- Access to the Acute Support Unit at Youthdale (ASU) for latency age children helps in differential diagnosis and recommendations.
- Access to the Crisis Mobile service and Transitional Psychiatric Unit at Youthdale helps address urgent issues as well as plan for difficult transitions.

Areas for Improvement:

ISSUE	NEED	GAP	BARRIER	RECOMMENDATIONS
SYSTEM OF CARE				
LEGISLATION Various key pieces of legislation and regulation direct the service system to meet the needs of children and their families related to Consent to Treatment and Consent to Exchange Information. These include but are not limited to : Personal Health Information Protection Act (PHIPA)Child and Family Services Act (CFSA) Education Act	We need to ensure that children and youth have appropriate and equitable access to services across sectors based on their capacity to consent under the law. Across sectors there is a need to have consistency in a child's right to		X	• The service system for latency age children needs to have common practices related to consent for treatment and sharing of information to support referrals between organizations in any sector. • Ministries need to review and update legislation as it relates to the rights of latency-aged children.

ISSUE	NEED	GAP	BARRIER	RECOMMENDATIONS
Health Care Consent Act, 1996 (HCCA) Substitute Decisions Act, 1992 Family Law Act 1990 There are inconsistencies across sectors as to how various legislation is understood and applied. As a result, children have inconsistent access to services across sectors. *This leads to coordination challenges and confusion for clients and service providers.*	provide consent or access service (.i.e. a child under 12 may access service without parental consent in one sector where as they cannot access service in another sector.			• Develop best practice guidelines related to custody and access • Develop best practice guidelines related to Circle of Care practices in Health. • Clarify who owns the record at different ages
DIVERSITY AND EQUITY Children and families of diverse backgrounds and/or languages do not have access to similar mental health services across Toronto.	Accessible services that meet the cultural and language needs of children and families including newcomers, refugees, Francophones, etc. within their local community.	X		• Use service mapping data and other available data (e.g. through City of Toronto/United Way) to identify the current distribution of CYMH services for clients with language and cultural interpretation service needs.
The availability of culturally specific and relevant services is dependent on organizational resources. Many organizations do not have the resources to access skilled interpreters. Organizations as not able to have a full range of staff that represents the diversity of Toronto. Latency age children may be put in positions of translation for parents that is not appropriate for mental health services. Lack of funding for this need creates variability across Toronto to universally	Availability of consistent core CYMH services for clients from ethno specific backgrounds and/or diverse languages.	X		• Ensure funding is made available for translation or interpretation. • Develop a strategy for prioritizing high needs communities (e.g. as

ISSUE	NEED	GAP	BARRIER	RECOMMENDATIONS
available mental health services for clients of diverse backgrounds. The allocation and distribution of resources and availability of consistent services is not known for ethno specific or language related client needs. Some specialized services may not be readily available.				identified by the City and the United Way.)
FUNDING MODELS Funding decisions (across and within Ministries) have contributed to services being developed in silos. The process for how various funding ministries define and prioritize client need and make funding decisions/allocations have been unclear and inconsistent. This leads to wide variability and some duplication of services for latency-aged children between differently funded organizations and across sectors.	Improved rationalization and coordinated distribution of funding within and between Ministries for CYMH services.	X	X	• The Lead agency to support funding decisions for MCYS funded agencies and facilitate linkages to Ministries of Education and Health to ensure funding is allocated to service providers that have expertise in delivering CYMH services.
PROFESSIONAL DEVELOPMENT There are expectations for the delivery of evidence informed Practices and effective outcomes (as demonstrated through ongoing Evaluation.) Ongoing training and professional development related to latency age children is expensive, but necessary to building parenting knowledge and skills. Professional development (PD) for staff in acquiring evidence	There is a need for consistency of approach, practice and service delivery for CYMH needs. This requires a planned approach for prioritizing service needs, identifying best practice, and developing	X		• Funding to be dedicated for professional development across CYMH providers. • Conduct an environmental scan to assess the needs and gaps across Toronto for specific mental health services for latency age children this should be tied to service mapping and service availability. • Identification of core clinical skills that need to

ISSUE	NEED	GAP	BARRIER	RECOMMENDATIONS
informed practices is agency specific and based on available money within organizational budgets. As budgets have decreased, funding for professional development has diminished. .	communities of practice.			be available across Toronto for delivery of mental health services for latency age children (e.g. family therapy, trauma assessment and treatment, attachment, anxiety and depression, neuro-developmental disorders (ASD, FAS-D, Learning Disabilities) • Identification of professional development gaps as well as determination of which service providers should be providing what services to latency age children. • Development of a systematic and planned approach for professional development in EIP/EBP CYMH practices. (e.g.,Triple P, Facing Your Fears, Collaborative Problem Solving; CBT for Anxiety, SNAP, Fun Friends etc.) • Development of a common approach to assessment and treatment reporting and documentation to promote continuity of care and improved collaboration (e.g. training of staff in the writing of key consistent information in clinical reports.) • Training for staff as to how to best use interpreters and translators within clinical mental health settings.
CENTRALIZED INFORMATION				

ISSUE	NEED	GAP	BARRIER	RECOMMENDATIONS
There is a lack of centralized information regarding availability, type and location of mental health services within and across CYMH serving sectors. This contributes to possible duplication of services, wait lists, extended wait times, coordination challenges and confusion for clients and service providers.	Centralized data base regarding availability and location of CYMH services which incorporates information across sectors.		X	• Explore IT methodologies that can help to improve type of information gathered, timeliness of information, and access to service availability across different funding sources. • Seek and consider input from Intake workers as to how to enable and leverage current information and recommend that this input be shared with centralized point of access group.
SERVICE AVAILABILITY and ACCESSIBILITY There are wait lists for intensive/longer term services needed by latency age children and families who have complex mental health and family related needs. Latency age children may be on multiple wait lists for varying types (Individual, Family, in-home) and intensity of services. Latency age children and their families are not necessarily receiving the services they need but are accepting the service that is available due to wait lists for longer term/more intensive services. Children are also aging out (in organizations where there are age restrictions) while waiting for more intensive services. Lack of clarity regarding the varying types of and resources allocated to intensive type of	Intensive, longer term services for children and their families with complex mental health needs. Coordinated/ collaborative case planning across service sectors is critical. Common understanding and practice regarding which children are appropriate for	**X**	X	• Map types and availability of longer and more intensive services (e.g., individual, in-home, etc.) • Utilize mapping information to determine which latency age children are needing and needing and using briefer types of services vs. longer/intensive services. • Develop equity in distribution of intensive and in- home services across Toronto. • Develop common approaches to Intensive In Home Services and embed evaluation. • Consider impact of age restrictions on continuity of care for latency age children and their families • Consider a centralized approach to directing referrals for appropriate levels of intensity or duration types of services

ISSUE	NEED	GAP	BARRIER	RECOMMENDATIONS
services (e.g. Intensive In-Home Services (CDI - Intensive Child, Home and School (ICHSl) and Hincks Dellcrest Intensive In Home Treatment Service (IIHTS) as well as Intensive Child and Family home or community based services provided by some CYMH and that are part of their suite of counselling services.	which type of service.			(e.g. CARS, Section 23 Centralized intake pilot project are examples of a method for directing client service particularly where there is a need for more intensive/longer services) • Consider development of a priority or triaging mechanism that also monitors availability of other services during waiting time. • Ensure there is clarity of understanding of which types of intensive services are most effective for latency age children and their families with a range complexity of needs and issues.
SERVICE COORDINATION/CASE MANAGEMENT Service coordination is a fundamental need for the delivery of effective child based mental health services. Children and families with mental health needs often have multiple needs that require more than one mental health or other type of service. Children/families often need assistance to ensure that their services are coordinated and well managed.	A system that is easily understood, by parents and caregivers and supported by service providers through effective service coordination. There needs to be a commitment across Ministries/sectors to ensure effective transfer of service coordination for the family. Service Coordination is a process that supports children and families to get the service that they need and helps to ensure the	X		• Funders to support dedicated funding to provide Service Coordination as part of every service provider's responsibility across organizations and service sectors. • Establish core expectations of service coordination across sectors. • Provide "warm transfers" i.e. personal transfer meetings (by phone or in person) if there is consent to on-going service(s) at another organization. • Establish criteria for staffing and caseloads based on the need for service coordination and treatment. (e.g., additional service coordination is

ISSUE	NEED	GAP	BARRIER	RECOMMENDATIONS
	integration of service provision across organizations.			often required during transitional points such as from pre-school to elementary school, elementary school to high school, etc.) • Explore other models of shared care.
SERVICE NAVIGATION The current system is complex and difficult to navigate. Family navigators enable and support parents in their service journey (e.g. Sunnybrook-for youth and adults, HSC))	Parent/caregiver require increased knowledge of and capacity in managing the system.	X		• Support for Service Navigators across Toronto for latency age children and their families.
TRANSITION NEEDS OF LATENCY AGE CHILDREN				
CONTINUITY OF CARE There are service gaps when latency aged children are stepping up or down from more intensive services. While there are some Emergency Department Pathways (ED) pilot projects /agreements that are designed to connect families to community based services, these are not well known. Emergency Department pathways/agreements do not come with extra funding nor do they address the problem of wait lists/times for community-based services.	Latency age children who are entering or exiting from intensive services such as emergency room, residential and/or Day Treatment need step up/down programs that are aligned with best practice.	X	X	• Identification and mapping of organizations with ED pathway agreements. • Identify service requirements of children needing services that are more intensive and those who are leaving intensive services. • Consider consistency of approaches for step up and step down models. • Development of a plan for resources required.

ISSUE	NEED	GAP	BARRIER	RECOMMENDATIONS
TRANSITIONAL ISSUES TO & FROM PROGRAMS AND MINISTRIES SERVING LATENCY AGE CHILDREN The shift to full day kindergarten has increased the number of referrals of young children coming from full day kindergarten care who display behavioral problems in schools. The shift from middle school to high school is a particularly vulnerable developmental shift for children who have mental health challenges or for whom transitions are particularly difficult. These children often need extra support. Currently specialized supports (e.g. consultation teams of various disciplines in education and children's mental health) are siloed in various Ministries. Children being discharged from Residential (type) treatment (including hospitals) are often discharged to home/community would benefit from a "step down" program which would also benefit their families.	Support and early intervention services are crucial for young children with behavioral problems transitioning into regular classes. Support for latency age latency age children at risk for or with mental health difficulties are required to transition effectively		X X	• Allocate early intervention resources in partnership with Boards of Education. • Incorporate service coordination between Ministries through increased use of case conferences with defined service plans that indicate who is taking responsibility for what part of service. • Review expectations and resources allocated to transition support across sectors. • Review and address restrictions between sectors and providers which limit the availability of service providers to support effective transitions (e.g. availability of professionals to case conferences/reviews/planning meetings)
ADMISSION PROCESSES Admission into Day Treatment from School/Boards is not centralized across all school boards nor are there common tools for assessing need, level of complexity and urgency which often leads to disparities regarding accessibility to services.	Process for admission into day treatment programs that is systematic, understood and managed. This process will require methods for individualization and	X	X	• Consider centralized access mechanism for all latency age children referred to day treatment (current centralized intake pilot process is for those children most in need) • Development of shared assessment tools and

ISSUE	NEED	GAP	BARRIER	RECOMMENDATIONS
	prioritization while still considering available resources and resourcing for varying levels of client need.			reports to support this process. • Identification of services needed for children at high risk but who are not able to accepted into existing Day Treatment programs (often due to lack of adequate or sufficient resources to maintain children safely) • Expand centralized day treatment intake pilot project to all boards of education across Toronto for referrals to Da • School boards to develop a common approach for referrals to day treatment programs. • School board to make available and provide up to date psycho-educational testing as part of admission process to Day Treatment programs • Resources allocated from CYMH for transition support of latency age children back to community schools. • Community schools and CYMH organizations to have proactive partnership plans for the effective return of children to community schools
DISCHARGE PLANNING Discharge planning needs to occur in all sectors (school, health, CMHOs) so that children moving between services, school programs, and developmental stages are not lost. Children with	Process for discharge from day treatment programs that is systematic, understood and managed.		X	• Consider development of consistent clinical documentation formats ensuring that discharge and transition planning is

ISSUE	NEED	GAP	BARRIER	RECOMMENDATIONS
mental health issues that require day treatment often will have ongoing mental health needs throughout their schooling.

The discharge process from Day treatment back to Schools/Boards is challenging. There are no formal agreements between day treatment programs and receiving schools about how the transfer should occur, who needs to be involved in the "moment" as well as for ongoing support, establishing a relationship at the beginning of day treatment, before discharge and subsequent provision of support for a successful re-entry.

There appear to be fewer special education placements for students in the TDSB. | Clarity is needed to determine respective roles and responsibilities of day treatment and school board in the discharge process. This process still needs individualization based on existing resources as well as type of client presenting problems.

Chronic mental health issues in children may not dissipate after day treatment interventions. Children with chronic mental health needs often require continued focused support and intervention within community schools.

School Boards continuously review practices to determine the most effective models of supporting students. As these practices differ, agencies will need to work with each Board to determine best ways to integrate | X

X

X | X

X | embedded into recording template.
• CYMH organizations to heighten their focus on building children's skills to return effectively to a community school.
• Create systemic monitoring of all referrals entering to Day Treatment and discharged from Day Treatment to help understand and plan for the continued mental health needs of latency age children.
• From the moment of admission to a Section Program, organizations and Education need to be working together on a discharge/transition plan to ensure case effective discharge/transition planning. (e.g. : Education personnel be informed and invited to attend case conferences in Day Treatment. Agency staff request that a student be discussed at School Support Team (SST) meeting. Agency staff, family, and all other supports to participate in the SST.)
• Educators need to have sufficient allocated time to participate in case planning and discharge meetings
• Ensure discharge planning involves additional community based services |

ISSUE	NEED	GAP	BARRIER	RECOMMENDATIONS
	students back into classrooms.			(e.g., Home based services, involvement of CARS.)
SPECIALIZED SUPPORTS				
ASSESSMENT AND CONSULTATION There is a lack of timely specialist consultation services (e.g. psychology, psychiatry, speech and language, etc.) which affects timely referrals, service coordination and treatment. The lack of timely specialized consultation services further embeds children's struggles with mental health issues and diminishes academic success. The complexity of problems that emerge for latency age children requires specialized assessments to inform education and treatment plans (e.g. , psychiatry, psychology, speech and language, occupational therapy etc.). Students usually need specialized assessments to assist in identification and placement, as well as at discharge to support a successful transition back to a community school. In spite of agency and Boards trying to meet the needs of these children, there are not enough specialist resources available nor is there equity across organizations having these services across Toronto. Many CYMH agencies do not have in house consultations services (e.g. psychology	Every agency requires specialized services to support the needs of latency age children. Specialized consultation is critical for emerging issues e.g. psychiatry, psychology, speech and language, occupational therapy. Additional services are now being offered through Youthdale for psychiatric consultation for children.	X	X	• Map available specialist services across Toronto for latency age children. • Establish a triaging protocol for assessments and consultation across sectors in order to facilitate required services to meet latency age children's needs. • Agencies, health and education develop a plan for how to meet the need for timely specialist assessments and support.

ISSUE	NEED	GAP	BARRIER	RECOMMENDATIONS
/psychiatry) to support academic and treatment planning. Children may wait long periods for assessments and then subsequent treatment.				
PSYCHIATRY/MEDICATION MANAGEMENT Consultants providing psychiatric support only provide medication oversight while a child is in Residential treatment. Latency age children with complex mental health needs often require ongoing medication that requires continual re-assessment. The provision of medication management fits under Specialized Supports but the issue of on-going medication management when the child moves around the system, is a transition of care as well as a system of care issue. Few community based organizations have in house psychiatric consultatants and those that do, need to allocate them to residential or day treatment programs. Children in outpatient programs often also require these services but there is very limited access to these services. (Generally, family doctors are not experienced in children's mental health and are not necessarily comfortable with monitoring of medications for children with CYMH issues.)	Need for on-going Specialized consultation services including medication management while a child and family is in service with an agency and across sectors.	X	X	• Map existing psychiatric resources for community and intensive services for latency age children. • Consider a more centralized approach for referrals to psychiatry/psychology, which also triages need and risk. • Develop formal agreements between Ministries to provide training to family physicians.
CRISIS SERVICES Insufficient crises services specific to the needs of latency	Crisis support services specifically	X	X	• Develop two-way partnership agreements between hospitals and

ISSUE	NEED	GAP	BARRIER	RECOMMENDATIONS
aged children. Access to Youthdale crisis unit for latency age children is viewed as the last resort. There is limited access to hospital beds without 1-1 support provided by children's mental health when a child comes from a residential placement.	for latency age children.			CYMH agencies that include improved access mechanisms between the community, crisis services, and hospitalizations. • Promote and utilize the Youthdale Mobile Crisis team as well as the Transitional Unit for latency age children (recognizing and managing the additional consent requirement for latency age children)
SPECIALIZED COUNSELLING Increase in the number of referrals for families with children with neuro-developmental disorders (e.g. FASD, ASD) who require specialized counselling and support, as well as milieu services. There is a lack of services for children with FAS-D as well as long waiting lists for specialized services. Families of children with these issues do not necessarily access family based services despite the need. Children on the Autism Spectrum that are not severe often have mixed profiles for which CYMH nor Education have sufficient dedicated services.	Treatment availability for these children and their families. CYMH staff has knowledge and skills in ASD/FAS-D and are knowledgeable about available services.	X		• Mapping of service availability for children with FAS-d and ASD diagnosis • Provide on-going specialized training to inform family counselling for CYMH staff working with families with children diagnosed with FAS-D and ASD in order to increase the range of service options.
IN-HOME INTENSIVE Limited in-home services (includes limited wrap around services) for latency age children. Agencies face the challenge of having to cut back	Intensive in home services for latency age children and their families are provided to those who can most	X		• Utilize literature review and any existing evaluation reports to determine effectiveness of intensive in-home services

ISSUE	NEED	GAP	BARRIER	RECOMMENDATIONS
other services to provide intensive services in home.	benefit from these services			• Mapping of availability of in home services (as above under accessibility)
RESPITE SERVICES Limited respite services for children with complex mental health problems or dual diagnoses.	Respite services that are appropriate for children and families with significant mental health or dual diagnosis needs	X		• Clarify best practise in this area • Develop a resource list of appropriate respite services (both in home and out of home) to inform parents and prevent family breakdown.

We respectfully submit this summary document to highlight the needs of latency age children and focus the spotlight on this important transition age as an opportune time to fully assess/understand their needs and determine how best to build resilience and skills for latency age children and their parents.

Appendix 5: Results from the 7-12 Working Group Survey

CYMH LATENCY AGE SERVICES TORONTO JUNE 2017

Sarah Holden ~ Chis King ~ Ewa Deszynski

The Etobicoke Children's Centre

BACKGROUND

▸ The Latency Age group was asked by the Lead Agency, EMYS, in 2016 to conduct a S.W.O.T analysis of mental health services for latency age children, provide recommendations for improvement, and identify key priority items.

▸ To support the S.W.O.T. analysis, the Latency Age group developed a survey (Appendix A, B,C,D,E) to examine:

  ○ Current Capacity (by FTE and education background) serving latency age children in Toronto

  ○ Type of Services and Evidence Based Mental Health Interventions offered (Identified by MCYS Fund Code and Specific)

  ○ Location of Services (where specific Mental Health Interventions were being provided for latency age children).

METHOD

▸ The Latency Age group agreed that the following ten Toronto organizations, that are known to provide core latency age mental health services would be surveyed (Adventure Place, Aisling Discoveries, Centre Francophone, Child Development Institute, George Hull Centre, Hincks Dellcrest, JCFS, Skylark, The ECC, Yorktown). It was understood that there are also other agencies that serve latency age children that would need to be canvassed at a future date.

▸ Due to time and resource limitations, hospitals, child welfare, and CYMH centres who do not identify the provision of mental health services to latency age children as being a significant part of their mandate, were **not** surveyed.[1] A follow up survey can be disseminated to these organizations in the future for additional information.

▸ Surveys information was gathered using an Excel data entry template and information was subsequently collated.

METHOD

Agencies were asked:

▸ to use existing Ministry submissions to reduce workload when completing this survey.

▸ for their primary location and assigned to North, East, South and West Toronto.

▸ to provide the postal codes for the location of their mental health interventions.

▸ to submit the total number of referrals received in 2016-2017 by all age ranges (using MCYS definitions), type of evidence based mental health interventions provided, total planned FTE and educational background of these FTE. The educational background was asked in order to help understand the type of training and educational background that is present in Toronto for latency age children.
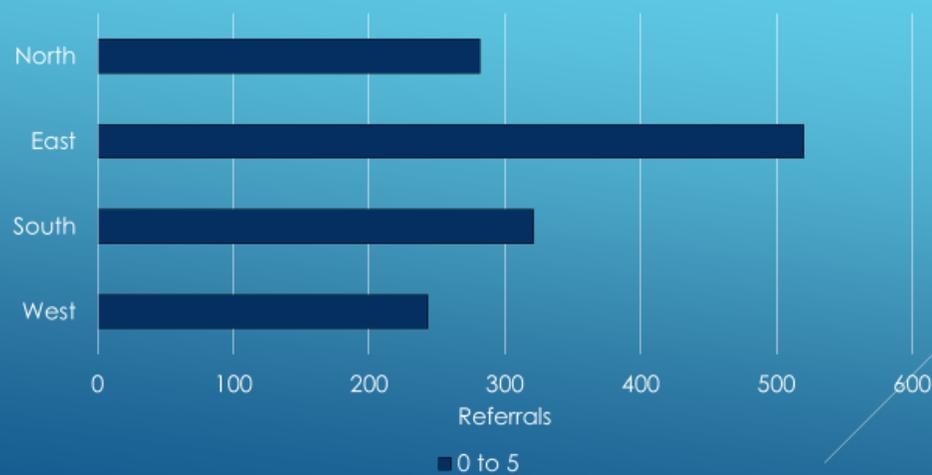
METHOD

▶ The Ministry age definitions for children and youth does not align with the prevalent mental health definitions for latency which is generally 6-12. Because the Ministry age categories span children and youth (0-5), (6-10), (11-14), and (15-18), the actual available FTE for latency age(6-12) children could not be easily accessed using agency MCYS submissions.

▶ To address this issue, agencies were asked to submit numbers of clients referred for **all** ages as well as their total clinical FTE for relevant data elements. FTE was then proportionately assigned based on numbers of children/youth served in each age category. **CAUTION:** *given this method, the FTE for latency age children from contributing agencies is not precise and should not be used to assume available resources without accurate verification.*
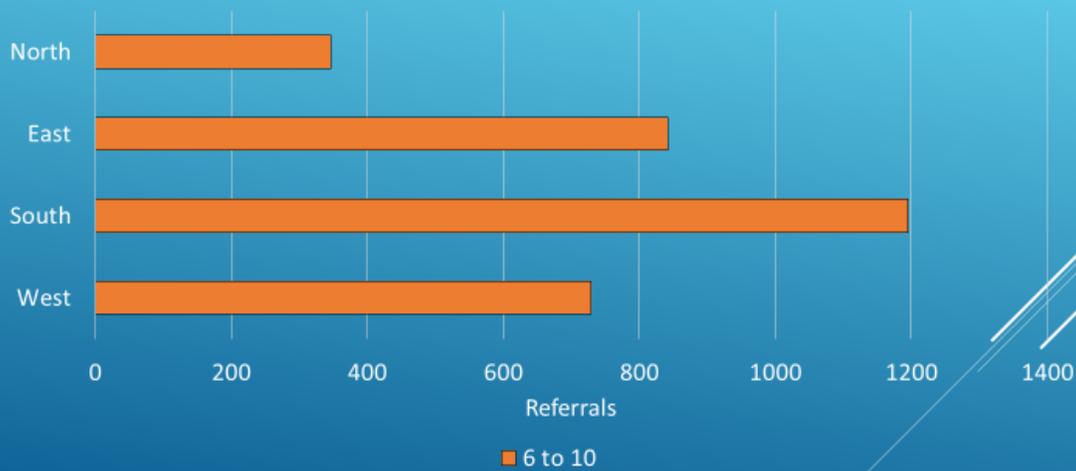
KEY SURVEY QUESTIONS (SEE APPENDICES A, B,C,D,E)

▶ How many CYMH referrals are received by latency serving organizations?

  · Referrals received by ages 0 to 5, 6-10, 11-14, and 15-18 years old & by organization [1]

▶ What is the clinical FTE available at these organizations to serve latency age clients? What are the professional designation of these clinical staff?

  · FTE allocated for 0 to 5, 6-10, 11-14, and 15-18 years old by organization

  · Professional designations (to determine availability of different resources across Toronto) [2]

▶ Where are latency age MH interventions offered across Toronto? [3]

  · Overview map

  · Detail map

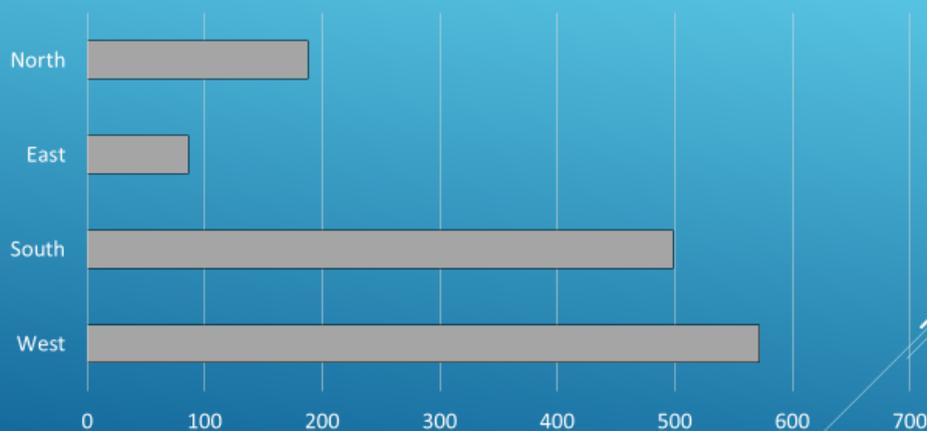▶ Which are the most commonly used interventions for latency age clients?

RESULTS

1(A) HOW MANY CYMH REFERRALS WERE RECEIVED BY SERVICE AREA FOR CHILDREN 0-5?
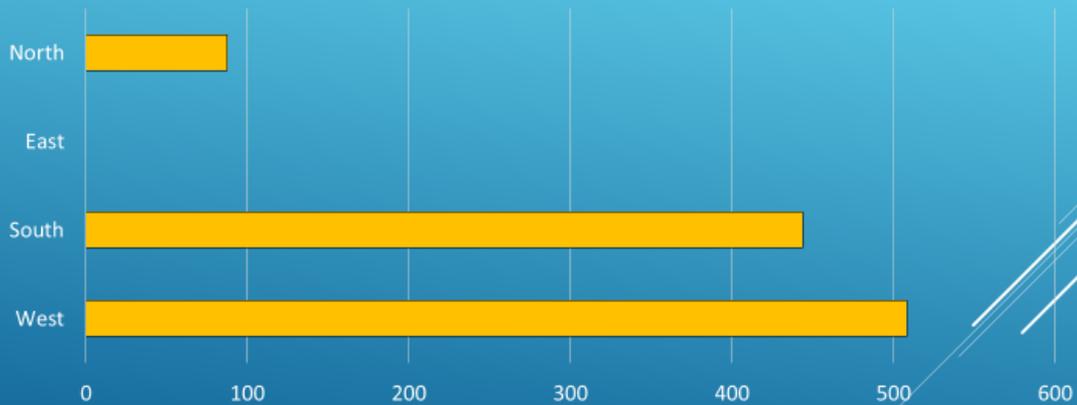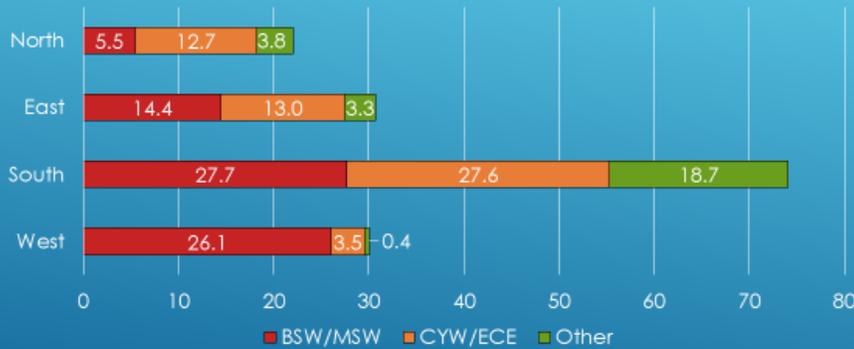
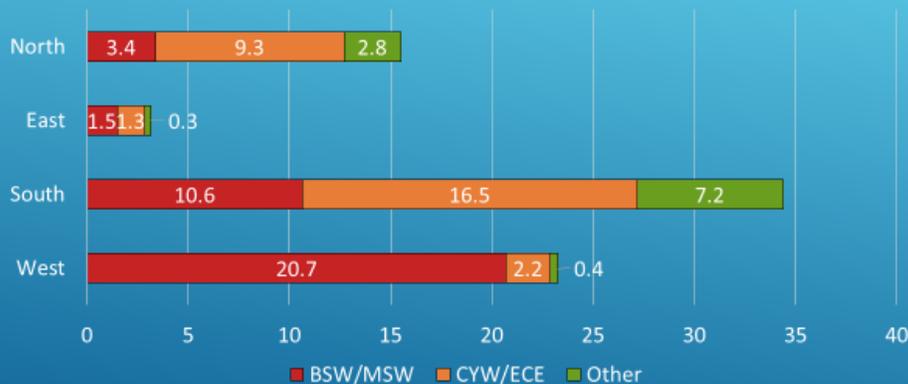1 (D) HOW MANY CYMH REFERRALS ARE RECEIVED BY SERVICE AREA FOR YOUTH 15-18?

2 (A) WHAT IS THE CURRENT CLINICAL FTE PROVIDED BY LATENCY AGE AGENCIES FOR CHILDREN AGE 0 - 5 BY SERVICE AREA?

2 (B) WHAT IS THE CURRENT CLINICAL FTE PROVIDED BY LATENCY AGE AGENCIES FOR CHILDREN AGE 6 -10 BY SERVICE AREA?

North: BSW/MSW 5.5, CYW/ECE 12.7, Other 3.8
East: BSW/MSW 14.4, CYW/ECE 13.0, Other 3.3
South: BSW/MSW 27.7, CYW/ECE 27.6, Other 18.7
West: BSW/MSW 26.1, CYW/ECE 3.5, Other 0.4

Legend: BSW/MSW, CYW/ECE, Other

2 (C) WHAT IS THE CLINICAL FTE PROVIDED BY LATENCY AGE AGENCIES FOR CHILDREN/YOUTH AGE 11 -14 BY SERVICE AREA?

North: BSW/MSW 3.4, CYW/ECE 9.3, Other 2.8
East: BSW/MSW 1.5, CYW/ECE 1.3, Other 0.3
South: BSW/MSW 10.6, CYW/ECE 16.5, Other 7.2
West: BSW/MSW 20.7, CYW/ECE 2.2, Other 0.4

Legend: BSW/MSW, CYW/ECE, Other

2 (D) WHAT IS THE CLINICAL FTE PROVIDED BY LATENCY AGE AGENCIES FOR YOUTH AGE 15 -18 BY SERVICE AREA?

Number of Children & Youth Referred by Age within a Service Area₁

	0 to 5	6 to 10	11 to 14	15 to 18	Total
North	282	347	188	87	903
East	520	842	86	0	1448
South	322	1194	498	444	2458
West	243	729	572	508	2052
Total	1366	3112	1344	1039	6861

Available FTE for Children age 6-10 by Service Area[1]

	BSW/MSW	CYW/ECE	Other	Total
North	5.5	12.7	3.8	22.0
East	14.4	13.0	3.3	30.7
South	27.7	27.6	18.7	74.1
West	26.1	3.5	0.4	30.0
Total	73.7	56.8	26.3	156.8

Available FTE for Children 11-14 by Service Area

	BSW/MSW	CYW/ECE	Other	Total
North	3.4	9.3	2.8	15.5
East	1.5	1.3	0.3	3.2
South	10.6	16.5	7.2	34.4
West	20.7	2.2	0.4	23.3
Total	36.2	29.3	10.8	76.3

3. WHICH ARE THE MOST COMMONLY USED INTERVENTIONS WITH LATENCY AGE CHILDREN?

| Intervention	Frequency
Family Therapy	7*
Cognitive Behavioural Therapy (CBT)	5
Psycho-Educational Services	5
Brief Therapy (e.g. Solution-Focused, Brief Narrative, etc.)	4
Trauma-Informed Counselling	4
Attachment Based Family Therapy (ABFT)	3
Narrative Therapy	3
Trauma Focused CBT	3

* Seven organizations identified Family Therapy as one of the Top 5 most frequently used interventions for latency children.

LATENCY AGE SERVICES
&
MENTAL HEALTH INTERVENTIONS
BY
POSTAL CODE

4 (A) LATENCY AGE CYMH AGENCIES BY POSTAL CODE

All agencies reported providing services South of the 401.
All agencies EXCEPT JF & CS, Skylark, and YCFC reported providing provide services North of the 401.
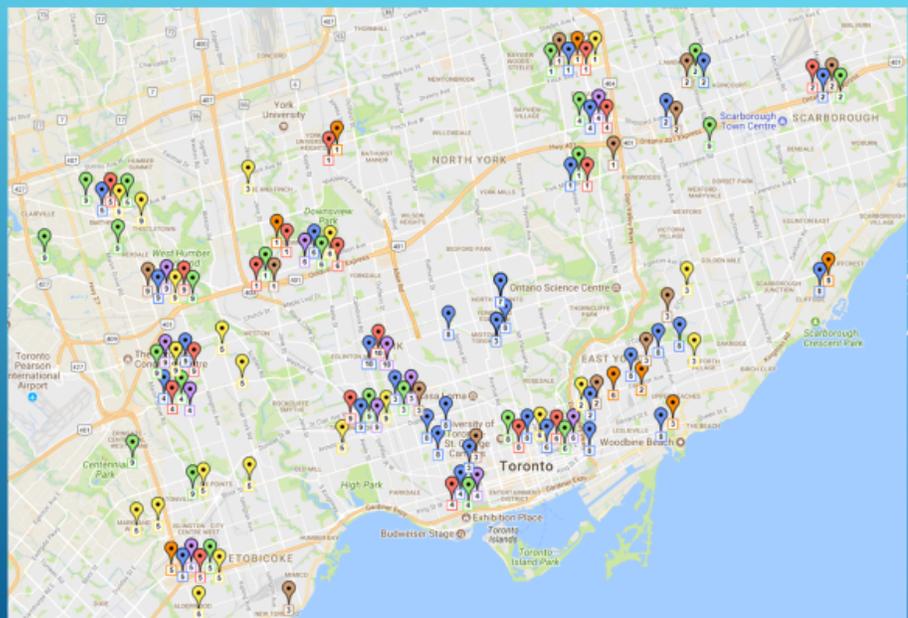
- ☑ Adventure Place
- ☑ Aisling Disoveries
- ☑ CDI
- ☑ Francophone Centre
- ☑ George Hull
- ☑ Hincks-Dellcrest
- ☑ Jewish Family
- ☑ Skylark
- ☑ The ECC
- ☑ YCFC
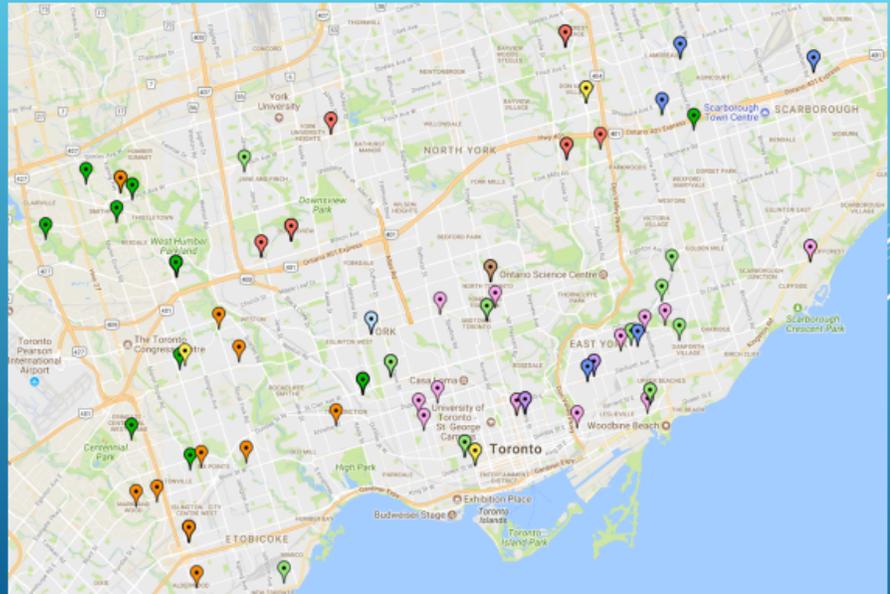
4 (B) SERVICES PROVIDED BY CYMHC, DATA ELEMENT/TYPE AND LOCATION

1 – Adventure Place
2 – Aisling Discoveries
3 – CDI
4 – Centre Francophone
5 – George Hull
6 – Hincks-Dellcrest
7 – Jewish Family
8 – Skylark
9 – The ECC
10 – YCFC

- ☑ Brief Therapy
- ☑ Counselling
- ☑ Family Skills Building
- ☑ Group - Skills Building
- ☑ Intensive In-home
- ☑ Treatment Group
- ☑ Other

4 (C) SERVICES PROVIDED BY CYMCH, DATA ELEMENT, TYPE & LOCATION

1 – Adventure Place
2 – Aisling Discoveries
3 – CDI
4 – Centre Francophone
5 – George Hull
6 – Hincks-Dellcrest
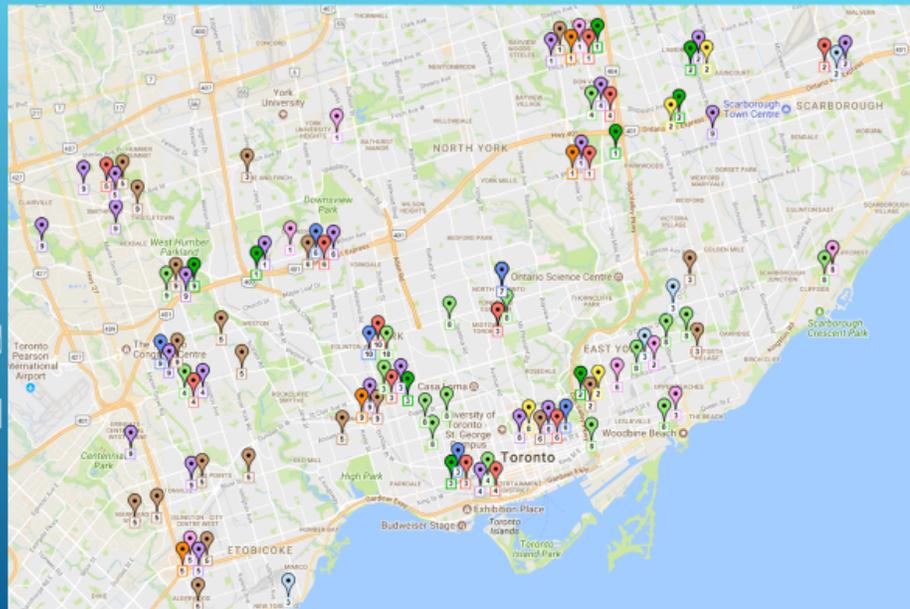7 – Jewish Family
8 – Skylark
9 – The ECC
10 – YCFC

☑ Counselling/Therapy - CBT Based
☑ Counselling/Therapy - Art Based
☑ Counselling/Therapy - Attachement Based
☑ Counselling/Therapy - Family Based
☑ Counselling/Therapy - Mindfulness Based
☑ Family Skills Building
☑ Group - Skills Building
☑ Intensive In-home
☑ Treatment Group - Externalizing
☑ Treatment Group- Internalizing

PRELIMINARY ANALYSIS

PRELIMINARY ANALYSIS

The three most commonly offered "core" interventions for latency age children are:

- ▸ Family Therapy (offered by 7/10 organizations as one of their "Top 5" core interventions)
- ▸ CBT (offered by 5/10 organizations as one of their "Top 5" core interventions)
- ▸ Psycho-educational services (offered by 5/10 organizations as one of their "Top 5" core interventions)

PRELIMINARY ANALYSIS

How many children age 6-10 were referred in each service area?[1,2,3,4]

- ▸ North: 347
- ▸ East: 842
- ▸ South: 1194
- ▸ West: 729

How many children age 11-14 are referred in each service area?[1,2,3,4]

- ▸ North: 188
- ▸ East: 86
- ▸ South: 498
- ▸ West: 572

PRELIMINARY ANALYSIS (refer to Slide 18)[1,2,3]

There appear to be some pockets of Toronto where there are few CSP services for latency age children.

▶ **Central North-South Corridor** (e,g.,Willowdale, York Mills, Bedford Park)

▶ **South East**: (e.g. ,South East Scarborough)

▶ **West**: (e.g., North West Etobicoke and South West Etobicoke- both bordering on Mississauga; Bloor West (along Six Points)

PRELIMINARY ANALYSIS
Intervention Type (refer to Slide 19)

▶ The Yonge and Eglington (North) area appears to have few Brief Therapy services.

▶ East York (East) appears to have few Family Skills Building services.

▶ North Rexdale/Thistletown (North –West) appears to have limited Group Treatment services

*

FUTURE CONSIDERATIONS

FUTURE CONSIDERATIONS

The following are recommendations that can augment and build on this initial analysis:

► **LITERATURE REVIEW:** Conduct a literature review regarding what Mental Health interventions are most effective for latency age children with internalizing or externalizing behaviors.

► **STAGE II SURVEY:** Administer survey to those organizations (that receive MCYS funding) that were not surveyed in this study, using similar questions. Because of Ministry definitions of age, there are likely agencies who traditionally may have been identified as serving children under 6 or over 13 that also serve latency age children. In the longer term, it will be important to address the challenge of the MCYS age definitions so that comparisons are based on agreed upon definitions.

► **REAL TIME DATA:** Based on the data received, it is became apparent that latency age services are provided in multiple locations in numerous neighborhoods and communities To be more precise regarding where latency age clients are actually being served, it may be useful to gather "real time" non- identifying data regarding latency aged clients served during a particular time period across Toronto (e.g. agency where the clients were served, age at start of fiscal year and first three digits of the postal code.

FUTURE CONSIDERATIONS

▶ **COMPARISON TO CENSUS DATA:** City of Toronto, Statistics Canada and other demographic data sources need to be analyzed alongside the prevalence data to better predict whether there are actual service "deserts" (e.g., identification of high needs areas where clients do not have access to services that they need, or where there may need to be a particular type of expertise). A challenge will be the timeliness of the census data and how to interpret and use ward data.

▶ **TRANSPORTATION ANALYSIS:** A comparison of census data along with transportation routes and access may help to inform where service locations may be best situated (e.g. see Toronto Public Health analysis for Speech and Language).

▶ **USE OF A CONSISTENT SCREENER:** A consistent screener for latency age children at beginning of service would help to inform the kinds of mental health issues these children are facing. This information alongside a review of the most effective evidence-based practices for these presenting issues would help to identify which mental health interventions should be universally available across the City and also which specialized services may be more localized.

FUTURE CONSIDERATIONS

▶ **EXAMINATION OF WAIT LISTS AND WAIT TIMES:** This survey did not ask about wait times nor wait lists. This requires a very careful and consistent definition in order to compare well across core service providers. However, consistent tracking of wait lists and wait times across organizations and in relation to resource allocation may help to distribute or shift resources to serve those children in most need.

▶ **DIVERSITY:** This survey did not inquire about skill or language availability required to serve the range of diverse needs across Toronto. It would be recommended that this be added to a Stage II survey.

FUTURE CONSIDERATIONS

▸ **DATA MINING**: A substantive amount of information was provided by the agencies surveyed for this study. Not all of the data has been presented nor an analysis provided; the data should be mined further (e.g. seperate out the varying mental health interventions by area, compare to prevalence as well as census data to identify possible gaps in local priority neighborhoods). When a standardized screener is implemented, it will be important to have a consistent method to evaluate outcomes.

▸ **RESOURCES & TYPE**: FTE analysis used a broad stroke method as opposed to inquiring about very specific FTE related to latency age. To have done so would have required substantial more effort from the organizations surveyed. It would be valuable to be clear about the types of issues that are prevalent across the city, what services are best aligned with those issues, and then ensure that the resources and skills are aligned with the needs. This could be a stage II activity.

CONCLUSION:

Due to 100% participation rate by the agencies, a significant amount of information was received for this survey. Further data mining of this information and data gathering from other core service providers is important in order to have a more complete picture of prevalence, service availability and access. Mapping of interventions shows that there are many interventions being offered throughout the city and many organizations are clearly providing services in areas other than their "home" base. However, there seem to be some areas where there are gaps and this should also be further studied. There are a variety of skills and resources available to service areas but it is not known how these resources can be best deployed until there is an alignment with census and prevalence data. Having a mechanism to gather and share with each other the information that we currently gather would be helpful in beginning to align resources, skills and need.

THANK YOU!!!

- Thank you to all participating agencies and their staff from Adventure Place, Aisling Discoveries, Centre Francophone, CDI, George Hull Centre, Hincks Dellcrest, JCFS, Skylark, The ECC, and Yorktown Child and Family Services. Thank you to all members of the Latency Age group for their guidance and support of this survey.

- Thank you to evaluation staff of participating agencies who added their evaluation lens to the development of the survey, responding quickly, gathering and checking the information, and responding to follow up questions.

- Thank you to Chris King and Sarah Holden who assumed responsibility for this project with care, diligence, responsiveness and perseverance.

APPENDICES

APPENDIX A
Latency Age Mental Health Intervention

Agencies were provided with the following list of interventions that were identified by the Latency Age Committee. Agencies were asked to identify which interventions were used under which funding code.

Acceptance and Commitment Therapy (ACT)
Art Therapy
Assertiveness Training
Attachment Based Family Therapy (ABFT)l
Brief Therapy (e.g. Solution Focused, Brief Narrative, etc.)
Cognitive Behavioral Therapy (CBT)
Collaborative Problem Solving (CPS)
Dialectical Behaviour Therapy (DBT)
Dina Dinosaur
Eye-movement desensitization and reprocessing (EMDR)
Family Capacity Building
Family Therapy
Friends for Life Program
Fun Friends Program
Incredible Years (IY)
In-home Parent Support/Training
Intensive In-home
Interpersonal Psychotherapy (ITP)
Mindfulness Based Stress Reduction (MBSR)
Motivational Interviewing (MI)
Multi Systemic Therapy (MST)
Multifunctional Family Therapy (MFT)
Narrative Therapy
Neurofeedback (NFB)
Parent Management Training (PMT)
Parent–child interaction therapy (PCIT)
Play Therapy
Psycho-Educational
Rational-Emotive Behaviour Therapy (REBT)
Stop Now and Plan (SNAP)
Trauma Focused CBT
Trauma-informed Counselling
Triple P Parenting Program
Young Warriors (Integra)
[INSERT OTHER]

APPENDIX B: Survey Questions

INTERVENTION INVENTORichY iNSTRUCTIONS

The Latency Age Working group is interested in understanding which treatment interventions/modalities are available for the latency age group (7-12) across Toronto. Column A outlines a list of treatment modalities and/or interventions and asks you to identify which of these your organization's staff provide. You may also add additional unlisted interventions at the bottom. If you select 'Yes' in column B ("Do you provide this intervention to clients aged 7 - 12?"), please also indicate:
   -under which fund-code (columns C & D) this intervention is provided (you can select two different fund codes if needed),
   -the format in which it is delivered (columns E, F, G, H, & I), and
   -if it is one of the most frequently used (top 5) interventions (column J) at your organization

Intervention	Do you offer this intervention for children aged 7-12?	Under which funding code(s) do you offer this service? (Primary)	Under which fund code(s) do you offer this service? (Secondary)	Is this intervention offered through individual counselling?	Is this intervention offered through family counselling?	Is this intervention offered through group counselling?	Is this intervention offered in residential services?	Is this intervention offered in day treatment services	Is this one of the "top 5 interventions" used in your organization?
Acceptance and Commitment Therapy (ACT)									
Art Therapy									
Assertiveness Training									
Attachment Based Family Therapy (ABFT)									
Brief Therapy (e.g. Solution Focused, Brief Narrative, etc.)									
Cognitive Behavioral Therapy (CBT)									
Collaborative Problem Solving (CPS)									
Dialectical Behaviour Therapy (DBT)									

APPENDIX C: Survey Questions By Funding Code

Intervention	Brief (A348)	Counselling/ Therapy (A349)	Family/Caregiver Skills (A351)	Intensive Services (A353)	Targeted Prevention (A356)
Acceptance and Commitment Therapy (ACT)		X			
Art Therapy		X			
Assertiveness Training		X			
Attachment Based Family Therapy (ABFT)		X		X	
Brief Therapy (e.g. Solution Focused, Brief Narrative, etc.)	X	X			
Cognitive Behavioral Therapy (CBT)	X	X			
Collaborative Problem Solving (CPS)		X	X		
Dialectical Behaviour Therapy (DBT)		X		X	
Dina Dinosaur		X		X	
Eye-movement desensitization and reprocessing (EMDR)		X			
Family Capacity Building	X	X	X		
Family Therapy		X			
Friends for Life Program		X			X
Fun Friends Program		X			X
Incredible Years (IY)			X		
In-home Parent Support/Training		X		X	
Intensive In-home		X		X	
Interpersonal Psychotherapy (ITP)		X			
Mindfulness Based Stress Reduction (MBSR)		X	X	X	
Motivational Interviewing (MI)		X		X	
Multi Systemic Therapy (MST)					
Multifunctional Family Therapy (MFT)					
Narrative Therapy	X	X		X	
Neurofeedback (NFB)					
Parent Management Training (PMT)			X		
Parent–child interaction therapy (PCIT)		X			
Play Therapy		X			
Psycho-Educational		X	X	X	X
Rational-Emotive Behaviour Therapy (REBT)					
Stop Now And Plan (SNAP)		X		X	
Trauma Focused CBT		X			
Trauma-informed Counselling		X			
Triple P Parenting Program		X	X		
Young Warriors (Integra)		X			

APPENDIX D: Mental Health Interventions by Delivery Method & Most Frequently Used

Intervention	Individual Counselling	Family Counselling	Group	Residential	Day Treatment	# identified as Top 5
Acceptance and Commitment Therapy (ACT)	X	X	X			0
Art Therapy	X	X	X	X	X	0
Assertiveness Training	X	X	X			0
Attachment Based Family Therapy (ABFT)	X	X	X		X	3
Brief Therapy (e.g. Solution Focused, Brief Narrative, etc.)	X	X				4
Cognitive Behavioral Therapy (CBT)	X	X	X	X	X	5
Collaborative Problem Solving (CPS)	X	X	X	X	X	2
Dialectical Behaviour Therapy (DBT)	X	X	X	X	X	1
Dina Dinosaur		X	X		X	1
Eye-movement desensitization and reprocessing (EMDR)	X					0
Family Capacity Building	X	X	X	X	X	1
Family Therapy	X	X	X	X	X	7
Friends for Life Program			X		X	0
Fun Friends Program	X		X		X	1
Incredible Years (IY)			X		X	0
In-home Parent Support/Training	X	X		X	X	0
Intensive In-home	X	X		X	X	0
Interpersonal Psychotherapy (ITP)	X					0
Mindfulness Based Stress Reduction (MBSR)	X	X	X	X	X	1
Motivational Interviewing (MI)	X	X		X	X	1
Multi Systemic Therapy (MST)						0
Multifunctional Family Therapy (MFT)						0
Narrative Therapy	X	X		X	X	3
Neurofeedback (NFB)						0
Parent Management Training (PMT)	X	X	X			0
Parent–child interaction therapy (PCIT)	X	X				0
Play Therapy	X	X			X	2
Psycho-Educational	X	X	X	X	X	5
Rational-Emotive Behaviour Therapy (REBT)						0
Stop Now And Plan (SNAP)	X	X	X		X	1
Trauma Focused CBT	X	X	X	X	X	3
Trauma-informed Counselling	X	X	X	X	X	4
Triple P Parenting Program		X	X	X	X	2
Young Warriors (Integra)			X	X		0

APPENDIX E: Mental Health Interventions by Postal Code

Intervention	# of Agencies	# of Postal Codes	Quadrant: North	Quadrant: East	Quadrant: South	Quadrant: West
Acceptance and Commitment Therapy (ACT)	3	4	2	0	1	1
Art Therapy	6	7	1	1	3	2
Assertiveness Training	1	1	0	0	0	1
Attachment Based Family Therapy (ABFT)	6	23	2	2	15	4
Brief Therapy (e.g. Solution Focused, Brief Narrative, etc.)	8	18	7	1	4	6
Cognitive Behavioral Therapy (CBT)	7	18	4	2	6	6
Collaborative Problem Solving (CPS)	5	11	2	2	3	4
Dialectical Behaviour Therapy (DBT)	4	8	2	1	3	2
Dina Dinosaur	2	4	3	1	0	0
Eye-movement desensitization and reprocessing (EMDR)	1	1	0	0	0	1
Family Capacity Building	7	13	2	1	6	4
Family Therapy	10	22	4	3	9	6
Friends for Life Program	5	8	4	0	2	2
Fun Friends Program	5	6	2	0	1	3
Incredible Years (IY)	2	4	2	1	0	1
In-home Parent Support/Training	9	10	X	X	X	X
Intensive In-home	8	8	X	X	X	X
Interpersonal Psychotherapy (ITP)	2	2	1	0	1	0
Mindfulness Based Stress Reduction (MBSR)	5	6	0	0	0	6
Motivational Interviewing (MI)	5	8	2	1	3	2
Multi Systemic Therapy (MST)	0	0	0	0	0	0
Multifunctional Family Therapy (MFT)	0	0	0	0	0	0
Narrative Therapy	7	24	2	2	17	3
Neurofeedback (NFB)	1	3	0	0	1	2
Parent Management Training (PMT)	1	3	0	0	1	2
Parent–child interaction therapy (PCIT)	4	10	2	1	3	4
Play Therapy	6	12	3	1	4	4
Psycho-Educational	8	1	0	0	0	1
Rational-Emotive Behaviour Therapy (REBT)	2	4	0	1	1	2
Stop Now And Plan (SNAP)	3	9	0	2	5	2
Trauma Focused CBT	8	15	3	1	4	5
Trauma-informed Counselling	7	14	3	1	5	5
Triple P Parenting Program	5	11	5	1	2	3
Young Warriors (Integra)	2	4	0	0	2	2