RESIDENTIAL TREATMENT WORKING GROUP

Final Report

July 2017

east metro youth services

TORONTO moving on mental health LEAD AGENCY

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MESSAGE FROM THE CHAIR

In early 2016, the lead agency mandated the Residential Treatment Working Group (RWG) to report on the current state of residential treatment in Toronto to inform evidence based decision making and planning. The mandate included: developing an inventory of existing services, service demand, system capacity, emerging needs/trends, client profiles, occupancy rates, lengths of stay and service gaps. The mandate was further extended through 2016/2017 to allow the RWG the opportunity to review the Ministry of Children and Youth Services (MCYS) Panel of Expert Report and to complete the work initiated in Phase 1.

Residential treatment is historically underfunded. Agencies across the City report running deficits between $80,000 - $120,000 annually. The majority must fundraise or supplement residential treatment budgets through other avenues. The RWG acknowledges the current system with existing funding is not sustainable. There is also recognition that despite the strengths that C.A.R.S. brings to the system, we are not currently functioning as a system. Decisions are, for the most part, being made at individual agency levels without the benefit of system data and knowing a decision's impact on the system of services.

Over the course of the last five years, the system has lost 26 transfer payment beds (Thisteltown, LOFT, CDI and HDC closures) and 80 per diem beds (Oolagen, EMYSx2, HDC, Delisle, LOFT, Casatta, Enterphase, Kennedy and Storey). Centralized Access to Residential Services (C.A.R.S.) beds have reduced from 204 beds in 2005 to 152 in 2016. There was a recognition that if action was not taken quickly, residential treatment services will be further eroded. The RWG felt strongly that we need to move to a place where individual agencies are no longer making decisions in isolation but where there is a system-wide approach to planning.

The RWG is recommending a thoughtful data driven response to systems changes. There are lessons to be learned from latency age changes which have led to increased access to evidence informed in home intensive services while leaving a gap in residential treatment services for children ages 6-12.

While C.A.R.S. has collected rich data on behalf of the system, there are gaps in information that need to be filled before concrete recommendations can be made about how many beds are needed and for which client needs. Although systems gaps were identified, more data is required to determine priorities and how gaps in one area can be filled without creating others.

There was a consensus amongst the RWG that C.A.R.S. is a strength of the system and could be expanded to provide a central access point for all intensive service, thereby providing families with one access point to the full continuum of intensive services. The RWG also strongly supported the recommendations of Children's Mental Health Ontario (CMHO) and Kinark that we develop a system in Toronto where tiers of treatment are provided and clients receive an appropriate level of treatment supports (psychiatry, psychology, OT, etc.) based on a structured assessment of needs. The RWG heard from youth and families who informed us that the system is unwieldy and daunting. There is an imperative on the system that we move forward in a timely fashion to meet the needs of families before further resources are lost.

Members of the RWG represented core service providers. The RWG felt strongly that the voices of service recipients and other stakeholders are needed to inform systems changes going forward and we need to partner with them in determining priorities. The RWG is therefore recommending a multi-sector advisory committee (partnering with education, child welfare, youth justice and health - possibly caregivers). The first phase of work would be to collect and analyze more data with the goal of recommending systems changes.

I cannot thank the members of the RWG enough for their commitment and the thoughtful client centered approach they took to the work. Attendance at meetings among the highest I have seen. Every member took initiative to work between meetings so we could keep the process moving forward. We are all committed to systems improvement and change and would be happy to provide leadership and partner with the lead agency and our community partners to implement our recommendations.

Debbie Schatia, M.S.W.
Executive Director
Turning Point Youth Services

INTRODUCTION

Moving on Mental Health (MOMH) is an important part of Ontario's Comprehensive Mental Health and Addictions Strategy. The plan ensures infants, 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, Lead Agency Toronto Service Area

Collective Impact Framework – 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 join to work toward a common agenda.

John Kania and 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-enforcing activities**
   Co-ordinating collective efforts to maximize the 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. 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.

DEFINING RESIDENTIAL TREATMENT

The CMHO report Residential Treatment: Working towards a new system framework for children and youth with severe mental health needs 2016, clearly identifies the distinction of residential treatment from residential care. Residential care does not provide treatment as the primary focus of the placement. This distinction and the importance of providing context and purpose between residential treatment and residential care increased after the release of the Residential Services Panel Report.

Residential Treatment, as defined by MCYS, is part of the core services classified "Intensive Out-of-Home Service" in the Community-Based Child and Youth Mental Health Program Guidelines and Requirem*ents #1: Core Services and Key Processes, 2015.* In its report *Strengthening Children's Mental Health Residential Treatment through Evidence and Experience (Oct 2015)*, Kinark Child and Family Services further defines residential treatment programs as "24-hour out-of-home facilities that provide mental health treatment using an inter-professional, multi-disciplinary team approach that makes therapeutic use of the daily living milieu."

As outlined in the analysis and recommendations of this report, the RWG concludes that residential treatment is a key part of the Intensive Services continuum of treatment which often looks different with each child or youth receiving care.

MANDATE OF THE RESIDENTIAL WORKING GROUP

The RWG was established February 2016 and ended its mandate in February 2017. Their mandate was to develop a comprehensive map of the residential treatment services landscape and provide recommendations for moving forward.

METHODOLOGY

Working Group Meetings (See Appendix 1 for Working Group membership list)

Membership of the RWG represented a selection of agencies providing residential treatment services in Toronto. 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.

Key Informant Consultations and Presentations

Syl Apps Youth Centre: Syl Apps Youth Centre is a secure residential treatment centre in Oakville, ON. Debbie Schatia, RWG Chair, spoke with Syl Apps about their programs as they identified a need for youth to be able to transition from SAYC to residential treatment programs in Toronto.
Pine River: Debbie Schatia went out to the facility in late May for a tour and informal informational meeting about their program and to identify areas relevant to the Toronto Residential Treatment system.

Lynwood Charlton Centre, Hamilton: Debbie Schati and Darren Fisher, lead agency, Project Manager, spoke to Maggie Inrig, Director of System Planning at Lynwood Charlton Centre, about their centralized Intake and assessment process as well as the work they are doing as a community to enhance and realign their residential treatment beds.

Latency Age Working Group (LAW) (See **Appendix 6** for the LAW Final Report): This multi-sectoral working group was established in June 2015 and concluded in June 2016. Several members of the RWG, including the Co-Chair from C.A.R.S., were also members of the LAW. The analysis and recommendations of the LAW were brought forward for discussion and analysis as they relate to residential treatment. A draft of this group's final report was presented to the RWG.

Centralized Access to Residential Services (C.A.R.S.) – (See **Appendix 2** for information and reports presented by C.A.R.S.) - Skylark Children and Youth Services operates C.A.R.S. program on behalf of the Toronto office of MCYS. Providing a single point of entry for residential placement, C.A.R.S. played a unique role as a member of the working group presenting information and data for review and analysis.

Review of Relevant Reports (See **Appendix 3** for a complete list of reports reviewed)
There has been an increased interest in residential mental health treatment in recent years. Several reports have been produced looking at the strengths, gaps and challenges of designing, implementing and effectively integrating residential programs into the continuum of care for children and youth as well as integrating with other sectors such as health, social services and education. The working group reviewed several of these reports which relate to their mandate of residential treatment under the MCYS core services funding envelope.

In addition to the reports and information presented throughout the term of the working group, the working group reviewed and discussed an additional three key reports recently released.

CMHO: Residential Treatment: Working towards a new system framework for children and youth with severe mental health needs 2016.
According to CMHO), "service providers note residential treatment is chronically underfunded and that current funding models do not match the complex needs of the children, youth and families who require these services. Service providers can no longer keep up with increasing demand and many are being forced to reduce their treatment beds and/or close their residential programs altogether." (CMHO, Residential Treatment: Working towards a new system framework for children and youth with severe mental health needs, 2016).

Assessing the current agency capacity to respond effectively to the challenges in providing quality residential care in Toronto was based on two questions:

- What evidence-based treatment supports are offered to children/youth in residential treatment?
- What other supports are offered to children/youth in residential treatment?

The working group reviewed the CMHO report, and determined that many of the report recommendations are beyond the responsibility of lead agency with the exceptions of the following:

- Adopt the CMHO report recommendations around tier system
- Supporting a universal assessment as part of the intake process to help define what services children/youth/families are directed to

Provincial Advocate Report

In 2016, The Ontario's Provincial Advocate's for Children and Youth issued a report: Searching for Home, Reimagining Residential care.

- Overall the group felt there were issues of relevancy and scope and whether the recommendations pertain to CYMH residential treatment (many apply to other types of residences or do not reflect the reality of residential treatment services)
- The group agreed issues around licensing and per diems, as well as exit interviews and engagement, are worth further exploration
- Building relationships with family (or equivalent) should be embedded into the philosophy of care
- The group supports the recommendations for providing funding/capacity for recruitment and training
- Many of the recommendations were not relevant to Toronto agencies or have already being applied
- Discussion around licensing and accreditation
    - i.e. licensed versus unlicensed per diem homes
    - Licensing could be improved to focus more on quality and improved outcomes
- Building relationships with family (or equivalent) should be embedded into the philosophy of care

Panel of Expert Report

MCYS commissioned a panel of experts to review all residential care in the Province of Ontario. In 2016, they published: *Because Young People Matter, Report of the Residential Services Review Panel.*

- The group disagrees with the funding recommendation about per diem funding and recommends continuation of transfer payment system with additional funding being provided through STEPS-based funding as a centralized model
- There was not support the removal of the terms "treatment" and "specialized"
    - Reviewed definition of "effective treatment" (changed to "residential treatment") and "context of residential treatment"
- Support for the recommendation to create an advisory council of parents and youth in the building of the system (beyond residential but all intensive)
- Support the continuation of C.A.R.S. data and tracking of children and youth receiving services in Toronto. *It was noted that a gap exists with Child Welfare clients as they move in/out of Toronto.*
- Develop a publicly accessible directory of licensed services, including a range of elements
    - Requires a dedicated resource to help parents navigate and make appropriate decisions

Analysis and discussions stemming from the review:

- There is a need for baseline data and contextual information around continuity of care, length of placements, the relationship of where you live versus receiving treatment (better understanding of success factors, pathways between services etc.)
- The system does some case conferencing but there should be structures to ensure case conferencing formats with all of the relevant participants occur at every transition point (warm hand offs and system navigation)

- Section 23 needs to be reviewed to increase access. It was noted that at times there can be barriers from the Ministry of Education to ensure children and youth living in residential settings get a full education (rather than limited courses)
- There needs to be a needs assessment of specialized/underserved populations to better identify how the system can adapt
    - There should be a process for more proactive work when servicing these populations (i.e. ARAO plans)
    - It was noted that French services is a major gap
- Support for a feedback system of client satisfaction (could be part of the role of the child/youth/family advisory committee?)

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, Debbie Schatia as Chair of the RWG 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. In total, seven consultations were held and 51 youth and family members participated.

REVIEW AND DISTRIBUTION PROECSS

In reviewing the mandate, available capacity and term, the RWG organized the preliminary work plan (March – June 2016) into six categories to better focus the discussion and analysis:

- Develop a lexicon with common definitions
- Identify exiting information
- Look at current demand
- Look at current agency capacity to respond effectively
- Identify program requirements are needed to provide good quality care
- Emerging Trends

Although the categories were separated into discrete discussion topics, it recognized they are interrelated and integrated. In addition to these six discussion categories, the working group engaged in a fulsome review and discussion around wait lists. This work formed the foundation of knowledge and analysis which informed the second phase of work (September 2016 – February 2017) during which the group identified key drivers of success and final recommendations.

Develop a Lexicon with Common Definitions (See Appendix 4)

Informal discussion of experiences among the working group participants identified inconsistent use and understanding of common terms among reports, peers, funders, media and the public. Specifically, there was a need to reinforce the interconnectivity of the issues (client profile, effective treatment, capacity etc.) and terms such as occupancy and waitlists.
To begin this process, the working group developed a list of common definitions to provide context and consistency to the working group discussions. Not comprehensive, the list is a starting point, designed to be a "living document" which can be added to and amended as necessary.

Identify the Information that Already Exists

Within the MCYS residential treatment system there is an abundance of information available. The challenge is to not only identify what information exists where, but also how to effectively access and extract this information in a useful format. The working group identified several topic areas and sources, as well as flagged those which were determined to be useful, but beyond the working group mandate or deemed too complex to acquire.

The working group also identified the need to better interpret the data and identify what is missing and needed to make informed system decisions. Areas of review for data and information included:

- Inventory of beds, client profile, length of stay, occupancy rates, waitlists (C.A.R.S.)
- Data related to the quicker access protocol between C.A.R.S. and service providers and how long beds are vacant as a result
- Gaps in the system (**See Appendix 2**)
    - Examples - language (French etc.), disability, culture, gender, GLBTQ, medically fragile with psychiatric issues, newcomers/refugees, FASD, ASD, sex trafficking, eating disorder
- Information about infant and young parent residential programs and day treatment Programs for francophone students **(See Appendix 5)**

The Centralized access to residential services

(For more information about the reports and data presented by C.A.R.S. to the working group, please contact Brian O'Hara, Director, C.A.R.S., Skylark Children Youth & Families)
C.A.R.S. program was identified as a central point for data collection and reporting. Skylark Children, Youth and Family Services operates C.A.R.S. on behalf of the Toronto office of the MCYS. C.A.R.S. provides a single point of entry for residential placement, eliminating the need for parents and case managers to call multiple residences to find openings. C.A.R.S.' database contains up-to-date data for every mental health residential program in Toronto, making it easier to match a child's needs with the appropriate facility. C.A.R.S. provides a variety of important services such as:

- Managing referrals to all mental health residential beds for children and youth in Toronto
- Matching individual requests for residential treatment with the most appropriate providers
- Monitoring response times and confirming admissions
- Tracking clients in placement
- Recording discharges
- Monitoring available resources
- Providing accurate overall system-based information for residential services

Every year C.A.R.S. processes referrals for 400-500 clients aged 6-18, making approximately 1,300 requests for residential placement, typically leading to actual placement for about 200 clients.
Other sources of data and information

In identifying existing available data and information sources, the working group identified several data sources listed below.

- Specialized assessment and consultation – C.A.R.S.
- Children's Services System Review & Consultation (CSSRC) report – C.A.R.S.
- Community table data – C.A.R.S.
- STEPS/UDSS - C.A.R.S.
- Whatever it takes (WIT) - EMYS/Griffin (**See Appendix 5** for a description of the WIT program)

In addition to the sources listed, the working group identified others as promising, but beyond the scope and/or capacity of the working group to gather and analyze, or were too complex and inconsistent to be useful at this stage.

- Data collection tools/ screeners which could help define complexity (CAFAS etc.) was determined to be beyond the current scope of the working group
- Police reports, hospital etc. were deemed too complex for the working group to compile
- Serious occurrence reports are complex and inconsistent even when rolled up, in agency annual reports, and not necessarily related to residential treatment programs

Understanding the Current Demand

To better understand and clarify the current demand, the working group identified key elements which could help provide a better understanding of the current demand on the residential system. As the single point of entry for residential placement, C.A.R.S. provided information to the working group on several of these elements:

- Based on the agreed definition of wait times, identification of the demand
- Number of youth coming from hospital in to residential treatment
- Regional issues/out of catchment (meeting the needs of Toronto children and/or those outside of Toronto, outside of the province
    - In reviewing the data, C.A.R.S. has determined that there are not high numbers of out of the region placements however an out of catchment protocol is in place

Some elements were beyond the current scope of the working group mandate:

- Placement history and instability (hard to access) – how many times youth move within and outside the system
- Transfer within the transfer payment agencies
- Outcome data

Current Agency-level Capacity to Respond Effectively

One of the first tasks of RWG was to develop a comprehensive inventory of existing residential programs in Toronto. C.A.R.S. provided a detailed residential program summary for Toronto (type of program, specializations, client profiles, number of beds, staffing levels, length of stay, psychiatric and medical services and support, types of therapy, assessment tools etc.) The working group reviewed and requested additional data that would assist them in formulating recommendations as well as strengthen future system planning.

EMERGING TRENDS

Gaps and Strengths

Part of the review of existing reports was an analysis through a lens on capacity to identify strengths and gaps which currently exist in the system. A full spreadsheet analysis was provided by C.A.R.S. which provided a snapshot of the current state of the system including: Inventory of beds, client profile, length of stay, occupancy rates, waitlists, treatment options available etc.

The RWG also felt it important to highlight existing system strengths as identified by the working group members. The intent was to ensure that as we recommend and implement change we are able to build on these strengths without losing existing capacity. Strengths identified by the working group include:

- A wide variety of programs or ages 0 (infants) – 18 years
- Continuum of service and age
- Fluidity of transitions (up until adult)
- C.A.R.S. - system navigation, central intake
- Access to STEPS flex funding
- Willingness of agencies to be adaptable and accommodate to child's needs even though the child may not fit strictly into the program
- Community Tables where a broad range of service providers work together to resolve a client's service challenges
- Sector-wide consensus to improve the system
- A sense of community, inclusion of child and family
- A focus on the welfare of the client
- A richness of knowledge, expertise and training of staff
- The system focuses on having qualified people in the different positions
- The system and agencies operate well beyond what the licensing requires and resources provided
- A willingness to work with Child Welfare and addiction organizations, CSSRC, hospitals, colleges and universities to take student placements
- Access to multiple services offered in all CYMH agencies – access to community-based services we all offer
- Involvement of families (broad definitions) in residential treatment as core service partners and work hard to engage them and to include systems of support
- Clients with complex needs and a variety of diagnosis/diversity are served
- Access to the Youthdale waitlist management program
- Access to Section 23 programs

C.A.R.S. provided a detailed analysis of gaps in the system having reviewed data from: community tables, WIT, STEPS and CSRC. Some general themes related to system gaps identified by the working group include:

- Psychiatric/medication management represents a high need but is not necessarily widely available in our programs
- There needs to be better identification of demographic data on who's accessing the system (culture, new comers, language etc.)
- There is a lack of transitional age residential options
- There needs to be a deeper look to identify priorities

- Lack of cross-ministerial coordination
- Need for adaptive assessments
- There is a lack of crash, admission assessment and respite options
- There is a need for further review of the gaps and options to better quantify the

Waitlists

The concept of waitlists is Included in the "Definitions" document. The working group however engaged in further discussion to better describe the contextual environment surrounding this important issue.

- For residential treatment, waitlists are mediated through the processes at C.A.R.S.
- It was noted that MCYS collects data by defining waitlists starting from when they start the service at an agency and are not necessarily accurate in defining the necessary services delivered or need
    - Waitlists should not be treated in the theory of hotels/hospitals where an empty bed can be filled right away without consideration of the needs of the clients on the waitlists or existing clients in the residences
    - This is an opportunity to recommend what to consider when discussing/defining waitlists
    - The system should look at client waiting times v. waiting lists and matching the two to ensure proper care and service

VISION OF THE FUTURE SYSTEM

With the assistance of Peter O'Donnell, the RWG participated in a visioning exercise. The purpose was to create a vision for residential services which would form the foundation of recommendations. The result was the development of guiding principles and a list of drivers for success. The final recommendations were formulated by exploring the system changes and the structures that would need to be in place achieve the drivers of success.

Guiding Principles

A residential treatment system that:

- Prioritizes the needs of infants, children, youth and young parents
- Strives to meet the needs of diverse populations and works to eliminate oppression and promote equity
- Supports and includes families/caregivers
- Is responsive and accessible
- Strives for seamless transitions.
- Promotes continuity of care and reduces duplication for clients
- Builds on existing strengths
- Matches intensity of resources to treatment needs and provides a continuum of service (in home intensive, respite and tiers of residential treatment) which includes access to a multidisciplinary team
- Is data driven, based on evidence informed practices and demonstrates effectiveness.
- Is transparent and accountable to stakeholders
- Supports system wide planning and decision making where agencies work as part of the system and make collective decisions rather than those based on individual agency need
- Infants, children and youth are considered a shared responsibility of the system

- Is flexible and adaptable always striving to identify and fill gaps
- Utilize best practices within available resources

Drivers of Success

- Eligibility criteria are clearly defined
- Centralized access, assessment and integrated service planning for clients
- Common assessment process including tool(s)
- Common data collection
- Key performance indicators
- The system provides young parents/ infants, children youth and their families' access to the full continuum of service including after care
- Access to centralized resources
- Resources are matched to intensity of need (for example: child/youth identified as "tier 4" has greater access to resources/multidisciplinary team; resources are provided to meet diverse needs and increase accessibility)
- System is integrated with other sectors
- Cross sectoral system planning tables to address system issues
- Treatment based on assessment
- Training and development for staff
- Strengths based and collaborative (youth and family engagement is fundamental and required)
- All programs are evidence informed, focus on quality improvement and contribute to the development of evidence (including longitudinal evaluation) while supporting innovation
- Properly and adequately funded and sustainable

RECOMMENDED AREAS FOR ACTION

Establish a broad-based cross-sectoral system planning table

The working group strongly recommends establishing a cross-sectoral system planning table as the foundation of moving forward. It is intended that this table would report to the lead agency and should have representation from Core service providers (with representation from the adolescent/latency and young parent groups) as well as from other related sectors such as child welfare, education and health The mandate for this group would be to:

- Review data to determine gaps and trends and communicate this information to the system
- Provide a forum at which changes to agency programs including program closures or reallocation of resources from residential treatment to in home intensive service, for example, could be discussed and considered from the perspective of the potential impact on the system
- Discuss and make recommendations re issues that impact and are of concern to the entire intensive services system in Toronto. e.g. How can the system become more responsive to changing needs, the creation of centralized resources e.g. psychiatry, psychology, etc.; what is the best use and access to STEPS funding; what is the appropriate level of resources for each program "tier" (level of intensity); etc. Evaluate the system e.g. in the areas of effectiveness, efficiency, accessibility, etc.
- The mandate of the planning table must also include the voice of youth and parents/caregivers. The terms of reference of the planning table should include a section which delineates how youth and family voice will be included

The working group also recommends, eventually, this table would oversee all intensive services (Ex: This group would be the table to provide the analysis and recommendations for considerations such as converting a residential treatment program into an in-home intensive service etc.). Given the complexity, a "phased" uptake approach could be considered, started more easily by having the group address residential services first.

Young Parents/Infants, Children Youth and their Families Should Have Access to the Full Continuum of Service Including After Care/Transitional Support

The continuum would, at minimum, include all intensive services: day treatment, in-home intensive services, residential treatment. A system-wide process should be developed by which a client's level of need is appropriately matched to the needed level of support provided by the program i.e. program "tiers". Clients whose needs require the most intensive level of services should have access to the widest and deepest range of supports and these supports should be well coordinated and seamlessly integrated.

Determine what services comprise the full continuum of services and identify which services and what level of intensity of these services is associated with each tier

We recommend the full continuum include the following:

- Respite
- Day treatment
- In-home intensive treatment
- Short-term assessment and stabilization homes
- Residential treatment (including tiers 2-4 which would also include programs that treat anywhere from 2-8 clients at one time)
- Homes for transitional age youth
- Psychiatry, psychology, etc.
- After care/transitional support

Prior to changing, adding or removing any existing services, the cross-sectoral system planning table would need to know how many of what types of services are needed. The work for this has already started through a gaps analysis which has been completed by the RWG. The initial year of planning however, needs to focus on a broader understanding of need. Further we need to identify gaps in the continuum and how to best address them. *An example is the current gap in latency aged residential treatment beds for children aged 10-13. A determination will need to be made about which agency might be in the best position to fill this gap without inadvertently creating gaps in other areas.*

- Gaps in services in transitional age clients- 10-13 and 18+ needs to be prioritized
- Ideally day treatment should be accessed as part of the continuum of centralized intensive services. To determine how this can best be accomplished, implications and considerations should be referred to and addressed at the Education Table
- We need further exploration of the role that can be played by: WIT, family navigators, tele-psychiatry and how they can be connected to the Intensive Services continuum? Explore closer connection/coordination between WIT and C.A.R.S. and wrap-around services

Determine which services and at what level of intensity comprise each "tier"
(for example: child/youth identified as needing "tier 4" level of services has greater access to resources/multidisciplinary team than a child/youth needing "tier 2").

- Resources should also be provided to meet diverse needs and to remove barriers which limit access to services
- Formalize funding/resource allocation to tiers (funding/ investment should follow the needs of the client – flexibility of the system to maximize investment for greatest impact)
- Inventory of existing resources and funding connected with specialized services
    - Who pays for services?
    - Partner with health?
    - Crisis team more accessible to the system

Centralized Access, Assessment and Integrated Service Planning for Clients

Clients tell us that our intake processes are intrusive and cumbersome and that they are regularly required to repeat their stories. Currently each agency has its own assessment process and often families are assessed by more than one agency without a clear understanding of the eligibility criteria or the treatment model that would best meet their needs. A centralized assessment process founded on clear eligibility criteria and integrated service planning (access to the full continuum of intensive services) will improve the system for infants, children, youth and families (similar to the current pilot for latency aged children).

Determine a process by which a client's level of need will be matched to the appropriate "tier" (See Appendix 7 for the definitions of the tiers)
This process can be facilitated by the Cross Sectoral System Planning Table. Some key activities:

- Eligibility criteria for Intensive Services need to be developed, documented and posted on web sites
- Screening tools and process to be determined and implemented, including determination of tier of service required based on client need
- Process and tools developed to determine which intensive service or combination of intensive services will be offered to meet the needs of the client. Intensive services should be divided into appropriate groupings e.g. Young Parent Resource Services, latency aged services, adolescent services etc. Community tables, triaging of clients and determination of the types and tiers of intensive services that will best meet the clients' needs should be organized with service providers from these grouping
- Develop a common assessment to determine youth and family readiness for intensive services
- Determine common KPIs. There will also need to be program or client specific KPIs. Strengths based and collaborative (youth and family engagement is fundamental and required) is a critical success factor and should be evaluated
- Develop a process to address particularly challenging to serve client needs e.g. bring community tables together for specific client needs
- Treatment-based assessment is a critical success factor. This can be addressed after the system is set up and would be rooted in the KPIs

Eligibility criteria are clearly defined

- Eligibility criteria for Intensive Services need to be developed, documented and posted on web sites. (Cross sectoral planning table role)
- A determination needs to be made through the screening process whether the client meets eligibility criteria for Intensive Services. All clients will be screened at an individual agency using the InterRai/ Latency age tool/ Young Parents screener. This tool, as well as a series of questions to be asked by all Intake Workers will be used to determine eligibility for intensive services
- A determination will need to be made about which tier of intensive service the client requires: tier 2,3, 4)

Common assessment processes and tool(s)

- The InterRai screener is used in other jurisdictions as part of the assessment process. Currently each agency has its own assessment tools. Ideally for families, agencies within streams (latency, adolescent, young parents) would use the same assessment tools
- Parents programs already have a common screening tool. A small workgroup will need to determine what other common assessment tools or questions will be used. A screening tool needs to be recommended for latency age children

Central orientation for intensive services

- Clients will be involved in the entire process beginning with an orientation to intensive services via e.g. video, after which discussion would occur with C.A.R.S. as to which service(s) they need

Building on existing capacity for centralized access and coordination – Expansion of the role and capacity of C.A.R.S.

- To aid C.A.R.S.'s initial decision-making, specific eligibility criteria will be determined for each grouping of service providers
- Informed consent from the client to be obtained at the outset so that information can be shared within the system
- Current community tables, facilitated by C.A.R.S., to continue for clients with complex needs that the system may find challenging to meet
- C.A.R.S. to continue to provide data to the lead agency and service providers regarding client profiles and system utilization
- C.A.R.S. will continue in its role to collect data on behalf of the system. (See "Data and Information Collection" section) On top of what is already collected, the following data should also be included:
    - Inter Rai/ Screener scores
    - More detailed information about the presenting problem(s)
    - Geographic mapping of clients for all Intensive services
    - Quantify gaps/needs- how many of what types of clients was the system serving and not able to serve
    - Analysis of who is NOT being admitted and why?
    - What happens to clients post discharge- some outcome data including where the client goes post discharge and lengths of stay

- Consideration should be given to seeking input from either the evaluator's group or a University researcher about how to collect and analyze the data in order to maximize the information we collect in year 1
- C.A.R.S., in an expanded role, would continue to provide centralized triage to residential services and potentially all intensive services (residential treatment, in home intensive services, respite and day treatment). All intensive services should form part of the continuum of services offered to clients once it is determined they meet eligibility for Intensive Services. C.A.R.S. will likely need a new name to reflect its expanded role
- C.A.R.S. would present appropriate referrals to the appropriate grouping of service providers who would collaboratively decide which service provider will provide the assessment of the child/family on behalf of the system provided it has not been completed prior to the referral to C.A.R.S.
- Once C.A.R.S. determines which agency will lead the assessment, that agency will complete the assessment. If it is determined their services are not the most appropriate that agency will make sure all information is transferred to the most appropriate service provider so the family repeats as little information as possible. The agency receiving the assessment will not re-do or restart the assessment but may add information which will help determine their ability to meet the treatment needs of the client

Data and Information Collection

While C.A.R.S. has gathered rich data about the current system, the group identified some important gaps in information. The working group is recommending that, over the course of the upcoming year, this data be collected and analyzed with a view to making recommendations for systems change (program changes to address service gaps, possible conversion of residential programs to in home intensive or extended day treatment programs etc.). The working group felt strongly that no system wide decisions should be made without a thorough data analysis of need and gaps. There was concern that without a system approach, programs may be converted or closed with a later realization (as was seen in the latency system) that an action to respond to one gap may create another unforeseen gap in another area of the system.

- We need an inventory of in-home intensive services currently available in the city. The working group has drafted a survey and can compile the data for the lead agency, C.A.R.S. and the system. This survey to be included into the lead agency data strategy and activities
- An analysis needs to be completed about the number and type of respite beds required
- Consideration should be given to reviewing existing data (year 1 service mapping, year 2 surveys etc.)
- Lead agency should partner with a university to conduct a longitudinal research project on the outcomes of residential treatment services. This is a critical success factor, however it can be addressed after the system is set up and would be rooted in the KPIs
- There needs to be a comprehensive environmental scan of best practices (within our system and in other jurisdictions)

System Sustainability and Advocacy

The working group recognized that sustainability needs to be a priority when making system changes. The reality however, is that the system is stretched and under resourced. As a result, the working group is recommending advocacy with government once data is collected and we have a better understanding of need and systems pressures.

The effectiveness and efficiency of the system is dependent on adequate resourcing:

- Respite beds are needed within the system – advocacy will be needed to remove licensing barriers that currently prohibit residential treatment programs from using their beds for respite
- Flexibility re age limitations on beds is needed to respond better to clients' needs – advocacy needed to remove any potential licencing barriers
- Is there a way to access funding and resources from other sources: Ministry of Health, Minstory of Education, MCYS-YJ, MCYS FASD strategy? Once data is collected analyzed by the advisory, other sources of funding could be prioritized
- The future role of HDC and its merger with SickKids needs to be better understood. Can Sick Kids resources be leveraged for the system?
- A funded system needs to include funding for training and include funding for the implementation of evidence informed treatment modalities. Backfill costs for staff to attend training are prohibitive. Agencies do not have resources to pay relief/part time staff to attend training yet relief staff are a vital part of the treatment team. Funding needs to be allocated to support training
- This will require advocacy at a ministry level. This may also require conversion of some residential treatment programs to in home intensive or extended day treatment programs etc. based on need and utilization rates
- The working group is recommending that resources not be reallocated or programs closed or converted until at least one year of data is collected and analyzed to better understand client needs. At this stage, we do not know how much in-home intensive, residential treatment or extended day treatment is required until greater analysis in completed

WORKING GROUP MEMBERS

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

- Debbie Schatia, Turning Point Youth Services (Working group Chair)
- Paul Allen, Youthdale Treatment Centres
- Ekua Asabea Blair, Massey Centre for Women
- Susan Chamberlain, George Hull Centre for Children and Families
- Carolyn Clark, Hinks Dellcrest
- Deanna Dannell, Griffin Centre Mental Health Services
- Zel Fellegi, Aisling Discoveries Child and Family Centre
- Darren Fisher, East Metro Youth Services, Toronto Lead Agency (Lead Agency liaison)
- Steve Gregory, Youthdale Treatment Centres
- Brian O'Hara, Delisle Youth Services CARS
- Shirley Shedletsky, Delisle Youth Services CARS
- Karen Prosper, Arrabon House
- Lydia Sai-Chew, Skylark Children, Youth & Families
- Delia Smith, Centre Francophone de Toronto

APPENDIXES

Appendix 1 Working Group Members

Appendix 2 Information and Reports Presented by C.A.R.

Appendix 3 Listing of Reports Reviewed by the Residential Treatment Working Group

Appendix 4 Lexicon of Definitions Proposed by the Residential Treatment Working Group

Appendix 5 Information about Specialized Programs

- WIT (Whatever it takes) Programs- EMYS/Griffin
- Infant and Young Parent Residential Programs
- Day Treatment Programs for francophone students

Appendix 6 Latency Aged Working group: Final Report (2016)

Appendix 7 Definition of Tiers for Intensive Services

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