SCHOOL FOCUSED WORKER INITIATIVE WORKING GROUP

Final Report

July 2017

east metro youth services

TORONTO moving on mental health LEAD AGENCY

CONTENTS

MESSAGE FROM THE CO-CHAIRS

The School Focused Worker Initiative (SFWI) Working Group was convened in November 2016 to review a collaboration between 11 Children's Mental Health Organizations and four Toronto based school boards. Representation from the involved parties was invited to participate in the discussions and the willingness and enthusiasm of the members to effectively partner with each other helped to develop tangible recommendations. In addition, the dedication, expertise and support of Lead Agency staff enabled this working group to complete its mandate within a tight time frame.

Although the French Language School Boards and a French language children's mental health organization participated to a limited degree, we recognize the specific needs and geographical challenges of these groups. Hence, a recommendation speaks to the development of a French Language Working Group.

We are proud of the achievements of the working group and pleased to present this report including recommendations to the Lead Agency Education Partnership Table. We also recognize the importance of forming an ongoing operational committee to continue with the implementation and oversight of these proposed recommendations. We look forward to the ongoing collaboration of these organizations.

Best regards,

Sheeba Narikuzhy, M.A. (Psychology), CRPO
Clinical Manager, East Metro Youth Services

John Wilhelm MSW, RSW
Chief Social Worker, Toronto Catholic DSB

INTRODUCTION

Broader Context:

The education table is an advisory body to East Metro Youth Services (EMYS), the lead agency responsible for the transformation of the community-based mental health system in Toronto. The table's primary function is to examine how to effectively partner with boards of education to ensure the best delivery of mental health services for children and youth in the following four priority areas: School Focused Worker Initiatives, Section 23, School Development Projects and Early Years.

As part of the Community Mental Health Plan, from September 2016 through to February 2018, the Education Partnership Table elected to work on two priority areas at a time. The Education Table is co-chaired by Toronto Catholic District School Board (TCDSB) and a Ministry of Children and Youth Services (MCYS) core service provider (CSP). Membership includes system leaders from all four school boards and MCYS core services funded mental health agencies that represent diversity in student/client age, geographical location and program mandates.

Members of this table are comprised of participants with relevant expertise, as well as individuals identified as having expertise beneficial to achieving the current mandate. Participants were chosen by the Co-Chair(s) and lead agency to ensure a balanced approach of incorporating broad collective impact, diversity and expertise within a manageable size and structure.
The Education Partnership Table meets at broader intervals to support the work of the four working groups with the objective to compile and submit recommendations for the lead agency in each of the stated four priority areas throughout the term of the mandate.

The first two working groups were Section 23 and School Focused Worker Initiative (SFWI) and were co-chaired jointly by representatives from boards of education and CSPs. Following the completion of the initial working group mandates in June 2017, the main Education Table provided feedback on initial findings, direction and support for recommendations.

Working Group Mandate

The SFWI Working Group began meeting in November 2016 and concluded in June 2017 having achieved the following:

- Approved the terms of reference and workplan that guided the working group
- Agreed to and facilitated the addition of each agency among CSPs running this program to the working group to provide a broader perspective
- Identified key components of work and tied each to timelines for development of recommendations
- Created, administered and analyzed a survey to determine capacity and distribution of services by across the city
- Prepared recommendations

The ***overall mandate*** of the SFWI Working Group included the following key areas:

- Evaluating current utilization of services;
- Mapping services
    - To improve the understanding of where and how services are currently delivered
- Identifying strengths and gaps
    - To improve awareness of strengths and gaps in the existing system
- Understanding of "best practice" related to access mechanisms, transitions processes and referral options
    - To improve access mechanisms and transitions for education to mental health services and mental health services to education
- Identify mental health/education service priorities
- Adopting a "systems" approach to the planning, description, implementation and evaluation of services

The membership was drawn from boards of education and CSPs was co-chaired by a representative from each. (See **Appendix A).**

METHODOLOGY

To understand SFWI services across the city of Toronto, the working group focused on:

- Articulating the historical development of these services
- Identifying strengths and gaps within the current system
- Developing an understanding of "best practice" mechanisms, transitions processes and referral options in addition to other options for the delivery of these services
- Adopting a "systems" approach to the planning, description, implementation and next steps for SFWI program

The focus of SFWI is to provide seamless and timely access to, through and from, appropriate community services that support students who are struggling with mental health problems. The working group created a mapping exercise, in the form of a questionnaire (see **Appendix B**), to better understand how the four school boards and 11 community mental health services collaborate in response to student mental health needs including:

- Current pathways to care from school to community mental health services
- The services provided to students referred by schools
- Communication and referral protocols

Further, a condensed history of the SFWI was provided and it was noted that there are variances across the city (see **Appendix C**). To be inclusive the working group expanded its initial composition and invited staff from relevant agencies and school boards to participate. Everyone's voice is important and has an impact on making the system better for children, youth and their families, however, due to staffing changes, time constraints and breadth of catchment areas, the working group proceeded with the expertise and input available during this examination.

STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS ANALYSIS

Various points arose regarding the preliminary SWOT analysis of this program (See **Appendix D**) including the need for integrating better pathways and consideration for the nuances of waitlists. The latter includes the procedural concern and the lag time which has been a difficulty for getting treatment for students. There is also a lack of consistency as various and different practices magnify the multiple levels of complexity in all school boards and community-based mental health treatment agencies. Another theme was the inconsistency among the resources for both schools and community-based agencies, locations and capacity.

RECOMMENDATIONS

The working group offers the following context and rationale for its series of recommendations:

Whereas, The SFWI working group has reviewed a tiered approach to mental health supports and believes that mental health providers in schools are generally well positioned to provide supports at a tier two level and mental health providers in children's mental health organizations are generally well positioned to provide supports at a tier three level, and;

Children, youth and families will be best served with a more seamless approach to mental health supports within this initiative amongst educational and children's mental health organizations;

The SFWI Committee recognizes that protocols and best practices are subject to change over time, and;

Ongoing dialogue and transparency are key factors in the successful implementation of this initiative, and;

Differences in opinion and variances in practices often arise over periods of time,

Recommendation 1

That an operational committee be established which shall be comprised of mental health professionals in the TCDSB and the Toronto District School Board (TDSB) and children's mental health organizations who are involved in the initiative.

That school mental health professionals and children's mental health staff report non-confidential client data (e.g. # of referrals, # of clients, # of months file is open) at the midway mark and end of each school year.

That a conflict resolution process be established by the committee.

Whereas, the SFWI Committee has emphasized that for a priority access system to be effective, the children, youth and families are informed of and ready for the services and have a reasonable level of commitment to counselling, and;

Children, youth and families should fully understand the objectives of priority access services and feel not pressured but committed to these services, and;

Children, youth and families are generally best supported in both the educational and children's mental health systems when pertinent and essential information is shared between mental health providers (e.g. the need to accommodate a student with an anxiety disorder during exam period), and;

Coordination of services is increasingly important when mental health providers in the educational system and children's mental health system are simultaneously providing supports to children, youth and families.

Recommendation 2

That the protocol includes best practices:

- In relation to an initial joint meeting, a mid-session meetings and a meeting upon termination of services
  regarding communication of the status of the file (i.e. open or closed).
- Regarding information sharing with involved persons who are not part of the mental health team (e.g. teachers, principals)

And, that each of the school B=boards and children's mental health organizations enter into individual partnership agreements based on this common protocol.

Whereas, the SFWI Committee recognizes the importance of a common and consistent intake process across the school boards and the children's mental health organizations, and;

Recommendation 3

That a common intake process be established and be included as part of the protocol and the intake process includes:

- On the first school day of each month, children's mental health organizations indicate the number of new available opportunities for counselling
- No later than two weeks afterward, the chiefs of social work at the TCDSB/TDSB provide consent forms and intake forms for each the referrals.
- If all available opportunities will not be used in any given months, the Chiefs of Social Work at the TCDSB/TDSB will notify the children's mental health organizations within two weeks of having received the number of openings.

Whereas, Children, youth and families would benefit from a better understanding as to where they can access mental health supports and services in both the education system and the children's mental health organization, and;

Children's mental health providers and schools would be able to better direct families to specific services with increased understanding of this initiative, and

Recommendation 4

That a common name be developed across this initiative with strong consideration be given to the name *Priority Access for Students (PAS)* and;

That a communication (e.g. pamphlet, web link, etc.) be established that clearly articulates the criteria for intake (e.g. age, geographical boundaries, etc.), the referral processes and the services that can be offered (e.g. length of services, qualification of mental health provider, type of approach - DBT, CBT, etc.)

Whereas, the two French language school boards have divergent boundaries beyond the Greater Toronto Area (GTA), and;

The French language community within the GTA have specific needs in obtaining culturally competent and language appropriate services.

Recommendation 5

That the French language school boards and the children's mental health organizations which provide French language counselling develop a committee to discuss the focus and parameters under this initiative.

Whereas, Advocacy efforts are warranted to change the existing policy at a systems level to promote equitable service access for transitional age youth. Referral criteria should be broadened to include all school aged children and youth from ages 3.8 to 21.11 as the current system is limited to students aged 6 - 18.

Recommendation 6

That the lead agency work closely with representatives from the school boards, CSPs and the relevant Ministries to:

- Ensure that programs and services continue to cover the needs of all children and youth including transitional-aged students
- Ensure that those children, youth and families who would not, for whatever reason, access children's mental health services get referred to the school focus initiative programs and minimally that an attempt is made to engage these clients from an outreach perspective. In addition, that existing best practice pathways are clearly identified by which other outreach staff can access those clients who may continuously need but refuse to participate in services.
- Ensure that staff are given the time to attempt outreach with clients and that their time is accounted for as necessary.
- Ensure that travel time and cost is factored into the service offered.

WORKING GROUP MEMBERS

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

- John Wilhelm (co-Chair), TCDSB
- Sheeba Narikuzhy (co-Chair), EMYS
- Angela Ball, Aisling Discoveries
- Rose D'Alimonte, TDSB
- Mark Dooner, TDSB
- Andreanne Fleck-Saito, School Mental Health ASSIST
- Leticia Gracia, George Hull
- Barbara Hanssmann, Griffin Centre
- Christie Hayos, Hincks Dellcrest
- Nancy Long, Etobicoke Children's Centre
- Patricia Marra-Stapleton, TCDSB
- Kathleen Patterson, CSViamonde
- Micheline Rabet, Conseil scolaire de district catholique Centre-Sud
- Audrey Rastin, BOOST
- Cheryl Tsagarakis, CTYS
- Janice Wiggins, EMYS Lead Agency

APPENDICES

Appendix A	Moving on Mental Health Toronto Education Table (Working Group) Membership
Appendix B	Questionnaire Agency/School Board Templates
Appendix C	Background Documents
Appendix D	SWOT Analysis Summary

Appendix A: Moving on Mental Health Toronto Education Table (Work Group)

- John Wilhelm (co-Chair), TCDSB
- Sheeba Narikuzhy (co-Chair), EMYS
- Angela Ball, Aisling Discoveries
- Rose D'Alimonte, TDSB
- Mark Dooner, TDSB
- Andreanne Fleck-Saito, School Mental Health ASSIST
- Leticia Gracia, George Hull
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- Audrey Rastin, BOOST
- Cheryl Tsagarakis, CTYS
- Janice Wiggins, EMYS Lead Agency

Appendix B: Questionnaire Agency/School Board Templates

The focus of School Priority Access Initiative is to provide seamless and timely access to, through and from appropriate community services that support students who are struggling with mental health problems. This mapping exercise aims to better understand how the 4 school boards and community mental health services that operate within this initiative are currently collaborating to respond to student mental health needs by collecting information on:

A. The current pathways to care from school to community mental health services

B. The services provided to students referred by schools

C. Communication and referral protocols

{Responses will be shared among the School Focused Worker Initiative Working Group which is an expert reference group to the Education Partnership Table established as an advisory body by EMYS Lead Agency}.

Your Name:

Title:

Agency name:

Address:

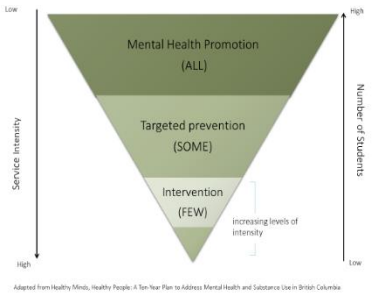
Population served (age, language, specific population…):
Specialized services:
Other:

Questions for Community Agencies

Are you currently providing a specific service through the School Priority Access Initiative? (If yes, please proceed to the below questions)

1. **The current pathways to care from school to community mental health services**
    a. What is your agency's geographical and population catchment area for children, youth and families referred through the School Priority Access Initiative?
    b. Please describe the designated service to support students referred by school mental health professionals through the School Priority Access Initiative?
    c. Please describe the process mental health professionals use to help students access this service or program.
    d. Once the student has completed a program, service or intervention what types of supports and monitoring are put in place to ensure continuity as appropriate?
    e. Please identify how this process has been successful.
    f. Please provide ideas for improvement.

g. When looking at the tiered model of service, which tier best describes the type of service currently offered to students referred by school mental health professionals:
    i. mental health promotion
    ii. prevention
    iii. intervention
    iv. other



2. Communication and referral protocols

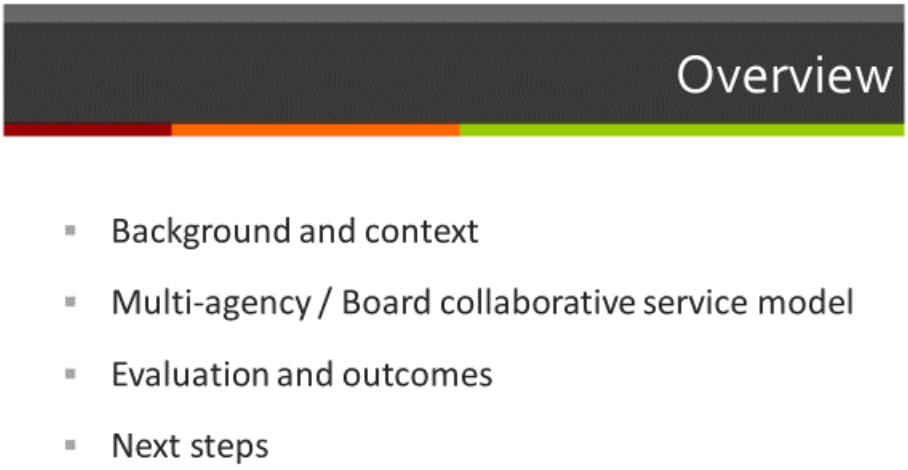
a. Do you currently have a specific and/or formal referral process protocols that supports the pathways to care from school to community mental health services with:
    i. TDSB, if yes why is this successful, how can it be improved?
    ii. TCDSB, if yes why is this successful, how can it be improved?
    iii. CSDCCS, if yes why is this successful, how can it be improved?
    iv. Viamonde, if yes why is this successful, how can it be improved?

b. Do you currently have formal communication protocols that supports the pathways to care from school to community mental health services with:
    i. TDSB, if yes why is this successful, how can it be improved?
    ii. TCDSB, if yes why is this successful, how can it be improved?
    iii. CSDCCS, if yes why is this successful, how can it be improved?
    iv. Viamonde, if yes why is this successful, how can it be improved?

c. Do you currently have formal process or communication protocol that supports on-going support and monitoring for students requiring more intensive treatment and intervention with?
    i. TDSB, if yes why is this successful, how can it be improved?
    ii. TCDSB, if yes why is this successful, how can it be improved?
    iii. CSDCCS, if yes why is this successful, how can it be improved?
    iv. Viamonde, if yes why is this successful, how can it be improved?

Appendix C: Background Documents

School-Focused Worker Evaluation 2015



Agency Partners

- Community Children's Mental Health Agencies
  - Aisling Discoveries Child and Family Centre
  - Boost Child Abuse Prevention & Intervention
  - Breakaway Addiction Services
  - Central Toronto Youth Services (CTYS)
  - Centre francophone de Toronto (CFT)
  - East Metro Youth Services (EMYS)
  - The Etobicoke Children's Services (ECC)
  - The George Hull Centre for Children and Families(GHC)
  - Griffin Centre (GC)
  - The Hincks-Dellcrest Centre (HDC)
  - Native Child and Family Services of Toronto (NCFST)
  - Rosalie Hall
  - Toronto Council Fire Native Cultural Centre

School Board Partners

- District School Boards (serving Toronto region)
  - Conseil scolaire de district catholique Centre-Sud (CSDCCS)
  - Conseil scolaire Viamonde (CSV)
  - Toronto Catholic District School Board (TCDSB)
  - Toronto District School Board (TDSB)

Context

- June 2011: Ontario government introduced a mental health and addictions strategy
  - *Open Minds, Healthy Minds* http://www.health.gov.on.ca/en/common/ministry/publications/reports/mental_health2011/mentalhealth_rep2011.pdf
  - Focus on children and youth in first 3 years (10 year strategy)
- November 2012: *Moving on Mental Health*
- September 2013: *draft Child and Youth Mental Health Service Framework*

Context cont...

- Mental Health Workers for Students in Schools
- Provincial initiative; operationalized differently in the various regions
- Toronto Region: Student Focused Worker Initiative
  - 13 community mental health agencies (child/youth)
  - 4 district school boards

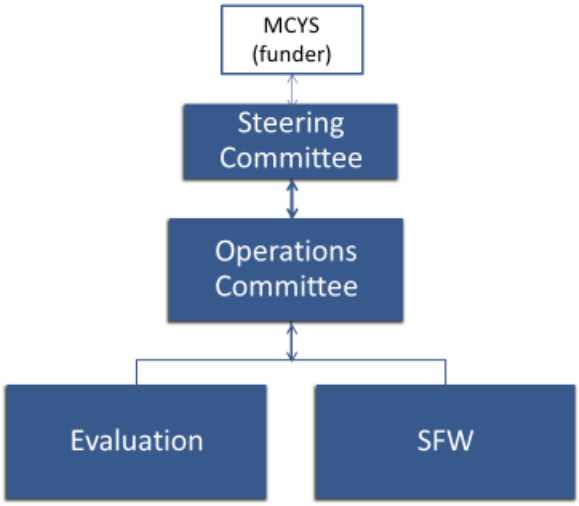
Student Focused Worker Initiative

- Fall 2011: funding for "*Mental Health Workers for Students in Schools*"; overlap with SAL initiative
  - Integrated SAL in Fall 2012 (4 youth agencies –1 FTE each)
- Community-based child and youth mental health agencies, working in collaboration with School Boards
- Cross-sectoral collaborative initiative: to provide access to timely mental health services for students having MH needs
- CTYS – coordinating role to support evaluation component and professional development / training event

Service Model Components

- To meet service targets, a shorter, time-limited service (up to 6 months) was originally determined by partners
- Consistent processes and reporting templates
- French translation (guide/template; staff development day)
- Family systems approach
- Outreach engagement model (mainly for youth)
- Smaller case loads: 10-15
- Supportive community of practice

Accountability Structure



Evaluation Period

- Referrals from 2013 / 2014 school year
  - September 2013 – June 2014
- Cases that were activated by August 31, 2014
- Outcomes monitored until November 30, 2014

Objectives

1. Improved access and pathways to mental health agencies
2. Student mental health outcomes
3. Collaboration between and among partners

Evaluation Component #1:
Access and Pathways to Mental Health Agencies

- Boards prioritize referrals
  - Students who have been identified as having mental health needs, requiring agency support
- Barrier-free intake processes

Evaluation Component #1:
Access and Pathways to Mental Health Agencies – Process

- Agencies to report data on a monthly basis
  - Template and guide created (translated into French)
  - Individual (anonymized) data for analyses
    - By school board
    - Service dates (referral, active, closure)
    - Demographics (gender, age, language, etc.)
    - Type of intervention
    - Client / caregiver strengths
    - Presenting problems
    - MH diagnosis
    - Outcome measures
    - *School participation
    - Reason for closure
    - Closing recommendations
    - Barriers to service
  - Input from Committee regarding data collection elements

***Client's involvement related to "School participation" - inclusive of involvement /connection to a wide variety of school based programming including traditional and non-traditional forms of education, such as Day Treatment, Residential Programming, on-line and/or alternative school programming; it does not include School Board Attendance data.**

Overview Statistics:
Boost Prevention Program (September 2013-June 2014)

	TDSB	TCDSB	Total
Number of Schools	16	8	24
Number of Classrooms	49	23	72
Number of Students	699	522	1221

	TDSB Classrooms	TDSB Students	TCDSB Classrooms	TCDSB Students
I'm a Great Little Kid*	25	102	15	321
I'm a Great Kid**	19	441	6	152
Grade 7/8 Program	5	156	2	49
RSVP Program			1	15

Child abuse prevention programs delivered to whole classes (self-esteem, communication, making good choices, respect for self and others, touch, how and where to get help). [*Grade 1-3; ** Grade 4-6]

Overview Statistics:
Youth Wellness Navigation Program (YWNP) – Council Fire

- Culturally based program activities
  - Physical, spiritual, emotional and mental well-being of Aboriginal students and youth
  - Personal wellness and academic goals
  - Includes school-based programming such as "We are of the Land" (classroom based), monthly "Big Drum Social & Feast"; also reading circles and arts-based initiatives
- During September 2013 – June 2014 school year:
  - 92 children (5-12), 672 youth (13-17), 1389 young adults (18-29)
    - separate from cases referred for intervention
- Akwe:go (age 7-12) and Wasa-Nabin (age 13-18) one-one supports

Overview Statistics:
Valid* Referrals by School Board

CSDCCS	CSV	TDSB	TCDSB	Other	Total
3	20	347	182	20	572
0.5%	3.5%	60.7%	31.8%	3.5%	100%

* Referrals September 2013 – June 2014; school aged (JK – high school)

CSDCCS - Conseil scolaire de district catholique Centre-Sud
CSV - Conseil scolaire Viamonde
TCDSB - Toronto Catholic District School Board
TDSB - Toronto District School Board

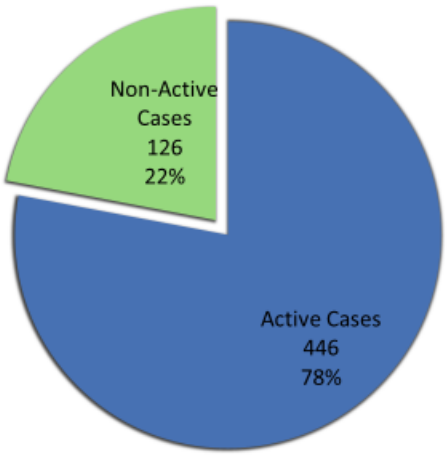
Overview Statistics:
Valid* Referrals by Agency

ADC	BKWY	CFT	CTYS	ECC	EMYS	GHC	GC	HDC	NCFST	TCF
42	79	25	54	30	101	43	71	72	35	20
7.3%	13.8%	4.4%	9.4%	5.2%	17.7%	7.5%	12.4%	12.6%	6.1%	3.5%

* Referrals September 2013 – June 2014; school aged (JK – high school)

ADC - Aisling Discoveries Child and Family Centre
BKWY - Breakaway Addiction Services
CFT - Centre francophone de Toronto
CTYS - Central Toronto Youth Services
EMYS - East Metro Youth Services
ECC - The Etobicoke Children's Services
GHC - The George Hull Centre for Children and Families
GC - Griffin Centre
HDC - The Hincks-Dellcrest Centre
NCFST - Native Child and Family Services of Toronto
TCF - Toronto Council Fire Native Cultural Centre

Total Cases Referred* (n = 572)

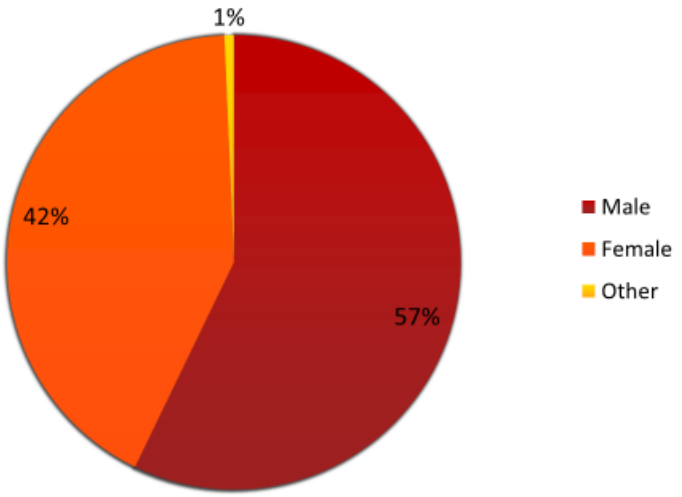


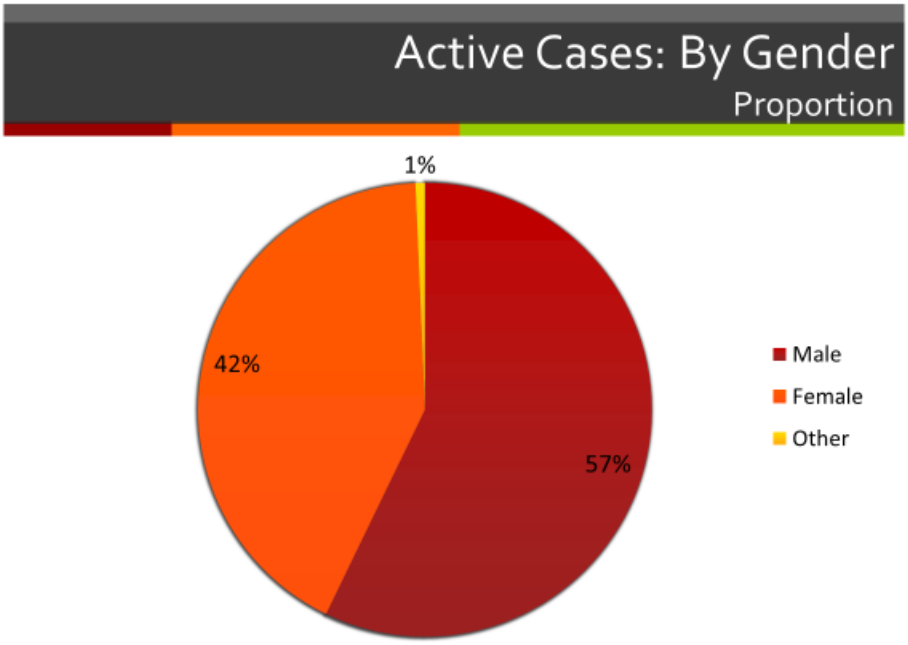
*Referred for MH service (Sept 2013 – June 2014, JK to high school)

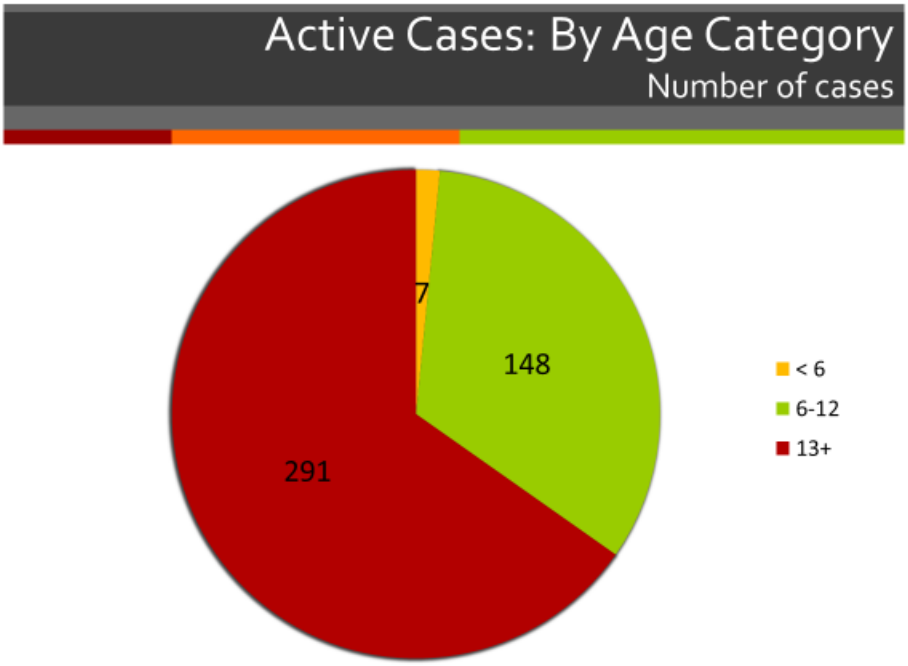
Following Analyses …

- Based on the 446 "active" cases
  - Cohort of students from 2013-2014 school year
  - Client level data collected from agencies

Active Cases: By Gender
Proportion




Active Cases: By Gender
Proportion
1%
42%
57%
Male
Female
Other


Active Cases: By Age Category
Number of cases
7
148
291
< 6
6-12
13+

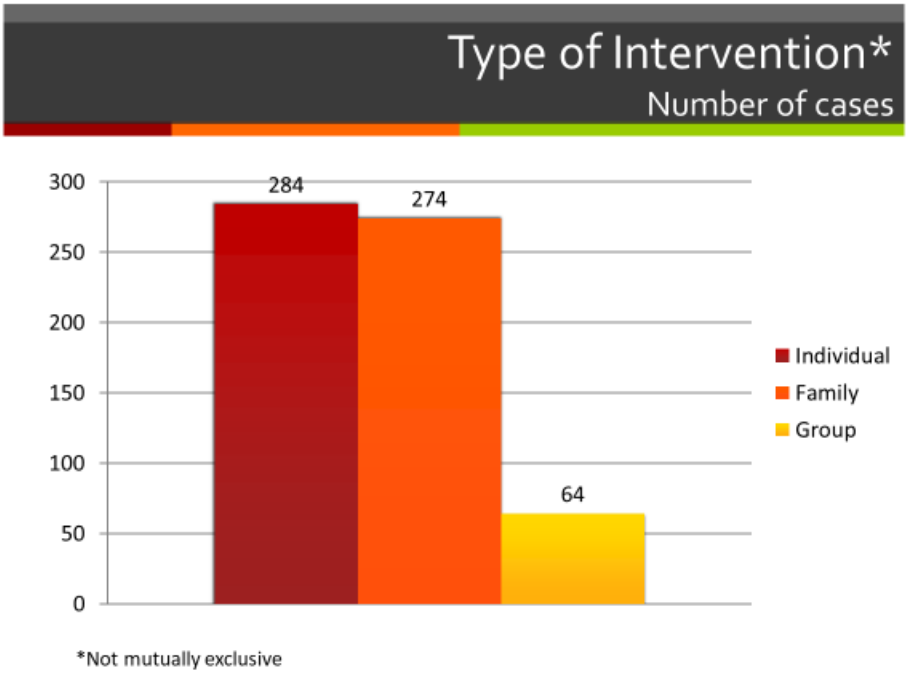
Active Cases - Language

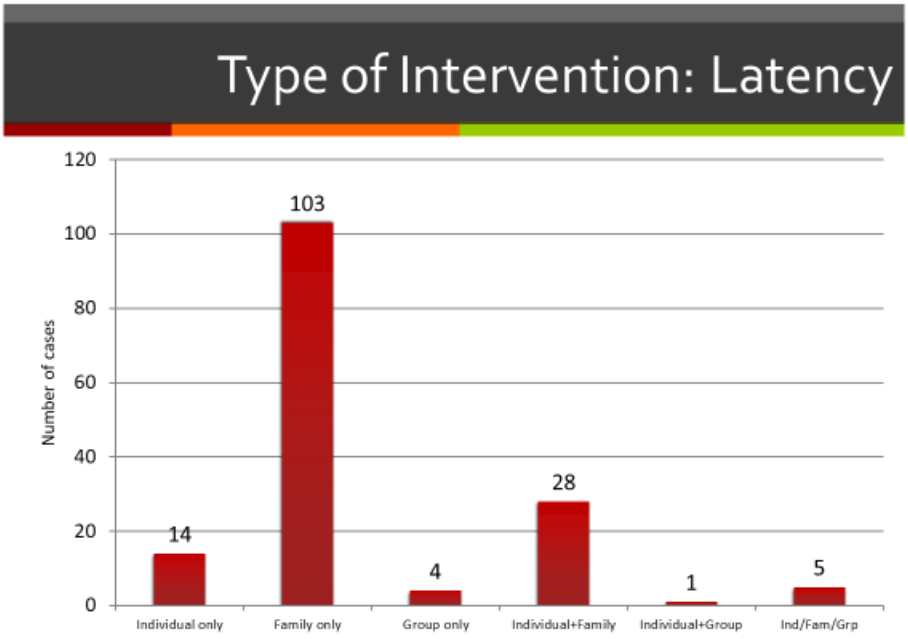
- Majority were English speaking (n = 394; 88%)
- Other 12% were identified as:
  - French: n = 10
  - ESL: n = 13
  - English/ESL: n = 15
  - English/French: n = 3
  - French/FSL: n = 11

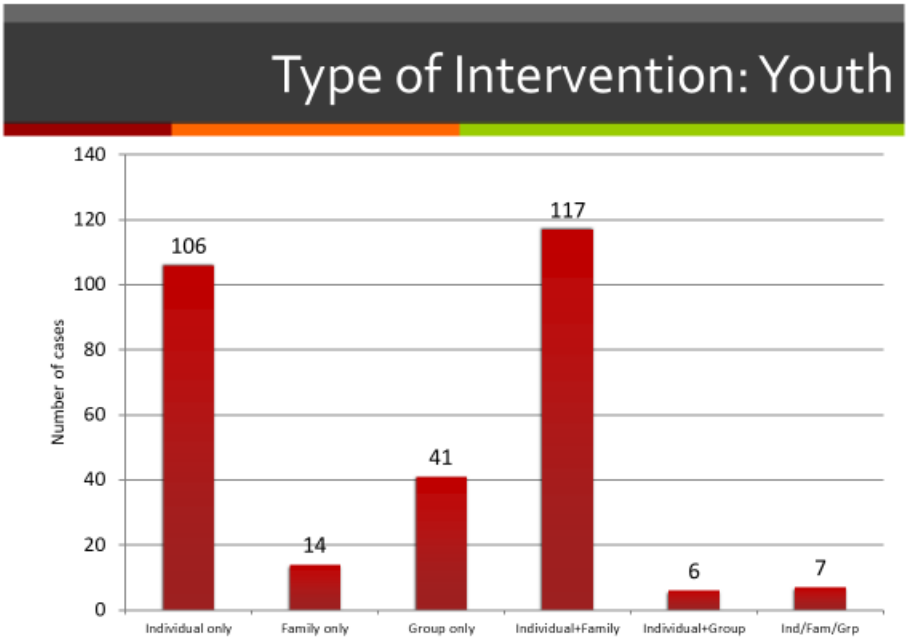
Active Cases – Other Context

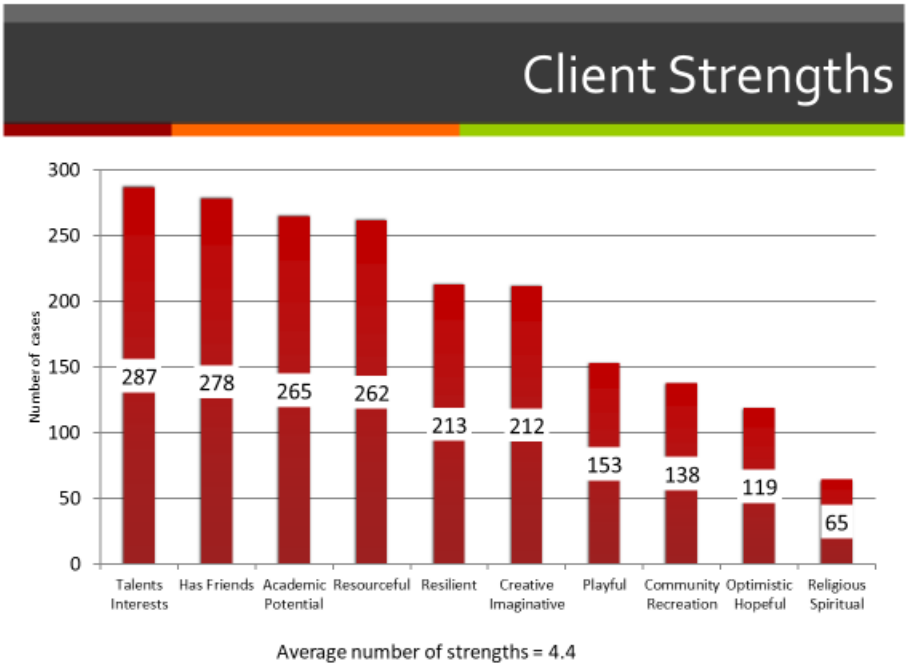
- 38 (8.5%) were SAL students
- 32 (7.2%) identified as FNMI
- Translation requested for 15 clients *
- CAS involvement
  - Current: n = 40 (9%) – (latency=17; youth = 23)
  - Past: n = 67 (15%) – (latency=31; youth = 36)
  - 11 of these are included as both current and past

*under-represented

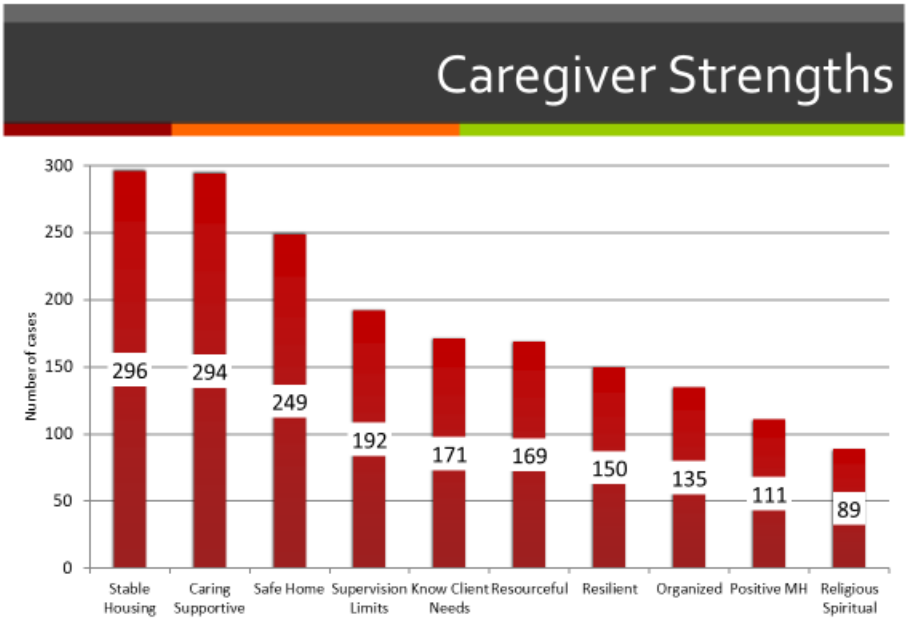

Type of Intervention*
Number of cases
300
250
200
150
100
50
0
284
274
64
Individual
Family
Group
*Not mutually exclusive


Type of Intervention: Latency
Number of cases
120
100
80
60
40
20
0
14
103
4
28
1
5
Individual only
Family only
Group only
Individual+Family
Individual+Group
Ind/Fam/Grp

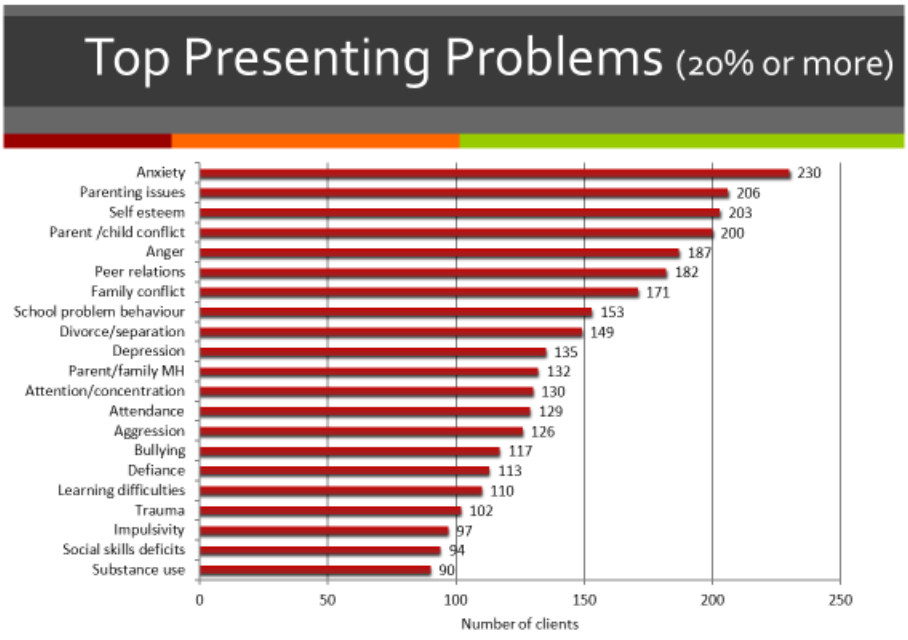




Average number of strengths = 4.4



Average number of strengths = 4.9

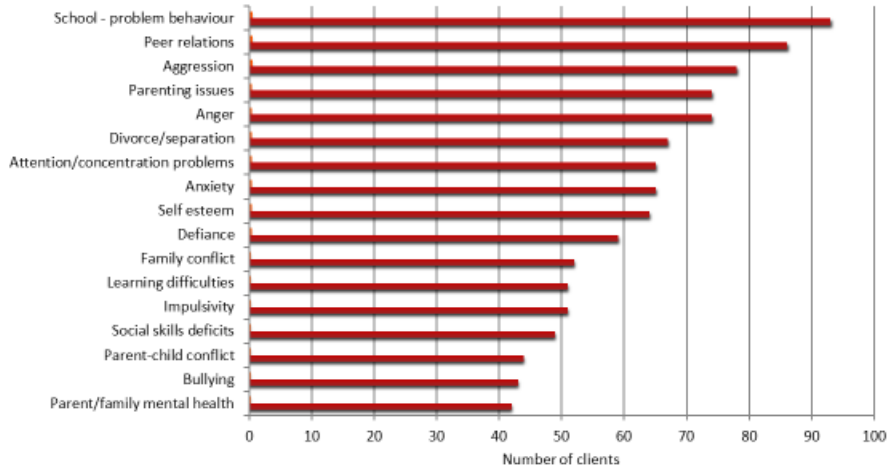


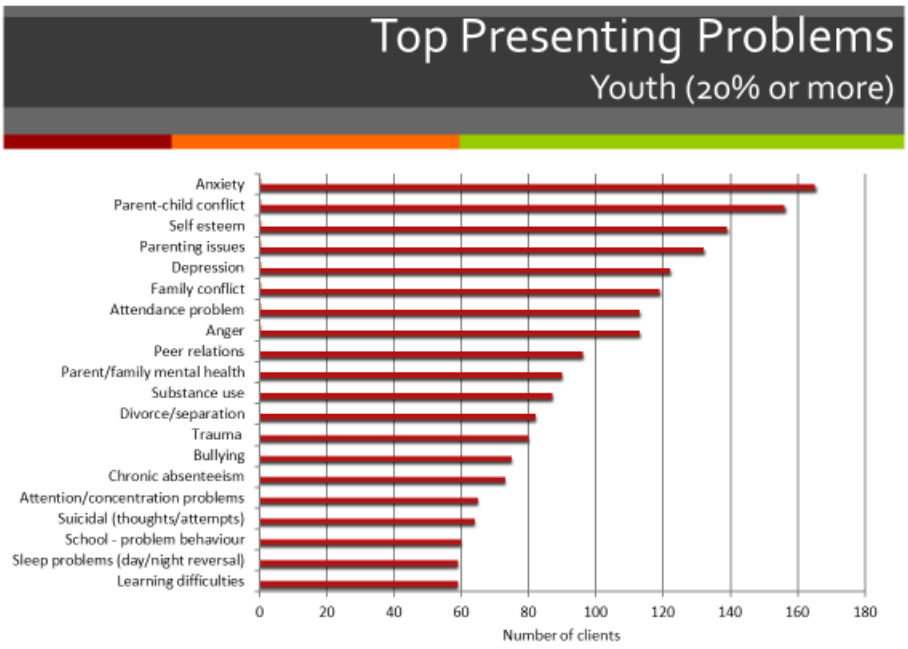
Average number of presenting problems = 8.6

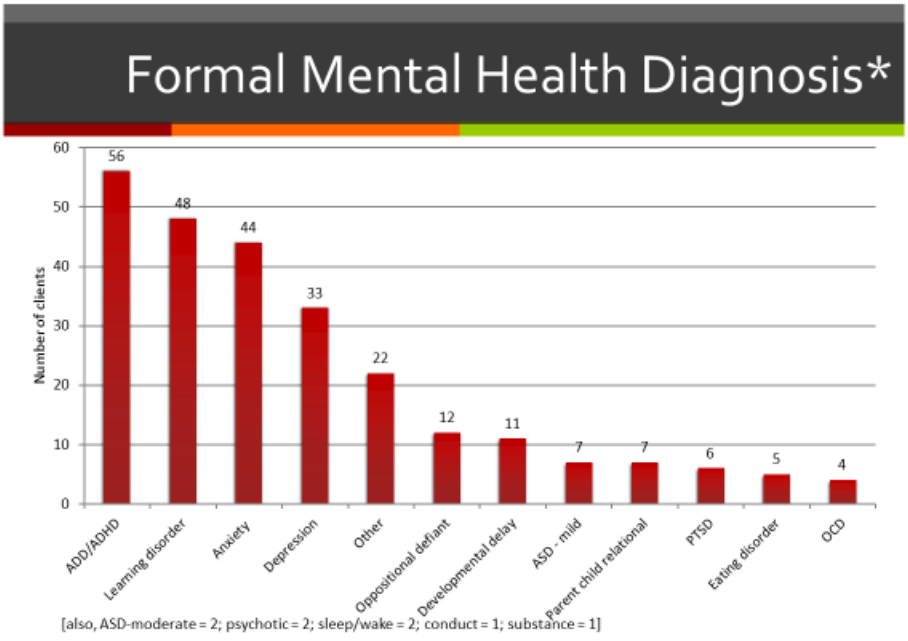
Presenting Problems (10-20%)

- Chronic absenteeism (n = 86)
- Sleep problems; day/night reversal (n = 79)
- Suicidal thoughts (n = 74)
- Loss/bereavement/grief (n = 71)
- Self-harm (n= 56)
- Parent/family addictions (n = 55)
- Parent/family health issues (n = 51)
- Eating issues (n = 47)
- Community behaviour (n = 43)

Top Presenting Problems
Latency (20% or more)







[also, ASD-moderate = 2; psychotic = 2; sleep/wake = 2; conduct = 1; substance = 1]

*251 (61%) clients did not have a formal MH diagnosis

Service Stats

- Length of service

	< 1 mo	1-3 mo	3-6 mo	6-9 mo	9 mo – 1 yr	> 1 year
n	12	64	157	128	59	26
%	3%	14%	35%	29%	13%	6%

- Reason for closure
  - Incomplete: n = 143 (32%)
  - Complete: n = 193 (43%)
  - Still open: n = 110 (25%)

Length of Service by Age Group

Latency

	< 1 mo	1-3 mo	3-6 mo	6-9 mo	9 mo – 1 yr	> 1 yar
n	5	23	59	43	22	3
%	3%	15%	38%	28%	14%	2%

Youth

	< 1 mo	1-3 mo	3-6 mo	6-9 mo	9 mo – 1 yr	> 1 yar
n	7	41	98	85	37	23
%	2%	14%	34%	29%	13%	8%

Challenges Impacting Engagement

Top 6 barriers to service:

1. Caregiver multiple demands
2. Chaotic family environment
3. Client mental health
4. Family mental health
5. Communication barriers (language or lack of communication)
6. Transportation

Accessing MH Services (#1)
Summary

- Complex mental health needs - anxiety and relational issues (e.g., family, peer, self-esteem) most prevalent
- Presenting problems identified in categories related to client, family and school
- Collaborative conversations between referral source and mental health agency prior to first contact with client resulted in greater engagement
- Enhanced relationships between MH / education partners
- Outreach a positive component of the service model
- Systemic approach enhanced outcomes
- Many are Tier 3 clients (more severe MH); require longer service / complex care

Data Limitations

- Data collection period - not comprehensive of all clients being served during this period:
  - Clients who started service prior to September 2013 excluded
  - Some agency programs were limited by school calendar
  - Not all were cases were complete by end of November 2014
    - Improvements/outcomes under-represented
- Data collection elements
  - Challenges with collecting elements that were both inclusive and reflective of all agencies
  - Sensitivity to amount of data requested by SFWs
  - Client level data collection from school boards not within the purview of this evaluation

Evaluation Component #2: Student Outcomes

- Aggregate CAFAS scores (Child and Adolescent Functional Assessment Scale)
- ORS (Outcome Rating Scale)
- Personal Plan of Care
- Other (e.g., GAINS, French measures)
- School participation

CAFAS Context

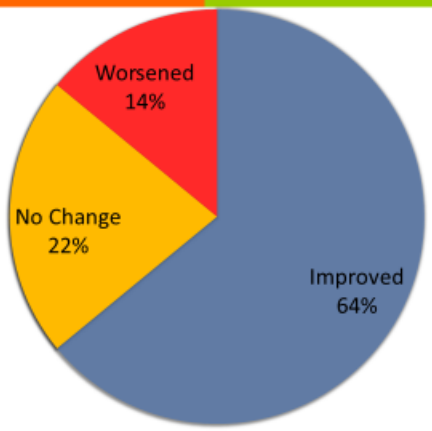
- Child and Adolescent Functional Assessment Scale (CAFAS)
  - Client CAFAS has 8 subscales: School, Home, Community, Behaviour Towards Others, Moods, Self-Harm, Substance Use, Thinking
  - Total CAFAS open/close collected
- Total CAFAS used as an outcome measure at 7 agencies
  - Aisling, CTYS, ECC, EMYS, GHC, GC, HDC
- For clients that were 'active', 228 completed both an 'open' and 'closing' CAFAS
  - Additional 46 clients – open CAFAS only

CAFAS Definitions by Severity Interval

Severity Intervals		Opening CAFAS*
0-30	May not need ongoing services	19.7%
40-70	May need ongoing outpatient services	48.5%
80-100	May need outpatient care with additional supportive services	21.9%
110-130	May need intensive community-based services	6.2%
> 140	May need very intensive services, residential or inpatient	3.7%

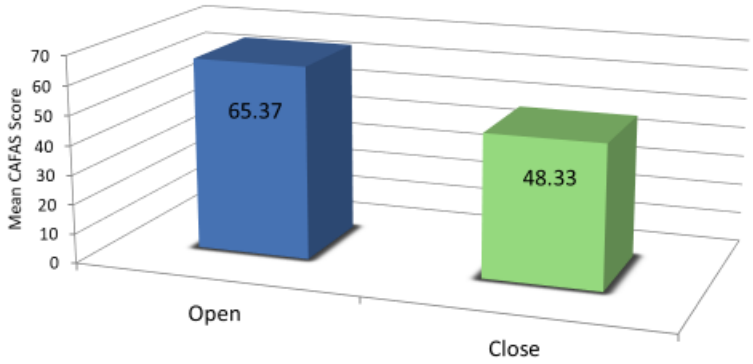
* Proportion of cases at intake in each of the severity intervals

Change in Overall CAFAS Scores



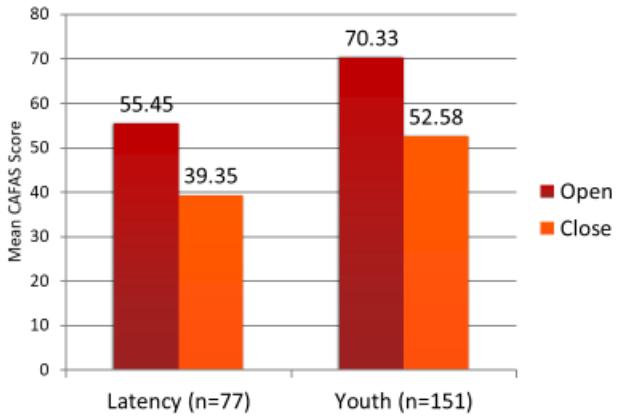
*Note: in the improved group, 110/146 (75%) reduced CAFAS by ≥ 20 points (clinically meaningful)
- This includes cases that may still be open
- For SAL clients, 68% saw improved functioning in their CAFAS scores and 12% saw no change

Change in Mean CAFAS Score (n=228)



Note: A reduction of ≥ 20 points is considered clinically significant
Reduced CAFAS scores indicates improvement in functioning

Change in Mean CAFAS Score: by Age Category



Note: A reduction of ≥ 20 points is considered clinically significant

ORS Context

- Client-Directed Outcome-Informed therapy (CDOI)
  - Outcome Rating Scale (ORS) – before each session
  - Session Rating Scale (SRS) – after each session
  - Evidence-based practice; developed by Scott Miller and Barry Duncan
- ORS and SRS are completed at each session
  - Typically results are plotted over time; look for trajectory
- ORS – 4 components; each with a score 0-10
  - Individually (personal well-being)
  - Interpersonally (family, close relationships)
  - Socially (work, school, friendships)
  - Overall (general sense of well-being)

ORS Outcomes

- Total* ORS used as an outcome measure at Breakaway Addiction Services
- 67 clients completed both an 'open' and 'closing' ORS
  - Improved = 39 (58%)
  - No change = 20 (30%)
  - Worsened* = 8 (12%)
    - Of these 2 show less than a 0.5 change (insignificant)
- Treatment is informed by the individual components

Personal Plan of Care Context

- Personal Plan of Care is a framework which looks at individual "health and wellness" from a holistic world view.
- Each of the four quadrants/directions (spiritual, physical, emotional and mental) will be "assessed" from a sense of balance: "0" no balance → "10" complete balance

Personal Plan of Care Outcomes

- Personal Plan of Care (PPC) used as an outcome measure by:
  - Native Child and Family Services of Toronto
  - Toronto Council Fire Native Cultural Centre
- 34 clients completed both an 'open' and 'closing' PPC
  - Improved overall = 22 (65%)
  - No change overall = 12 (35%)
- Spiritual – 21 individuals reported an improved balance (1-5 range)
- Physical - 16 individuals reported an improved balance (1-7 range)
- Emotional - 18 individuals reported an improved balance (1-5 range)
- Mental - 20 individuals reported an improved balance (1-6 range)
- One individual reported a decrease in physical, emotional and mental; while an additional client reported a decrease in just the mental quadrant/direction

*School Participation:
Pre-post Change

- Better: n = 133 (30%)
- Same: n = 195 (44%)
- Worse: n = 27 (6%)
- No response for 91 (20%)

Note: School participation was not an issue for some clients (all client participation data provided by agency SFWs).

- ✓ Success seen for SAL clients
  - ✓ Better 41%
  - ✓ Same 45%
  - ✓ Worse 15% (n=5)

***Client's involvement related to "School Participation" - inclusive of involvement /connection to a wide variety of school based programming including traditional and non-traditional forms of education, such as Day Treatment, Residential Programming, on-l-line resources, and/or alternative school programming; does not include School Board attendance data.**

Closing Recommendations

Top 6 recommendations:

- Ongoing individual counseling - n = 173
- Ongoing family counseling – n = 149
- School academic support – n = 88
- Alternate school placement - n = 54
- Additional assessment - n = 45
- Day treatment - n = 34

Client Outcomes (#2)
Summary

- Improved mental health functioning as evidenced by improved CAFAS scores
- Improved outcomes as evidenced by improved ORS and Personal Plan of Care scores
- Increased participation in school
- Many recommended for additional treatment/support

Component #3: Collaboration

- Reflective activity
  - T1 SFW and committee members
  - T2 Operations Committee members
- Professional Development / Training Event
  - May 2014

Collaboration – T1

- Reflection - Spring 2014
  - 23 Committee members (Operations Committee; Steering Committee)
  - 88 Student Focused Workers (agency; board)
  - 11 of 13 agencies represented
  - 3 of 4 school boards represented

Collaboration – T1
Closed Ended Component

- Scale: always, mostly, seldom, never
  - always = 4 → never = 1; n.a./unknown = 0
- Committee form included 20 questions regarding collaboration
- SFW form was comprised of 12 questions:
  - 6 related to collaboration; 6 related to access to service/intake processes

Collaboration - T1
Closed Ended: Committee Findings (n=23)

- 17 of 20 questions: mean score 3.0 - 3.7 (top 5 listed)
  - Goals could not be achieved with one organization; need collaboration of the partners
  - Those involved want it to succeed
  - Being involved with benefit the students
  - Formal/informal communication
  - Regular meetings to ensure consistency of process and discuss ongoing issues
- Clear sense of their roles/responsibilities (mean = 2.8)
- Trust & clear process for decision-making among partners (mean = 2.4)

Collaboration - T1
Closed Ended: SFW Findings (n=88)

- Collaboration (mean scores):
  - Will benefit students (3.4)
  - Will improve access to child/youth MH services (3.4)
  - Formal/informal communication (3.1)
  - Clear sense of roles/responsibilities (3.1)
  - Willingness to compromise/reach consensus (2.9)
  - Trust between staff (2.9)
- Access to service (mean scores):
  - Coordination of intake/assessment (3.2)
  - Wait list less than 3 months (3.2)
  - Access is quick / direct (3.1)
  - Outreach strategies used by agencies (2.8)
  - Regular communication between front-line staff (2.7)
  - Intake is seamless, regardless of agency (2.6)

Collaboration - T1
Open Ended: Committee Findings

- **Strengths**
  - Quicker access to services for students/families
  - Relationship building: between/among education and mental health agency partners
  - Ability to overcome traditional silos: client/family is central
  - Better coordination of services
  - Resource / knowledge sharing
  - Identify gaps and trends; challenges/successes
  - Regular data collection; regular meetings
  - French translation (data collection and PD)
  - Consistent representation by partners
  - Role of coordinating agency
  - Ability of school boards to prioritize cases

Collaboration - T1
Open Ended: Committee Findings

- **Challenges**
  - Depth of the MH concerns not fully known at intake
  - Complex mental health needs require longer service than originally envisioned
  - Demand for services exceeds capacity
  - Peak referral times October – June; other times with limited referrals - challenges for case assignment
  - Difficulties with engagement for some clients/families
  - Different processes for each board
  - Not all partners participated at the same level
  - Limited role for the Steering Committee
  - Terms of Reference used in 'draft' form
  - Funding parameters

Collaboration - T1
Open Ended: SFW Findings

- **Strengths**
  - Timely access to MH services for children, adolescents and families; reduced wait list
  - Transparency of intake process
  - Ability to prioritize referrals
  - Community outreach by agencies
  - Access to other programs within agencies
  - Engagement with families
  - Collaboration between schools and agencies
  - Collaboration at the Ministry level (MCYS/Education)
  - Partnership enhanced continuity of service
  - Increased trust for families around MH services
  - Relationships / team work – great communication

Collaboration - T1
Open Ended: SFW Findings

- **Challenges**
  - Location of service seen as barrier by some families
  - Demand for services exceeds capacity
  - Stigma of accessing MH services in the community
  - Lack of interpretation services for families
  - Consistent communication between some partners
  - Less outreach for younger clients
  - Differing processes for each board
  - No formal mechanism for 'community of practice' for front line workers (MH/education)
  - Service used differentially within boards
  - Request for more inter-sectoral professional development
  - Some differences in understanding of client MH needs

Collaboration – T2

- Reflection – January 2015 (n = 16)
  - After the end of the data collection
  - Operations Committee members, in consultation with staff at their organization(s)
  - 12 of 13 agencies represented
  - 2 of 4 school boards represented
  - Open-ended regarding strengths, challenges and suggestions going forward

Reflection at End of Evaluation: T2

Strengths of the Collaboration

- Inter-sectoral relationship building
- Enhanced understanding of other agencies, boards and services
- Networks and linkages between organizations
- Dedicated representation from agencies and school boards
- Able to reach a client population that otherwise would not have access to MH services; reduction of barriers
- School/agency link helps families navigate services
- Training day - opportunity for front line workers to network, learn and share
- Help to expedite partnership agreements with boards
- Evaluation - identify issues and outcomes
- Opportunity to explore themes and challenges
- CTYS as coordinating agency (coordination of data collection, meetings, PD, etc.)
- Sharing of resources/information; challenges and successes
- Flexible program; community outreach with youth population

Reflection at End of Evaluation: T2

Challenges of the Collaboration

- Some differences in understanding of client MH needs (board / agency)
- Different service models / varied connection to the collaboration
- Limited opportunities for front line workers to collaborate with other agencies
- Evaluation did not include a narrative component
- Changes in staff, and locations of agencies
- Differing referral processes by boards; varied intake procedures with agencies
- Transitions / reintegration to school
- Resources / time commitment
- Challenges of outreach (funding, transportation, time)
- Demand for services exceeds capacity
- Build on opportunities to connect MH with French school boards
- Lack of referrals in September / July/ August

Reflection at End of Evaluation: T2

Challenges of this Client Population

- Clients/families with complex needs; e.g, suicidality, anxiety, depression, self-harm, social isolation, parent-child conflict, trauma
- Clients require more than 6 months of service
- Time / resources required for engagement phase
- Transient populations
- Unique issues and treatment considerations for LGBTQ as well as FNMI populations
- Barriers with translation, transportation, location, scheduling
- Outreach necessary for some clients
- Services to address parent/caregiver MH
- Readiness for child/adolescent/family engagement

Reflection at End of Evaluation: T2

Suggestions Going Forward

- Ongoing collaboration and coordination through a community of practice
- Streamline referral/intake processes
- Forum to update pathways to service, specific to each agency
- Increased opportunity for front line workers to network
- Consider using technology to enhance collaboration and communication
- Include 'health' as a partner
- Support for caregivers with MH
- Funding for translation, transportation, outreach
- Resources for specific populations: e.g., LGBTQ, FNMI, French
- Annual training day / professional development
- Maintain partnership to support mandate of SFWI
- Continue to recognize need for service for SAL clients (youth MH)

Professional Development/Training
May 22, 2014

- Exploring attachment, trauma and child/adolescent brain using Dyadic Developmental Psychotherapy
  - Dr. Sian Phillips and Robert Spottswood
- Representatives from the 13 agencies and 4 school boards were invited to attend
  - 73 registered
  - 67 attended

Professional Development/Training
May 22, 2014 - Findings

- Evaluations completed by 55 attendees (82%)
  - 91% reported training definitely relevant to their work
  - 87% reported content definitely enhanced their clinical knowledge
  - 95% reported video segments furthered their understanding and contributed to their learning about this topic
  - 62% would definitely use these techniques in their work (with an additional 36% who would 'somewhat' use these techniques)
  - Overall positive feedback; balance between theory and practice
  - Great opportunity to connect, but would like more time to network
- Recommendations
  - Staff development day in 2015
  - Networking opportunities should be integrated into the training, to strengthen partnerships
  - Community of practice groups to support ongoing clinical work between agencies and school boards

Evaluation Summary

1. Successful link to mental health agencies
   - 572 referrals in school year; 446 (78% became active)
2. Student outcomes
   - Improved outcomes measured by CAFAS, ORS, PPC
   - Improved *school participation
3. Collaboration between and among partners
   - Development of a positive inter-sectoral relationship
   - Training day / PD event

***Client's involvement related to "School Participation" - inclusive of involvement /connection to a wide variety of school based programming including traditional and non-traditional forms of education, such as Day Treatment, Residential Programming, on-l-line resources, and/or alternative school programming; does not include School Board attendance data.**

Additional Findings

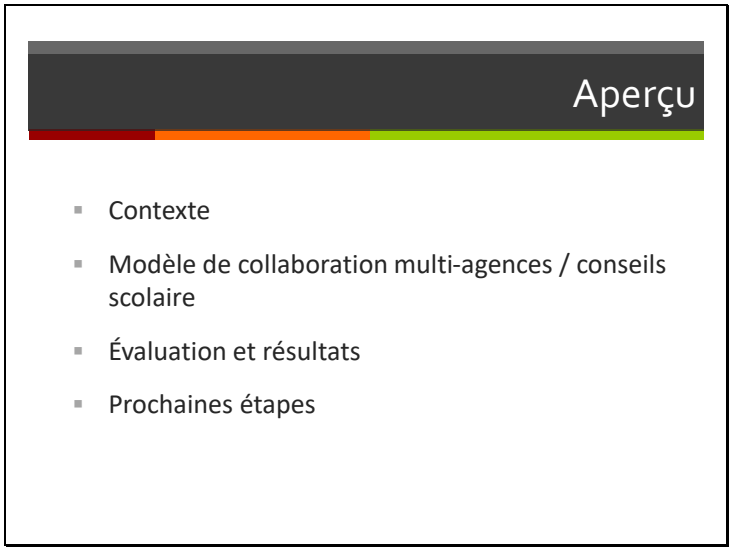
1. Relationships developed through SAL collaborative provided a framework to build the SFW initiative
2. Established access mechanisms to service, enhancing pathways to care
3. Outreach to agencies strengthened relationships and data compliance
4. Recognition and appreciation of client/family complex MH needs
5. Investment in staff / inter-sectoral relationships - strengthened the sector
6. Reducing stigma and ultimately increasing MH services for clients/families

Next Steps

- Continue collaboration with partner agencies / boards through a community of practice
- Share findings with direct service workers
- Future professional development / training across agencies
  - Celebrate and build on success of May 2014 event

Questions

School-Focused Worker Evaluation 2015 (FRENCH)



Organismes partenaires

- Agences communautaires de santé mentale pour enfants
  - Aisling Discoveries Child and Family Centre
  - Boost Child Abuse Prevention & Intervention
  - Breakaway Addiction Services
  - Central Toronto Youth Services (CTYS)
  - Centre francophone de Toronto (CFT)
  - East Metro Youth Services (EMYS)
  - The Etobicoke Children's Services (ECC)
  - The George Hull Centre for Children and Families (GHC)
  - Griffin Centre (GC)
  - The Hincks-Dellcrest Centre (HDC)
  - Native Child and Family Services of Toronto (NCFST)
  - Rosalie Hall
  - Toronto Council Fire Native Cultural Centre

Conseils scolaires partenaires

- Conseils scolaires de district (desservant la région de Toronto)
  - Conseil scolaire de district catholique Centre-Sud (CSDCCS)
  - Conseil scolaire Viamonde (CSV)
  - Toronto Catholic District School Board (TCDSB)
  - Toronto District School Board (TDSB)

S

Contexte

- Juin 2011 : Le gouvernement de l'Ontario lance une stratégie de santé mentale et de lutte contre les dépendances
  - *Esprit ouvert, esprit sain http://www.health.gov.on.ca/fr/common/ministry/publications/reports/mental_health2011/mentalhealth_rep2011.pdf*
  - Met l'accent sur les enfants et les jeunes les 3 premières années (stratégie de 10 ans)
- Novembre 2012 : *Pour l'avancement de la santé mentale*
- Septembre 2013 : *Ébauche – Cadre de prestation des services de santé mentale aux enfants et aux jeunes*

Contexte (suite)

- Travailleurs/travailleuses en santé mentale en milieu scolaire
- Initiative provinciale; fonctionne différemment dans les différentes régions
- Région de Toronto : initiative des travailleurs sociaux dans les écoles
  - 13 agences communautaires de santé mentale (enfants/jeunes)
  - 4 conseils scolaires

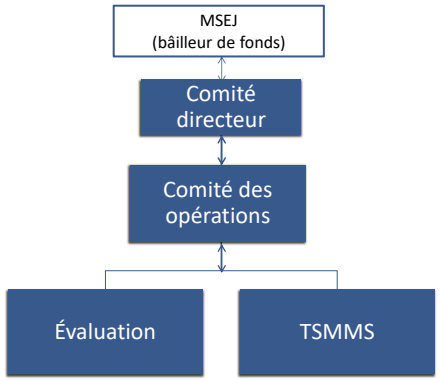
Initiative des travailleurs/travailleuses en santé mentale en milieu scolaire (TSMMS)

- Automne 2011 : financement des travailleurs/travailleuses en santé mentale en milieu scolaire; chevauchement avec le programme Supervised Alternative Learning (SAL)
  - Programme SAL intégré à l'automne 2012 (4 agences de services aux jeunes – 1 ETP chacune)
- Agences communautaires de santé mentale pour les enfants et les jeunes, travaillant en collaboration avec les conseils scolaires
- Initiative de collaboration intersectorielle : fournir l'accès aux services de santé mentale au moment opportun aux élèves qui en ont besoin
- Central Toronto Youth Services (CTYS) – rôle de coordination pour soutenir l'évaluation et le perfectionnement professionnel / événement de formation

Composantes du modèle de service

- Pour atteindre les objectifs de service, les partenaires ont initialement décidé d'offrir un service limité dans le temps (d'une durée pouvant atteindre 6 mois)
- Processus uniformes et gabarits de rapports
- Traduction en français (guide/gabarit; journée de perfectionnement du personnel)
- Approche fondée sur les systèmes familiaux
- Modèle de services d'approche et de mobilisation (surtout pour les jeunes)
- Nombre de cas plus bas : 10-15
- Communauté de pratique pour l'entraide

Structure de responsabilité



Période d'évaluation

- Clients aiguillés pendant l'année scolaire 2013-2014
  - Septembre 2013 – Juin 2014
- Cas activés en plus tard le 31 août 2014
- Résultats surveillés jusqu'au 30 novembre 2014

Objectifs

1. Vois accès amélioré vers les agences de santé mentale
2. Résultats sur le plan de la santé mentale pour les élèves
3. Collaboration entre les partenaires et au sein de ceux-ci

Composante d'évaluation 1 :
Vois accès amélioré vers les agences de santé mentale

- Les conseils scolaires préconisent l'aiguillage
  - Élèves identifiés comme ayant des problèmes de santé mentale et ayant besoin du soutien des agences
- Processus de prise en charge sans obstacle

Composantes d'évaluation 1 :
Vois accès amélioré vers les agences de santé mentale – Processus

- Agences devant déclarer leurs données chaque mois
  - Gabarit et guide créés (et traduits en français)
  - Données individuelles (anonymes) pour analyses
    - Par conseil scolaire
    - Dates de service (aiguillage, dossier actif, fermeture)
    - Données démographiques (sexe, âge, langue, etc.)
    - Genre d'intervention
    - Points forts des clients/personnes responsables
    - Problèmes initiaux
    - Diagnostic de santé mentale
    - Indicateurs de résultats
    - *Participation à l'école
    - Raison de la fermeture
    - Recommandations finales
    - Obstacles au service
  - Apport du comité concernant les éléments de collecte des données

***Engagement du client lié à la participation à l'école - participation / connexion à un large éventail de programmes scolaires y compris formes d'éducation traditionnelles et non traditionnelles, comme traitement de jour, programmes en établissement, programmes scolaires en ligne ou parallèles; ne comprend pas les données du conseil scolaire sur les présences.**

Statistiques générales :
BOOST Prevention Program (sept. 2013-juin 2014)

	TDSB	TCDSB	Total
Nombre d'écoles	16	8	24
Nombre de classes	49	23	72
Nombre d'élèves	699	522	1 221

	TDSB Classes	TDSB Élèves	TCDSB Classes	TCDSB Élèves
I'm a Great Little Kid*	25	102	15	321
I'm a Great Kid**	19	441	6	152
Prog. 7e/8e année	5	156	2	49
RSVP Programme			1	15

Programmes de prévention des abus offerts en classe (estime de soi, communication, faire les bons choix, respect de soi et des autres, toucher, où et comment obtenir de l'aide). [*1re – 3e année; ** 4e – 6e année]

Statistiques générales :
Youth Wellness Navigation Program (YWNP) – Council Fire

- Activités fondées sur la culture
  - Bien-être physique, spirituel, émotionnel et mental des élèves et des jeunes autochtones
  - Buts scolaires et reliés au bien-être personnel
  - Comprend des programmes scolaires comme « We are of the Land » (offert en classe) et le programme mensuel « Big Drum Social & Feast »; aussi, cercles de lecture et initiatives fondées sur les arts.
- Pendant l'année scolaire de septembre 2013 à juin 2014 :
  - 92 enfants (5-12 ans), 672 jeunes (13-17 ans), 1 389 jeunes adultes (18-29 ans)
    - distincts des cas aiguillés pour une intervention
- Akwe:go (âge 7 à 12 ans) et Wasa-Nabin (âge 13 à 18 ans) – soutien individuel

Statistiques générales :
Aiguillages valables* par conseil scolaire

CSDCCS	CSV	TDSB	TCDSB	Other	Total
3	20	347	182	20	572
0,5 %	3,5 %	60,7 %	31,8 %	3,5 %	100 %

* Aiguillages de septembre 2013 à juin 2014; âge scolaire (maternelle-école secondaire)

CSDCCS - Conseil scolaire de district catholique Centre-Sud
CSV - Conseil scolaire Viamonde
TCDSB - Toronto Catholic District School Board
TDSB - Toronto District School Board

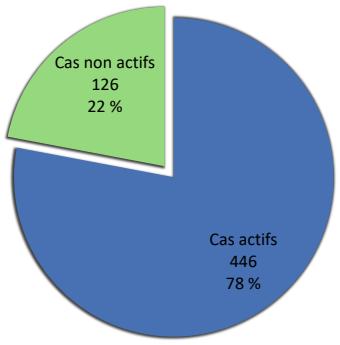
Statistiques générales : Aiguillages valables* par agence

ADC	BKWY	CFT	CTYS	ECC	EMYS	GHC	GC	HDC	NCFST	TCF
42	79	25	54	30	101	43	71	72	35	20
7,3 %	13,8 %	4,4 %	9,4 %	5,2 %	17,7 %	7,5 %	12,4 %	12,6%	6,1 %	3,5 %

* Aiguillages de septembre 2013 à juin 2014; âge scolaire (maternelle-école secondaire)

ADC - Aisling Discoveries Child and Family Centre
BKWY - Breakaway Addiction Services
CFT - Centre francophone de Toronto
CTYS - Central Toronto Youth Services
EMYS - East Metro Youth Services
ECC - The Etobicoke Children's Services
GHC - The George Hull Centre for Children and Families
GC - Griffin Centre
HDC - The Hincks-Dellcrest Centre
NCFST - Native Child and Family Services of Toronto
TCF - Toronto Council Fire Native Cultural Centre

Nombre total de clients aiguillés* (n = 572)



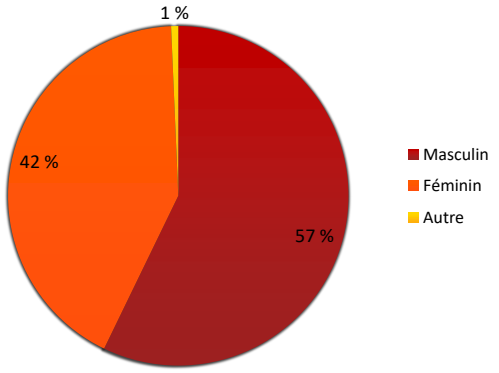
*Aiguillés pour services en santé mentale (sept. 2013 – juin 2014, maternelle – secondaire)

Analyses...

- Fondées sur les 446 cas « actifs »
  - Cohorte d'élèves de l'année scolaire 2013-2014
  - Données sur clients recueillies auprès des agences

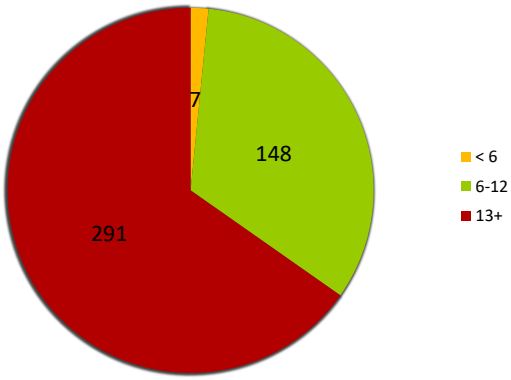
Cas actifs : selon le sexe

Proportion



Cas actifs : par catégorie d'âge

Nombre de cas



Cas actifs : langue

- La majorité était anglophone (n = 394; 88 %)
- Le reste, 12 %, était :
  - Francophone : n = 10
  - ALS : n = 13
  - Anglophone/ALS : n = 15
  - Anglophone/francophone : n = 3
  - Francophone /FLS : n = 11

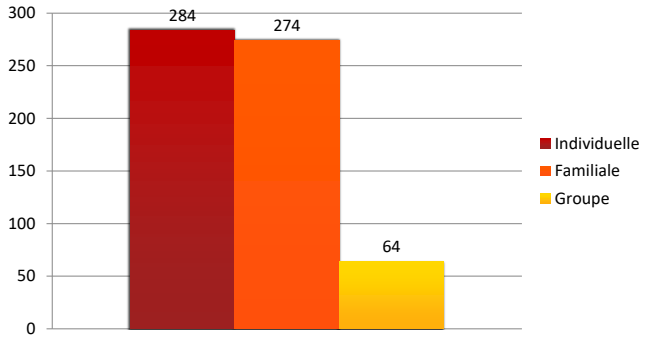
Cas actifs : autre contexte

- 38 (8,5 %) étaient des élèves participant à un programme SAL
- 32 (7,2 %) étaient des clients des Premières Nations, métis et inuit
- Traduction requise pour 15 clients*
- Participation de la société de l'aide à l'enfance (SAE)
  - Actuelle : n = 40 (9 %) – (âge latent = 17; jeunes = 23)
  - Passée : n = 67 (15 %) – (âge latent = 31; jeunes = 36)
  - 11 de ces cas sont inclus dans la participation actuelle et passée

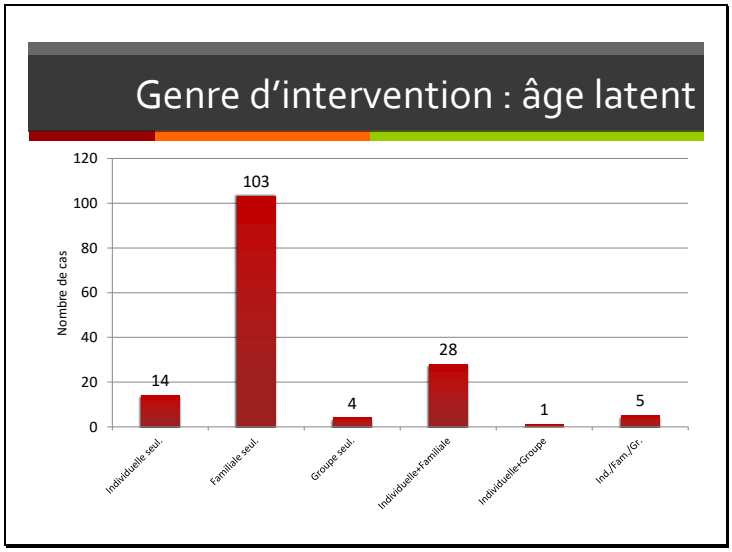
*Sous-représentés

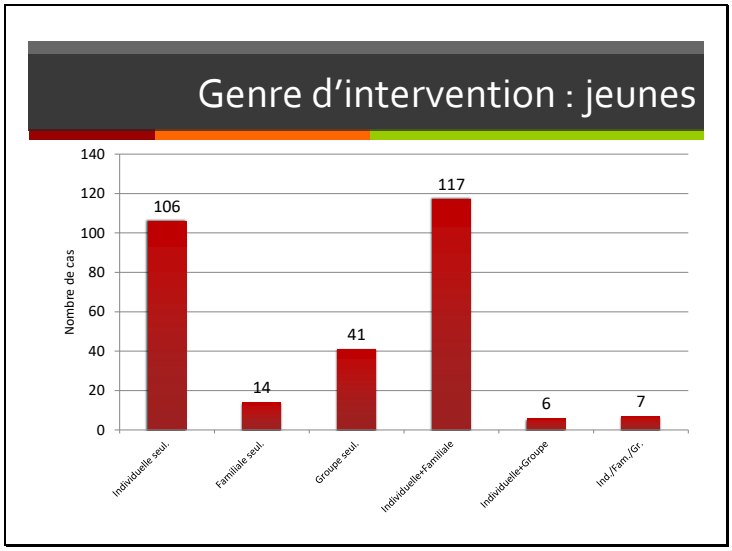
Genre d'intervention*

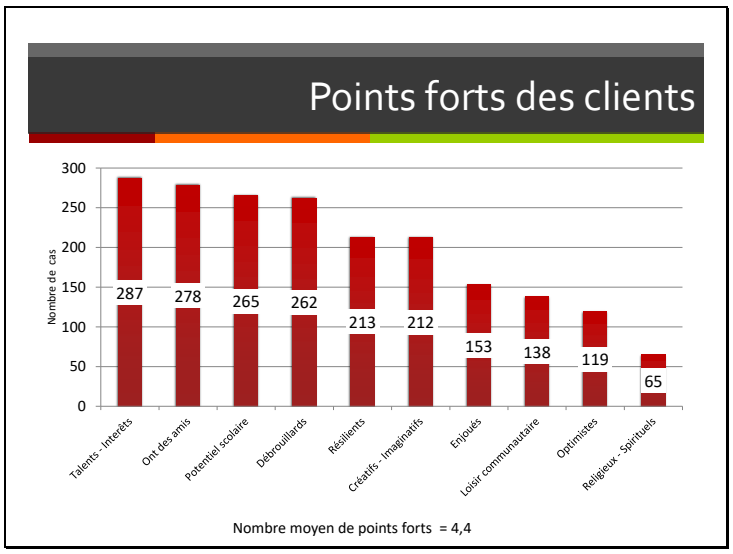
Nombre de cas

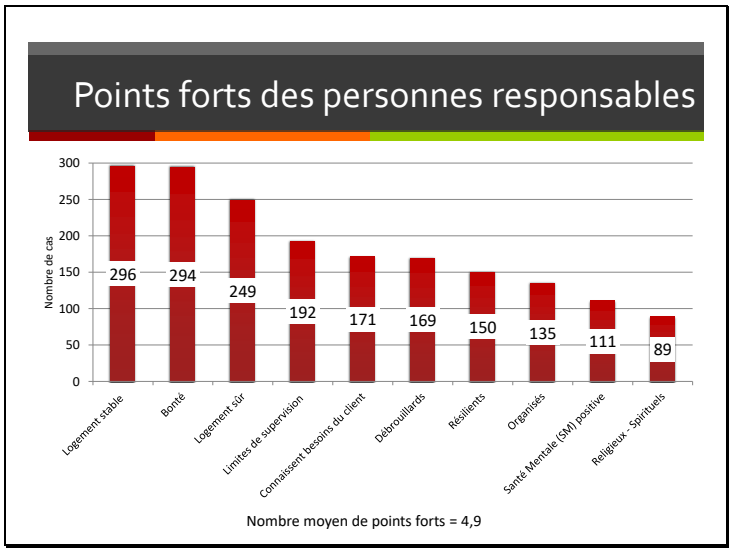


*Pas incompatible

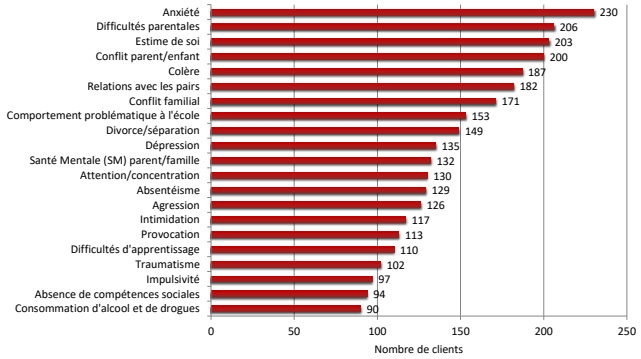

Genre d'intervention : âge latent
Nombre de cas
120
100
80
60
40
20
0
14
103
4
28
1
5
Individuelle seul.
Familiale seul.
Groupe seul.
Individuelle+Familiale
Individuelle+Groupe
Ind./Fam./Gr.


Genre d'intervention : jeunes
Nombre de cas
140
120
100
80
60
40
20
0
106
14
41
117
6
7
Individuelle seul.
Familiale seul.
Groupe seul.
Individuelle+Familiale
Individuelle+Groupe
Ind./Fam./Gr.


Points forts des clients
Nombre de cas
300
250
200
150
100
50
0
287
278
265
262
213
212
153
138
119
65
Talents - Intérêts
Ont des amis
Potentiel scolaire
Débrouillards
Résilients
Créatifs - Imaginatifs
Enjoués
Loisir communautaire
Optimistes
Religieux - Spirituels
Nombre moyen de points forts = 4,4


Points forts des personnes responsables
Nombre de cas
300
250
200
150
100
50
0
296
294
249
192
171
169
150
135
111
89
Logement stable
Bonté
Logement sûr
Limites de supervision
Connaissent besoins du client
Débrouillards
Résilients
Organisés
Santé Mentale (SM) positive
Religieux - Spirituels
Nombre moyen de points forts = 4,9

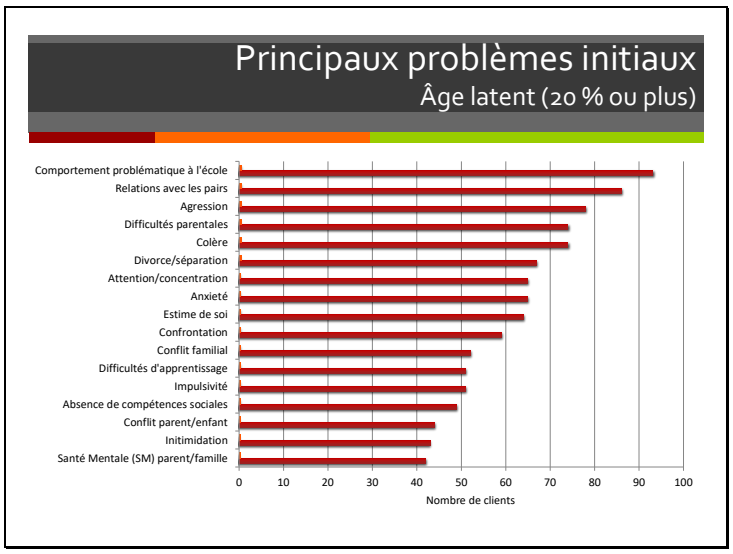
Principaux problèmes initiaux (20 % ou plus)

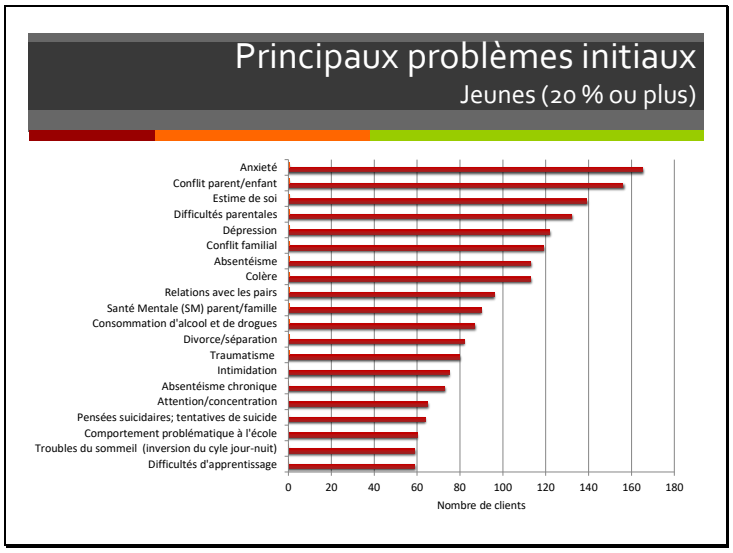


Nombre moyen de problèmes initiaux = 8,6

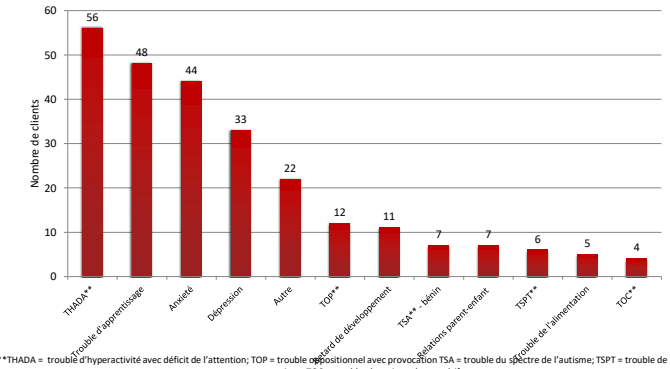
Problèmes initiaux (10 % - 20 %)

- Absentéisme chronique (n = 86)
- Troubles du sommeil; inversion du cycle jour-nuit (n = 79)
- Pensées suicidaires (n = 74)
- Perte/deuil (n = 71)
- Automutilation (n= 56)
- Toxicomanie des parents/dans la famille (n = 55)
- Problèmes de santé chez les parents/dans la famille (n = 51)
- Troubles de l'alimentation (n = 47)
- Comportement en société (n = 43)


Principaux problèmes initiaux
Âge latent (20 % ou plus)
Comportement problématique à l'école
Relations avec les pairs
Agression
Difficultés parentales
Colère
Divorce/séparation
Attention/concentration
Anxieté
Estime de soi
Confrontation
Conflit familial
Difficultés d'apprentissage
Impulsivité
Absence de compétences sociales
Conflit parent/enfant
Initimidation
Santé Mentale (SM) parent/famille
0 10 20 30 40 50 60 70 80 90 100
Nombre de clients


Principaux problèmes initiaux
Jeunes (20 % ou plus)
Anxieté
Conflit parent/enfant
Estime de soi
Difficultés parentales
Dépression
Conflit familial
Absentéisme
Colère
Relations avec les pairs
Santé Mentale (SM) parent/famille
Consommation d'alcool et de drogues
Divorce/séparation
Traumatisme
Intimidation
Absentéisme chronique
Attention/concentration
Pensées suicidaires; tentatives de suicide
Comportement problématique à l'école
Troubles du sommeil (inversion du cyle jour-nuit)
Difficultés d'apprentissage
0 20 40 60 80 100 120 140 160 180
Nombre de clients

Diagnostic formel de problème de santé mentale*



**THADA = trouble d'hyperactivité avec déficit de l'attention; TOP = trouble oppositionnel avec provocation TSA = trouble du spectre de l'autisme; TSPT = trouble de stress post-traumatique; TOC = trouble obsessionnel compulsif
[aussi, TSA – modéré = 2; psychose = 2; trouble du cycle sommeil-éveil = 2; trouble des conduites = 1; consommation d'alcool et de drogues = 1]
*251 (61 %) clients n'ont pas reçu de diagnostic formel

Statistiques sur le service

- Durée du service

	< 1 mois	1-3 mois	3-6 mois	6-9 mois	9 mois – 1 an	> 1 an
Nbre	12	64	157	128	59	26
%	3 %	14 %	35 %	29 %	13 %	6 %

- Raison de la fermeture du dossier
  - Incomplets : n = 143 (32 %)
  - Complétés : n = 193 (43 %)
  - Encore ouverts : n = 110 (25 %)

Durée du service par groupe d'âge

Âge latent

	< 1 mois	1-3 mois	3-6 mois	6-9 mois	9 mois – 1 an	> 1 an
Nbre	5	23	59	43	22	3
%	3 %	15 %	38 %	28 %	14 %	2 %

Jeunes

	< 1 mois	1-3 mois	3-6 mois	6-9 mois	9 mois – 1 an	> 1 an
Nbre	7	41	98	85	37	23
%	2 %	14 %	34 %	29 %	13 %	8 %

Obstacles à la participation

Les 6 principaux obstacles à la prestation de services :

1. Demandes multiples des personnes responsables
2. Milieu familial chaotique
3. Santé mentale du client
4. Santé mentale de la famille
5. Obstacles à la communication (langue ou manque de communication)
6. Transport

Accès aux services de santé mentale (1)
Sommaire

- Besoins complexes en matière de santé mentale – anxiété et problèmes relationnels (p. ex., avec la famille ou les pairs, faible estime de soi) sont le plus prévalents
- Problèmes initiaux relevés dans les catégories liées au client, à sa famille et à l'école
- Les conversations entre la source d'aiguillage et l'agence de santé mentale avant le premier contact avec le client ont accru la participation
- Amélioration des relations entre partenaires santé mentale/éducation
- Services d'approche : élément positif du modèle de service
- Une démarche systémique améliore les résultats
- Beaucoup de clients sont de palier 3 (problèmes de santé mentale plus graves); ont besoin de services plus longtemps et de soins complexes

Limites des données

- Période de collecte des données – ne comprend pas tous les clients ayant reçu des services pendant cette période :
  - Les clients qui ont commencé à recevoir des services avant septembre 2013 sont exclus
  - Certains programmes des agences étaient limités par le calendrier scolaire
  - Tous les cas n'avaient pas été complétés à la fin de novembre 2014
    - Améliorations/résultats sous-représentés
- Éléments de la collecte de données
  - La collecte de données représentatives de toutes les agences a été difficile
  - Prise en compte de la quantité de données requises par les TSMMS
  - La collecte des données sur les clients auprès des conseils scolaires n'entre pas dans le cadre de cette évaluation

Composante de l'évaluation 2 : résultats pour les élèves

- Scores regroupés de l'échelle d'évaluation fonctionnelle des enfants et des adolescents (CAFAS- Child and Adolescent Functional Assessment Scale)
- Échelle d'évaluation des résultats (ORS – Outcome Rating Scale)
- Plan de soins individualisé
- Autres (p. ex., GAINS, indicateurs francophones)
- Participation à l'école

Contexte de la CAFAS

- Échelle d'évaluation fonctionnelle des enfants et des adolescents (CAFAS)
  - Comprend 8 sous-échelles : école, maison, collectivité, comportement envers les autres, humeurs, automutilation, consommation d'alcool et de drogues, pensées
  - Données de la CAFAS intégrale recueillies au début et à la fin du service
- CAFAS intégrale utilisée comme indicateur de résultat dans 7 agences
  - Aisling, CTYS, ECC, EMYS, GHC, GC, HDC
- Pour 228 des clients « actifs », une CAFAS a été remplie au début et à la fin du service
  - Pour 46 autres clients, une CAFAS a été remplie au début du service seulement

Définitions des intervalles de gravité de la CAFAS

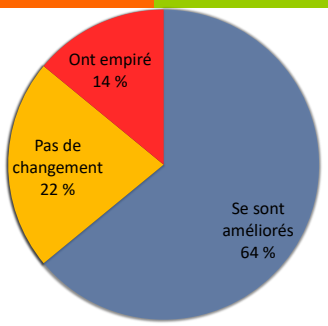
Bénin

Grave

Intervalles de gravité		CAFAS au début*
0-30	N'a peut-être pas besoin de services continus	19,7 %
40-70	Peut avoir besoin de services externes continus	48,5 %
80-100	Peut avoir besoin de services externes accompagnés de services de soutien supplémentaires	21,9 %
110-130	Peut avoir besoin de services communautaires intensifs	6,2 %
> 140	Peut avoir besoin de services très intensifs, en établissement ou en hôspitalization	3,7 %

* Proportion de cas au début de la prestation du service dans chaque intervalle de gravité

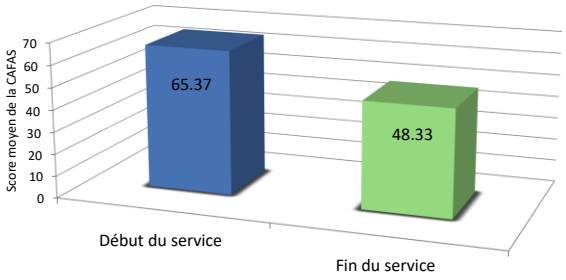
Changements dans les scores globaux de la CAFAS



*Nota : Pour 110 clients sur 146 (75 %) du groupe des clients dont les résultats se sont améliorés, le score de la CAFAS a diminué de ≥ 20 points (cliniquement significatif)

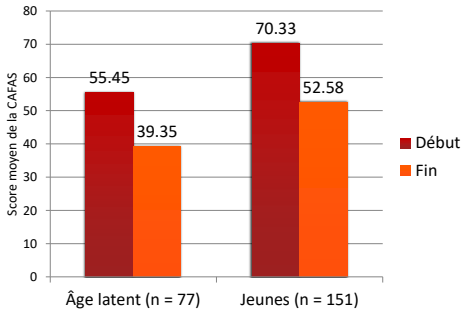
- Comprenant les cas toujours actifs
- 68 % des clients du programme d'apprentissage parallèle dirigé ont amélioré leur score de la CAFAS et 12 % n'ont connu aucun changement

Changement dans le score moyen de la CAFAS (n = 228)



Nota : Une baisse de ≥ 20 points est jugée cliniquement significative.
Une baisse des scores indique une amélioration du fonctionnement.

Changement dans le score moyen de la CAFAS : par catégorie d'âge



Nota : Une baisse de 20 points est jugée cliniquement significative.

Contexte de l'ORS

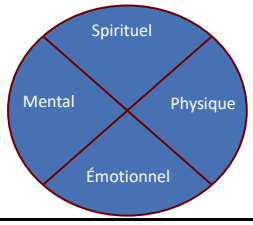
- Thérapie fondée sur les résultats et axée sur le client
  - Échelle d'évaluation des résultats (ORS) – avant chaque séance
  - Échelle d'évaluation de la séance (SRS) – après chaque séance
  - Pratique fondée sur des données probantes; élaborée par Scott Miller et Barry Duncan
- L'ORS et la SRS sont remplies à chaque séance
  - Les résultats sont généralement représentés par une courbe de temps; chercher trajectoire
- ORS – 4 éléments, chacun ayant un score de 0 à 10
  - Individuel (bien-être personnel)
  - Interpersonnel (famille, proches)
  - Social (travail, école, amitiés)
  - Global (sensation générale de bien-être)

Résultats de l'ORS

- L'ORS intégrale sert d'indicateur de résultat à Breakaway Addiction Services
- 67 clients ont rempli une ORS au début et à la fin du service
  - Se sont améliorés = 39 (58 %)
  - Aucun changement = 20 (30 %)
  - Ont empiré = 8 (12 %)
    - Dont 2 montrant un changement inférieur à 0,5 (non significatif)
- Le traitement est façonné par les éléments individuels

Contexte du plan de soins individualisé

- Personal Plan of Care est un cadre d`intervention qui considère la santé et le bien-être d'une personne d'un point de vue global.
- Chaque quadrant (spirituel, physique, émotional, mental) est évalué selon l'équilibre : 0 = pas d'équilibre →10 + équilibre complet



Résultats du plan de soins individualisé

- Le plan de soins individualisé sert d'indicateur de résultat à :
  - Native Child and Family Services of Toronto
  - Toronto Council Fire Native Cultural Centre
- 34 clients ont rempli un plan de soins au début et à la fin du service
  - Se sont améliorés globalement = 22 (65 %)
  - Aucun changement global = 12 (35 %)
- Spirituel – 21 personnes ont déclaré un équilibre amélioré (intervalle de 1 à 5)
- Physique – 16 personnes ont déclaré un équilibre amélioré (intervalle de 1 à 7)
- Émotionnel – 18 personnes ont déclaré un équilibre amélioré (intervalle de 1 à 5)
- Mental – 20 personnes ont déclaré un équilibre amélioré (intervalle de 1 à 6)
- Une personne a déclaré une détérioration des aspects physique, émotionnel et mental; un autre client a déclaré une détérioration de l'aspect mental.

*Participation à l'école : Avant et après le changement

- Meilleure : n = 133 (30 %)
- Pas de changement : n = 195 (44 %)
- Pire : n = 27 (6 %)
- Aucune réponse pour 91 clients (20 %)

Nota : La participation à l'école n'était pas un problème pour tous les clients (toutes les données sur la participation des clients fournies par les TSE des agences).

- ✓ Résultats pour les clients du programme d'apprentissage parallèle dirigé :
  - ✓ Meilleure 41 %
  - ✓ Pas de changement 45 %
  - ✓ Pire 15 % (n = 5)

***Engagement du client lié à la participation à l'école - participation / connexion à un large éventail de programmes scolaires y compris formes d'éducation traditionnelles et non traditionnelles, comme traitement de jour, programmes en établissement, programmes scolaires en ligne ou alternatives; ne comprend pas les données du conseil scolaire sur les présences.**

Recommandations à la fin du service

Six principales recommandations :

- Counseling individuel continu – n = 173
- Counseling familial continu – n = 149
- Soutien scolaire à l'école – n = 88
- Placement dans une autre école – n = 54
- Évaluation supplémentaire – n = 45
- Traitement de jour – n = 34

Résultats pour les clients (2)
Sommaire

- Amélioration de la santé mentale comme le prouvent les scores améliorés de la CAFAS
- Amélioration de la santé mentale comme le prouvent les scores améliorés de l'ORS et du plan de soins individualisés
- Participation accrue à l'école
- Beaucoup de recommandations de traitement ou de soutien supplémentaire

Composante 3 : collaboration

- Réflexion
  - T1 TSE et membres des comités
  - T2 Membres du comité des opérations
- Événement de formation et de perfectionnement professionnel
  - Mai 2014

Collaboration – T1

- Réflexion – Printemps 2014
  - 23 membres des comités (comité des opérations et comité directeur)
  - 88 travailleurs sociaux dans les écoles (agences et conseils)
  - 11 des 13 agences étaient représentées
  - 3 des 4 conseils scolaires étaient représentés

Collaboration – T1
Évaluation fermée

- Échelle : toujours, la plupart du temps, rarement, jamais
  - toujours = 4 → jamais = 1; sans objet/ne sait pas = 0
- Le formulaire des comités comprenait 20 questions concernant la collaboration
- Le formulaire des TSE comprenait 12 questions :
  - 6 se rapportaient à la collaboration; 6 à l'accès au service et aux processus de prise en charge

Collaboration - T1
Évaluation fermée : conclusions des comités (n=23)

- 17 questions sur 20 : score moyen 3,0 – 3,7 (liste des 5 premiers)
  - Impossible d'atteindre les buts avec un seul organisme; la collaboration des partenaires est nécessaire
  - Les intéressés veulent que l'initiative réussisse
  - L'engagement profitera aux élèves
  - Communication formelle et informelle
  - Rencontres régulières pour assurer l'uniformité du processus et discuter des problèmes en cours
- Comprennent bien leurs rôles et responsabilités (moyenne = 2,8)
- Confiance entre les partenaires et processus clair pour la prise de décisions (moyenne = 2,4)

Collaboration - T1
Évaluation fermée : conclusions des TSMMS (n = 88)

- Collaboration (scores moyens) :
  - Profitera aux élèves (3,4)
  - Améliorera l'accès aux services de SM pour les enfants et les jeunes (3,4)
  - Communication formelle/informelle (3,1)
  - Comprennent bien leurs rôles et responsabilités (3,1)
  - Volonté de faire des compromis, de trouver un consensus (2,9)
  - Confiance entre employés (2,9)
- Accès au service (scores moyens) :
  - Coordination de la prise en charge et de l'évaluation (3,2)
  - Liste d'attente de moins de 3 mois (3,2)
  - Accès rapide et direct (3,1)
  - Services d'approche utilisés par les agences (2,8)
  - Communication régulière entre les employés de première ligne (2,7)
  - Prise en charge harmonieuse, quelle que soit l'agence (2,6)

Collaboration - T1

Évaluation ouverte : Conclusions des comités

- **Points forts**
  - Accès plus rapide aux services pour les élèves et leur famille
  - Établissement de relations entre les partenaires de l'éducation et des agences de santé mentale, et au sein de ceux-ci
  - Capacité de mettre fin au travail en vase clos traditionnel : le client et sa famille sont au centre
  - Meilleure coordination des services
  - Échange de ressources et de connaissances
  - Détermination des lacunes et des tendances; défis et succès
  - Collecte de données et réunions régulières
  - Traduction en français (collecte de données et perfectionnement professionnel)
  - Représentation uniforme des partenaires
  - Rôle de l'agence de coordination
  - Capacité des conseils scolaires à prioriser les cas

Collaboration - T1

Évaluation ouverte : Conclusions des comités

- **Défis**
  - L'ampleur des préoccupations de SM n'est pas entièrement connue à la prise en charge
  - Les besoins complexes nécessitent un service plus long que prévu
  - La demande de services dépasse la capacité
  - Les mois où les aiguillages sont les plus nombreux : octobre – juin; les autres mois où ils sont limités : défis pour l'affectation des dossiers
  - Certains clients/familles ont de la difficulté à participer
  - Processus différents pour chaque conseil
  - Les partenaires ne participent pas tous au même niveau
  - Rôle limité pour le comité directeur
  - Le mandat utilisé dans sa version provisoire
  - Paramètres de financement

Collaboration - T1
Évaluation ouverte : Conclusions des TSE

- **Points forts**
  - Accès rapide aux services de SM pour les enfants, les adolescents et leur famille; réduction de la liste d'attente
  - Transparence du processus de prise en charge
  - Capacité à prioriser les clients aiguillés
  - Services d'approche communautaire par les agences
  - Accès à d'autres programmes des agences
  - Engagement avec les familles
  - Collaboration entre les écoles et les agences
  - Collaboration au palier des ministères (MSEJ/Éducation)
  - Le partenariat améliore la continuité du service
  - Confiance accrue des familles dans les services de SM
  - Relations / travail d'équipe – très bonne communication

Collaboration - T1
Évaluation ouverte : Conclusions des TSMMS

- **Défis**
  - L'emplacement du service est un obstacle pour certaines familles
  - La demande de services dépasse la capacité
  - Stigmatisation des clients par rapport aux services de SM dans la collectivité
  - Manque de services d'interprétation pour les familles
  - Communication constante entre certains partenaires
  - Moins de services d'approche pour les plus jeunes clients
  - Processus différents pour chaque conseil scolaire
  - Aucun mécanisme officiel pour une « communauté de pratique » des travailleurs de première ligne (SM/éducation)
  - Service utilisé différemment à l'intérieur des conseils scolaire
  - Demande de plus de perfectionnement professionnel intersectoriel
  - Les besoins des clients en matière de SM sont compris différemment

Collaboration – T2

- Réflexion – janvier 2015 (n = 16)
  - Après la collecte des données
  - Membres du comité des opérations, en consultation avec le personnel de leur(s) organisme(s)
  - 12 des 13 agences étaient représentées
  - 2 des 4 conseils scolaires étaient représentés
  - Évaluation ouverte concernant les points forts, les défis et les suggestions sur la suite des choses

Réflexion à la fin de l'évaluation : T2

Points forts de la collaboration

- Établissement de relations intersectorielles
- Meilleure compréhension des autres agences, conseils et services
- Réseaux et liens entre les organismes
- Représentation spécifique des agences et des conseils scolaires
- Capacité de joindre des clients qui autrement n'auraient pas accès aux services de SM; réduction des obstacles
- Les liens entre les écoles et les agences aident les familles à naviguer dans les services
- Journée de formation – occasions de réseauter, d'apprendre et d'échanger pour les travailleurs de première ligne
- Contribue à accélérer les ententes de partenariat avec les conseils scolaire
- Évaluation – détermination des enjeux et des résultats
- Occasion d'explorer des thèmes et les défis
- CTYS à titre d'organisme de coordination (coordination de la collecte de données, des réunions, du perfectionnement professionnel, etc.)
- Échange de ressources et de renseignements; défis et succès
- Programme souple; services d'approche auprès des jeunes

Réflexion à la fin de l'évaluation : T2

Défis de la collaboration

- Différences dans la compréhension des besoins en SM des clients (conseils/agences)
- Différences dans les modèles de service et les liens avec la collaboration
- Occasions limitées pour les travailleurs de première ligne de collaborer avec d'autres agences
- L'évaluation ne comprenait pas d'analyse narrative
- Changements dans le personnel et l'emplacement de certaines agences
- Processus d'aiguillage différents entre conseils scolaire; procédures de prise en charge différentes entre les agences
- Transitions/réintégration à l'école
- Ressources/temps requis
- Défis liés aux services d'approche (financement, transport, temps)
- Demande de services dépasse la capacité
- Établir des occasions de relier la SM avec les conseils scolaires de langue française
- Manque d'aiguillages en septembre, en juillet et en août

Réflexion à la fin de l'évaluation : T2

Défis de cette clientèle

- Clients/familles ayant des besoins complexes, p. ex., idées suicidaires et tentatives de suicide, anxiété, dépression, automutilation, isolement social, conflits parent-enfant, traumatisme
- Les clients ont besoin de plus de 6 mois de service
- Temps et ressources nécessaires pour l'étape d'engagement
- Populations de passage
- Problèmes uniques et facteurs de traitement propres à la communauté LGBTQ ainsi qu'aux membres des Premières Nations, métis et inuit
- Obstacles liés à la traduction, au transport, à l'emplacement, aux horaires
- Services d'approche nécessaires pour certains clients
- Services portant sur la SM des parents ou autres personnes responsables
- Préparation à l'engagement des enfants, des adolescents et des familles

Réflexion à la fin de l'évaluation : É2

Suggestions pour la suite des choses

- Collaboration et coordination continues par une communauté de pratique
- Simplification des processus d'aiguillage et de prise en charge
- Forum pour mettre à jour les voies d'accès au service, propres à chaque agence
- Occasions accrues de réseautage pour les travailleurs de première ligne
- Possibilité d'utiliser la technologie pour améliorer la collaboration et la communication
- Inclure le secteur de la santé comme partenaire
- Soutien aux parents et autres personnes responsables ayant un problème de santé mentale
- Financement pour la traduction, le transport et les services d'approche
- Ressources pour des groupes spécifiques : p. ex., LGBTQ, Premières Nations, Métis et Inuit, communauté francophone
- Journée de formation et de perfectionnement professionnel annuelle
- Maintien des partenariats pour soutenir le mandat de l'initiative des travailleurs sociaux dans les écoles
- Continuer à reconnaître le besoin de service pour les clients du programme d'apprentissage parallèle dirigé (SM des jeunes)

Formation/perfectionnement professionnel 22 mai 2014

- Exploration de l'attachement, du traumatisme et du cerveau de l'enfant et de l'adolescent au moyen de la psychothérapie dyadique
  - Sian Phillips et Robert Spottswood
- Les représentants des 13 agences et des 4 conseils scolaires ont été invités
  - 73 se sont inscrits
  - 67 y ont assisté

Formation/perfectionnement professionnel 22 mai 2014 - Conclusions

- Évaluations remplies par 55 participants (82 %)
  - 91 % ont déclaré que la formation était définitivement pertinente à leur travail
  - 87 % ont déclaré que le contenu avait accru leurs connaissances cliniques
  - 95 % ont déclaré que les segments vidéo leur avaient permis de mieux comprendre le sujet et avaient contribué à leur apprentissage
  - 62 % utiliseraient définitivement ces techniques dans leur travail (et 36 % les utiliseraient probablement)
  - Rétroactions globales positives; équilibre entre la théorie et la pratique
  - Bonne occasion d'établir des liens, mais auraient aimé plus de temps pour réseauter
- Recommandations
  - Journée de perfectionnement du personnel en 2015
  - Les occasions de réseauter devraient être intégrées dans la formation pour renforcer les partenariats
  - Les groupes de communauté de pratique soutiendraient le travail clinique continu entre les agences et les conseils scolaires

Sommaire de l'évaluation

1. Lien efficace vers les agences de santé mentale
   - 572 aiguillages pendant l'année scolaire; 446 (78 %) sont devenus des dossiers actifs
2. Résultats pour les élèves
   - Résultats améliorés selon la CAFAS, l'ORS, le plan de soins individualisé
   - Participation à l'école améliorée*
3. Collaboration entre les partenaires et au sein de ceux-ci
   - Établissement d'une relation intersectorielle positive
   - Journée de formation et de perfectionnement professionnel

*Engagement du client lié à la participation à l'école - participation / connexion à un large éventail de programmes scolaires y compris formes d'éducation traditionnelles et non traditionnelles, comme traitement de jour, programmes en établissement, programmes scolaires en ligne ou parallèles; ne comprend pas les données du conseil scolaire sur les présences.

Conclusions supplémentaires

1. Les relations établies grâce à une collaboration avec le programme d'apprentissage parallèle dirigé ont jeté les bases de l'élaboration de l'initiative des travailleurs sociaux dans les écoles
2. Des mécanismes d'accès au service ont été établis, améliorant l'accès aux soins
3. Les services d'approche des agences ont renforcé les relations et la conformité dans la présentation des données
4. Reconnaissance et compréhension des besoins complexes des clients et des familles en matière de SM
5. L'investissement dans les relations entre employés et intersectorielles a renforcé le secteur
6. Réduit la stigmatisation et accroît les services en SM pour les clients et les familles

Prochaines étapes

- Poursuivre la collaboration entre les agences et les conseils scolaires partenaires par l'entremise d'une communauté de pratique
- Échanger les conclusions avec les travailleurs de première ligne
- Fournir de la formation et du perfectionnement professionnel aux agences
  - Célébrer l'événement de mai 2014 et s'inspirer de son succès

Questions

Summary of Results from SFWI Survey

The questionnaire for School Boards was reviewed first and discussion points that arose as a result of comments are noted here. Additionally where an issue is flagged, it is colour-coded in green: opportunities are coded in blue

A. TDSB has 4 learning centres across Toronto (Rose and Mark and their colleagues' catchment area are shown on the attached map)

TDSB and TCDSB and the agencies have no consistency in boundaries; CS Viamonde's boundary is "Toronto"

Question about matching school(s) to agency Should this give families a number of options?

Question 3 "Referrals" – TDSB – gets notification from agencies

- Catholic Board splits clients 30/60
- Staff go through the Chiefs first to discuss the case, then in touch with contact person at agency
- > > starting to streamline a bit more now that the agency knows the name of who is making the referral
- TCDSB – agency notifies how many spots are available; there are variations of methodology; some group consultation meeting; triage of spots with nuances; consents and permissions are signed in advance
- Viamonde—similar to what's described going through the Chief Social Worker
- Agencies were asked to contribute here—BOOST has a waitlist now although they keep a couple of spots open for crisis/intense
- Is it an issue for cymh agencies to have this divergence among Boards?
- Perception is "pathway" is the only way you get in
- GHC's waitlist is 8 months for counselling, 5 months for Brief Services; Students do get priority—referrals come in and there is a waiting list and waiting lag time; Now the process is not smooth and is cumbersome for families—holding a spot but the program is not full
- Families have challenges moving from a school social worker to agency
- In reference to SAL spots—historically this was for kids who would not attend mental health agencies—Now, shifted focus to what agency does
- School kids are sometimes less in need than those coming through the front door
- The system is going through a transition
- Opportunity to "marry" the needs of the kids/students through the systemic change to a Centralized Point of Access (CPA)

- Similarly there are geographic concerns in North York where 70% will stay; therefore there are pressures on direct service, and the concerns of hitting targets; this uses up a lot of resources but the same client is not necessarily able to access the rest of the agency services (although they can)
- CTYS has a team that is dedicated to outreach but not necessarily able to utilize these for students ???? should not have to be in the first place
- VARIANCE BY AGENCY: how many high-risk kids are out there not being seen by centres—therefore this is why SFWI is more flexible and helpful
- MORE ACCESS to come in the front door
- Hincks has the same picture if a spot becomes available and a client needs more intensive at home—the other service will open up
- Part of the different approaches in the past was the heavy outreach, although families often say they want in at the initial moment; then the agency meets the family and the family says "no"
- Readiness is important and the likelihood of families sticking to it is higher with SIR
- Standardized forms and systems are impactful in the moment
- Engagement might mean engaging the student in other services
- Define collectively how to get families to engage so they are going/ready

Question 4: Average Length of service

- TDSB ideal is six months
- TCDSB can extend beyond 6 months if they have more than 6 sessions
- In 2014/15 as a collaborative; moved to shared agreement that it would be a year rather than six months
- The # MCYS put on agencies was impossible; it is now recorded differently
- According to previous data, most come in the counselling and therapy door, but end up in intensive
- Difference among agencies
- Noted that a six-month interval check in with Board social worker is important and the Chiefs should have knowledge of the dynamic

Question 5 Capacity

- TCDSB social worker should know the family; tried 3 to 6 sessions or in initial assessment; social worker is conduit for school; therefore, at the end student will not need level of 'intensive'
- Viamonde is the same; those who impact francophone students; joint Centre francophone and Hincks-Dellcrest thus need to define espace jeunesse program

Question 7 Services in School Board and who receiving

- TDSB sees about 2500 kids in each of the sectors; support/assess situation; lots of crisis work
- TCDSB—similar—over 6000 kids a year; there are many who are highly complex eg. expulsions, violent offences and crisis work
- Better Pathway—who needs to go and get best opportunity
- Boards should be better able to educate the intake of families (collaborative level of awareness); those services connected for various mandated programs; a lot of this is tackled in the autumn
- Viamonde does 6 to 8 sessions in school before referral (3 or 4 Social Workers in Toronto—challenge is to cover the territory ie. 1 to approx.. 30)
- Sickkids linkage to access services in French ie. Using the technology
- No one has money for interpreters

Question 9 Permit non-School Board employees to provide individual counselling?

- Initially TDSB to come in for closing interviews—yes
- Space is a huge issue
- That is why partnership agreements are so important especially for liability issues
- Some schools allow, and some schools do not
- Two agencies report they had specific directives not to go into the schools
- Knowledge through channels is important
- TCDSB historically have a third-party protocol; complication of "who" owns the notes; it is a legal issue that has been challenged
- Kids do not really want to be 'seen' in secondary schools; therefore opportunity for "after school" permit options
- Important that the incoming staff are part of a registered College
- Viamonde—this has not been an issue in the past although in last 2 years trying to frame it a bit more as right now it is not as flexible

- Ideally students should be served up to age 21; Transition Age is an issue especially as the presumed cut-off for cymh is age 18 (Aging out) which now is recognized by health and school boards in transformation and the LHINs' expectation for transitional-aged youth (opportunity to make and push forward recommendations)
  "obstacles to funding mean obstacles to service"

The focus of this meeting then switched to responses for the Agency Questionnaires.

Question 1 Geographic Population

- Generally, agencies said they are flexible if the clients can get to them; especially consideration for the client who wants a (eg.) specific gender; expertise in specifically identified areas
- Consideration is from the perspective of geographically going where there is a specialty service which is open to receiving clients who can geographically get there
- Can this expertise get into other areas? Train the trainer; worker with expertise travels across area; worker located centrally where any family could access
- There are co-competencies across the system/City; agencies have developed specific program knowledge; there could be cross referrals and the sharing of resources
- Who holds the case and how we support them
- Develop a Community of Practice for help in different modalities
- Some agencies report closed groups of workers and various channels while others blend offerings
- Noted: a huge number of 5, 6, 7 year olds where expertise is needed and will be determined by kids' needs
- Creativity and flexibility needed in priorizing
- Diversity of the social worker caseload has been beneficial
- Referral forms currently in use may have a lot of inconsistencies
- Initial information (for the agency) is important in the assignment of cases
- TCDSB is preparing more at the front end in contrast to the TDSB
- Agencies agree that it is helpful if there is a parameter up front; especially helpful in the initial meetings
- Pointed out that TCDSB and TDSB are structured differently, especially given their respective sizes; variations also occur internally

STUDENT FOCUSED WORKER INITIATIVE - INTAKE REFERENCE SHEET

Name of Agency	Aisling Discoveries Child and Family Centre	Boost Child Abuse Prevention & Intervention	Breakaway Addiction Services	Central Toronto Youth Services (CTYS)	Centre francophone de Toronto
Name of Program	Student Support Services		School Based Workers	Student Focused Worker Program	
Age range of clients	5-12 years	4-18 years	12-25 years	12–18 years	7 –18 years
Geographic boundaries	East Toronto / Scarborough / East York	City of Toronto	City of Toronto	South quadrant	City of Toronto
Primary area of focus	Emotional - behavioural issues	Violence and Abuse Prevention	Addiction / Harm Reduction	Family systems (informed by attachment & trauma theory)	French language mental health services
Level of Intervention	Family and group counselling Individual counselling as required	Group: classroom + small group programming	Individual, family, group	Individual, family	Individual, family, group
Intake	**Paula Carrie** pcarrie@aislingdiscoveries.on.ca Tel: 416-321-5464 ext. 281 Fax: 416-321-1510	**Audrey Rastin** rastin@boostforkids.org Tel: 416-515-0938 Fax: 416-515-1227	**Anne Taylor** annet@breakawayaddictions.ca Tel: 416-234-1942 Ext 225 Fax: 416-234-5702	**Jessica Arruda** Jessica.arruda@ctys.org Tel: 416-924-2100 ext. 245 Fax: 416-924-2930	**Kathleen Patterson** kathleenp@centrefranco.org Tel: 416-922-2672 ext. 295 Fax: 416-922-4254
"Point" person Email Telephone	**Paula Carrie** pcarrie@aislingdiscoveries.on.ca Tel: 416-321-5464 ext. 281 Fax: 416-321-1510	**Audrey Rastin** Manager, Prevention & Public Education rastin@boostforkids.org Audrey - 416-515-0938 416-515-1100 ext. 59229	**Max McConnell** Manager, Family and Youth Initiative maxm@breakawayaddictions.ca 416-234-1942 ext. 233	**Cheryl Tsagarakis** Manager, Client Services cheryl.tsagarakis@ctys.org 416-924-2100 ext. 249	**Catherine Desjardins** Superviseur en chef, Thérapeute en santé mentale / Chef supervisor, Mental Health Therapist CatherineD@centrefranco.org 416-922-2672 ext. 417
FTE	**2**	**2**	**2**	**4**	
Brief description of service	Priority access for school referrals for elementary school age children (and their families) with	***I'm A Great Kid!*** Primary prevention programs	Outpatient services to youth 12-25 and their families who are struggling with problems	Family focused intervention (up to 6 months) for youth and their families;	Provide services to French speaking children and youth struggling with mental

	social, emotional and/or behavioural difficulties that impact negatively on the child's performance primarily at school or home or in the community with a focus on building on family strengths. Short term (3-6 month) family or group counselling; individual if warranted Access to other agency program as required	(classroom based); help develop/practice skills that make them less vulnerable to abuse and violence ***RSVP*** (Relationship Skills for Violence Prevention): 12 week program that provides support/ education to teen girls at risk of experiencing violence in a personal relationship	related to substance misuse and/or exhibiting high risk behaviours. Also provide outreach to schools and youth centres	Case management support Dedicated SAL Youth and Family Counselor Access to other programs as necessary Flexible hours; community outreach model	health issues as well as their families. Clinical treatment, access to other consultation (psychological, psychiatric), school consultation, presentations, workshops Website: http://www.centrefranco.org

	East Metro Youth Services (EMYS)	The Etobicoke Children's Centre (ECC)	The George Hull Centre for Children and Families	Griffin Centre
Name of Agency				
Name of Program	**PAS (Priority Access for Schools)**	**School Priority Access Program**	**Student Focused Program**	**School Focused Work**
Age range of clients	12-18 years	3.8–12 years	0-18 years (in general) 4–18 for Student Focused Programs	12-18 years
Geographic boundaries	Scarborough/East York	West Toronto	Etobicoke/West Toronto	North York / West Toronto
Primary area of focus	Individual, family, group	Child and family therapy	Children's Mental Health	Mental health and Dual Diagnosis
Level of Intervention	Mostly Individual & family therapy	Up to 3 months of service	Individual, family, group, trauma assessment	Individual and family
Intake	**Cindy Broderick-King** cbroderick-king@emys.on.ca Tel: 416-438-3697 Ext. 502 Fax: 416-438-7424	**TDSB Intake Contact: Melissa Healy** melissahealy@etobicokechildren.com Tel: 416-240-1111 ext. 2528 Fax: 416-240-1171 **TCDSB Intake Contact: Andrea Del Vecchio** andreadelvecchio@etobicokechildren.com Tel: 416-240-1111 ext. 2533 Fax: 416-240-1171	**Fadia Zakkak** fzakkak@georgehull.on.ca Tel: 416-622-8833 ext. 258 Fax: 416-622-7068	**Farida Patrawala** fpatrawala@griffin-centre.org Tel: 416 222-1153 Ext. 188 Fax: 416-222-1321
"Point" person Email Telephone	**Sheeba Narikuzhy** Clinical Supervisor snarikuzhy@emys.on.ca 416-438-3697 ext. 256	**Nancy Long** Program Manager nancylong@etobicokechildren.com 416-240-1111 ext. 2244	**Eva Casino** Supervisor of Student Focused Program ecasino@georgehull.on.ca 416-622-8833 ext. 243	Supervisor of Youth & Family Support Services 416-222-1153 ext.
FTE	**4**	**2**	**4**	**4**
Brief descripti	3 dedicated individual and family therapists to	Early response to school aged children with issues that may be interfering	Clinical treatment services (up to 6 months)	Supports/services to youth and their families who are currently facing challenges

on of service	provide individual, family & group counselling Case management support Short term support to clients and families for 3-6 months (IFT 1/week or up to 2/week)	with their performance at school, home, or in the community Social, emotional and behavioural challenges; programs build on family strengths/resiliencies	Address mental health needs of children/their families Access to other consultation and treatment as necessary	as a result of mental health issues and/or dual diagnosis MH areas: school refusal, anxiety, depression, ADHD, trauma, high conflict and substance use
Name of Agency	**The Hincks-Dellcrest Centre**	**Native Child and Family Services of Toronto (NCFST)**	**Rosalie Hall**	**Toronto Council Fire Native Cultural Centre**
Name of Program	**PASS (Priority Access for Students at School)**	**School Focused Social Workers for Aboriginal Students**	**Community Care and Treatment Team**	**Youth Wellness Navigation Program**
Age range of clients	5-12 years	5-24 years * includes students in alternative education	12-21 years (if enrolled in school)	Up to 18 years of age
Geographic boundaries	City of Toronto / East York / North York	City of Toronto	City of Toronto	City of Toronto
Primary area of focus	Children with emotional and/or behavioural issues and their families	Aboriginal students	Pregnant and Parenting Youth	Cultural/community wellness
Level of Intervention	Flexible family therapy	Individual, family and group	Direct support/service to pregnant and parenting youth population "at-risk" youth with mental health needs	Community/school
Intake	**Amy Paul** apaul@hincksdellcrest.org Tel: 416-924-1164 ext. 2133 Fax: 416-633-7141	**Charlene Avalos** cavalos@nativechild.org Tel: 416-969-8510 ext. 3131 Fax: 416-928-0706	**Call and ask for intake** **Rotating Intake** Tel: 416-438-6880 Fax: 416-438-2457	**Karolina Jonsson** youthwellness@councilfire.ca Tel: 416 360-4350 ext. 231 Fax: 416 360-5978
"Point" person Email Telephone	**Ana Paolini** Program Supervisor Outpatient Services Sheppard Site apaolini@hincksdellcrest.org 1-855-944-HOPE (4673)	**Jeff D'Hondt** Manager, Clinical Services jdhondt@nativechild.org 416-969-8510 ext. 3492	**Jane Kenny** Director of Programs and Mission janekenny@rosaliehall.com 416-438-6880 ext. 251	**Andrea Chrisjohn,** Board Designate **Diane Simone**, Ed. Sector Manager **Denise Toulouse,** Capacity Development Officer andrea@cfis.ca lbssuport@councilfire.ca

	Ana 416-924-1164 ext. 2206			cdo@councilfire.ca 416-360-4350 ext. 231
FTE	**3**	**2**	**1**	**2**
Brief description of service	Services for students attending school in the North and South quad Client seen in the context of their family; 12 family therapy sessions (extension is required) Access to other services (assessment, treatment, day /residential programs)	Healing and teaching circles for students Facilitation of workshops outline Aboriginal history, healing practices and culture Referral to individual/family counselling	Pregnant and parenting youth with mental health needs; assist in reaching potential Coordination of services for client between/among providers Additional referrals as required	Provide wellness support for youth from Aboriginal community Counselling/cultural programming Educational and employment service

Appendix D: SWOT Analysis Summary

School Worker Focused Initiatives SWOT Analysis (Grouped)

Identifiable STRENGTHS

STRENGTH—social workers/counsellors like this referral process and for the families based on what way it was done 4 years ago—families want involvement, and one clear way

Family intervention—desired outcome; understanding of family modality to have a choice/empowerment

Intervention lens—limitations of interpretation for who has' control' over what is done as an agency

STRENGTH --figuring out do clients need or want service? So service agency developed face to face meeting with the school social work teams (enhanced collaboration)

Strengths—the flexibility—people think outside the box, and from agencies also figure out; on the flip side some agencies feel the need to be less flexible; some inconsistency within the areas especially in terms of the age start, age intake, and upper end ages

STRENGTH—opportunity to streamline services between school boards and community mental health treatment centres/agencies

School Mental Health Assist model

Navigation elements/lot of case management

Most complex are the school avoidant who do not actually want to leave their homes—you would ideally have a matrix of who you provide what in terms of range to keep staff from burning out—provide a triage into other programs; provide a balance

There needs to be a great deal of agility within the agencies and staffing models

STRENGTH—collaborating on CBT groups in terms of co-facilitation (mutual learning) ie. TDSB and agency jointly facilitate

Collaborative efforts in the community for vulnerable youth

Social workers continue the work in the context of school after an agency has finished with youth—this is a secondary intervention to prevent relapse/window of tolerance & ability to stabilize

Agreement of family and continuity

CHALLENGES

Waitlists

Still waitlists infers i. waiting for service or ii. There are 12 in need of service, and only 3 spots exist

Waitlists even though supposed to be "priority"

Inconsistency in process

GAP—not currently known why the SAL issue; more so a question via TDSB recognize that there are different geographic areas with different staff involved

Inconsistency between SAL referrals—public school board needs to understand why kids are school avoidant so do they know how to attend to mental health issues, and may be able to help support a referral

Process and lag time has been a difficulty; time for treating of kids

Difficulty is lack of consistency

Procedural concern when the time frames of process take time from the system

Capacity ie. What type of services are available—priority access has slowed down via the referral, and ways of engaging as the family is not necessarily ready

Various and different practices magnify there are multiple levels of complexity

Hard to follow and track in terms of what the intake is

It has been over 3 years since meetings to discuss

NEED—school Boards to thoroughly understand what agencies each need/deliver

Differences in Approach

Contrast is that School culture thinks about the elementary and secondary terminologies compared to exact ages

Multitude of Ministries causes further confusion, and even within one Ministry, inconsistency in funding especially in community agency leads to further confusion

Transfer payment budget package changed; cost absorption means that must do more with the same amount of $--possible reduction of caseloads/staff levels—3 years ago—Ministry said do with the $ what you will; Ministry went to counting service hours (rather than exact client #s)

How do you DECIDE how to take the school referrals in those agencies that have simply pooled the Ministry $ within the organization's core services?

Accountability to keep on track of mental health

From School Board example—you get general and enveloped funding—this is significant in comparison as in specific agencies you have had a shift. Every school Board does it differently too.

Concern of spending school board resources on addressing the Tier 3 kids at the expense of the Tier 2 kids—down the line these interventions might cause more backlog; notably school boards are equipped to deal with crisis

Difficulty--Treatment cycle compared to school year cycle—therefore need to figure out a better way of managing this (noted June)

September is a dry month of referrals which is a drawback for agencies; school cadence by March—November and December are months when things really ramp up for student needs as well

Additional Factors

Anything prioritized by the school—it has not been typical that the agency screens out based on presenting issues unless thoroughly outside scope of practice (STRENGTH & WEAKNESS)

--question in terms of Equity

Add into the mix some do not get the acting out kids (who also have mental health needs)—many agencies get the internalizing kids

Factors include geography (depending on agency boundary—inclusion or exclusion); especially recognize that TDSB just went through a geographic structural change

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