Multi-Year Planning Process
Service Area Planning Template

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Introduction

Ontario's, ***Roadmap to Wellness: A Plan to Build Ontario's Mental Health and Addictions System*** will help improve mental health services in communities across Ontario, and support Ontarians living with mental health and addictions challenges. To support the strategy, Child and Youth Mental Health (CYMH) Lead Agencies within each of Ontario's 33 geographical service areas are being asked to provide leadership and lead local planning efforts to help move this important work forward.

One of the principal ways in which lead agencies will carry out their leadership role is through engaging with their local core service providers and community partners in a multi-year planning process and the completion of a Service Area Plan. By conducting a thorough assessment of service area needs, focusing on key priorities and establishing a new desired state or vision for the future, Lead Agencies will be better equipped to plan effectively with their community partners for system improvement. This multi-year planning process consists of the following sections to be completed by each lead agency across the province. Sections of the template include:

1. Executive summary
2. Stakeholder engagement
3. Service Area Needs
4. Service Area Plan
5. Multi-year Service Area Action Plan
6. Appendix A – 2020-21 CYMH Investment Plan
7. Appendix B – 2021-22 Service Area Resource Reallocation Plan

Based on the identified service area needs and priorities, Lead Agencies are asked to submit Appendix A – 2020-21 CYMH Investment Plan by **Monday, August 17, 2020.**

The balance of the document, including any **proposed core service resource reallocations to be implemented for April 1, 2021,** should be returned to your program supervisor by **Wednesday, September 30, 2020.** Recommended changes should support improvements to the Child and Youth Mental Health System.

Each section requires that lead agencies, in collaboration with core service providers and key community partners, collect and present quantitative and/or qualitative information to reflect the required data elements. Lead Agencies will be required to analyze and report on the highlights of this information and communicate the "*so what"* or "*meaning"* it has for the service area.

Data submitted via this template will be used by:

- The ministry to:
    - Inform investment/resource allocation decisions and changes to policy through provincial trending and analysis;
    - Strengthen transparency and accountability across the sector; and
    - Ensure taxpayer dollars are spent effectively and efficiently
- Lead Agencies to strengthen and continuously improve service planning and provision, and monitor the impact of services on clients and in the community over time; and

Lead agencies are expected to reflect the voices of children, youth, family, and caregivers in the data and information they collect.

Timeline

Each lead agency will be expected to complete the new investment template (Appendix A) and submit it to their respective Ministry of Health Program Supervisor on or before **August 17, 2020.** The balance of the plan, including resource reallocation plans, is due September 30, 2020.

The Ministry will review the submitted documents and provide feedback where appropriate.

The Ministry will review the Planning and Allocation Template 2020-21 Investment Proposal and the Resource Reallocation Plans and provide a response as soon as possible.

1. Executive summary

This section should provide a high-level summary which may be used for public posting (approximately 2-3 pages in length), which includes a brief overview of the service area needs, identified gaps and challenges, and goals and priorities for a three-year plan.

Background

Windsor-Essex County is home to over approximately 398,953 residents, 84,150 of which are children and youth aged 0-18 years. Windsor Essex is the 4th most culturally diverse community in Canada, with a newcomer population of 21% (Statistics Canada, 2011). Approximately 1.9% of children and youth (0-19 years) in Windsor-Essex identify French as their mother tongue and almost 8, 500 residents identify as Indigenous (Statistics Canada, 2016).

In general, Windsor-Essex residents have lower social determinants of health compared to the rest of Ontario. For example, approximately 26% of families with children between the ages of birth to 5 years and 22.6% of families with children between the ages of birth to 17 years in Windsor-Essex live in low-income households, a rate that is significantly higher than the provincial average (19.8%; Canadian Community Health Survey (CCHS), 2016). The unemployment rate among the population aged 15 and over in the Windsor-Essex region is 9.7%, and lone-parent families make up 18.4% of all families living in the Windsor-Essex region compared to the provincial rate of 17.1%. Windsor-Essex is home to over 500 senior-led families (65+ years old) raising children under the age of 18 (Statistics Canada, 2016). Furthermore, a substantially higher proportion of families are involved with child protective services in Windsor-Essex compared to other regions in Ontario (6.6% vs. 3.9%) and nearly 1 in 5 (19.1%) Black youth residing in the City of Windsor are living (or have lived) in subsidized housing, compared to 3.1% in the larger City of Windsor population. Overall, just over 4% of individuals who are experiencing homelessness on any given night in Windsor-Essex are families with children under the age of 18 (Windsor-Essex Point in Time Count, 2018).

In addition, children and youth living in Windsor-Essex have high physical and mental health risks, including a greater proportion of youth in Windsor-Essex being considered overweight or obese compared to the province (33.7% vs. 24.7% in Ontario, CCHS, 2016). Fewer Windsor-Essex youth (73.6%; ages 12-17 years) report feeling a sense of belonging to their community compared to other youth living in Ontario (84.8%; CCHS, 2016), and the rate of local emergency department visits for youth self-harm injuries has increased by 117% for youth ages 10-17 between 2011 and 2017 (Windsor-Essex County Health Unit, 2019).

Multi-Year Planning Process

To understand the current landscape and possible future directions for service improvements over the next three years, we conducted a comprehensive environmental scan, which included three components:

1. Examining the current demographic profile of children, youth, and families in Windsor-Essex and local service utilization data.

    a. Using both local, provincial, and national data sources, including Statistics Canada census profile data, BI dashboard data for our service area and for the province, and published scorecards (e.g., ICES, 2017).
2. Conducting a literature and policy review to understand current trends in children and youth mental health
    a. Using academic research, “grey” literature, and government strategies to identify emerging themes and opportunities in the child and youth mental health sector
3. Collecting stakeholder feedback on service and system level challenges, opportunities for improvement, suggestions for new investments, and perceptions of the “ideal” future state of the children and youth mental health system in Windsor-Essex.
    a. Three surveys were deployed to gather input from 4 core service providers, 25 community partners, and 104 families in Windsor Essex. Survey findings are detailed in Appendix D.

These three activities provided the foundation for our planning discussions among core service providers and community partners and ultimately informed the development of our goals and priorities for the next three years.

Key Findings

Service needs
The local data collected as part of the multi-year planning process revealed three main service needs of children, youth, and families living in Windsor-Essex.

1. Unmet service needs for children and youth with complex mental health and developmental disorders
    - 76% of children and youth deemed eligible for services in 2017 had complex mental health needs (vs. 53% in Ontario);
    - 68% of children and youth required more than Brief Services (vs. 50% in Ontario)
    - 117% increase in emergency department visits in Windsor-Essex among youth (10-19 yrs) for deliberate self-harm between 2011 and 2017 (Windsor-Essex County Health Unit, 2019).

2. Improving wait-times for core services
    - In 2019, the average wait-times for Counselling & Therapy was 490 days and 588 days for Intensive Treatment Services. These wait-times are among the highest in the province (CMHO Kids Can’t Wait Report, 2020).

3. Increase support for families navigating the system

- 57% of families reported that they were not aware of the different types of services available and did not know where to go to get the help they need.
- All four Core Service Providers reported that system navigation for families was needed in Windsor-Essex.

System challenges

Each stakeholder group was asked to indicate what they thought some of the top challenges were within our service area. The top challenges identified are summarized below.

1. Wait-times for service
2. Existing services insufficient to meet needs
3. Lack of awareness of available services
4. Increased demand for services
5. Unclear pathways/lack of system navigation
6. Lack of access to services
7. Lack of funding to drive improvement

Goals and Priorities

Three priorities were identified for core services:

1. Improve wait times for service through strategic investments
2. Improving system navigation and create clearer pathways through the development of a new collaborative family navigation program
3. Improve collaboration and system integration between core service providers

Three priorities were identified for community services:

1. Address system gaps for complex cases by improving availability and access to specialized services within our service area
2. Improve central access/coordinated access by creating a well-known central access point for families, children and youth trying to access services, with well-established and clear pathways through the system
3. Improve collaboration among community partner organizations through strategic planning and engagement sessions

Moving forward

We will strive to improve access to services and to improve the quality of the services that are being offered in the Windsor Essex service area through evidence-informed decision making. We will also strive to address gaps in services and increase inter-sectorial collaboration in an effort to create a more seamless, integrated system for children, youth and families. Over the course of the multi-

year planning cycle, we will continue to engage our core service providers, community agencies and those with lived experience as we seek to achieve the priorities outlined in this multi-year plan.

2. Stakeholder engagement

2.1 Strategy for engagement

Please provide a narrative on how you currently engage with core service and community partners in the planning process, and/or how you intend to engage with them to inform this new multi-year planning process.

Engagement strategy

Current strategy of engagement	Development of the Multi Year Plan for Windsor-Essex has involved numerous engagement strategies with stakeholders to ensure that this planning process is well-informed and collaborative. Core Service Providers (CSPs), which include Children First (0-5), Regional Children's Centre (6-12), Maryvale Adolescent & Family Services (13-18), and Family Respite Services (respite for families with children/youth with mental health issues) worked collaboratively to develop, monitor, and plan the priorities for the new investments for core services for the 3-year planning process. CSPs were asked to complete a survey with their team members input to identify the main barriers/challenges/gaps, opportunities for new investments, and priorities for improvement within their organization and within the Windsor-Essex service area. These survey results were then presented alongside data gathered from literature and an environmental scan of Windsor-Essex to help inform and guide the discussion of a planning meeting held with CSPs to identify the priorities for new investments. In order to address the community priorities, both families and community partner organizations were engaged. Family input was gathered through a parent/caregiver survey that was distributed through partner organization social media channels, as well as partner organization patient and family advisory councils. Additionally, a survey was sent out to Director's Forum, which is a community table of leaders from the following areas, in addition to the CSPs listed above: • child welfare • youth justice including diversion • developmental services

	• two English Boards of Education • two French Boards of Education • preschool speech and language • children's treatment services • the municipality • Community Health Centre • CCAS • CMHA • community living • hospitals • adult mental health services • Public Health, Probation, and the John Howard Society Following these surveys, the Director's Forum came together for their quarterly meeting, and were presented both provincial and regional data, summarized data from all 3 surveys, as well as the core service priorities identified by the CSPs. Using this data, a planning session was conducted that allowed the partners to identify the community priorities that should be addressed over the next 3 years. Additionally, a visioning session was held with CSPs to identify a mission, vision, and values for our service area, using the input received from families and community organizations.
Proposed strategy of engagement for multi-year planning cycle	• Over the course of the multi-year planning cycle, we will continue to engage our core service providers, community agencies and youth and families with lived experience as we seek to achieve the priorities outlined in this multi-year plan. Some of the engagement activities will include but are not limited to: o Quarterly meetings (or as needed) with CSPs to discuss planning, implementation, and evaluation of the 3 priorities for core services o Quarterly meetings (or as needed) with Directors Forum to engage community service providers in the planning, implementation, and evaluation of priorities for community services o Quarterly meeting of the service area Data Quality committee o Action and implementation teams will be put in place and meet, as needed o Ongoing engagement of our community through our children, youth and family engagement committees will occur through various forums including parent and family engagement committees and child and youth committees

	○ Ongoing engagement of broader community as needed and appropriate • Some challenges to engagement exist, in particular related to the COVID-19 pandemic. The pandemic has required most engagement to occur virtually, which does not allow for the same level of engagement or the same methods of engagement that would typically be used for planning sessions, information gathering etc. Additionally, many of our family, child, and youth engagement groups are not able to meet or are meeting virtually during this time. This means that it may be difficult to engage our partners, youth, and families as our methods of communication and dialogue have shifted, and innovative measures will need to be developed to engage individuals that do not have access to appropriate technology to provide feedback and input virtually.

3. Service Area Needs

3.1 Population sociodemographic profile

Please complete the following table with service area population sociodemographic data using the following indicators.

Windsor-Essex County is home to over approximately 398, 953 residents, 84 150 of which are children and youth aged 0-18 years. Windsor Essex is the 4th most culturally diverse community in Canada, with a newcomer population of 21% (Statistics Canada, 2011). Approximately 1.9% of children and youth (aged birth to 19 years) in Windsor-Essex identify French as their mother tongue and almost 8, 500 residents identify as Indigenous (Statistics Canada, 2016).

In general, Windsor-Essex residents have lower social determinants of health compared to the rest of Ontario. For example, approximately 26% of families with children between the ages of birth to 5 years and 22.6% of families with children between the ages of birth to 17 years in Windsor-Essex live in low-income households, a rate that is significantly higher than the province (19.8%; Canadian Community Health Survey (CCHS), 2016). The unemployment rate among the population aged 15 and over in the Windsor-Essex region is 9.7%, and lone-parent families make up 18.4% of all families living in the Windsor-Essex region compared to the provincial rate of 17.1%. Windsor-Essex is home to over 500 senior-led families (65+ years old) raising children under the age of 18 (Statistics Canada, 2016). Furthermore, a substantially higher proportion of families are involved with child protective services in Windsor-Essex compared to other regions in Ontario (6.6% vs. 3.9%) and nearly 1 in 5 (19.1%) Black youth residing in the City of Windsor are living (or have lived) in subsidized housing, compared to 3.1% of all youth in the City of Windsor population. Overall, just over 4% of individuals who are experiencing homelessness on any given night in Windsor-Essex are families with children under the age of 18 (Windsor-Essex Point in Time Count, 2018).

Children and youth living in Windsor-Essex also have high physical and mental health risks, including a greater proportion of youth in Windsor-Essex being considered overweight or obese compared to the province (33.7% vs. 24.7% in Ontario, CCHS, 2016). Fewer

Windsor-Essex youth (73.6%; ages 12-17 years) report feeling a sense of belonging to their community compared to other youth living in Ontario (84.8%; CCHS, 2016), and the rate of local emergency department visits for youth self-harm injuries has increased by 117% for youth ages 10-17 between 2011 and 2017 (Windsor-Essex County Health Unit, 2019).

Please see table below illustrating other key service population sociodemographic indicators.

Population health indicator by category	Description (if required)	Value	% of total population	Source	Comments
DEMOGRAPHY					
Number of children and youth from birth to 14 years old		66,770	16.7%	2016 Population Census (Statistics Canada, 2016)	• Windsor-Essex County is home to a slightly higher proportion of children and youth from birth to 14 years old compared to the province (167% vs. 16.4%) • Overall, the number of children and youth from birth to 14 years old living in Windsor-Essex has decreased slightly from 2011 (17.6%) to 2016 (16.7%)
Number of children and youth (birth – 4 years)		20, 170	5.1%	2016 Population Census (Statistics Canada, 2016)	• The proportion of children from birth to 4 years old residing in Windsor-Essex (5.1%) is similar to that of the province (5.2%), however, the number of children birth to 4 years old living in Windsor-Essex is slightly decreasing compared to estimates from 2011 (n=21, 095)
Number of children and youth (5 – 9 years)		22, 630	5.7%	2016 Population Census (Statistics Canada, 2016)	• The proportion of children and youth aged 5 to 9 years old residing in the Windsor-Essex service area (5.7%) is slightly higher than the provincial rate (5.6%) for the same age cohort. • However, overall, the proportion of Windsor-Essex children and youth aged 5

					to 9 years old is decreasing compared to estimates from the 2011 census (5.9% for the same age group)
Number of children and youth (10 – 14 years)		23, 965	6.0%	2016 Population Census (Statistics Canada, 2016)	• The prevalence of children and youth aged 10 to 14 years old residing in Windsor-Essex is higher than provincial rates (5.6% in Ontario) • However, this proportion of children and youth living in Windsor-Essex has slightly decreased over time, with estimates for this age group being 6.3% in 2011.
Number of youth (15 – 19 years)		25,220	6.3%	2016 Population Census (Statistics Canada, 2016)	• A similar downward trend is noted in this age group living in Windsor-Essex. The 2011 census rate of children and youth 15 to 19 years of age was 6.9% compared to 6.3% in 2016. • The proportion of children and youth aged 15 to 19 living in Windsor-Essex (6.3%) is slightly higher than that of the province (6.0%).
Number of transition youth (20 – 24 years)		27,080	6.8%	2016 Population Census (Statistics Canada, 2016)	• The proportion of young adults residing in Windsor-Essex (6.8%) is slightly higher than that of the province (6.7%). • The prevalence of young adults in Windsor-Essex is on the rise, with 6.8% of the population estimate in 2016 compared to 6.5% of the population estimate in 2011.
Number of children and youth from birth to 24 years		119, 070	29.8%	2016 Population Census	• Overall the proportion of children, youth, and young adults residing in Windsor-Essex is trending downward compared to

				(Statistics Canada, 2016)	the proportion of children and youth from the same age group in 2011 (31%).
GENDER and DIVERSITY					
Gender (birth – 14 years) Gender (birth -19 years)		Male: 34, 370; Female: 32, 405 Males: 47, 420; Females: 44, 575		2016 Population Census (Statistics Canada, 2016)	
Francophone population (birth – 19 years)			1.9%	2016 Population Census (Statistics Canada, 2016)	• The prevalence of Francophone children and youth (birth to 19 years of age) is slightly lower than provincial rate (1.9% vs. 2.7%)
Indigenous population (birth – 14 years)		2, 337	3.5%	2016 Population Census (Statistics Canada, 2016)	• The prevalence of Indigenous children and youth (birth to 14 years of age) residing in Windsor-Essex is slightly lower than province (3.5% vs. 4.1%)
New immigrants or newcomers (birth – 14 years)		4, 941	7.4%	2016 Population Census (Statistics	• Windsor-Essex is home to a slightly higher rate of new immigrant children and youth compared to provincial rate (7.4% vs. 6.7% in Ontario).

				Canada, 2016)	
Visible minorities (birth – 18 years)		19, 115	21.2%	2011 National Household Survey	• More recent Information for this indicator is limited in Windsor-Essex region, however, estimates from 2011 census suggest that a substantially lower proportion of children and youth living in Windsor-Essex identify as visible minorities compared to the province (21.2% vs. 31.7% in Ontario) • Of note is that the 2011 National Household survey found a slightly higher proportion of Black Youth residing in the city of Windsor compared to the provincial rate (5.6% vs. 5.3% in Ontario).
EDUCATION					
Population aged 20+ without a high school diploma		62 035	19.1%	2016 Population Census (Statistics Canada, 2016)	• The proportion of the adult population without a high school diploma residing in Windsor-Essex is substantially higher to that of the province (17.5%)

3.2 Existing Service Area Priorities

Please document existing priorities in your service area.

Existing service area priorities	1. Priority one involves clarifying the care pathways for youth aged 13-18 who are seeking mental health services. There is confusion in the service area of where these youth receive the right service given that there are a number of agencies which provide 'general counselling' to this age group. 2. The second priority involves development of a Central Access mechanism to provide a reliable access and navigation path to mental health services for children/youth, families, and referral sources. 3. The third priority involves core providers who work with children in JK/SK, the local children's treatment provider and education to address the needs of this population and to develop strategies to deal with the rising number of these children being referred for intensive services as well as being suspended or expelled from school.

3.3 Other community assets, challenges and opportunities

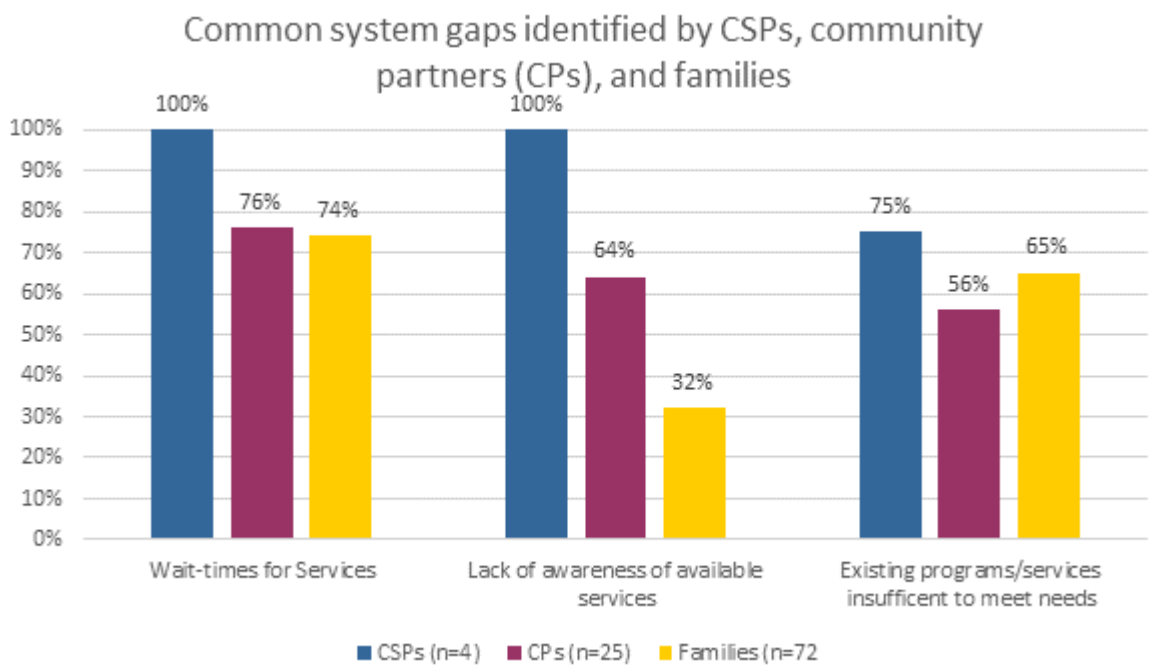
Please indicate what additional forces and/or impacts may act as assets, challenges or opportunities within your service area (please include qualitative and/or quantitative information to support this, where possible).

Service area assets	Our strong history of family engagement in Windsor-Essex has enabled a comprehensive understanding service needs, strengths, and opportunities within our community. In particular, we have positive partnerships with all community agencies providing services to children, youth, and families, as evidenced by comprehensive participation at our local community groups and tables and commitment to improving community collaboration and engagement. Other initiatives that may act as assets within our community to support our multi-year plan and system priorities include: • **Windsor Essex OHT** – comprised of over 45 local healthcare programs and service providers that range from acute and primary care to social services, and community agencies. The WE OHT will allow a new model of collaboration between system partners that can be leveraged to support children, youth, and families as they navigate the CYMH system. • **Primary pathways** project– an existing project sponsored by CHEO and the Centre of Excellence to build primary care physicians capacity to create organizational structures that practice and support inter-provider communication, develop standardized referral pathways and pilot the integration of the HEADS-ED tool to

help guide assessment and decision-making for children and youth with mental health concerns in primary care practices.

- **Crisis response team at RCC and Inpatient Acute Care Beds at Maryvale** – Children and youth who visit the emergency department and/or are hospitalized for a mental health crisis are provided crisis intervention and support by two of our Core Service Provider agencies (RCC and Maryvale). These two agencies have worked together to streamline transitions within the crisis continuum in the Windsor-Essex service area and collaboratively planned and continuously improved this core service delivery model. In 2018, RCC and Maryvale conducted a critical review of the crisis protocols and follow-up care in place for families within Windsor-Essex. Through extensive stakeholder engagement, including youth, parents, and frontline staff, and scientific literature a current state analysis was undertaken, which led to co-designed action plans for each agency.
- **Partnerships and Integration**: Windsor-Essex service area is comprised of 4 Core Service agencies who have a well-established and formal collaborative partnership. The advantage of a smaller size of the service area is that it allows for shared processes and protocols to be planned and implemented in an efficient and collaborative manner.
- **Common CIS**: All core service provider agencies use a common CIS (EMHware) which has been enhanced to allow for the collection of the BI data elements. All staff have received required training on the BI enhancements and the core service agencies have developed a Data Quality Committee working group to collaboratively review and monitor service and system-level key performance indicators.
- **Central access infrastructure**: the Windsor Essex CSPs have developed the infrastructure to implement a central access mechanism, which functions with a primary access point (257-KIDS) before direction through a standardized screening process (InterRAI Screener+).
- **Local planning, research, and evaluation expertise**: Hôtel-Dieu Grace Healthcare, acting as Lead Agency, has local planning, project management, research, and evaluation expertise through the Project Management Office, and the Planning, Research and Evaluation Services Department. This expertise can be leveraged throughout the 3 year planning process and to ensure that the core and community priorities are operationalized and implemented based on evidence and best-practice recommendations.
- **Lead Agency Data Analyst & Decision-Support**: A FTE data analyst/decision support position that is dedicated to Lead Agency and focused on reviewing and reporting out service level BI data. This role is integral to the local Data Quality Committee, which has recently launched and includes representatives from

	Lead Agency and each core service agency. The Data Quality committee meets quarterly to discuss issues around service area data quality, performance measurement, and cost-effectiveness of services.
Service area challenges	Through our engagement work, we identified a number of significant factors within our community that may impact the mental health and well-being of our local families. In particular, the COVID-19 pandemic has been hugely disruptive to the local health and mental health care system as well as the lives of children, youth, and families in Windsor-Essex and across the province. The pandemic has altered both the accessibility and availability of mental health programs and services and negatively impacted family functioning, social connectedness, financial stressors, education, and employment situations. The impact of the pandemic on the mental health of children, youth, and families is likely to persist for many years to come. Other significant factors within our community that impact families include the prevalence of childhood poverty in Windsor-Essex, a rate that is among the highest in the province, and issues unique to border cities, including human trafficking and accessibility to illicit substances. There are also many challenges and barriers that exist within our mental health service system that negatively impact the ability to meet the needs of children, youth, and families and have a positive impact on the mental health and well-being of our local families. As part of our engagement strategy for this multi-year plan, we asked our core service providers, community partners, and local families to identify the main challenges within our mental health service area (please see Appendix D for detailed survey results). Many common challenges were identified by these three stakeholder groups. The graph below illustrates the frequency of the top-rated, most system gaps reported by our core service providers (CSPs), community partners (CPs), and families based on our engagement surveys.



Service area opportunities	There are a number of existing opportunities within the Windsor-Essex service area that can be leveraged strategies to help meet our 3 year service area priorities. For example, over the past 5 years, our service area has recognized the value of bringing youth and family voices forward in our service planning and delivery. Our core service provider agencies have developed strategies for youth and family engagement and established a number of youth and parent groups to enable sharing and exchanging of information among people with lived experiences, service providers, and adult allies. One of these programs, Youth in Partnership (YiP), has recently expanded its model to include a diverse range of groups for school aged children (10-12 years old), teens (13-17 years old), and transitional aged youth (16-18 years old) that meet monthly to address youth mental health concerns and build our local youth capacity in mental health. Other opportunities within our service area include establishing community collaboration committees to share information collectively and drive practice and system-level improvements and establishing coordinated service planning. This work will build off the coordinated access mechanism that currently exists (i.e. 257-KIDS), to streamline processes between CSPs and community providers, to allow for seamless referrals and clearer pathways through the system. Additionally, the WeCare for Kids beds located at RCC include a total of 8 funded beds - 2 of

	which are designated to the CK service area. There is a sense by many stakeholders that these beds are currently being underutilized. With a relatively new building – this facility should be viewed as an opportunity for the service area. Finally, as suggested by our community partner survey results (Appendix D), the COVID-19 pandemic has presented the opportunity to build our local capacity to develop and provide services to families through online and other virtual spaces. These lessons can be used to help expand the supports we have available for children, youth, and families.

3.4 Quality and performance

Quality and performance indicators are critical for ensuring accountability and assessing the cost-effectiveness of services. While there are several indicators that are consistently measured across health and mental health, those indicators selected are: effectiveness, efficiency, safety and timeliness (these were chosen based on: the 2016 Auditor General's report, key performance indicators outlined by the former Ministry of Children and Youth Services, literature on quality and performance, and conversations with Lead Agencies). Please indicate your planned strategy for measuring the domains below, and how you will use the information you obtain to plan for your service area.

Overall strategy for quality and performance measurement in Windsor-Essex:

The dedicated Lead Agency Data analyst and decision support personnel plays a key role in managing and reporting on service-level data to allow for continual review of system performance measurement. The newly launched Data Quality Committee, which has representatives from each of the 4 Core Service Providers in Windsor-Essex, meets quarterly to discuss issues around core service definitions and data quality, as well as review of performance indicators for the purposes of influencing evidence-informed service-level planning and continuous quality improvement of programs and services. The following indicators are tracked by the Data Quality Committee on an ongoing basis.

Effectiveness: measures how well mental health services achieve a desired outcome

A number of indicators are tracked over-time to ensure that programs and services are having a positive impact on children, youth, and families in Windsor-Essex. In particular, key performance indicators such as the number and % of children/youth having positive response at end of service (POSOC#, CPOSOC#) are based on our standard practice of utilizing to the InterRAI ChYMH to measure overall symptom improvement, as well as other program specific evidence-based outcome measures. To track accountability of staff assessing outcomes at the end of service, we also review the number of children/youth with assessment conducted at discharge. Our target is at least 80% of children/youth are assessed at discharge to determine impact of service. The number of and % of clients discharged transitioning to other services overall and by transition service provider type is monitored to ensure that families who have further services needs within the system are able to get the support they need, as well as determining how many children and youth do not require further service at discharge.

Efficiency: measures how well mental health services achieve desired results with the most cost-effective use of resources

The following BI solution indicators reflecting service efficiency are monitored on a quarterly basis by the Data Quality Committee:
1) service utilization (INDSER#)
2) average service duration (MHSD#)
3) average client direct service hours (HOUDIRS#)
4)The number of children and youth receiving only brief service (BSNOS#);
5) The proportion of children and youth receiving only brief service (BSNOS# / INDSER#)

Safety: assesses potential risk of an intervention to the client or the environment, to ensure appropriate mitigation strategies are in place

For each child, youth and family who has ongoing contact with community mental health services in Windsor-Essex, a safety plan is developed to assess potential risks of intervention to the client and outline appropriate actions or mitigation strategies. In addition, all adverse incidents are reported using safety issue report forms and reviewed by the individual CSPs. At the service area level, the Data Quality Committee is working collaboratively to build a framework and associated metrics for formally monitoring safety. For example, the Committee is considering tracking safety data as recommended by Wolpert et al., 2014, including measures of ineffective engagement of services (e.g., percentage of clients who drop-out after one contact with service agency without positive outcome), ineffective practice (e.g., percentage of families on wait-lists outside of median wait-times for that service), and adverse incidents (e.g., cases of youth self-harm, review of youth suicide/death, use of restraint). The development of this framework to support our continuous quality improvement efforts will be undertaken by the Data Quality Committee and include a scan of best practice literature and stakeholder engagement as to what might constitute indicators of good and poor practice.

Timeliness: assesses wait times and delays for those who receive care

Timeliness of programs and services are monitored using the following BI key performance indicators at the service level and by core service provider: 1) Average time on service wait lists (MHWT#) 2) The number of children and youth active on wait-lists

Service Area Plan

Please share your lead agency's vision, mission, values and strategic directions for the service area. This will help agencies set priorities for the next three-year period.

Mental Health and Addictions: Our Vision:

A province where all Ontarians have access to high-Quality, easily accessible mental health and addictions support throughout their lifetime, where and when they need it.

4.1 Service area vision and mission statement

Service area vision statement	Stronger together. Healthier children, youth, and families.
Service area mission statement	Working together for strong and healthy families, by providing evidence-informed support, when and where it is needed.
Service area values	• Family Centred • Kindness • Responsive • Evidence-informed • Collaborative

4.2 Gap analysis

Please conduct an analysis of existing gaps related to both core services (in the first table below) and community mental health services (in the second table below), to identify priorities that should be considered during planning. The results from these gap analyses should inform your multiyear service area action plan outlined in Section 5.

4.2.1. Analysis of current state versus need – Core services

Current state	There are four core service providers in Windsor Essex that offer 9 of the core services and key processes as outlined in the PGR01. Wait times and access to services are currently an issue, as many county locations are underserved and there is a need for additional programming to reduce waitlists. Furthermore, pathways through the system are not always clear for families and gaps exist where certain populations such as transitional youth and complex cases do not receive the services they require.
Future state	In an ideal future state, Windsor Essex core services will be streamlined and there will be clear pathways through the system for all children and youth who need access to mental health services, through increased system navigation as a service area. The future state will also include improved access to services by increasing service offerings in county areas, improving access to underserved vulnerable populations, and offering additional counselling and therapy services overall to reduce wait times.

GAP ANALYSIS					
Current state	Future state	Gap identification (Y/N)	Gap description	Gap solutions/actions	Gap evaluation
List specific and factual attributes in need of improvement in your service area	*List specific idealized attributes you would like to see in the future state*	*Is there a gap between current and future states?*	*Describe issues/elements/factors that characterize the gap between the current and future state*	• *List <u>all</u> possible solutions, with specific actions, for bridging the gap between the current and future state. These solutions should directly address factors responsible for the gap.*	*Identify how you will evaluate the effectiveness/success of your response to this gap*

Limited access to counselling and therapy services in county regions of Windsor-Essex (i.e., Amherstburg, Kingsville, and Leamington)	Equal access to mental health services across Windsor Essex, regardless of geographic location.	*Yes*	There is currently limited access to Counselling and Therapy services in the county regions of Windsor-Essex, with the bulk of these services being offered within the City of Windsor. Some areas, such as Amherstburg and Kingsville, do not have any facilities offering services, yet they have demonstrated a considerable need. Families residing within the county regions are currently having to travel into the city in order to access services for their child/family member. The purpose of this initiative is to increase Counselling and Therapy services by 1 FTE to serve the county regions in order to improve access to families who are not	• Improve accessibility to Counselling and Therapy services by investing 1 FTE staff member at Maryvale, which will increase capacity Counselling and Therapy services distributed across 3 county regions to 5 days per week: ○ 2 days/week in Amherstburg (currently no services offered) ○ 2 days/week in Kingsville (currently no services offered) ○ an additional day in Leamington (increasing Counseling and Therapy to 5 days/week in this location) ○ Includes on-going supervision/consultation with Child Psychologist (approx. 1x/month) for all Counselling and Therapy staff ○ Includes in-depth supervision/mentorship of new staff with senior staff therapist	*Please see Appendix C for full evaluation plan* • *Increase of 50 families served in the next year* • *Reduced wait-times for service* • *80% of families reporting positive outcomes at the end of service (POSOC#, Family Feedback survey)* • *80% of children/youth display positive outcomes at end of service (CPOSOC#)*

			able to travel to other regions such as Windsor. Adding an additional FTE would also have a direct effect on reducing the wait-time for Counselling and Therapy, which is currently an average of 57 days.		
Limited access to groups for children and families dealing with mental health	All families are able to access family support services at the moment they require them, at times that are convenient for them.	Y	Offerings for these groups is currently limited, which has resulted in long wait times for service. Additionally, the groups are not currently offered at times that are conducive to most families (i.e., evenings and weekends). Some of these wait times have been exacerbated by the COVID-19 pandemic, which has moved the groups to a virtual platform, and allowed for reduces families	This project involves the hiring of the 1 FTE certified clinician to lead two separate evidence-based child and family capacity building and support groups: 1) Circle of Security and 2) FRIENDS Resilience. This project will respond to existing demand for service to reduce wait time while also allowing for increased capacity for service utilization for an additional 25 families. Each group program will be offered approximately 4 times over the course of the year (evenings and weekends) for a total of 8 groups annually. This project will allow for delivery of programs using virtual technology to adapt to COVID-19 circumstances which has also created barriers for accessing services.	*Please see Appendix C for full evaluation plan* • Increase in at least 25 families served • Wait-list reduced from 41 to 16, reflecting 39% improvement • All families report intervention was beneficial (Family Feedback Survey) • 20% reduction in anxiety symptoms (Assessment Surveys) • At least 80% of families report secure attachment classifications

			that can partake in the group at a time.		following completion of the program (Assessement Surveys)
A need for system navigation to ensure equitable and efficient access into, and transition through, the mental health system.	Clear pathways through the system, with clear indications of what services are available and how to access and navigate those services.	Y	Many underserved communities in Windsor-Essex are not aware of CYMH services that are available to them or how to access appropriate care for their families in a timely fashion. This is especially prevalent in vulnerable populations, as well as those with complex mental health needs. Furthermore, there is a significant need to focus on improving transitions of care for emerging adults/transitional aged youth who age out of the child and youth system into the adult sector.	• Servicing vulnerable/high-risk communities in Windsor-Essex; • Engaging with families one-on-one to determine basic, informational, and mental health service needs of child/youth and other family members, as appropriate; • Providing appropriate referrals to community services; • Acting as a liaison and advocate for families by connecting directly with community organizations/service providers in order to reduce any access barriers and ensure smooth transitions for families within the system and for transitional aged youth into the adult system; • Assessing if there are other practical barriers keeping this family from effectively dealing with their mental health needs; • Following up with families regularly (or as appropriate) during their care journey to determine needs are being met	*Please see Appendix C for full evaluation plan* • 70 families served • Wait time of 1-2 business days • All families report receiving adequate support based on involvement with the navigation program and the services they received (Family Feedback Survey) • All families report being satisfied with the program (Family Feedback Survey) • All families report being satisfied with referred programs and services (Family Feedback Survey)

				and service referrals are successfully completed; • Working collaboratively and seamlessly as one system navigation service for Windsor-Essex to improve system functioning and transitions of care for children, youth, and families; • Working closely with coordinated access and coordinated service planning to maximize system resources and a streamlined approach for families.	• 80% of families display positive outcomes at end of service

4.2.2. Analysis of current state versus need – community mental health

Current state	Community mental health services in Windsor Essex are often fragmented between community organizations. This is reflected through service gaps for many children and youth with complex, who are often unable to receive services due to lack of services within the community for specialized populations (e.g., dual diagnosis). There is a lack of coordinated access to ensure all children and youth are receiving the services they need, which is amplified through silos that exist within the community.
Future state	The ideal future state of our community mental health services will include collaboration and connectedness between community partners. It will function as a system where all children, regardless of diagnoses, will have access to appropriate services, where and when they need them. It will also include a central access point with clear pathways for families, to eliminate gaps in care.
GAP ANALYSIS	

Current state	Future state	Gap identification (Y/N)	Gap description	Gap solutions/actions	Gap evaluation
List specific and factual attributes in need of improvement in your service area	*List specific idealized attributes you would like to see in the future state*	*Is there a gap between current and future states?*	*Describe issues/elements/factors that characterize the gap between the current and future state*	*List <u>all</u> possible solutions, with specific actions, for bridging the gap between the current and future state. These solutions should directly address factors responsible for the gap.*	*Identify how you will evaluate the effectiveness/success of your response to this gap*
System gaps for complex cases	All children and youth, regardless of diagnoses, will be able to receive adequate services when and where they need them.	Y	• Currently, there are a group of high risk children and youth with significant mental health issues that require a level of service beyond Intensive Treatment Services; • Lack of risk assessment tool to identify children and youth who have service needs beyond what is	• Define specific target population with involvement of community partners and local families • Engage with other Lead Agency partners around the province to understand existing work in this area • Conduct thorough scan of current policies for support and treating children and youth with complex mental health needs. • Determine method and evaluation criteria for policy review and alternative solutions; • Survey key	• **Defining the problem**: stakeholder engagement, including local families with lived experience, in defining target population and associated indicators for identifying population using key informant interview and focus group methodology • **Policy review**: collaboratively develop method and evaluation criteria for conducting policy review with local experts in research and evaluation

			currently offered; • No residential or live-in services are offered within Windsor-Essex, which leads to some families needing to seek services outside of our community • Lack of funding for resources dedicated to responding to the needs of these children and youth	stakeholders within our community and around the province to understand the scope and the extent of this service gap in other service areas, identify possible solutions • Summarize findings and policy recommendations and share widely with community and provincial partners • Generate business case for addressing service gap, including implementation and evaluation plan	• **Summary of findings:** articulate findings and recommendations in a policy ready report to serve as a foundation for collaboration and discussion among our community partners regarding service gaps and possible solutions • **Solution Development with community partners**: Collaboratively develop local action plans to address service gaps through local planning sessions • Create plan for implementation and ongoing monitoring of process and outcomes
Lack of central/coordinated access	One central access point will exist for children,	Y	The pathway to access CYMH services in Windsor Essex is often unclear, and results in	• Literature review of effective coordinated/central access systems	• Client satisfaction survey • Tracking metrics and outcomes in

	youth, and families to be connected to the CYMH services and support they require, through a clear pathway.		a fragmented journey and a lack of awareness of services.	• Current state mapping for CSPs • Planning sessions with CSPs and future state mapping • Implementation of central/coordinated access to CYMH services in alignment with other children and youth services	EMHware i.e., number of referrals, client outcomes (InterRAI)
Lack of collaboration between partner organizations	Formal approach to how community partner organizations work together to identify and meet the mental health needs of children, youth, and families.	Y	• Engagement survey results show that many of our community partners rate our ability to work together collaboratively "somewhat well" (average score: 5.9/10, please refer to Appendix D), suggesting there is room for improvement; • Agencies working within silos in the community	• Engaging in strategic planning activities with community partners to identify shared vision, mission, and values; ○ Determine methodology for engaging community stakeholders in strategic planning process, including measurement plan ○ Targeted engagement of key stakeholders (through	• Community partners engaged in strategic planning process • Development of mechanisms and approach to working together as a system • Youth and families within the community have increased knowledge and awareness of mental health system and available community services

			which hampers ability to identify children and youth with mental health issues early and ensure they get the support they need; • Currently no formalized framework or approach for working together as a system and sharing local knowledge and information	agreed upon methodology, eliciting feedback regarding current state, areas of improvement, and long-term goals; • Collaboratively develop approach and framework for working together as a system to address needs of children, youth, and families, including action planning for meeting identified goals • Develop plan for informing families and community at large about system-level approach	

4.3 Goals for your service area

Considering your vision, mission and gaps as identified above, please document two main goals for your service area, one for core services and another for community mental health.

Goal 1:	Among our core service providers within the Windsor Essex service area, we are striving to improve access to services and to improve the quality of the services that are being offered through evidence informed decision making.
Goal 2:	Within the Windsor Essex service area, in partnership with our broader service partners we are striving to address gaps in services and to increase inter-sectorial collaboration in an effort to create a more seamless, integrated system for children, youth and families.

4.3.1 Core service priorities

From the goals identified above, please list *up to three* priorities aimed at addressing core service gaps in the table below.

Priorities	Description	Objectives	Timelines (yr 1, 2 or 3)
Improve wait-times for service	Timely access to core services for which children, youth, and families are currently waiting, specifically, counseling and therapy services, which reflects the highest level of service utilization within the Windsor-Essex service area (78% of children and youth deemed eligible for service in 2019-2020) and some of the highest wait-times (490 days in 2019), and family capacity and support groups, which currently has over 40 families waiting for services.	• Investment in counseling and therapy services ○ Increase capacity to serve 50 more families per year and offer services full time in 3 different county locations (i.e., Amherstburg, Leamington, and Kingsville) (please see Appendix C for detailed implementation and evaluation plan) • Investment in family capacity and support services ○ Increase capacity of 2 evidence-based programs to serve at least 25 more families per year and offer a	Yr1 Yr1

		greater number of groups at accessible times for families in evenings and on weekends (please see Appendix C for detailed implementation and evaluation plan) • Launch and sustain a CYMH service area data and quality improvement committee, including representation from all CSPs. o Develop Terms of Reference o Conduct quarterly meetings o Develop data measurement plan for monitoring and evaluating effectiveness, efficiency, safety, and timeliness of programs and services	Yr1, Yr2, and Yr3
Improve system navigation and clearer pathways	A lack of clear service pathways has created information gaps for children, youth, and families and community partners. This results in families lacking awareness of mental health services available to them within the community and where they can go to receive the help they need.	• Collaborative planning to develop a family navigation service • Comprehensive service mapping process with core service and community partners, including articulation of service area pathways to provide clarity to service users and referral sources • Identify family navigation service program goals, and objectives, inputs, activities, and outcomes • Set up program operations and hire 1.7 FTE staff • Development of pilot implementation and evaluation plans for pilot program (please see Appendix C)	Yr1 Yr1 Y1 Yr2

		• Conduct community awareness campaign of new service • Conduct pilot evaluation	Yr2 & Yr3

Improve community collaboration and system integration	Increase collaboration between core service providers.	• Collaboratively develop formal approach and framework for working together as a system to address needs of children, youth, and families
		  ○ Conduct environmental scan and review of existing best-practice frameworks
		  ○ Elicit feedback from key stakeholders
		  ○ Engage youth and families in the process
			Yr1

4.3.2 Community mental health priorities

From the goals identified above, please list *up to three* priorities aimed at addressing community mental health gaps in the table below.

Priorities	Description	Objectives	Timelines (yr 1, 2 or 3)
Address system gaps for complex cases	Currently some families are receiving services outside Windsor-Essex, or they are going without appropriate services due to a lack of existing services to address the needs of children and youth with complex mental health issues	• Define specific target population with involvement of community partners and local families • Engage with other Lead Agency partners around the province to understand existing work in this area • Conduct thorough scan of current policies for support and treating children and youth with complex mental health needs. • Determine method and evaluation	Yr1 Yr1 Yr1 Yr1

		criteria for policy review and alternative solutions; • Survey key stakeholders within our community and around the province to understand the scope and the extent of this service gap in other service areas, identify possible solutions • Summarize findings and policy recommendations and share widely with community and provincial partners • Generate business case for addressing service gap, including implementation and evaluation plan	Yr2 Yr2 & Yr3 Yr2
Central/Coordinated Access	Implementation of central/coordinated access to CYMH services in alignment with other children and youth services	• Literature review of effective coordinated/central access systems • Current state mapping for CSPs • Planning sessions with CSPs and future state mapping • Implementation of central/coordinated access to CYMH services in alignment with other children and youth services	Yr1 & Yr2
Improve collaboration among partner organizations		• Engage in strategic planning activities with community partners to identify shared vision, mission, and values; ○ Include youth and family in planning process ○ Determine methodology for engaging community stakeholders in strategic planning process, including measurement plan ○ Conduct targeted engagement of key stakeholders (through	Yr1

		agreed upon methodology) , eliciting feedback regarding current state, areas of improvement, and long-term goals; • Collaboratively develop approach and framework for working together as a system to address needs of children, youth, and families, including action planning toward identified goals • Develop plan for informing families and community at large about system-level approach	Yr2 Y2 & Yr3

The Lead Agency three year priorities for the Windsor-Essex service area were endorsed by the Hotel-Dieu Grace Healthcare board of directors at the September 30, 2020 board meeting.

It was moved by L. Lombardo and seconded by E. Kelly THAT the Board of Directors approve the recommended priorities for the Child and Youth Mental Health Windsor-Essex service area, including the following Core Service Provider priorities of improving wait-times for service, improved system navigation and clearer pathways, improved community collaboration and system integration; and the Community Mental Health priorities of; addressing system gaps for complex cases, Centralized / Coordinated Access and improved collaboration between partner organizations. CARRIED

4. Multi-year Service Area Action Plan

Based on the priorities identified above, please describe specific action plans for each priority that will help you to address existing needs and challenges, as well as make improvements to the core services, key processes, pathways and protocols within the service area over a three-year period.

5.1 Action plan template

Priority	Most responsible person (MRP)	Team	Deliverable(s)	Timeline(s)
CORE SERVICE PRIORITIES				
1. Improve wait-times for service	Connie Martin Lori Kempe Terra Cadeau	Maryvale Children First HDGH Lead Agency	Recruit 1 FTE for counselling and therapy Recruit 1 FTE for family capacity and support Monitor impact of investment	Q4 Q4 Q1 and ongoing
2. Improve system navigation and clearer pathways	Terra Cadeau	HDGH Lead Agency with RCC/Maryvale	Conduct evidence based review Develop program model, implementation and evaluation plan	Q3 Q3

			Recruit 1.7 FTE (between RCC and MV) Monitor impact of investment	Q4 Q1 and ongoing
3. Improve community collaboration and system integration	Terra Cadeau	HDGH Lead Agency	Launch service area data quality committee Formalize quarterly CSPs meetings through the development of a shared Terms of Reference	Q3 Q4/Q1
COMMUNITY MENTAL HEALTH PRIORITIES				
1. Address system gaps for complex cases	Terra Cadeau	HDGH Lead Agency	Conduct analysis of current state Connect with LAs in west region to define the problem and determine interest in a collaborative solution Establish a local working group to conduct full review and develop business case for addressing the system gap	Q3 Q3 Q4 – Q3

2. Central/Coordinated Access	Terra Cadeau	HDGH Lead Agency	Work with RCC and other key stakeholders to determine alignment with other intakes and entry points into the system Review and update process map Develop protocols for intake and referral Determine training needs Develop implementation plan Implement central/coordinated access for CYMH	Q3/Q4 Q3/Q4 Q4 Q4 Q1/Q2 Q1/Q2
3. Improve collaboration among partner organizations	Terra Cadeau	HDGH Lead Agency	Set up meetings with inter-sectorial partners to understand how the Lead Agency can assist in addressing system issues and increase collaboration Review need for specific planning table	Q4 Q4

			(beyond Director's Forum) Meet with OHT leadership to understand how the Lead Agency can collaborate with the team to ensure CYMH issues are included in priorities/planning	 Q2/Q3

6. Appendix A: Planning and Allocation Template for 2020-21 CYMH Investment Proposal

In the event that the plan identifies a core service provider receiving funding under more than one detail code, please complete one row per core service detail code

Please also complete the included Excel document

Windsor Essex Planning and Allocation Template 2020-21 Investment Proposal					
Core Service Provider Name	Community Mental Health Need Being Addressed (please tie this into identified service area gaps and priorities with consideration for performance indicators and performance outputs)	Detail Code	Activity (describe what is being paid for)	Identified Target(s) (increases in data elements for identified detail code)	2020-21 Allocation to Core Provider
Children First	A need for increased access to groups for children and families dealing with mental health has been demonstrated in Windsor-Essex. Two existing evidence-based programs (The Circle of Security1 and FRIENDS resilience programme2) available to families are currently being delivered virtually due to restrictions surrounding the COVID-19 pandemic. However, to maintain the fidelity of these two programs, only 3-5 families can access	A351	The addition of 1 FTE Therapist would allow these programs to reduce waitlists, as well as offer additional programming hours on evenings and weekends, for children and families who may not be able to access the program during regular working/school hours.	INDSER# 25	$71,000

	these services at one time via OTN. Currently, there are over 40 families on the wait-list for these two programs at Children First. In addition, services are not currently offered on weekends or evenings, which creates a battier to access for many families.				
Maryvale	There is currently limited access to Counselling and Therapy services in the county regions of Windsor-Essex, with the bulk of these services being offered within the City of Windsor. Some areas, such as Amherstburg and Kingsville, do not have any facilities offering services, yet they have demonstrated a considerable need. Families residing within the county regions are currently having to travel into the city in order to access services for their child/family member.	A349	By increasing Counselling and Therapy by 1 FTE to serve the county regions, the accessibility of services would improve for youth who are not able to travel to other regions such as Windsor, and would also reduce the waitlist for Counselling and Therapy by adding an additional FTE. This 1 FTE would be distributed as 5 days across 3 locations. - 2 days/week in Amherstburg (currently nothing offered) - 2 days/week in Kingsville (currently nothing offered) - an additional day in Leamington (increasing to 5 days/week)	INDSER# 50	$101,400
Maryvale	There is a need for system navigation to	A354	The addition of a 1 FTE System Navigator would allow for increased care coordination	INDSER# 40	$91,560

	ensure equitable and efficient access into, and transition through, the mental health system. Many underserved communities in Windsor-Essex are not aware of CYMH services that are available to them or how to access appropriate care for their families in a timely fashion. This is especially prevalent in vulnerable populations, as well as those with complex mental health needs. While the need for these communities is great, there are many barriers to access, including lack of awareness of services, and lack of the CYMH system reaching in.		for the most complex and complicated cases in some of the most vulnerable populations in Windsor-Essex. This position would work in partnership with the System Navigator housed at RCC, and they would function as support for the entire service area and would work jointly to offer system navigation and care coordination. The majority of this function would occur offsite, at locations within the community, such as the Newcomer Welcome Centre.		
HDGH-RCC	There is a need for system navigation to ensure equitable and efficient access into, and transition through, the mental health system. Many underserved communities in Windsor-Essex are not aware of CYMH services that are	A354	The addition of a 0.7 FTE System Navigator would allow for increased care coordination for the most complex and complicated cases in some of the most vulnerable populations in Windsor-Essex. This position would work in partnership with the System Navigator housed at Maryvale, and they would function as support for the entire service area and would work jointly to offer system	INDSER# 30	$70,540

	available to them or how to access appropriate care for their families in a timely fashion. This is especially prevalent in vulnerable populations, as well as those with complex mental health needs. While the need for these communities is great, there are many barriers to access, including lack of awareness of services, and lack of the CYMH system reaching in.		navigation and care coordination. The majority of this function would occur offsite, at locations within the community, such as the Newcomer Welcome Centre.		

By signing below, the lead agency is confirming that all service providers that are identified in the proposal understand and agree to the commitments outlined in the proposal:

_____ _____

Name *Signature*

Instructions:

- Please complete and submit this template and submit to your MOH Program Supervisor by **August 17, 2020**.
- Please ensure that the total amount allocated in the plan does not exceed the service area's total 2020-21 investment amount.
- Identify Community Mental Health needs or service gap being addresses (forward any supporting documentation as an appendix to plan).
- Please ensure that proposed activities meet the criteria for investment which includes program and service delivery costs required to establish and/or expand a service (e.g. offer programs/services at a higher frequency, increasing hours of existing staff in order to serve a higher volume of clients, etc.). Associated program cost to the agency (e.g. supervision, administration costs) are also eligible.

Out of Scope: Lead agency system management activities and functions, addressing existing program pressures except in circumstances where the addressed pressure contributes to an increase or measurable improvement in services.

Column Title Descriptions

- Core Service Provider Funding Recipient: the name of the Core Service Provider to that will be contracted to receive funding.
- Community Mental Health Needs being addressed: the rationale for providing the service to address the identified need in alignment with gaps/needs analysis and **Roadmap to Wellness: A Plan to Build Ontario's Mental Health and Addictions System**.
- Detail Code: The detail code that the funding will be attributed to.
- Activity: Describe the plan to implement the new service. What are the program and service delivery costs to establish/expand the service?
- Identified Target: Please identify the increase in service data elements that will be achieved with the investment.
- 2020-21 Allocation to Service Provider: Identify the proposed allocation amount to this agency for the specified activity.

Ministry Review Criteria

The ministry will review plans against the following criteria. Where the plan does not satisfy all criteria, the ministry will work with the lead agency to resolve the issue.

Criteria
✓ *All sections of the plan have been completed, including all service provider signatures*
✓ *Plan is consistent with the uses of funding outlined in the funding submission guidelines*
✓ *If applicable, start-up and/or one-time service-related activities are reasonable and needed, and estimated costs represent value-for-money. There is sufficient rationale to justify the cost.*
✓ *Plans demonstrate that service needs were identified through past or current community consultation*
✓ *Plans identify anticipated results and performance measurement*
✓ *Detailed budgets only include eligible expenditure categories*

Child and Youth Mental Health Core Services Detail Codes

Detail Code	Description
A348	CYMH Brief Services
A349	CYMH Counselling/Therapy Services
A350	Crisis Services
A351	Family/Caregiver Skills Building and Support
A352	Coordinated Access and Intake
A353	Intensive Treatment Services
A354	Case Management and Service Coordination
A355	Specialized Consultation/Assessment Services
A356	Targeted Prevention

7. Appendix B – 2021-22 Service Area Resource Reallocation Plan

Please complete the following table if you intend to propose resource reallocations **to implement April 1, 2021**. This table will be used to support a dialogue between the lead agency and the ministry and will be used by the ministry as a key input into service area resource allocation for **April 1, 2021**. It is important to note that where changes are to be proposed the change must be actionable for April 1, 2021.

Service Area	**Proposed change and rationale:** • *Detail directly impacted service provider(s), and proposed funding/service target changes* • *Provide a clear rationale supported by data/evidence* • *Demonstrate alignment with system goals / priorities and PGR expectations*	**Description of community engagement:** • *Describe any discussions to date regarding the proposed change* • *Outline the confirmed/anticipated stakeholder perspective (impacted service provider; community etc.)*	**Proposed Implementation:** • *Outline implementation considerations including timing of proposed change*	**Other:** • *Detail any other information you think the ministry needs to be aware of in assessing this proposed change*
	No proposed change at this time			

Proposal Summary

Please include a separate proposal summary table for each proposed change identified above. The table should clearly indicate the reallocation of funds and/or service targets from one or more agencies to others.

Example: Proposed Change #1

	Agency A	Agency B	Agency C	Agency D	Agency E
2021/22 Core Service Code	A348	A	N/A	N/A	N/A
2020/21 Allocation	100,000	150,000			
Change being proposed (increase or decrease)	**-50,000**	**+50,000**			
2021/22 Proposed Allocation	50,000	200,000			
2020/21 Service targets	50	100			
Change being proposed (increase or decrease)	**-25**	**+25**			
2021/22 Proposed Service Targets	25	125			
Rationale	Not enough demand for this service to justify funding allocation.	Waitlist for service will be addressed by the increase in funding.			

Note: The sum of the 2020/21 Allocation row needs to be the same as the sum of the 2021/22 Proposed Allocation row. Please speak to your program supervisor with further questions.

Guidelines and Definitions

Evidence/Supporting Documentation

- Evidence/documentation to support the Lead Agency's proposed resource reallocation recommendation must be linked to the Multi-Year Planning Process: Service Area Planning priorities (either pre-existing or new) and relevant to the proposed change or rationale for proposed change in reallocation between core service providers and/or across CYMH core service and key process detail codes.
- When weighing the evidence/documentation provided, consider:
  - The sufficiency of the evidence (e.g. based on the significance of the proposed change, how many meaningful consultations took place and with how many impacted service providers);
  - The reliability of the evidence (i.e. source of the evidence); and,
  - The timeliness of the evidence (i.e. most current data available)

Non-acceptance of a Lead Agency Recommendation

- Criteria for <u>non-acceptance</u> of a proposed resource reallocation recommendation:
  - Recommendation promotes change that will make significant changes to the service landscape **without** broad consultation, Mental Health and Addiction Programs Branch and stakeholder buy-in, and a well-articulated and understood implementation plan.
  - Recommended change is **not** consensus-based i.e. program supervisor cannot verify that impacted core service providers are in agreement/support of the proposed change.
  - The evidence presented is **not** relevant to the proposed change or does not provide support of the recommended change or the rationale for change.
  - The change **will not** reasonably result in enhanced experience of the service system by children, youth and their families.
- Non-acceptance of a proposed resource reallocation will be communicated to lead agency through the Mental Health and Addiction Programs Branch Director.

Definitions

<u>Significant community concerns:</u> Impacted core service providers express concerns regarding proposed resource reallocation recommendation and the concern is assessed as reasonable.

<u>Clear rationale:</u> Evidence/documentation presented is current, relevant and sufficient to support the recommendation with a direct link to addressing service gaps or service area needs. Upon review of evidence/documentation to support the proposed resource

reallocation recommendation, it is at the discretion of the Program Supervisor, to decide if there is a clear rationale for the recommended change.

Appendix C: Implementation and Evaluation Plans for New Investments
Counselling & Therapy New Investment Implementation Plan

Project Details

Project Purpose	There is currently limited access to Counselling and Therapy services in the county regions of Windsor-Essex, with the bulk of these services being offered within the City of Windsor. Some areas, such as Amherstburg and Kingsville, do not have any facilities offering services, yet they have demonstrated a considerable need. Families residing within the country regions are currently having to travel into the city in order to access services for their child/family member. The purpose of this initiative is to increase Counselling and Therapy services by 1 FTE to serve the county regions in order to improve access to families who are not able to travel to other regions such as Windsor. Adding an additional FTE would also have a direct effect on reducing the wait-time for Counselling and Therapy, which is currently an average of 57 days.
Identified Objectives	The objectives of this project are to: • Reduce the waitlist for Counselling and Therapy – focusing on the county regions within the Windsor-Essex service area • Improve accessibility of Counselling and Therapy to county locations
Project Scope	The following categories of work are within scope: • 1 FTE of Counselling and Therapy would equate to 5 days distributed across 3 county regions ○ 2 days/week in Amherstburg (currently no services offered) ○ 2 days/week in Kingsville (currently no services offered) ○ an additional day in Leamington (increasing Counseling and Therapy to 5 days/week) ○ Includes on-going supervision/consultation with Child Psychologist (approx. 1x/month) for all Counselling and Therapy staff ○ Includes in-depth supervision/mentorship of new staff with senior staff therapist Areas of work currently *out of scope* include: • Additional Counselling and Therapy offered within the City of Windsor

Target Population	Youth ages 13-18 in the county regions of Windsor-Essex in need of mental health services	
Roles, Responsibilities, and Salary	***Maryvale***	• Provide 1 FTE of Counselling and Therapy across county regions of Windsor-Essex • 1 FTE = $101,400

Evaluation Plan

Evaluation Question	Outcome	Indicator	Data Source	Expected Outcomes/Targets
Does expanding access to Counselling and Therapy services in the county region reduce existing wait-list?	Increase number of families that receive counselling and therapy support services	# of families accessing services (INDSER#50)	EMHware	Increase in 50 families served
		# of families waiting for service		
		# of days waiting for service (MHWT#)		
		Referral Source		
		# of direct service hours for Counselling and Therapy (HOUDIRS#)		Based on service plan
Does this service lead to positive improvements?	The number of caregivers and/or youth who have ended service and who report that	# of children/youth with positive outcomes (POSOC#)	Family Feedback survey/EMHware	80% of families who display positive outcome at end of service

	positive outcomes have been achieved at end of service			
	The number of children/youth who have ended service and who display positive outcomes at end of service	# of caregivers/youth with positive outcomes (CPOSOC#)	EMHware	80% of families who display positive outcome at end of service

Project Charter

Project Details

Project Purpose	A need for increased access to groups for children and families dealing with mental health has been demonstrated in Windsor-Essex. Two existing evidence-based programs (The Circle of Security[1] and FRIENDS resilience programme[2]) available to families are currently being delivered virtually due to restrictions surrounding the COVID-19 pandemic. However, to maintain the fidelity of these two programs, only 3-5 families can access these services at one time via OTN. Currently, there are over 40 families on the wait-list for these two programs at Children First. In particular, Circle of Security, which is an attachment-based parenting group designed to improve the development of the parent-child relationship currently has 10 families on the waitlist. This is a small group (5-6 families), 8-week psycho-educational intervention program that focuses in enhancing the caregiver-child relationship. The second program, Friends Resilience, is a 10-session cognitive behavioural therapy program, which has both a component for children with anxiety, as well as a parent group component. This program is designed to improve emotional well-being and reduce symptoms of anxiety and depression. There are currently 31 families on the waitlist for Friends Resilience. The purpose of this initiative to provide caregiver(s) a service which promotes and enhances their understanding and ability to respond to their child's mental health needs. Evening and weekend offerings of these two group programs will reduce the number of families waiting for service and increase accessibility to these services while supporting and strengthening the parent child relationship. Parents will learn how to support their child's emotional development, enhance self-esteem, and respond effectively to their children's cues.
Identified Objectives	The objectives of this project are to: • Support timely, effective early intervention. • Reduce the need for more intensive and intrusive intervention. • Develop family capacity to support their child's ability to successfully manage emotions.

	• Improve child and youth social emotional development and build foundational resilience skills.	
Project Scope	This project involves the hiring of the equivalent of 1 FTE certified clinician to lead two separate evidence-based child and family capacity building and support groups: 1) Circle of Security and 2) FRIENDS Resilience. This project will respond to existing demand for service to reduce wait time while also allowing for increased capacity for service utilization for an additional 25 families. Each group program will be offered approximately 4 times over the course of the year (evenings and weekends) for a total of 8 groups annually. Integral to this project is expansion of the delivery of these two specific services to include evenings and weekends. The scope of this project adds to the flexible continuum of supports (scheduling and settings) available at Children First and the community of Windsor-Essex. This project will allow for delivery of programs using virtual technology to adapt to COVID-19 circumstances which has also created barriers for accessing services. Positive clinical outcomes will be anticipated by providing caregivers understanding and ability to respond to their child's mental health needs in a timelier manner, with intention to reduce the need for more intensive services. Pre-Post data will be collected and interpreted to evaluate the effectiveness of these programs and the compared against the objectives and scope of this defined project.	
Target Population	This project will be delivered to the target populations for each group-based program: - Circle of Security group provided to caregivers who have children ages birth to 10; and - FRIENDS Resilience group program provided to caregivers and children ages 4-7 with anxiety. This parent/child concurrent delivered group aims to target both parent and child anxiety and the interrelationship that can take place (for example see : https://childmind.org/article/how-to-avoid-passing-anxiety-on-to-your-kids/)	
Roles, Responsibilities, and Salary	***Children First***	• Provide 1 FTE therapist to expand offerings of Circle of Friends and Friends Resilience • 1 FTE = $71,000

Evaluation Plan

Evaluation Question	Outcome	Indicator	Data Source	Expected Outcomes/Targets
Does enhancing the number of groups offered on evenings/weekends reduce existing wait-list?	Increase number of families receive family capacity and support services	# of families accessing services (INDSER#)	EMHware	Increase in at least 25 families served
		# of families waiting for service		Wait-list reduced from 41 to 16, reflecting 39% improvement
		# days waiting for service (MHWT#)		
What are families experiences with the FRIENDS or Circle of Security programs?	Families report that programs were enjoyable, helpful, and useful in meeting their specific needs		Family Feedback survey	All families report intervention was beneficial
Does this service lead to positive improvements?	Families participating in FRIENDS programme report improvements in child's anxiety and self-esteem.	Strengths and Difficulties Questionnaire (Goodman, 1997); Preschool Anxiety scale (Spence & Rapee, 1999)	Assessment surveys completed before and after program completion.	20% reduction in anxiety symptoms (Alish & Dunsmuir, 2015)
	Families participating in the Circle of Security program report improved attachment	Circle of security parent/guardian survey (Hoffman, Marvin, Cooper & Powell, 2006)	Assessment surveys completed before and after program completion.	At least 80% of families report secure attachment classifications following completion of the program (Hoffman, Marvin, Cooper, & Powell, 2006)

Appendix I
Strengths and Difficulties Questionnaire

Strengths and Difficulties Questionnaire

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of your child's behaviour over the last six months.

Child's Group Number:

Date:

	Not True	Somewhat True	Certainly True

Considerate of other people's feelings			
Restless, overactive, cannot stay still for long			
Often complains of headaches, stomach-aches, or sickness			
Shares readily with other children, for example toys, treats, pencils			
Often loses temper			
Rather solitary, prefers to play alone			
Generally well behaved, usually does what adults request			
Many worries or often seems worried			
Helpful if someone is hurt, upset, or feeling ill			
Constantly fidgeting or squirming			
Has at least one good friend			
Often fights with other children or bullies them			
Often unhappy, depressed or tearful			
Generally liked by other children			
Easily distracted, concentration wanders			
Nervous or clingy in new situations, easily loses confidence			
Kind to younger children			
Often lies or cheats			
Picked on or bullied by other children			
Often offers to help others (parents, teachers, other children)			

Thinks things out before acting			
Steals from home, school or elsewhere			
Gets along better with adults than with other children			
Many fears, easily scared			
Good attention span, sees chores or homework through to the end			

Do you have any other comments or concerns?

Overall do you think that your child has difficulties in one or more of the following areas: emotions, concentration, behaviour or being able to get on with other people?

No	Yes – Minor difficulties	Yes – Definite difficulties	Yes – Severe difficulties

If you have answered "Yes", please answer the following questions about these difficulties:

- **How long have these difficulties been present?**

Less than a month	1-5 months	6-12 months	Over a year

- **Do the difficulties upset or distress your child?**

Not at all	Only a little	Quite a lot	A great deal

- **Do the difficulties interfere with your child's everyday life in the following areas?**

	Not at all	Only a little	Quite a lot	A great deal
HOMELIFE				
FRIENDSHIPS				
CLASSROOM LEARNING				
LEISURE ACTIVITIES				

- **Do the difficulties put a burden on you or the family as a whole?**

Not at all	Only a little	Quite a lot	A great deal

Please specify who is completing this form by ticking off the appropriate box.

Mother □

Father ☐

Other ☐

Thank you very much for your help

Appendix II

Pre-School Anxiety Scale

PRESCHOOL ANXIETY SCALE

(Parent Report)

Child's Group Number:

Date:

Below is a list of items that describe children. For each item please circle the response that best describes your child. Please circle **4** if the item is **very often true**, **3** if the item is **quite often true**, **2** if the item is **sometimes true**, **1** if the item is **seldom true** or if it is **not true at all** circle the **0**. Please answer all the items as well as you can, even if some do not seem to apply to your child.

		Not True at All	Seldom True	Sometimes True	Quite Often True	Very Often True
1	Has difficulty stopping him/herself from worrying	0	1	2	3	4
2	Worries that he/she will do something to look stupid in front of other people	0	1	2	3	4
3	Keeps checking that he/she has done things right (e.g., that he/she closed a door, turned off a tap)	0	1	2	3	4
4	Is tense, restless or irritable due to worrying	0	1	2	3	4
5	Is scared to ask an adult for help (e.g., a preschool or school teacher)	0	1	2	3	4
6	Is reluctant to go to sleep without you or to sleep away from home	0	1	2	3	4
7	Is scared of heights (high places)	0	1	2	3	4
8	Has trouble sleeping due to worrying	0	1	2	3	4
9	Washes his/her hands over and over many times each day	0	1	2	3	4
10	Is afraid of crowded or closed-in places	0	1	2	3	4
11	Is afraid of meeting or talking to unfamiliar people	0	1	2	3	4
12	Worries that something bad will happen to his/her parents	0	1	2	3	4
13	Is scared of thunderstorms	0	1	2	3	4

14	Spends a large part of each day worrying about various things	0	1	2	3	4
15	Is afraid of talking in front of the class (preschool group) e.g., show and tell	0	1	2	3	4
16	Worries that something bad might happen to him/her (e.g., getting lost or kidnapped), so he/she won't be able to see you again	0	1	2	3	4
17	Is nervous of going swimming	0	1	2	3	4
18	Has to have things in exactly the right order or position to stop bad things from happening	0	1	2	3	4
19	Worries that he/she will do something embarrassing in front of other people	0	1	2	3	4
20	Is afraid of insects and/or spiders	0	1	2	3	4
		Not True at All	**Seldom True**	**Sometimes True**	**Quite Often True**	**Very Often True**
21	Has bad or silly thoughts or images that keep coming back over and over	0	1	2	3	4
22	Becomes stressed about your leaving him/her at preschool/school or with a babysitter	0	1	2	3	4
23	Is afraid to go up to a group of children and join their activities	0	1	2	3	4
24	Is frightened of dogs	0	1	2	3	4
25	Has nightmares about being apart from you	0	1	2	3	4
26	Is afraid of the dark	0	1	2	3	4

27	Has to keep thinking special thoughts (e.g., numbers or words) to stop bad things from happening	0	1	2	3	4
28	Asks for reassurance when it doesn't seem necessary	0	1	2	3	4
29	Has your **child ever experienced anything really bad or traumatic** (e.g., severe accident, death of a family member/friend, assault, robbery, disaster)	**YES**	**NO**			
	Please briefly describe the event that your child experienced……					

If you answered **NO** to **question 29**, please do not answer questions 30-34. **If you answered YES**, **please DO** answer the following questions.

		Not True at All	**Seldom True**	**Sometimes True**	**Quite Often True**	**Very Often True**
30	Has bad dreams or nightmares about the event	0	1	2	3	4
31	Remembers the event and becomes distressed	0	1	2	3	4
32	Becomes distressed when reminded of the event	0	1	2	3	4
33	Suddenly behaves as if he/she is reliving the bad experience	0	1	2	3	4

34	Shows bodily signs of fear (e.g., sweating, shaking or racing heart) when reminded of the event	0	1	2	3	4

Please specify who is completing this form by ticking off the appropriate box.

Mother ☐

Father ☐

Other ☐

Thank you very much for your help

Appendix III

Circle of Security Parent Survey

Children First

Circle of Security – Parenting Group

Parent/Guardian Survey

Please Circle the number that best describes how much you agree or disagree with each of the following statements:	**Strongly Disagree 1**	**Disagree 2**	**Neutral 3**	**Agree 4**	**Strongly Agree 5**
My level of stress about parenting is high.	1	2	3	4	5
I have a positive relationship with my child(ren).	1	2	3	4	5
I recognize the behaviours that trigger my negative response to my child.	1	2	3	4	5
I identify and respond to my child's needs for support to explore and for comfort and contact.	1	2	3	4	5
When I fail to respond to my child's needs I look for ways to repair our relationship.	1	2	3	4	5
I step back and think about my child's behavior is telling me about his/her needs before I react.	1	2	3	4	5
I feel confident that I can meet the needs of my child(ren).	1	2	3	4	5

Why did you decide to join this group?

_____

_____

How many children do you have? _____

What are the ages of your child(ren)? Check all that apply:

___ Newborn up to age 3 ____Preschool (ages 3-5) ____ Kindergarten
____School age ____ Highschool ____ Post Secondary School

What is your age? ___<19 ____19-24 ___ 25-30 ____31-36
___37-42 ____43- 48 ___49-54 ____ 55+

Are you : ___Parent ___Grandparent ___ Foster Parent ___ Guardian

Gender: ___ Male ___ Female

_____ _____
Child's Group Number Date

Survey adapted from Circle of Security-Parenting International with their permission

Aug/16 KC

Case Management and Service Coordination
New Investment Implementation Plan

Project Details

Project Purpose	There is a need for system navigation to ensure equitable and efficient access into, and transition through, the mental health system. Many underserved communities in Windsor-Essex are not aware of CYMH services that are available to them or how to access appropriate care for their families in a timely fashion. This is especially prevalent in vulnerable populations, as well as those with complex mental health needs. Furthermore, there is a significant need to focus on improving transitions of care for emerging adults/transitional aged youth who age out of the child and youth system into the adult sector. This program will work closely with coordinated access, coordinated service planning, etc. to ensure no duplication of effort for a maximization of system resources and a streamlined approach for families.
Identified Objectives	The objectives of this project are to: • Ensure equitable and efficient access to CYMH services for the most vulnerable families and those with complex/complicated mental health needs; • Connect families with a system navigator that will engage with them one-on-one throughout their care journey to help them access timely and appropriate mental health care to meet their individual needs; • Reduce barriers to accessing mental health services; • Improve transitions of care within the system for all families in Windsor-Essex, with a specific focus on emerging adults transitioning between child and youth system and adult sector.
Project Scope	The following activities of work are within scope: • Servicing vulnerable/high-risk communities in Windsor-Essex; • Engaging with families one-on-one to determine basic, informational, and mental health service needs of child/youth and other family members, as appropriate; • Providing appropriate referrals to community services; • Acting as a liaison and advocate for families by connecting directly with community organizations/service providers in order to reduce any access barriers and ensure smooth transitions for families within the system and for transitional aged youth into the adult system; • Assessing if there are other practical barriers keeping this family from effectively dealing with their mental health needs;

	• Following up with families regularly (or as appropriate) during their care journey to determine needs are being met and service referrals are successfully completed; • Working collaboratively and seamlessly as one system navigation service for Windsor-Essex to improve system functioning and transitions of care for children, youth, and families; • Working closely with coordinated access and coordinated service planning to maximize system resources and a streamlined approach for families.	
Target Population	Vulnerable/high-risk children and youth, especially: • Families with complex mental health needs • Low-German Mennonite community • New immigrants • Working poor • Transitional aged youth/emerging adults	
Roles, Responsibilities, and Salary	***Maryvale***	• Provide 1 FTE System Navigator to service county regions at locations such as the Newcomer Welcome Centre county location • 1 FTE = $91,560
	HDGH-RCC	• Provide 0.7 FTE System Navigator • 0.7 FTE = $95,442*0.7 = $66,809.40

Evaluation Plan

Evaluation Question	Outcome	Indicator	Data Source	Expected Outcomes/Targets
Is the navigation service accessible to families?	Service is accessible to families in Windsor-Essex region	# of families/individuals served (INDSER#)	EMHware	80 families served
		# of days waiting for service (MHWT#)		1-2 business days
		# of follow-up visits with family		

Does navigator meet families' needs?	Families with complex mental health needs receive required support to navigate system	# and type of service referrals for family Direct service hours and duration of service (HOUDIRS#, MHSD#)	EMHware, Family Feedback survey (see Appendix I)	All families report receiving adequate support based on involvement with the navigation program and the services they received
Are families satisfied with the navigation program?	Families feel satisfied with the navigation program	NAVSAT (Fisherman & Levitt, Markoulaskis & Weingust, 2017)	Family feedback survey (see Appendix I)	All families report being satisfied with program
Are families satisfied with their referred services?	Families feel satisfied with the services they received as a result of their involvement with the family navigation program	NAVSAT (Fisherman & Levitt, Markoulaskis & Weingust, 2017)	Family feedback survey(see Appendix I)	All families report being satisfied with referred programs and services
Does this service lead to positive improvements?	The number of caregivers and/or youth who have ended service and who report that positive outcomes have been achieved at end of service The number of children/youth who have ended service and who display positive outcomes at end of service	# of children/youth with positive outcomes (POSOC#) # of caregivers/youth with positive outcomes (CPOSOC#)	EMHware	80% of families who display positive outcome at end of service

Appendix I

The Navigation Satisfaction Questionnaire (NAVSAT)

Part 1: Navigation Service

1. How satisfied are you with the Navigator's ability to list and understand your concerns?	**Extremely Dissatisfied**	**Dissatisfied**	**Fairly Dissatisfied**	**Not dissatisfied nor satisfied**	**Fairly Satisfied**	**Satisfied**	**Extremely satisfied**
2. How satisfied are you with the information given about potential treatment options for your child/family member?	Extremely Dissatisfied	Dissatisfied	Fairly Dissatisfied	Not dissatisfied nor satisfied	Fairly Satisfied	Satisfied	Extremely satisfied
3. How satisfied are you with how the Navigator understood the impact of the situation on your family?	Extremely Dissatisfied	Dissatisfied	Fairly Dissatisfied	Not dissatisfied nor satisfied	Fairly Satisfied	Satisfied	Extremely satisfied
4. How satisfied are you with the Navigator's confidentiality and respect for you and your child/family member's rights?	Extremely Dissatisfied	Dissatisfied	Fairly Dissatisfied	Not dissatisfied nor satisfied	Fairly Satisfied	Satisfied	Extremely satisfied
5. How satisfied are you with the intake procedures?	Extremely Dissatisfied	Dissatisfied	Fairly Dissatisfied	Not dissatisfied nor satisfied	Fairly Satisfied	Satisfied	Extremely satisfied
6. How satisfied are you with your frequency of contact with the Navigator?	Extremely Dissatisfied	Dissatisfied	Fairly Dissatisfied	Not dissatisfied nor satisfied	Fairly Satisfied	Satisfied	Extremely satisfied
7. How frequently did you have contact with the Navigator?	Less than once every 2 months	Once every 1-2 months	Once every month	Once every three weeks	Once every two weeks	Once per week	More than once per week

8. To what degree do you feel the Navigator recommended the most appropriate resources for your child/family member?	Extremely small degree	Small degree	Fairly small degree	Moderate degree	Fairly large degree	Large degree	Extremely large degree
9. To what degree do you feel the Navigator truly understands the mental health system?	Extremely small degree	Small degree	Fairly small degree	Moderate degree	Fairly large degree	Large degree	Extremely large degree
10. In general how helpful did you find the Navigator?	Extremely unhelpful	Unhelpful	Fairly unhelpful	Not helpful nor unhelpful	Fairly helpful	Helpful	Extremely helpful
11. How likely are you to recommend this service to family and friends?	Very unlikely	Unlikely	Not sure	Likely	Very likely		
12. In general, how satisfied are you with the navigation service?	Extremely Dissatisfied	Dissatisfied	Fairly Dissatisfied	Not dissatisfied nor satisfied	Fairly Satisfied	Satisfied	Extremely satisfied

Part 2: Referred Service

1. Indicate which treatment(s) you were provided with: (list of options)
2. Please indicate the method(s) of treatment delivery: (list of options)
3. Location of treatment service: (list of options)

---

4. How effective has the referred service been in giving you advice to deal better with your child/family member's issues?	Extremely Ineffective	Ineffective	Fairly Ineffective	Neither effective or ineffective	Fairly Effective	Effective	Extremely effective

5. How effective has the referred service been in improving your child/family member's well-being?	Extremely Ineffective	Ineffective	Fairly Ineffective	Neither effective or ineffective	Fairly Effective	Effective	Extremely effective
6. How satisfied are you with the information given to you by the referred service about your child/family member's treatment procedures?	Extremely Dissatisfied	Dissatisfied	Fairly Dissatisfied	Not dissatisfied nor satisfied	Fairly Satisfied	Satisfied	Extremely satisfied
7. How satisfied are you with the communication you had/have with the team of the referred service?	Extremely Dissatisfied	Dissatisfied	Fairly Dissatisfied	Not dissatisfied nor satisfied	Fairly Satisfied	Satisfied	Extremely satisfied
8. How satisfied are you with the referred services' ability to listen and understand you child/family member?	Extremely Dissatisfied	Dissatisfied	Fairly Dissatisfied	Not dissatisfied nor satisfied	Fairly Satisfied	Satisfied	Extremely satisfied
9. How satisfied are you with the frequency of contact with the referred service	Extremely Dissatisfied	Dissatisfied	Fairly Dissatisfied	Not dissatisfied nor satisfied	Fairly Satisfied	Satisfied	Extremely satisfied
10. In general, how satisfied are you with the referred service?	Extremely Dissatisfied	Dissatisfied	Fairly Dissatisfied	Not dissatisfied nor satisfied	Fairly Satisfied	Satisfied	Extremely satisfied

Fishman, K.N., Levitt, A.J., Markoulakis, R. *et al.* Satisfaction with Mental Health Navigation Services: Piloting an Evaluation with a New Scale. *Community Ment Health J* **54,** 521–532 (2018). https://doi.org/10.1007/s10597-017-0201-0

Appendix D: Engagement Survey Results

Core Service Provider Survey Results

Main challenges

All four core service providers were asked to identified key challenges and barriers that families face while accessing the CYMH system. Similar other our other stakeholder groups, wait-times for service were identified as the main challenge facing our CYMH system in Windsor-Essex.

Mental Health System Challenge	# of Responses (N=4)	% of Responses
1. Reducing wait-times for service	4	100%
2. Increased demands for programs/services	3	75%
3. Existing programs/services insufficient to meet current needs	3	75%
4. Lack of standard measurement to tools/access to data	1	25%
5. Staff training/expertise	1	25%
6. Other*	1	25%
7. Capacity/Staffing resources	0	0%
8. Lack of funding to drive innovation/quality improvement	0	0%

***Other options include**: community gaps in services for secure treatment.*

Core service providers were asked to identify in which core service were long wait-times an issue. Both ITS and Counselling and Therapy were identified as services in which wait-times were a largest issue.

Core Service in which wait-times are a challenge	# of Responses (N=4)	% of Responses

1.	Intensive Treatment Services (ITS)	4	100%
2.	Counselling and Therapy	4	100%
3.	Specialized consultation and assessment	2	50%
4.	Crisis support services	2	50%
5.	Brief Services	1	25%
6.	Family skill building and support	0	0%
7.	Targeted Prevention	0	0%
8.	Secure Treatment	0	0%

Top challenges/gaps our service area faces in meeting the needs of children, youth, and families identified by CSPs:

1. Access to ongoing counselling -development of support programs for children with dual diagnosis -development of crisis table that is more family friendly
2. Lack of services for children who do not meet criteria for RCC or other community centres.
3. Gap in service providers with placements.
4. Transportation funding for families.
5. Lack of secure treatment locally for youth under 16 (ex: GTA Robert Strong Centre)
6. Lack of adequate funding for basic core services which already exist, due to years of chronic under funding (counselling and therapy, system navigators and parent child coaches)
7. Lack of services for children and youth with aggressive and assaultive behavioral problems
8. Lack of services and resources for Complex/dual diagnosed children of all ages

Suggestions for improvement on care coordination and/or system navigation in our service area:

1. Addressing silos of funding - bouncing families between education, health and MCCSS - one plan that is responsive
2. Coordinated Service Planning needs to be formalized. CSN also needs a formal plan for lead on cases. Defined transitional care (Outreach Team).
3. Staff engagement. Collaboration improvement between organizations and service coordination is needed.
4. Fund more system navigators and ensure: a) county communities receive fair share of support and b) diversity is addressed

5. I think there should be more clarity once children pass the middle years. Could a coordinated access with a common screening tool (or the HEADS-ED tool) help to provide this clarity for self and community referrals?
6. Care Coordination - let's have a fulsome conversation about allowing children and families to continue to receive services until they have attained their service planning goals or when it makes sense to the child/youth/family instead of needing to discontinue service due to the child's age.

Top priorities for improvement in our service area over the next 3 years identified by CSPs:

1. Having appropriate specialized consultation and treatment available locally
2. Improving wait times for counselling
3. Improved integration of mental health and education
4. Improve Community collaboration among our partners
5. Live-in care/residential support services for kids in group homes and community living.
6. Transitional youth kids 16-18 crisis gaps in access to service after admission.
7. Strengthen by more adequately funding existing services
8. Increase access to services by being in various locations
9. Support development of services for very difficult to manage behavioural youth
10. Improved communication among core service providers (Are we still 0-6yrs; 6-12yrs; and 13 yrs+ and Family Respite?) for example RCC offers a walk in for families with children from 0-18. Children First offers counselling clinic 0-6 and Maryvale offers walk-in services for their population (both service providers in City and County locations) Coordinated access. We need to be clear about roles as there has been so much change (lead agency vs access mechanism vs CSP vs resolution table). If as service providers we are unclear (and front line staff are definitely unclear) then how can we expect families to navigate our system?

Suggestions for what we should keep in mind as we engage in our community planning over the next 3 years:

1. How we engage families in this conversation and in our planning. How will we remove these barriers?
2. Community connections and partnerships.
3. Engaging families and youth (e.g., YiP, PFAC committees) and staff engagement.
4. I think reviewing the core services and age groups served will help to inform our conversation. I am open to new and innovative ways to offer services. We need to be transparent in our conversations "listen to understand, not listen to respond".

Director's Forum Community Partner Survey

Main challenges

All community partner members of Director's Forum were asked to complete a short engagement survey to provide input and feedback on important issues, challenges, and opportunities for improvement in the CYMH system in Windsor-Essex over the next 3 years. Twenty-five (25) partner agencies completed the survey. Results are displayed below.

Community partners were asked to their perceptions of the main challenges or barriers families face when accessing CYMH services in Windsor-Essex. Similar to our other stakeholder groups, wait-times for programs and services was top ranked among the main system challenges in our community.

Mental Health System Challenge	**# of Responses (N=25)**	**% of Responses**
9. Reducing wait-times for service	19	76%
10. Lack of understanding about what services are available	16	64%
11. Lack of funding to drive innovation/quality improvement	15	60%
12. Existing programs/services insufficient to meet current needs	14	56%
13. Increased demands in programs/services	14	56%

14.	Limited information sharing among community organizations	13	52%
15.	Capacity/Staffing resources	12	48%
16.	Staff training and expertise	7	28%
17.	Lack of standard measurement tools/access to data to drive quality improvement	6	24%
18.	Other*	3	12%

***Other options include**: Lack of peer support for parents and youth; Stigma for youth getting support; timeliness of supports for youth; Children/youth in need of acute, intensive treatment services continue to come into the care of the CAS rather than remain with their families in their communities.*

Top 1 or 2 main challenges/gaps in our system that impact our ability to effectively meet the needs of the children, youth, and families in Windsor-Essex identified by our partners:

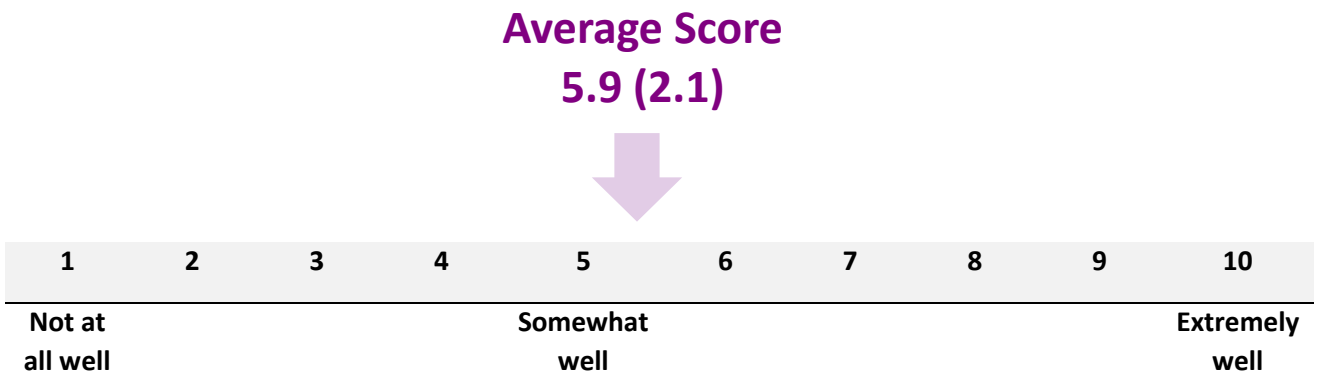
1. Staff training and expertise
2. Lack of funding to drive innovation/quality improvement
3. Lack of standard measurement tool
4. Wait Times
5. Limited information sharing among community organizations
6. We are finding that those who require immediate attention and being hospitalized are being released without the proper supports in place to keep them successful in maintaining balanced mental health.
7. Meeting the treatment needs of children's whose profile/needs are too great for our Intensive Services Programs in the community
8. Services for children with a developmental disability.
9. No need for 3 different agencies. One agency with different programs. Family system mental health. The system of the family creates the mental health of the family. So the mental health system needs look for family system supports.
10. With little understanding of all the services a family can access to support them we are unable to help families access the supports...staff need to be informed and learn to look beyond their own services
11. Insufficient funding for front line positions - therapists, CYW's. etc and supervisors

12. Insufficient funding for organization's infrastructure
13. Sharing how to navigate and access services with other partners and public.
14. Lack of crisis residential services, lack of local residential services overall
15. During COVID - people knowing that the MH of their child is not typical response, getting the services to the right families at the right time.
16. Acute, intensive services that are provided in-home to meet family needs
17. lack of services for conduct disordered, behavioural children/youth where "abandonment" to CAS is seen as the pathway to treatment.
18. Our organization works primarily with children with dual diagnosis- dev. disability and mental health. Significant behavioural issues continue to come to our local resolution table and are resulting in family breakdown with little program support in our community.
19. Very few appropriate resources for difficult to serve children, and what resources exist usually may not be deployed due to mandate issues. Also, accountabilities for these cases are unclear or disputed.
20. Mental health services need to be a multi-disciplinary, wholistic approach and mental health first aid training for all professionals in human services, and policy that reduces stigma
21. I think that the wait times for services is the biggest challenge for youth and their families.
22. Existing programs/services insufficient to meet current needs
23. Lack of funding to drive innovation/quality improvement
24. Insufficient programs and services to meet family needs including increased wait times. Additionally, training for our teachers etc such as “The Decider" who are with our children for the a large piece of their day (pre-pandemic)
25. updated training to build capacity and long wait times
26. High wait times
27. Probably wait times/ staff availability due to case loads.
28. Organizations not working as a system (duplication, competing for work). Significant duplication of services
29. Lack of awareness of what is available in community.
30. Schools are not equipped to manage some of the high level mental health issues that are presenting in schools.
31. There is still not a seamless transition from one service to another.
32. Lack of knowledge or resources for referral to families is a gap for both providers, families and the youth. Providers’ program changes occur with changes in funding and being able to keep up with new programs is difficult.

33. Mental health services for youth is lacking that wrap around holistically to those youth and families affected by serious mental health
34. Youth who sexually offend and internet addiction

Community Collaboration

Community partners were asked to rate how well children and youth services agencies work together as a system to meet the needs of families. The average score for how well community services work together was 5.9 out of 10, suggesting that there is room for improvement in our approach to collaboration.



Suggestions for improvement on community collaboration and working together as a system identified by our partners:

1. More collaboration as to which agency is best able to meet the needs of families instead of remaining in silos - then at least families also have a choice.
2. Regular communication among community organizations with decision-makers "at the table"
3. Centralized access among community partners
4. Education in schools provided starting in grade 4
5. We need to work TOGETHER
6. More collaboration driven by identifiable goals; agencies appear very much as silos in servicing the community
7. Stop putting each other down, in every discussion, at all levels, no one is better than the other. Collectively, we move forward or backwards.
8. If we have made a system decision for change implement it, try it, if it does not work, adjust it, we have completed the surveys, attending the planning meeting, drawn our charts, conducted focus groups and lets be brave and embrace change. Look at COVID we changed everything, it can be done.

9. I believe there is a willingness to work together but agencies need to know about each other's services to be able to support families - enhance service providers system understanding - similar to what use to be the "blue book" where all services were listed...or promote 211 and ensure it is complete.
10. Agencies must honour the age groupings/ populations each organization is responsible for, based on years of community planning, in order to make the pathways very clear and understandable to the public and professionals in referring fields.
11. It is getting better with time. Still a way to go.
12. Transition of care as children/youth enter adult sector.
13. Continue to share programs with each other. We need to reach those kids who do not go to therapy or are connected to an organization earlier then when it becomes a crisis I would like to see us do a campaign as all organizations instead of us each doing our own. Same messages.
14. Continue with the local resolution table to identify acute high risk cases that require intensive, short term residential stays to stabilize children/youth. Community common value based approach that above all has an emphasis on keeping children with caregivers in the community
15. I think that we are moving in the direction of increasing silos according to funding again. I think of some of the more "wraparound" philosophy that had us think outside the box and begin with the family concerns. It takes flexibility both with staff but also with the use of funding.
16. Clarity in accountabilities and mandates. Ministerial intervention when warranted.
17. A mental health situation table in Windsor with agency decision makers to explore innovative ways to walk beside individuals and families living with mental illness.
18. I think that increased communication between agencies would be helpful in avoiding duplication of services.
19. Open communication and being notified of when a service is terminating and discussing as a community how that loss service will be accommodated for.
20. Involvement of family members. Having a system navigation team member that is able to support and guide families to the correct services and programs linking them directly. Additionally that navigation member supports the family through all aspects of their care including during wait times.
21. I think service agencies work very well together
22. Everyone does great job working together. I believe it is a funding/ space issue.
23. Including all organizations that work with target population, awareness of "who does what" (there is still significant confusion and lack of awareness on the part of both organizations and clients)
24. Look at an overlap in age groups so that if a child was close in age to the next service provider they could start services there instead of starting at one agency for a short period and then have to transfer over to another.
25. Integration in communication and clear identification of each organizations roles /scope

26. Encouraging staff from child and youth agencies to familiarize themselves as part of their training or encourage staff to annually familiarize themselves with services available to children and youth by providing an incentive to further strengthen partnership amongst service providers.

Other forces that may act as challenges or opportunities within Windsor-Essex:

1. Increased fragmentation of services due to COVID. Are the school mental health services better suited to meet the needs of children across the ages? Should there be more collaboration/conversations as to pathways to community agencies? Consider what makes sense to families.
2. Inadequate funding in child/youth sector
3. Impact of COVID19 on mental wellness/isolation
4. Homelessness, addictions, incarceration
5. Service gaps for children whose needs are beyond what our Intensive Treatment services can provide for. (ie. children/youth presenting with homicidal behavior, psychosis and severe mental health); lack of funding and framework to develop this programming.
6. Poverty, diversity, transportation, COVID, knowledge of supports and how to access them. We need not just to work collectively as a mental health system but collectively as many systems.
7. There are less resources for early years to address mental health and seems the focus should be on early years and teaching resiliency, coping, parenting, etc. to address potential problems before they get bigger and more expensive
8. Our community has recently lost senior individuals and leaders who have immense clinical acumen and understanding of child and adolescent mental health and how the system should work
9. Protective measures for COVID could impact children's adaptation to their new environment and their social emotional wellbeing.
10. Increased anxiety around pandemic.
11. Windsor Essex Children's Aid Society does not take kids into care for MH purposes which leaves a significant gap that must be addressed for these children & youth
12. Clear access points to service
13. Stigma around Mental Health in general
14. COVID!
15. Lack of resources and programs for complex needs where conduct and behavioural issues are apparent
16. There are many things that influence us in Windsor-Essex. Continued pressures re: poverty, high multicultural/diverse backgrounds of families and significant pressures on young people related to drugs and alcohol, suicide, social media.
17. Local substance abuse issues, particularly opioid, greatly affecting families.

18. Economic issues arising from pandemic likely to promote family dysfunction, particularly in regards to child abuse.
19. Homelessness, trauma in the early years, access to nutritional support, in-home treatment for entire family, grief and loss services
20. Increased access and use of substances like meth, crack, heroin.
21. Social media normalization of drug use and violence.
22. Human trafficking is a much wider-spread issue than is being addressed.
23. Reducing services, (eg. CAS bed closure at Maryvale) for high needs youth have a high impact on present services that cannot meet their needs
24. Current Pandemic, back to school, family dynamics, parenting, unemployment, determinants of health, newcomers
25. High unemployment and local addiction issues
26. Drug inflow and accessibility of substances.
27. Housing always
28. COVID -19 Pandemic
29. TickToc/social media technology addictions
30. Poorly designed education system that does not support children and youth with specific mental health or developmental needs.
31. Homelessness and the risk of homelessness of youth
32. Impact of racism on youth mental health
33. Impact of behaviour online - current trend is for youth to "slut shame" on anonymous accounts, posting private pictures or videos which leads to shame, embarrassment, cyberbullying, humiliation, etc etc. Youth are struggling with fitting in amidst a very hypersexualized society and engaging in behaviours they are not mature enough to handle - this causes a wave of issues with respect to their mental health and well being as it transcends into so many ares of their life - family, school, self esteem etc.

Main priorities identified by community partners for CYMH services in Windsor-Essex over the next 3 years:

1. No wait for service
2. Clear pathways
3. Consistent application of InterRAI (across the ages)
4. Full implementation of HEADS ED tool or implement a Perception of Care tool across all agencies (need the voice of children/youth/families)
5. Creation of a Youth Hub model adequate services for "emerging adults" family support group with some peer support
6. Emergency response, support team to work with them in their actual living environment- whatever that may look like - available 24/7
7. Meeting the treatment needs of children's whose profile/needs are too great for our Intensive Services Programs in the community (ie. children/youth presenting with homicidal behavior, psychosis and severe mental health)
8. Services for children with a developmental disability (including placements).

9. Community collaboration and unified approach
10. One phone number for any service.
11. Peers, Families and Youth Voices.
12. We have wonderfully skilled and trained staff, but we are not the only experts. The more we invest in this area, the more we build capacity in many areas of our community.
13. Phone and online supports. Not replace in person supports but to provide the best experiences and outcomes when using them; measuring outcomes of this support, training staff in best practices in this area, making constant improvements and measuring outcomes again.
14. Strengthening parenting skills in early years enhancing service providers understanding of existing services funding for responsive services that directly support families
15. Increased capacity to provide outpatient counselling, increase capacity to provide System Navigation, Increased capacity to provide 24/7 mobile crisis intervention, more day services for cottage 5 type population, day treatment in the county, long term maturational services (day and residential) for severely disturbed , often aggressive, kids , usually teens.
16. Residential treatment services for complex youth
17. Increased services for DD and ASD clients
18. Increased collaboration between community partners to meet client needs system navigation, transition of care, access to services.
19. Families and children/youth know where to get assistance
20. Children/youth have COPING mechanisms and can CALM themselves
21. Promotion of physical and emotional aspects - sleep, physical activity, social emotional responses, etc.
22. Stop having exhausted, compromised and ill equipped caregivers jump through structural barriers, like insisting people come to our offices, have a mobile unit that delivers services in the home environment
23. Children/youth at risk of coming into CAS care should be treated as VIP's and provided with an urgent response pathway to acute, intensive services
24. Address systemic inequities through analysis of data that would show those families from equity seeking groups and those living in poverty are disproportionally impacted with mental health, addictions, homelessness and marginalization in our community
25. There have been announcements about additional supports for mental health being put into schools, but little dialogue about how that is integrated into a treatment system. We need to have a seamless system where people have clearer roles and can access the type of treatment and support that they need.
26. Treatment needs for children with developmental disabilities get sidelined because they have dd. Children are children. We need to look at what kinds of behavioural support can be integrated into our system. Waiting for a year to go to CPRI for an assessment is not an acceptable solution.

27. How do we support children and teens that are frequently accessing the Rotary home and other crisis oriented programs? Perhaps we can take some of the lessons we have learned from our virtual services to expand the support available to families and children.
28. Desperately need properly staffed local/regional residential resources for handling difficult to serve children and youth.
29. Greater adherence to designated age considerations for treatment within specific organizations. Additional services in SE Essex County.
30. Improved integration of youth justice leadership in operations.
31. Wholistic Indigenous approaches to maintain the good life, removing the stigma that comes with mental health, increased education and mental health first aid for all professionals in the human service industry
32. Wait Times for treatment
33. Human Trafficking
34. Access to substances
35. With COVID-19 we will see an increase and the need to address anxiety, PTSD, OCD, financial hardships over the next several years.
36. It appears there are very high needs youth in our community that we continue to struggle to service i.e through the resolution table.
37. Housing for transient youth and youth in general continues to be an ongoing concern.
38. Identification first and foremost. There is astronomical wait time from our school boards for children to be identified. This also comes at an out of pocket expense for families that many cannot afford in order for this to be completed to get the needed supports for that child. Most often this identification is coupled with various mental health conditions. Schools are situation to be a consistent lens into the various uniqueness of each child's social emotional wellbeing. There needs to be direct supports from the school to the community and not for only extreme cases for experiences of death, loss, divorce, family/peer dynamics and abrupt changes that impact our youth.
39. Wait times for children with ASD
40. More education for parents and youth about anxiety and depression
41. Quicker access to treatment for anxiety and depression and coordinating diagnosis and treatment responses with our education partners
42. Wait times for RCC, caseload over loads, not enough staff/ social workers.
43. Eliminating duplication - not starting new programs that duplicate what is already in community. Transparent sharing of data, including youth, families in our planning.
44. Youth addictions live in treatment program.
45. Better collaboration with the school boards and mental health agencies. Working in collaboration instead of an “us vs. them” mentality.
46. Supportive housing
47. Substance Misuse
48. Case Management for Youth with mental illness
49. Clear contact pathway for youth and their families

50. Looking at internet addiction, pornography addiction and health relationships among youth (we are seeing many youth unaware of the meaning of consent).

If we are able to address our priorities for children and youth mental health over the next 3 years, our partners suggested what success could look like in our community:

1. EDI data would show improvements, better outcomes for children and families in WEC.
2. Seamless system (so although we have multiple agencies, families would not feel their experience is fragmented). We can share EMHWare data as a system.
3. No wait times
4. Improved support for families
5. Less strain on the hospital system and emergency response.
6. Less youth in the justice system, less youth homelessness,
7. More successful young people in school and society
8. Better service navigation between agencies
9. Keeping high needs/profile children within our own community if those appropriate supports and programs are available.
10. Improved relationship with community partners such as WECAS in particular if more intensive services are available.
11. Good mental health supports can reduce the stress for children, youth and families, by developing healthy family relationships. When kids live in healthy families they have the best chance of becoming confident skilled adults, who have the opportunity to succeed in completing schools, at careers and in their relationships. Healthier families, in turn, lead to a healthier Windsor-Essex community.
12. Lower costs to system, stronger families
13. Kids (and their families) will be seen within 48 hours and not suffer/regress waiting for service
14. The public will see the system as responsive
15. Less youth needing residential placements out of town
16. Better supports and services for DD and ASD clients
17. Increased client satisfaction overall
18. decreased wait times, clear knowledge of what is available and where to go, seamless transitions from child/youth to adult MH
19. More free talk about MH as a norm, the benefits of therapy are talked about
20. Families would feel that their needs are responded to quickly and efficiently, i.e., one plan Children/youth would not come into care to receive services, services would come to families, children/youth in their environment to be delivered in real time
21. Families will know that they have appropriate resources available to them in a timely manner. There will be lower wait times and clearer options. Children/youth will have support that they can access both in school and in the community.

22. We will have regular information available to practitioners about best or promising practices.
23. Improved local access for service with appropriate levels of resources. Ability to transition children/youth amongst service providers with firm handoffs. Clear clinical pathways for difficult to serve clients.
24. Agencies continually working together to plan for innovation in supporting individuals living with mental health, consider Indigenous wholistic practices in living with mental health issues, consider trauma informed community with a wholistic view.
25. Increased mental wellness for the entire family.
26. Increased work and school attendance for youths and parents.
27. Waitlist would be reduce and we would have to send fewer youth/children out of our community to access services.
28. I believe our children/youth would be better able to utilize the learned strategies and coping methods. CBT & DBT are well documented therapies/strategies that can involve the whole family including school personal and and other direct services.
29. Quicker access to services when children need it, primarily in school settings where they spend the majority of their time, and where transportation, parents' work schedules etc. do not pose barriers to accessing treatment I feel would have a significant impact on graduation rates, numbers of students accessing post-secondary education and a decrease in young adults accessing mental health services.
30. Youth and families requiring less intensive treatments or shorter term treatments.
31. Schools being able to accommodate the growing mental health needs of students.
32. Less hospitalization of youth, less homelessness of youth
33. Stronger social support networks and social connectedness - perhaps a child/youth hub of services - something that has been discussed a lot over the years

Ideal "future" state for CYMH system in Windsor-Essex:

1. Immediate response, less territorial, more collaboration.
2. Evidence based services, truly Family Centred Services
3. Integrated, inclusion, responsive
4. Complete case management with follow ups once released from care involving any and all agencies required for a successful and well balanced individual
5. A unified, community wide approach to mental health services within the area so that system navigation for families is clearer along with access to services. With this, comes improved partnerships and less recidivism thus not burdening agencies as much. Ultimately, the hope would be that this would also lower wait times, less staff turnover and reduced stigma for children/youth in mental health while keeping children in their home community for services.
6. Diversity - in who is at the planning tables (doing tables not lip service tables) Diversity - in who we serve. There are still too many people that are not included in our services. Diversity - in who provides the service Diversity - in how eliminate barrios Diversity - in

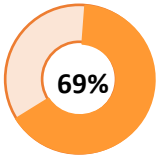
how we provide services, in person, phone etc. Diversity - how we measure success. Not just outcome. Sometime a win does not show up in a percentage and Talley. Sometimes a win is in the story, or the journey, or maybe just showing up.

7. Ideal state would be responsive not reactionary...responsive in that we give families with young children support and strengthening skills early on and therefore not reactionary by trying all kinds of programs that address mental health in later years. Basically, start at the source.
8. Kids get help / are seen within 48 hours of referral. The staff providing the service are highly skilled - crisis oriented services sufficiently available so that numbers going to emergency rooms is significantly reduced.
9. Seamless care with children and youth continuing to receive services when they reach out for them instead of being placed on a waitlist. Warm transfers from agency to agency.
10. Responsive, timely, transitional
11. Flowchart or pathways for children, flowchart or pathway for youth, normalizing MH
12. I think the system resources would be more mobile than institutional. The behavior consultants, psychologists, psychiatrists, CYW's, social workers etc would be available to children/youth and families as if they were in a treatment placement but in their home instead. A differential Response model would be in place to recognize that some of the children/youth in the community require VIP access in order to mitigate compounding risk factors.
13. I think that many families and youth feel the stigma of having to ask for help, an ideal state would be having easy to access help in a variety of formats that help people to come in and out of the system with fewer barriers. Sometimes you need a little support and sometimes you need a lot. We need a flexible, family centered model that allows us to meet people where they are.
14. Smooth care flow processes, particularly for difficult to serve clients. Current process involves many layers of organizational response, is not always inclusive in communication and does not have a mechanism for working across sectors to resolve impasses. Local/regional residential treatment resources for difficult to serve clients, supported with dedicated resources.
15. First aid training for individuals working in human services, a responsive systems with no wrong door policy to support individuals no matter where they ask for help, financial support should never be a barrier to accessing services, support the entire family unit at all cost.
16. Increased Mental Wellness
17. Youth would be able to access mental health services in a variety of manners, such as in-person, on-line, etc.
18. That our children are linked in a timely fashion with the appropriate services that support the child and the family.
19. Education for parents and educators to understand the signs of mental health issues in children so they know what to look for.
20. A clear pathway so families and educators know where to go to access services.
21. More training for professionals and a greater emphasis on working with the family system and not just the child.
22. More integration between mental health agencies and schools. Working as a fluid cohesive system.

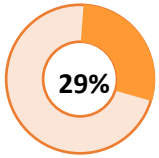
23. Easily Accessible with fast access, uncomplicated, demonstrated Positive Outcomes, Every Door is the right door, community is aware of resources
24. Building a public health policy, strengthening community action, and reorienting services toward promotion, prevention and early intervention.

Family Survey results

104 families in Windsor-Essex completed our engagement survey. Of those respondents, 69% had received or were currently receiving CYMH services in our community.

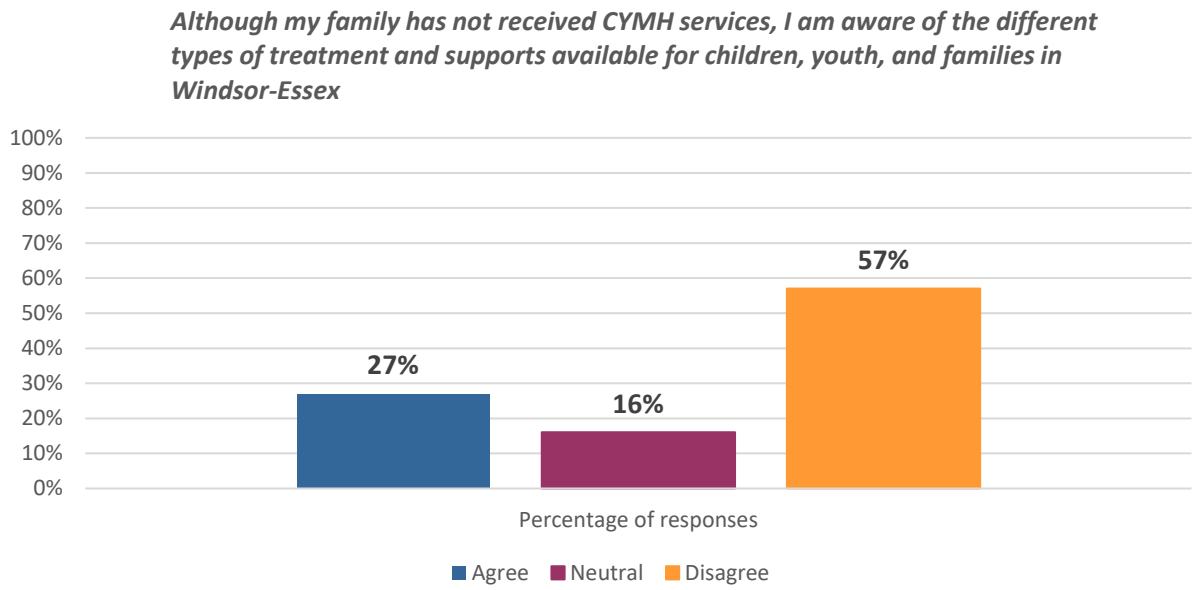


69% of survey respondents have received CYMH services



29% of survey respondents have not received CYMH services

In total, 30 survey respondents reported that they had not received CYMH services in our community. We asked these families if they were aware of the different types of services and supports that were available to families in Windsor-Essex and more than half (57%) reported that they were not aware of the supports available in our community.



Main challenges identified by families who have received CYMH services in Windsor-Essex

Similar to our core service provider and community partner stakeholders, families reported that wait-times for CYMH services in our community was the main barrier or challenge they faced when accessing services in Windsor-Essex. Other major challenges included that services that families need are either not offered (43%) or do not exist (22%) in Windsor-Essex county and not know where to go to get help the help families need.

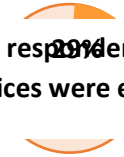
Mental Health System Challenge	# of Responses (N=72)	% of Responses
1. Wait-times for service	53	74%
2. Services my family needs are not offered in WEC	31	43%
3. Didn't know where to go to get help	23	32%
4. Services my family needs do not exist in WEC	16	22%
5. Services are not offered at convenient times	17	24%
6. Services are too far from my home	15	21%
7. Services are not provided in my preferred language	2	3%
8. Other*	11	15%

Other barriers/challenges identified by families: Services too short, only band-aid fix; Not always easy to get a referral from a doctor or forms completed for from a doctor. They need make mental health referrals easier; The intake process was long and we had to share my child's story many times before finally being connected for the necessary counseling services. We waited 6 months for services to be initiated; Services are not provided until you reach a certain age or some services cut off at a young age

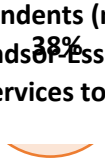
Effectiveness of CYMH services in Windsor-Essex

Based on their experience with the CYMH system in Windsor-Essex, families were asked to rate CYMH services in our community based on accessibility, quality, overall effectiveness, and their level of satisfaction with the services their family received.

Close to one third of survey respondents (29%) reported that programs and services were easily accessible and 38% reported that they were confident that that our community is delivering high quality services.

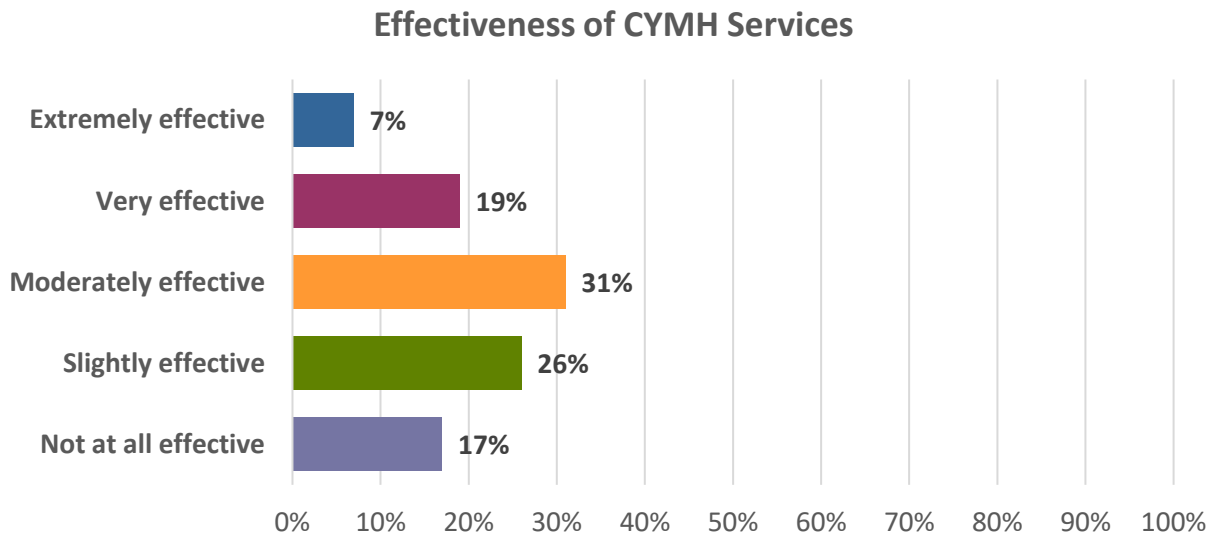


29% of survey respondents (n=21) felt that CYMH services were easily accessible

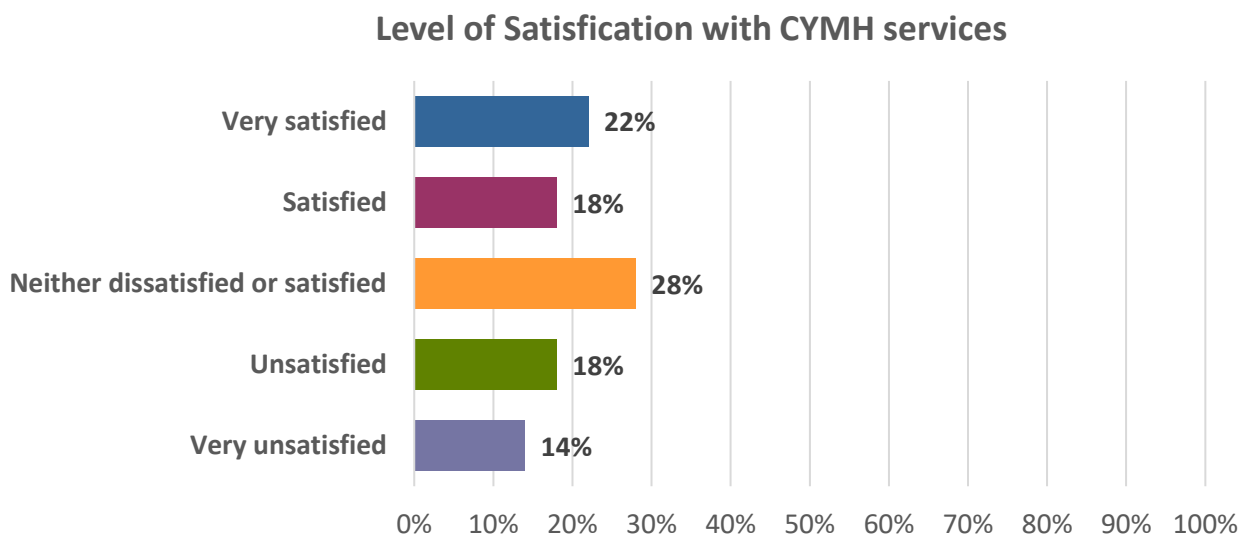


38% of survey respondents (n=27) felt confident that the CYMH in Windsor-Essex could deliver high quality services to families

Just over a quarter of survey respondents reported that the mental health services they received in our community were “very effective” or “extremely effective”, whereas 17% of families did not think services were effective at all.



Overall satisfaction with children and youth mental health services in Windsor-Essex was fairly low, with only 40% of families reporting being “very satisfied” or “satisfied” with their care. One of third of families reported not being satisfied with the services they were receiving or had received in the past.


Level of Satisfication with CYMH services
Very satisfied
22%
Satisfied
18%
Neither dissatisfied or satisfied
28%
Unsatisfied
18%
Very unsatisfied
14%
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%

Suggestions for improvement to CYMH services in Windsor-Essex

Based on their experience with the CYMH system in Windsor-Essex, families were asked what changes or improvements that they would like to see to mental health services. 55 of the 72 families who responded to the survey provided their suggestions for improvement.

1. More promotion. Flyers in the school. Centralize intake through RCC for all programs. Consistent branding for all organizations. One website for all organizations that is simple "kids mental Health .ca" or something.
2. Experienced clinicians who engage the family, not just the child. Working collaboratively with the counselor to develop realistic goals that will work for the child/family in the community.
3. Less turnover in staff so have consistent providers. Mental health services integrated in to schools.
4. Not every child will experience some form of recovery in the same time frame. Clinicians need to be able to be flexible in the service delivery model. One size does not fit all
5. Upgraded training for professionals in order to provide proper assessment and treatment. More involvement of the parent instead of treating the child in isolation.
6. I would like to see shorter wait times for families when given a referral and more mental health service options available in Windsor-Essex for children and families
7. More communication with family especially when it comes to teenagers once I hit a certain age we pretty well lose our rights to find what's going on with them with mental illness it doesn't help.
8. Services WHEN NEEDED without unnecessary gatekeeping are essential.
9. Less wait time (I think this has been achieved). Continuation of virtual services option. More streamlined intake process so services can start ASAP.
10. There is no system in our community that allows a child to start at a young age with services and continue straight through you constantly have to change organizations as they age out
11. Very long wait lists for regular 1:1 counselling at all mental health service agencies in our region and across the province.
12. A shorter wait time. And when a child says they are going to hurt themselves for the staff to take it seriously. Have a doctor that knows what they are talking about.
13. More options for teens to support mental health in their own high school so they do not need to seek services outside their community. Education for educators at the high school level to support accommodations needed.
14. More proactive outreach and programming in schools. More Supports for young children - look at high risk and focus on mental health promotion/prevention. More digital dependency interventions
15. Parents need to be reached out to before concerns arise. In our experience were we met with overwhelming information and emotions at the beginning of our joureny. I am most certain much of what I learnt in the first few meetings and interveiws I could have made myself familiar with prior through flyers, booklets, videos, websites....

16. More availability/awareness offered for lower income families.
17. Better access to services without extended wait times, better access to respite workers who will stay around long term, better access to mental health testings in the community that are not outrageously priced. Autism service wait lists are to long to be effective for kids when it's needed most.
18. Less wait to see psychiatrist, referral was over 4 months
19. Hospital social workers are not equipped to manage or evaluate a crisis situation a child has, and often times makes the emergency room visit ineffective, a waste of time and further complicates the crisis situation of the child. This needs a quick remedy because many times the crisis situation could be a life or death matter.
20. More emphasis on early intervention is needed. I first referred my son to RCC when he was in kindergarten. While they agreed that he suffered from anxiety, he was denied services since it wasn't affecting his grades. He had to get worse before he could get help. By the time he was 10 he was suicidal and unable to participate in learning at school. Had services been provided when he was younger, I believe he never would have gotten to that point, would have been more successful in school, and would be in a community school now instead of Trillium. His entire future is in jeopardy because no help was available in the early stages of his mental illness. Furthermore, very little opportunity is afforded for a child's parents to give input to their child's treatment providers. The parent's observations of their child's behaviours and responses to treatment are meaningful, and should be treated as such. Instead, they are disregarded. Plan of Care meetings should be an opportunity for parents and treatment providers to share information and observations. Instead, treatment providers talk at the parents (not to them), and parents are given no chance to speak, or even ask questions. Parents are treated as useless bystanders instead of collaborators. In sum, early intervention is needed, and Plan of Care meetings should be collaborative.
21. Provide staff that is properly trained, like hiring more staff if there is a shortage.
22. I'm sure that families whose children have severe mental health issues would need more support.
23. I would like there to be more funding from the government, so that all kids can access their needed care. I wish their were more healthcare professionals trained in a variety of areas so that a child could access one worker that met his needs rather than needing 3 separate workers.
24. we love the services provided by RCC however it is quite a distance to travel when coming from Tecumseh on a weekly basis. I wish RCC had an office in a more central location.
25. Make them easier to find
26. More workers, wider range of services, better communication within Windsor-Essex services. Better services within the hospital for treatment, faster turnaround time to see the Doctor and social worker especially during evening/night hours. Getting more doctors in so our kids dont have to change doctors so often. Accepting that children can have more than 1 mental health issue. Dont just treat 1 issue at a time, that doesn't help!!!
27. Longer programs. i feel nervous that it is only 12 weeks. i feel anxiety and wish it can be as long as needed

28. I would like to see the age for youths to be considered up to 18 years of age. Places like Maryvale and the Rotary home only serve 16-17 year old kids. Please consider raising the age 18-21 for mental health for youth.
29. Better services for teens experiencing suicidal thoughts, instead of the Rotory home!
30. I'd like to see programs in the school system available in French and English, I have a 9 yr old an high high anxiety. Testing in the school system is long waiting, we need to bring these improvements to our youth.
31. Face to face services.
32. More services, community organizations working together, streamlined referral process, more 'emergency/crisis' outreach similar to STEPS program offered at WECHC. We need someone to link to & stay connected to the individual at the onset of discharge for addiction. I feel this is a huge gap in service.
33. There are alot of suggestions and tool ideas which is needed but there's not alot of talking and letting the child to express and talk about the problem
34. much shorter wait times for treatment are needed
35. Shorter wait, knowledge of help available, more resources for kids ages 14-18. More counsellors that are covered under benefit programs. We had to spend so much money of our own for counselling. Have no idea how lower income families get help.
36. more free access. and easier to hear about.
37. I think all teachers, doctors and anyone that has contact with kids need more training to assist with difficult children .r kids with anxiety,perhaps there should be one or 2 in each school to work full time with behaviours or even have classes taught by a professional on how to cope with anxiety in the schools. And maybe teach them all how to be more empathetic when a parent reaches out for help and they actually take you seriously rather than say it is growing pains.
38. More available pediatric and adolescent psychiatrists - especially in leamington/kingsville. My daughter was referred to Leamington's one and only psychiatrist in September 2019 she had another emergency referral to the same doctor in the summer of 2020...it is now September 2020 and we've never heard from this doctor yet. Staff at leamington emergency department need to have mental health crisis training so that my anxious childs crisis does not escalate while seeking help. Pediatric psychiatry needs to be available at leamington emergency instead of being redirected to Windsor in a crisis situation More than one option for treatment should be available, whether inpatient or outpatient. If my child had a bad experience at Maryvale there should be other options for her for treatment that will still be covered by ohip, instead I was forced to seek treatment at a minimum cost of $120/hour, what about the families who could never afford that? They are forced to send their child into a facility in which the child's trauma took place? It's unconscionable.
39. I have dealt with both of my daughters mental health issues since they were preteens. We have used the teen health center which has been good. Now that they are adults, and my oldest is having extreme anxiety issues along with intense paranoia, I cannot find a single soul who will help me. I have made phone calls, I have emailed, I have even managed to convince her to go to the ER. It all

resulted in nothing. No one will help her. No one will help us. Their solution is for me to call the police on her. To say I'm heartbroken is a huge understatement

40. Increase number of child psychologists. Waited over 6 months after referral for an appointment. Ended up using the employee assistance program from work during the wait, but it is meant for triage and not any long term treatment. Having to get to know and trust another person was also difficult.
41. As a person in a position of privilege, I can pay for my problems to be solved. It may not be the same for other families and this is where our support system is lacking.
42. it needs much I'm onto a second generation of mental health and not much has changed since the first generation.
43. Long term mental health programs, Residential services needed.
44. I wish that we could meet in-person with our social worker, but understand due to covid restrictions that this is not possible at this time.
45. A more trans-disciplinary approach across clinicians. A mix of intervention types, including creative approaches to achieve engagement and availability to teens.
46. Shorter wait times to see a Psychiatrist. 24/7 coverage at the Windsor Regional Hospital Crisis Centre at the ER for Children. Expand youth mental health services to the age of 18. Many 16/17 year olds are not mature enough to be admitted to an adult mental health facility.
47. Better access to psychiatrists Access to more treatments, newer treatments Long term services for chronic mental illness
48. Better matching therapist to child.
49. I would like to see more outreach programs in the county so that we do not have to travel to Windsor. I also hope that we can continue with online care because it is still face to face and very convenient. Support groups for the children or parent and family support groups might also be something that would be helpful. To my knowledge, there are no such support groups in the area.
50. Services were great once we were in the system but getting in is difficult.
51. Services should be available to east side residents. Although bussing is possible it is extremely difficult to get children and teens with mental health issues or behavioural issues on a bus for over 1-2 hours each way for a counselling appointment.
52. More options. Less wait times to get in with a worker. More child psychiatrists especially ones that specialize or have knowledge of how to treat someone with FASD. Training for all mental health workers on FASD
53. More upstream services to focus on supports for youth
54. General family physicians need to be better informed about services and referral processes -We were able to obtain exceptional care With reduced wait time because we were able to pay privately for social worker / counselling services. Otherwise, if we didn't have those resources the org one would have been devastating.
55. Much more collaborative communication and commitment to a seamless service and support system. More awareness and assistance with service navigation. A family-driven system rather than organization driven