Organization Name: Contact Brant for Children's and Developmental Services

TPR #: 100925

Initiated In: 2019 - 2020

TP Subline and Name:

B091 - B245 / Child &Family Intervention - Operating

Detail Code and Service Name:

A352 - Coordinated Access and Intake

Legislation:

The Service Description Schedule is part of the contractual agreement between Ontario and the transfer payment agency. This Schedule outlines the services that Ontario is purchasing, with public funds, on behalf of the citizens of Ontario including specific expectations and conditions that apply, as defined in this document. The Service Provider will complete the activities as set out in Ontario completed section of this schedule. The Service Provider will also complete the activities, in accordance with any additional requirements that may be set out in the Agency Completed section.

MINISTRY COMPLETED SECTION

Service Objectives:

CHILD AND YOUTH MENTAL HEALTH SERVICES

Child and youth mental health (CYMH) services are funded by Ontario to achieve the vision of an Ontario in which child and youth mental health is recognized as a key determinant of overall health and well-being, and where children and youth grow to reach their full potential.

Ontario-funded child and youth mental health services are provided to children and youth under 18 years of age under the authority of the *Child, Youth and Family Services Act* (CYFSA). These services are not mandatory under the CYFSA but are provided to the level of available resources. Services and supports that address a range of social, emotional, behavioural, psychological and/or psychiatric problems are provided to children and youth who are at risk of, or who have developed, mental health problems, illnesses or disorders.

A Shared Responsibility: Ontario's Policy Framework for Child and Youth Mental Health, is the context within which services are provided. The Policy Framework has four goals:

- Promote optimal child and youth mental health and well-being through enhanced understanding of, and ability to respond to, child and youth mental health needs through the provision of evidence informed services and supports;
- Provide children, youth and families with access to a flexible continuum of timely and appropriate services and supports within their own cultural, environmental and community context;
- Provide community-based services that are coordinated, collaborative and integrated, creating a culture of shared responsibility; and
- Be accountable and well-managed.

The provision of core CYMH services is informed by evidence to support service quality. Evidence-informed practices combine the best available research with the experience and judgment of practitioners, children, youth and families to deliver measurable benefits. They are informed by research findings together with contextual and experiential evidence. This includes practice-based evidence, evidence-based practice, evaluation findings, the expertise of clinicians, and the lived experience of children, youth, and families.

SERVICE DESCRIPTION:

Coordinated Access:

Coordinated access is a collaborative, community-based approach to streamline access to mental health services and other types of supports. It helps children, youth and families access appropriate services and supports quickly and easily.

The intent of coordinated access is to minimize service gaps and duplication between service providers and sectors by establishing clear linkages among core service providers, and between core service providers and partners from the broader sector. In some service areas an access mechanism or core service provider may have the responsibility for managing the coordinated access process. The coordinated access process supports system-level planning and integrated case management. It is likely to involve parties and professionals such as district school boards, local schools, family health teams, psychiatrists, children's aid societies, special needs coordinating agencies, service planning coordinators and other local/regional planning and delivery partners.

Through the coordinated access process core service providers assess the needs of the child/youth and identify services to meet their needs (e.g., through access to core services or through collaboration with or redirection to other sectors that better match their needs). Developing and facilitating coordination among community agencies and partners is crucial.

Intake, Eligibility and Consent:

The intake process often represents the first point of contact for the child, youth or family into the CYMH service system and involves the collection of basic information about the child or youth requiring service. Screening, as part of intake, involves confirming eligibility based on age (under 18 years of age).

During the intake process, the client's mental health problems and presenting needs and the availability of services are also considered. As part of the intake process, the client's level of need and urgency is assessed in order to determine the appropriate service required, establish priority for service(s) based on risk, and identify the need for crisis services, where necessary. Preliminary service options are communicated to the child or youth and family at intake.

The process also includes obtaining any necessary consents regarding treatment, assessments and information sharing from the child, youth or substitute decision-maker. Consent to treatment may also need to occur throughout the treatment process.[1]

Identifying Strengths, Needs and Risks:

Core service providers are responsible for identifying the strengths, needs and risks of children and youth. The initial identification of strengths, needs and risks may occur simultaneously at intake to inform identification of initial service needs (e.g., brief services). This process involves using interviews, observations and results of standardized, evidence-informed tools to identify the strengths, needs and risks of children, youth and families. This information is then used to determine service and treatment needs, further inform triage and prioritization of children and youth for service when the level of risk is high, inform the development of a service plan, identify areas of strength to build upon and establish a baseline for outcome monitoring and measurement. Where the needs of the child or youth require longer-term interventions, a more thorough process to identify strengths, needs and risks will be undertaken to inform service planning, and this will occur throughout treatment to reassess changing service needs.

The results are discussed with the child or youth and their family in order to establish a clear understanding, engage and elicit their views and reach agreement about service recommendations. Under some circumstances, a specialized consultation or assessment, which is designed to provide advice in the assessment, diagnosis, prognosis and/or treatment of a child or youth, may be needed to fully identify strengths, needs and risks.

Child, Youth and Family Engagement:

[1]Core Service providers and staff must comply with applicable legislation including: the *Health Care Consent Act, 1996* (HCCA); the *Substitute Decisions Act, 1992;* and the *Personal Health Information Protection Act*, 2004 (PHIPA) – consult e-laws (www.e-laws.gov.on.ca) for further information.

Child, youth and family engagement is the process of partnering with children, youth and their families in the development and implementation of their service plans. It is an integral component of services delivered through the CYMH program, and part of the overall approach to operations and service delivery at all levels. Through engagement with children, youth and families, all core service providers will become more accountable to the population that they serve. Core service providers will be able to communicate the needs of children, youth and families.

Child, youth and family engagement recognizes that children, youth and families bring a unique and critical perspective to their treatment, from identifying their own needs, to understanding what strategies might be most successful to achieve their goals, and monitoring whether services are having the intended impact or outcome.

The term “engagement” implies an active partnership between children, youth and families, and core service providers. This requires that professionals listen to children, youth and families, engage them in two-way communication, and involve them in decision-making in a meaningful and purposeful way.

TARGET POPULATION SERVED

Children and youth under 18 years of age with a mental health problem who are in need of timely, effective intervention.

AVAILABILITY OF SERVICE

Intake processes to access services are available in every service area.

MINISTRY EXPECTATIONS

The following are minimum Ontario expectations for these processes:

Coordinated Access:

- Clear pathway protocols are in place to coordinate access and services for children, youth and families between and across core service providers and community partners from related sectors (including but not limited to primary care and education).
- Core service providers use information collected through collaboration with community partners to inform the approach to access and to service. The collection of information is supported by information-sharing protocols, subject to applicable legislation, regulation, and policy directives, including privacy and consent requirements.
- The impact of partnerships and collaborations with regard to child, youth and family access to appropriate services is regularly reviewed and assessed by the lead agency through their planning work.

Intake, Eligibility and Consent:

- A clear intake process is developed that supports establishing eligibility of the child or youth for CYMH services.
- The process for intake screening and delivering services to clients is documented and the written process is available to families, children and youth when they make contact.
- The client's needs and urgency of treatment/intervention is assessed using evidence-informed tools.
- Preliminary service options are communicated to the child or youth and family at intake.
- Where appropriate, the child or youth and family are referred to other services.
- A client record is created to capture information and support service planning, service delivery and ongoing case management.
- Children and youth are prioritized for service based on need and urgency, and immediate crisis support and response is provided to those at risk or in crisis (e.g., impulsive self-harming behaviour), or efforts are made to help them access to immediate services.
- To the extent possible, service planning, coordination, treatment and/or communication will occur with all involved providers, including those from other sectors. This may involve information sharing with appropriate providers, subject to applicable legislation, regulation, and policy directives, and subject to privacy and consent requirements (see Service Description Schedule A354 - Case Management and Service Coordination for related minimum expectations).
- When there is a waitlist for service, clients will be informed at intake and at regular intervals about their status on the waitlist.
- Clients and families will be provided with information, supports and resources to help them while waiting, such as contact names and phone numbers, crisis contacts, referral to other services, and community services and supports they can access.

Identifying Strengths, Needs and Risks:

- A strengths, needs and risk assessment process is in place and adapted according to the intervention and treatment needs of the child or youth or family.
- The strengths, needs and risk assessment identify and evaluates the strengths, needs and resources of the child or youth and family that are relevant to the intervention and treatment process.
- The strengths needs and risk assessment will consider the child or youth within their family, community, cultural, socio-economic and religious contexts.
- The strengths needs and risk assessment will include information already gathered from the child or youth, parent/caregiver or other practitioners subject to applicable legislation, regulation, and policy directives including privacy and consent requirements, so they do not have to unnecessarily repeat themselves.

<u>Child, Youth and Family Engagement</u>:

- Youth and families are provided with orientation on youth and family engagement policies and practices and how they can take part in engagement activities.
- Children, youth and their families are engaged in the development and implementation of individual treatment or service plans and participate in processes to identify the impact of services.
- Participatory methods are used to evaluate the outcomes of services to the greatest extent possible.
- Children, youth and their families provide input into planning, evaluation and delivery of services.
- Children, youth and their families are given the opportunity to provide feedback on their overarching experience with the service.

The following minimum expectations apply to <u>all</u> core services funded by Ontario:

- Core services and key processes will be provided in a manner that respects the diversity of communities. There are many conditions that may constitute barriers or may reinforce existing barriers to accessing services, including stigma, discrimination, and lack of cultural competency. In order to reduce barriers, core service providers should:
  - Understand the demographics of the population within the service area, including Francophone, First Nations, Métis, Inuit, urban Indigenous children and youth, newcomers and minority populations and their linguistic and cultural needs;
  - Understand the geography of the community within the service area that you are serving, including rural and remote areas;
  - Be sensitive to factors such as poverty, discrimination, and imbalances of power that influence the client experience;
  - Understand issues respecting sexual orientation and gender identity, and the unique needs and challenges faced by young people who are lesbian, gay, bisexual, transsexual, transgender, asexual, queer, questioning, or two-spirited; and
  - Discuss with the client, when beginning to develop their service plan, what cultural or other service options would support their treatment.
- Core service providers will be responsible for complying with all relevant legislative, regulatory, and policy directives, including privacy and consent requirements.
- Core services will be delivered in an evidence-informed manner, using evidence-informed tools and practices to support positive outcomes for children and youth.
- Core service providers will review clients' progress on a regular basis and adjust services, as needed.
- The approach to the delivery of core services will be strengths-based, and centred on individuals, considering and respecting their needs and preferences.
- Clients will be provided with information regarding additional community services and supports that may be suitable and, where appropriate, supported in accessing these services (e.g., through a referral).

- Core services will be delivered by individuals with an appropriate range of skills and abilities necessary to respond effectively to the needs of children, youth and their families.
- The intervention/treatment process will promote client involvement, partnership and shared decision-making so that all parties understand the goals and desired outcomes.
- Key partners in multi-disciplinary service delivery will be brought together, where appropriate, to provide an integrated and coordinated service response to help meet the needs of children, youth and their families.

Processes to Support Service Delivery

Key processes contribute to the client experience and support the delivery of core services to children, youth and their families throughout their involvement with the CYMH service sector. These processes support a coordinated, collaborative and integrated approach to the delivery of CYMH community-based services for children, youth and their families. These processes are not specific to individual core services, but are common to and support all core services. They emphasize a client- and family-centred approach to service delivery that engages children, youth and families at every turn, from the moment the need for a service is identified, through the delivery of that service, and transition out of that service, to the point at which feedback is provided on how well the service has met their needs.

Key processes to support the provision of CYMH core services to children and youth include:
- Coordinated access;
- Intake, eligibility and consent;
- Identifying strengths, needs and risks;
- Child, youth and family engagement;
- Service planning and review;
- Case management and service coordination;
- Monitoring and evaluating client response to service; and
- Transition planning and preparation.

The following minimum expectations apply to <u>all</u> key processes that support the core services funded by Ontario:

- Core service providers are expected to use evidence-informed approaches to support the key processes, the high quality of services, and effective delivery of services to children, youth and families.
- Information gathered from the child, youth, family or practitioners that is necessary for the delivery of core services is to be shared among all relevant service providers, to the extent permitted by privacy and consent requirements (including applicable legislation, regulation, and policy directives). This will promote a client-focused approach to service delivery that is responsive to the needs of clients and will help reduce the need for children, youth and their families to repeat their stories.

- Key processes are delivered by individuals with an appropriate range of skills and abilities necessary to respond effectively to the needs of children, youth and their families.

Individual Planning and Goal Setting:

Each individual will have a current Plan of Care (POC) that reflects an assessment of his/her needs and preferences. The POC will identify the specific services/supports received by the individual, the expected outcomes and be based on the principles of person-centred planning, self-determination and choice.

Service System Planning and Information Reporting

In carrying out these requirements, the service provider will work in collaboration with the lead agency in their service area, where one has been identified, to plan for and align local services to the Program Guidelines and Requirements #01: Core Services and Key Processes so that children, youth and their families:

- Know what child and youth mental health services are available in their communities; and
- How to access the mental health services and supports that meet their needs.

The service provider will report required information based on key performance indicators for the child and youth mental health service system that are relevant to the service described in this Service Description Schedule (see Data Elements).

- Service providers and lead agencies will find this information useful to strengthen and continuously improve service planning and provision, as well as monitor the impact of services on clients and in the community over time.
- Ontario will find this information useful to inform changes to policy through provincial trending and analysis, strengthen transparency and accountability across the sector, and ensure taxpayer dollars are spent effectively and efficiently.

Agency Completed Section

Plan to Achieve Service Objectives *(standard term)*: *This section is to be used by the agency to describe how they will achieve the identified service objectives and respond to specified program/ service features. Comments can be made in a bullet point or narrative format and should have sufficient detail in order that the reader can appreciate the critical aspects of the service.*

- Description of how Service Objectives will be implemented.
  - As the Access Mechanism for child and youth services, provide clear linkages and coordinated access among core service providers and across other sectors
  - Provide children, youth and families with timely information and access to a continuum of appropriate services and supports, promoting optimal child and youth mental health and well-being

- Active engagement and partnering with children, youth and families starting with intake and listening to their story; having them identify their strengths, needs and priorities; and engaging them in decision making about their service choices
- Contact Brant services include: provision of general community information; intake for Ministry-funded child/youth mental health services, developmental services, Coordinated Service Planning and FASD supports; triage and referral to appropriate community cross-sectoral services; on-going service navigation and service coordination supports to children, youth and families; facilitate Case Resolution for Complex Special Needs children and youth; coordinate RPAC as appropriate
- Intake process includes determining eligibility; completion of the CYMH interRAI; the Common Tool for Intake to capture the child/youth/family's story including strengths, presenting needs and risks; assessing prioritization for need/urgency of services; creation of client record; service options as well as community resources are provided; engaging and partnering with the child/youth and family in the development and implementation of their service plan; informing of wait lists and with information/connection to resources while waiting; secure informed Consent for referrals to services and service coordination; and on-going service planning, coordination and navigation including transition preparation and planning
- Services and supports are provided to children and youth presenting with a range of social, emotional, behavioural, psychological and/or psychiatric problems, as well as for children with developmental disabilities, Autism, FASD and other special needs who may also require mental health services
- Provision of services are coordinated with community stakeholders to support collaborative and integrated approach (as reflected in protocols outlining partnerships and intake/service coordination processes); bring together multi-service service providers, as appropriate, to support an integrated and coordinated response to meet clients' needs.
- Support system planning and integrated case management through Access services and as the Coordinating Agency
- Collaboration with Lead Agency and other Core Services to implement CYMH services and system planning

- <u>Description of the specific services and service capacity</u>.
    - Coordinated access/single point access for child and youth mental health services, developmental services, Coordinated Service Planning and FASD supports:
        - Eligibility confirmation and Intake including identification of strengths, needs and risks as well as Prioritization for services
        - Gain informed Consent for referral of intake package to appropriate services, as well as provide information/linkage to other community resources across sectors
        - Child, youth and family engagement is primary through family-centered service approach
        - Individual planning and goal setting – begins at intake and on-going through service coordination supports

    - Service system planning with community partners; reporting of data and information from centralized client database
    - Facilitate the Brant Case Resolution Mechanism
    - Coordinate RPAC for Brant children and youth, as legislated in CYFSA
  - Lead Agency for Coordinated Service Planning in Brant. Collaborate with five other Brant organizations (including the CYMH Lead Agency) to provide a Service Planning Coordinator as the key service navigator/contact person for families with a child/youth with complex, multiple needs. Collaborate with other cross-sectoral stakeholders to provide coordinated service planning as a best practice and as a part of each professionals' role for all children and youth served (as outlined in the Brant Community Coordinated Service Planning Protocol).
  - As part of the Coordinating Agency mandate, provide FASD supports through the FASD worker to help families with a child/youth with FASD or suspected FASD to navigate the system and develop a coordinated service plan, as well as work with community to increase awareness of FASD and increase capacity to support children and youth with FASD
  - Centralized database used for Intake record as well as Coordinated Service Plan – this decreases families having to repeat their story as information can easily be shared, with consent
  - Manage the Brant Haldimand Norfolk Community Information Database, www.info-bhn.ca to provide easy access to information on local services and resources

- Specialized capacity and expertise
  - 19 years' experience providing single point access services including coordinated information, intake and referral, and service coordination
  - Highly knowledgeable staff with expertise to respond effectively and provide information to children/youth/families, partner stakeholders, and the broader community
  - Staffed by experienced individuals with the appropriate abilities and skills to respond effectively to children/youth and their families, complete intake process and triage to appropriate services, as well as work collaboratively with community stakeholders on behalf of an integrated service plan for clients
  - Staffed by experienced and skilled individuals who are respectful and sensitive to the social, linguistic and cultural diversity including Indigenous people, as well as individual diversity and abilities of children, youth and families; respectful of privacy and confidentiality and sharing information based on informed consent received
  - Provide leadership and build capacity on service coordination as the Coordinated Service Planning Lead Agency
  - Quality assurance through regular review of child/youth/family feedback using the Quality Satisfaction Survey developed with the Centre of Excellence, as well as community feedback on services and partnerships

- Policies and procedures to ensure accountability as well as operating under evidence-informed/best practices; includes policies and procedures regarding access to and sharing of personal information with consent
- Strategic directions established by a diverse community Board of Directors are used to drive and align service activities; the Board and staff monitor activities and data in meeting strategic directions
- Quality provision and management of information services based on policies and AIRS Standards

- Individual planning and goal setting
  - Individual planning and goal setting begins with the intake meeting with the child/youth/family who identify their strengths, needs and goals; this continues through the referral process and on-going service coordination supports
  - The intake referral package identifies supports being received by the individual as well as services being requested and previously received; the intake also identifies the expected outcomes of the referred service (goals) and is the initial development of the individual service plan
  - The intake record is updated as required, and Case Notes are regularly documented regarding the on-going development of individual planning and goals which are coordinated with the child/youth/family and other stakeholders
  - A Coordinated Service Plan is developed for children and youth with multiple, complex special needs.

- Community linkages and service collaboration (where appropriate).
  - Inter-agency Protocols with children's mental health agencies, other Ministry-funded agencies, and other sectors (including health and education) to support ease of access to services, sharing of information with consent, and coordinated service planning
  - Single point/coordinated access for child and youth services includes mandate to facilitate Case Resolution as well as RPAC reviews in Brant.
  - Lead Agency for Coordinated Service Planning in Brant; referral to a Service Planning Coordinator or FASD Worker appropriate
  - Manage the Brant as Haldimand Norfolk Community Information Database/website, www.info-bhn.ca; this resource is also utilized by 211 Ontario to provide information on Brant, Haldimand and Norfolk services through their 24/7 phone line and website
  - Coordinate the production and distribution of Your Guide twice annually in collaboration with community stakeholders in Brant, Haldimand and Norfolk; Your Guide is a printed and web-based publication outlining free workshops, courses, groups and events for children, youth and families such as parenting programs, pathways to services, Suicide Prevention resources and training
  - Actively participate in cross-sectoral system planning at the Strategic Leadership Table for children and youth services; facilitate the development and annual review of community protocols that support access and coordination including for children and youth with complex needs; provide an

annual System Report of demographics and statistics using our centralized client database to inform community planning
- Coordination with the other Contact Agencies/Access mechanisms and Coordinating Agencies regarding access services and coordinated service planning
- Coordination with the Lead Agency (Woodview) and core service providers regarding CYMH services and planning
- Co-located with the Lead CYMH Agency, Developmental Services Ontario satellite office, and Brant FACS satellite office; this has strengthened linkages and partnerships regarding clear pathways and seamless access to services

Service Location *(standard term):*
- Address: 643 Park Road North, Brantford, ON, N3T 5L8
- Type of location: Agency office.
- Area served: City of Brantford, County of Brant, Six Nations of the Grand River, and Mississaugas of the Credit First Nation

Method of Evaluation *(standard term):*
This section identifies the methods used to determine the program's success in meeting the stated Service Objectives. The agency will also evaluate relevant Service Delivery features including quality. Evaluation will provide the organization with needed information to self-correct identified gaps in the achievement of the stated service objectives.
Describe the agency's evaluation processes with specific reference to how:
- **Service objectives will be evaluated**
- **Quantitative (outputs) and qualitative (outcomes) evaluation will be implemented.**

    - Monthly monitoring of service statistics provided through client database (including but not limited to: unique clients, gender, intakes, referrals, requests for information, service coordination, Case Resolution and RPAC); comparison to previous years and monthly monitoring of service targets
    - Monthly monitoring of pressures reflected in wait lists with community partners, especially related to re-prioritization of clients for immediate service
    - Regular and on-going review of client information in the client database for quality referral reports
    - Submission of BI data to the Lead Agency and on-going support of the evaluation and outcomes of this collated information
    - Ongoing evaluation and feedback from consumers utilizing the Quality Satisfaction Survey (QSS) developed with the Centre of Excellence; quarterly QSS Reports reviewed by staff and Board re quality assurance; QSS submitted to Ministry
    - Annual Budget approval by the Board of Directors; accountability through Quarterly Reports to Ministry and Board, including budget, targets, outputs, QSS and feedback

- Financial accountability through monthly monitoring of expenditures and targets by the Board of Directors and CEO; annual Audited Financial Statement; and annual expenditure reporting (TPAR) to Board and Ministry
- Risk Management monitoring through annual review of related policies, insurance, and any Serious Occurrences by Board and CEO; accountable through reporting to Board and Ministry
- Annual review of Governance Policies, By-Laws, and Operational Policies by Board, CEO and staff
- Annual system review with partners of inter-agency Protocols as well as community Protocols and processes
- Regular communication and review with individual community partners regarding access criteria and prioritization
- Monthly Wait List and In-Service Reports to community partners re referred clients' status as waiting, in-service, or discharged to ensure tracking of clients' status re service and supports
- Evaluation and feedback from community stakeholders using the Community Partner Survey on Service Delivery as well as the Working Together - Reflection on Coordinated Service Planning by CSP Providers, Participants and Service Planning Coordinators
- Regular communication and review with the other Contact agencies/Access agencies and Coordinating Agencies regarding Access and Coordinated Service Planning/FASD services outputs and outcomes
- Follow expectations for Making Services Work for People as well as Agency Governance service description schedules