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:

A354 - Case Management and Service Coordination

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:

<u>Service Planning and Review</u>:

This process involves developing a service plan for service delivery to meet the needs of the child/youth, and reviewing progress in meeting the goals of the service plan. This service plan identifies the child or youth's needs to be addressed and the services to be provided. The plan also outlines who has responsibility for services (where multiple service providers are involved), and goals and objectives to be achieved through the services provided. The service plan must be developed, reviewed and updated in collaboration with the child or youth and family, and, if appropriate, the team of providers who are involved in the child or youth's life. The service plan is used to monitor client outcomes and status of current client need as services are being delivered, in order to account for changing needs or priorities. Service plans are to be reviewed on a regular basis by core service providers and updated when needs change, services are added or changed or services are complete.

Referrals may be part of a service plan or occur following the intake process, as additional needs are identified or if current services are not meeting the needs of the child or youth. Referrals may also occur when the child or youth transitions out of the CYMH system, and has ongoing needs for services or treatment. The objective is a smooth transition. Rather than simply providing information to the client, assistance is provided for the client's transition to a new provider and other services, as appropriate. The assistance to transition is supported by providing appropriate background information, as needed, to expedite the transfer to other services, reducing the number of times the client and/or their family needs to repeat their story, connecting directly, where appropriate with the new service provider, and by providing follow-up after

transition/exit (see Service Description Schedule A354 – Case Management and Service Coordination for minimum expectations).

Case Management and Service Coordination:

Case management and service coordination are processes which place the child or youth and family at the centre and bring together the key partners in service delivery to provide an integrated and coordinated response to best meet the needs children, youth and their families. Case management and service coordination are particularly important where a child or youth's needs are complex (level three or four on the continuum) and where they receive multiple services from one provider, or multiple services from multiple providers and/or sectors.

Case management and service coordination involves:

- Identifying the parties responsible for executing a service plan;
- Monitoring progress;
- Adjusting services;
- Connecting with other service providers, as needed;
- Helping with issues and questions as they arise;
- Planning discharge; and
- Measuring impact and outcomes.

These processes are adjusted, based on needs and complexity. The case management function addresses the client's service plan, while the service co-ordination function addresses the need for coordination among multiple agencies. Effective case management/service coordination requires communication between and among providers and sectors and the identification of clear pathways to care. Where multiple services from more than one provider are required to meet the child or youth's needs under their service plan, one provider should be identified as the primary provider. The primary provider is responsible for contacting the other service providers to discuss service delivery requirements and coordinate services. The primary provider may be the lead agency, another core service provider, service coordinator, or a cross-sectoral provider.

Children/youth with multiple and/or complex special needs may require multiple specialized services in addition to core services. It is expected that clients are connected with special needs coordinating agencies, when they are established, to develop pathways with the goal of providing coordinated services for children and youth with mental health concerns who also have other special needs.
This could include referring patients who are newly identified as having special needs beyond mental health needs services to the local special needs coordinating agency as they may also benefit from additional supports provided through coordinated service planning. Where the child/youth is a recipient of these services this would involve

working with the family's service planning coordinator to include core services in the child or youth's coordinated service plan.[1]

Monitoring and Evaluating Client Response to Service:

The process of monitoring and evaluating a child or youth's response to service, perception of care, service experience, as well as the clinical outcomes of service, is carried out through a variety of means, including interviews, observations and repeated administrations of standardized, evidence-informed tools. Both quantitative and qualitative information is used to monitor impacts and make appropriate adjustments to services. Any such adjustments are discussed with the child or youth and family, before being incorporated into the individual's service plan.

Ongoing monitoring provides evidence as to whether treatment is having the intended impact and, if it is not, ensures the necessary changes in treatment will be reflected in the service plan. The process may identify the potential need to increase or decrease the intensity of services and can be used to inform transitions to more or less intensive services or treatments or for discharge planning. Ongoing monitoring also provides a basis for outcome measurement and reporting.

Transition Planning and Preparation:

Transition planning prepares children, youth and families for transitions between core services, to other community supports, to adult mental health services, back to school or for discharge from services. Planning is accomplished through the setting of clear goals for treatment, as well as ongoing analysis and use of information to track progress and determine timing for transitioning to a new service or for discharge. It is important that transition planning and preparation occur at an early stage for all core services.

Transition planning and preparation supports continuity of care and results in minimal disruption to treatment gains. Early planning and preparation may involve the identification and provision of transition supports when a child or youth's needs are chronic. It is important for core service providers to recognize the chronicity of some cases and to be prepared to facilitate the transition of youth into the adult system in a way that limits service disruption for the client.

- Following discharge from services, a follow-up with the client is performed as a 'check-in' to monitor status, facilitate re-entry to the service system, if required, and/or provide time-limited support to help discharged clients connect with or access

[1]A service plan is distinct from the coordinated service plan being implemented under Ontario's Special Needs Strategy. Through coordinated service planning, children and youth with multiple and/or complex special needs will have one coordinated service plan that takes into account all of their goals, strengths, needs, as well as all of the services that they are and will be receiving. Coordinated service planning does not replace planning for a clinical service, such as core services. If a child/youth has multiple and/or complex special needs, it is expected that information from clinical service plans will be shared, with consent from the parent/guardian, for the purpose of the development, implementation and monitoring of a special needs coordinated service plan.

needed services. Planning for discharge or transitions between services should start as early as the initial service plan.

Following discharge it is considered a best practice that follow-up contact be made within three to six months of discharge to discern status and facilitate service access where needed. At the point of follow-up, if the child or youth reports or displays deteriorated functioning, it is determined whether the service plan needs to be re-opened or the child or youth's needs and strengths need to be reviewed and services recommended based on the reassessment results. Where appropriate the client may re-enter service to address new or unmet needs.

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

Service coordination processes are provided in every service area.

MINISTRY EXPECTATIONS

The following are minimum Ontario expectations for these processes:

<u>Service Planning and Review</u>:

- The service planning and review process focuses on the child or youth's strengths and resources, within the context of their family, agreed-upon goals and objectives, the management of safety and risk issues, and what can reasonably be achieved. This is informed by an assessment of strengths, needs and risks, and on the professional judgment of the core service provider.
- Each child or youth and family has a written service plan developed in collaboration with the child, youth or family as appropriate, to guide and monitor the intervention and treatment process (Where multiple sectors are involved see Service Description Schedule A354 – Case Management and Service Coordination).
- Information contained in the service plan is subject to applicable legislation, regulation, and policy directives, including privacy and consent requirements.
- Protocols for communicating changes to the service plan to clients and issues that may be related to all service providers involved must be clearly established at the outset.
- Intervention, treatment and referrals are reviewed and recorded in the child or youth's service plan on a regular basis. The review of intervention and treatment is used to modify the child or youth's service plan where necessary.
- There are written policies and procedures with other service providers that define the relationship and referral process to intake points/processes in the service system.

- Where a referral occurs, the transition is supported by providing background information, as needed, to expedite the process; reducing the number of times the client and/or their family needs to repeat their story; and connecting directly, where appropriate, with the new service provider. These activities may involve sharing client information with appropriate providers, subject to applicable legislation, regulation and policy directives, including privacy and consent requirements.
- The service plan makes provision for transitions and follow-up from service, between services, and where the overall responsibility for treatment shifts to another service provider.

Case Management and Service Coordination:

- Service coordination will take place through collaboration with all core service providers who are involved in the service plan.
- Case management and service coordination includes the clear identification of respective roles and responsibilities of all service providers involved, and the documentation and communication of these across involved providers and to the child, youth and their families.
- Case management and service coordination activities will respect the preferences of children, youth, and their families.
- Where appropriate, core service providers will work with the education sector to support service delivery that minimizes school transfers and maintains education programming.
    - Where a core service provider is the primary provider, they will, to the extent possible:
    - Provide the family with a stable point of contact from the start of their involvement in service through to their transition out of service or between services;
    - Work with other involved providers to support service planning, coordination and treatment;
    - Monitor services regularly to ensure that services are scheduled and delivered according to the child or youth's service plan; and
    - Maintain effective and clear communication with involved parties, including the child, youth and family.
- Lead agencies should work with core service providers, and broader sector partners to establish written policies and procedures that define case management/ service coordination in the service area. These should also describe the relationship(s) with, and referral processes between other intake processes in the service system to support effective pathways to, through and out of care. Written policies and procedures must be transparent to all parties, including clients and families.
- Where a child or youth has multiple and/or complex special needs and requires multiple specialized services in addition to core services (e.g., rehabilitation services, autism services or respite supports), their family may benefit from additional supports provided through coordinated service planning and should be referred to the special needs coordinating agency in their service delivery area.
    - It is expected that clients are connected with special needs coordinating agencies, when they are established, to develop pathways with the goal of

providing coordinated services for children and youth with mental health concerns who also have other special needs.
    - Clients who are newly identified as having special needs should be referred beyond mental health needs services to the local special needs coordinating agency as they may also benefit from additional supports provided through coordinated service planning.
    - Service providers will work with the family's service planning coordinator to include core services in the child or youth's coordinated service plan where the child/youth is a recipient of services available through the local special needs coordinating agency.
- When a core service provider takes a lead or substantive role in a community service plan on behalf of a child or youth involving multiple agencies and/or informal supports, services are coordinated and integrated.

Monitoring and Evaluating Client Response to Service:

- The core service provider will review and record intervention and treatment on a regular basis.
- The core service provider will share information among involved service providers to monitor and evaluate the client's response to services. Information sharing will take place subject to applicable legislation, regulation and policy directives, including privacy and consent requirements.
- The review of intervention and treatment, including the use of evidence-informed tools, is used to modify the service plan, if necessary.
- Services are designed with intended clinical outcomes, and progress towards clinical outcomes is measured, evaluated and services adjusted as needed.

Transition Planning and Preparation:

- Planning for discharge and transition begins from the point when a child or youth enters into treatment or service.
- Discharge is a planned process in which core service provider staff and the child or youth and family negotiate a plan for case closure.
- Where case closure is unplanned, efforts are made to inform and involve the client, as appropriate under the circumstances.
- There is a written discharge report for each child, youth and/or their family, with details appropriate to the nature of service provided.
- Where a child/youth is transitioning to another service provider, or to another service system (e.g. education system), the core service provider should work in partnership with all (including the child or youth, their family, and involved providers) to develop a seamless transition approach. This will support reducing the number of times the child, youth and/or their family needs to repeat their story.
    - Transitioning to another service provider must be planned in advance, agreed-upon between child or youth and family, and all the providers, and communicated to everyone involved.

- Where appropriate, core service providers will work with the education sector to support service delivery that minimizes school transfers and maintains education programming.
- These activities may involve sharing client information with appropriate service providers, subject to applicable legislation, regulation, and policy directives, including privacy/consent requirements.

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 identified 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.
  - Provide children, youth and families with access to a flexible continuum of timely and appropriate services and supports as the Access Mechanism for child and youth services; provide clear linkages and coordinated access among core service providers and across other sectors and help reduce families having to repeat their story
  - The development of the service plan starts at intake by identifying the child/youth/family's strengths and needs, services involved or waiting and who has responsibility for each service, new referrals, and initial goals. The intake information is updated and available for further referrals as needed.

- Often as the stable point of contact as the agency that families start with (Access Mechanism), we support children, youth and families through services as well as their transition out of services (by referrals to new services, and on-going-service coordination with warm transfers, planning for transitions, and on-going information about resources).
- Continued involvement as the primary provider or active participant in service coordination as well as providing help with issues and questions as they arise.
- Provide children, youth and families with timely information so that they can make informed decisions. 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 – the intake process initiates the development of the service plan by identifying the needs to be addressed and the services to be provided; strengths to build upon, and involved services. Ongoing monitoring of the child/youth/family's response to coordinated services.
- Provision of services are coordinated with community stakeholders to support collaborative and integrated approach (as reflected in Access Mechanism 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. Transitions are supported by the intake information and Coordinated Service Plans, which are maintained in our centralized database, and reduces the need for families to repeat their story.
- The Service Coordination process is especially important when the child/youth's needs are complex or they are receiving services from multiple providers and sectors – Contact Brant's Access role across sectors supports this, as well as our role as the Lead Coordinating Agency and as the Case Resolution Mechanism. We identify parties involved in the service plan, facilitate case conferencing, actively participate if we are not the primary provider, help navigate and refer to new services through a clear access pathway, and provide leadership in transition planning. We work closely with the Lead CYMH Agency, which we are co-located with, around these children and youth with multiple/complex needs.
- 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
- 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 Mechanism for child and youth mental health services, developmental services, Coordinated Service Planning and FASD supports:
    - Provision of general community information.
    - Eligibility confirmation; Intake including identification of strengths, needs and risks as well as Prioritization for services

    - Triage and referral to appropriate community services. Gain informed Consent for referral of intake package to appropriate cross-sectoral services, as well as provide information/linkage to other community resources across sectors
    - On-going service navigation and service coordination supports to children, youth and families
    - 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
    - Centralized database used for Intake record as well as the Coordinated Service Plan – this decreases families having to repeat their story as information can easily be shared, with consent.
  - As the Lead Agency for Coordinated Service Planning in Brant, provide leadership in services that are coordinated, collaborative and integrated, as well as in transition planning and supporting transitions.
    - 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).
    - Promote the use of the Coordinated Service Plan template as the tool for writing any coordinated service plan
  - 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
  - Manage the Brant Haldimand Norfolk Community Information Database, www.info-bhn.ca to provide easy access to information on local services and resources
  - Actively support system planning and integrated services through community committees such as the Strategic Leadership Table (for child, youth and family system planning), and the Ontario Health Team

- Specialized capacity and expertise
  - 19 years' experience as the Access Mechanism and providing services including coordinated information, intake and referral, and service coordination. We are often the child/youth/family's stable point of contact

from the start of their involvement in service through to their transition through or out of services.
    - Provide leadership and build capacity on service coordination as the Coordinated Service Planning Lead Agency
    - 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 each client
    - 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
    - Quality assurance through regular review of child/youth/family feedback using the Quality Satisfaction Survey developed with the Centre of Excellence, the provincial MPOC used in Coordinated Service Planning, 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

- <u>Individual planning and goal setting</u>
    - Individual planning and goal setting begins with the intake meeting with the child/youth/family to 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 or supported with community stakeholder and the family.

- Community linkages and service collaboration (where appropriate).
  - Inter-agency Protocols for both Access and Coordinated Service Planning 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, as 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, Coordinated Service Planning supports
  - 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