SECTION 23 WORKING GROUP SUMMARY

Final Report

July 2017

TORONTO
moving on mental health
LEAD AGENCY

CONTENTS

MESSAGE FROM THE CO-CHAIR

We are pleased to present the first-year recommendations from the Education Partnership Table to the Lead Agency for consideration within the larger Moving on Mental Health Community Mental Health Plan (CMHP), and Core Service Delivery Plan (CDSP).

The Education Partnership Table was convened in September 2016 to examine how to effectively partner with Boards of Education to ensure the best delivery of mental health services for children and youth. The Table identified four priority areas to address during its 2-year mandate - Section 23 Programs, School Focused Priority Access Initiatives, Early Years, and School Development Projects. Section 23 Programs and School Focused Priority Access Initiatives were prioritized for year One and work groups were created for each area with memberships representing expertise in the content areas being explored.

In particular, the Section 23 work group was co-chaired by mental health and education representatives and it was convened monthly from September 2017 – June 2017. The group completed a SWOT analysis and environmental scan; mapping exercise; literature review; community survey; and a large focus group with key stakeholders. The group was exceptionally engaged and members remained focused on a vision of improving the system - throughout the process.

Recommendations that evolved from this group included:

- Re-Visioning the Program Model
- Develop a System Approach to Program Development and Oversight
- Develop Mechanisms to Improve Accountability
- Identify Clear Pathways and Foster Sustainability
- Create a Co-ordinated and Centralized Access System
- Create Co-ordinated and Integrated Transition Supports

Cheryl Webb
Executive Director
Adventure Place

OVERVIEW

The Section 23 Workgroup began meeting on October 20, 2016. Members meet monthly with the following mandate**:**

The **mandate** of the Section 23 Work group includes the following key areas:

Evaluating current utilization of services;

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

Evaluating Current Utilization of Services

As a means by which to evaluate the current utilization of Section 23 services across the city of Toronto, the workgroup focused on the following tasks:

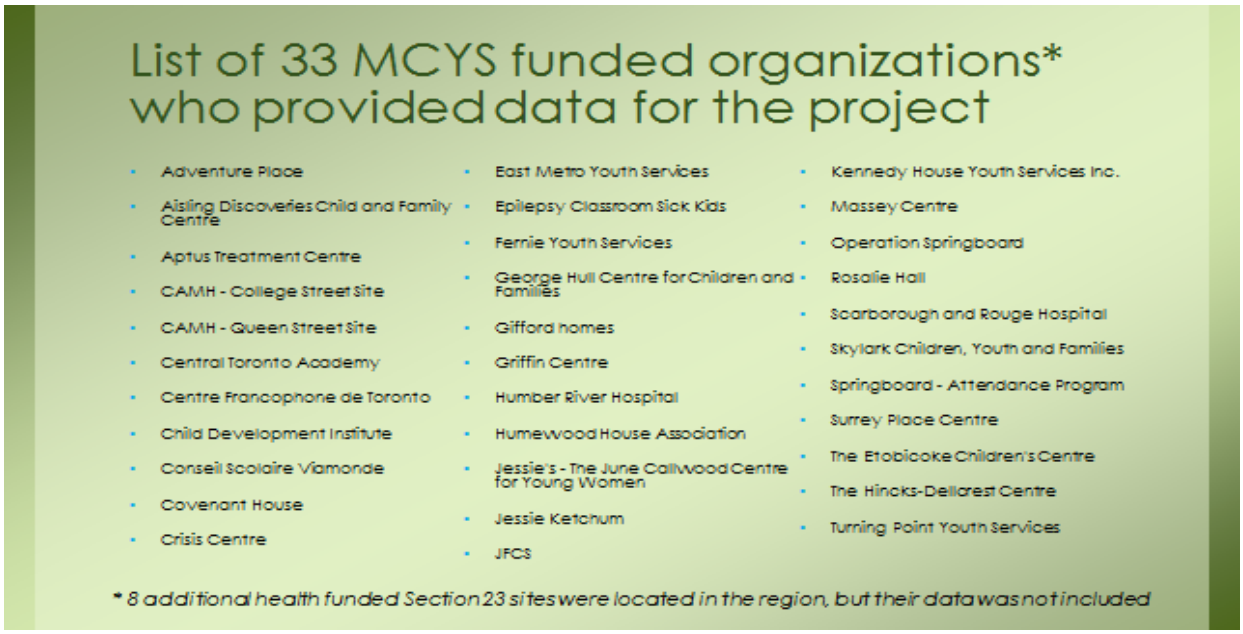
- Mapping current services;
- Identifying strengths and gaps within the current system;
- Developing an understanding of "best practice" related to day treatment access mechanisms, transitions processes and referral options in addition to other options for the delivery of intensive services;
- Identify mental health/education Section 23 service priorities;
- Adopting a "systems" approach to the planning, description, implementation and evaluation of Section 23 services.

Mapping

The work group mapped all Section 23 programs in Toronto that are co-funded by Ministry of Children and Youth Services and Ministry of Education (MCYS) (See map in Appendix 1). Where the map provided a clear understanding of where programs are located, it failed to inform on issues of capacity. As a result, the Ministry of Education provided additional program information and the work group developed a short survey to help gain a true understanding of scope and capacity across the city. The survey was sent to all of the agencies delivering Section 23 programs and the **response rate was 100%.** The survey results indicated that during the 2016-2017 fiscal year:

- **How many Section 23 locations exist across the city?**
  There were a total of 64 Section 23 sites distributed across the Toronto* (21 elementary, 34 secondary, 1 French site, 4 hospitals, and 4 mixed), at least 8 of these sites are not MCYS funded – for a total of 56 MCYS funded Section 23 sites. (see map – Appendix 1)

- **How many agencies deliver Section 23 programs across the city?**
  A total of 33 agencies deliver MCYS funded Section 23 services across the city



- **How many locations are there? Are centres distributed well across the city?**

How many Section 23 sites exist across the city? And how are they distributed[1]?

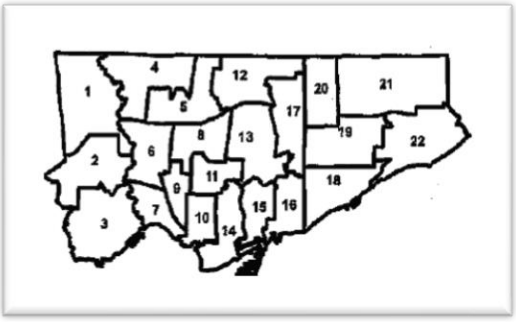
- There are a total of 64[2] Section 23 locations distributed across the city (21 elementary, 34 secondary, 4 mixed, 4 hospital, and 1 French)
  - In the North there are 7 elementary, 2 secondary, 2 mixed, 1 hospital and 1 French (13)
  - In the East there are 4 elementary and 11 secondary (15)
  - In the South there are 8 elementary, 18 secondary, 2 mixed, and 3 hospitals (31)
  - In the West there are 2 elementary and 3 secondary (5)

[1]Data taken from *Section 23 Programs 2016-2017 Map* produced by the planning division of TDSB June 2016

[2]The total count of 64 includes both MCYS funded and health funded sites

The densest geographic region is in wards 14 and 15 located in downtown Toronto which contains 13 sites combined.

There are two wards which do contain a single Section 23 site (3 and 18)

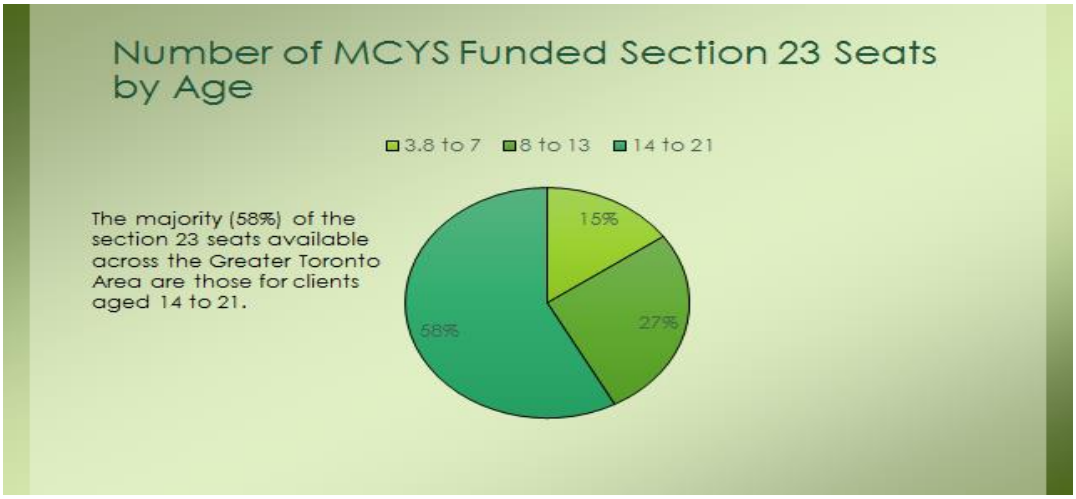


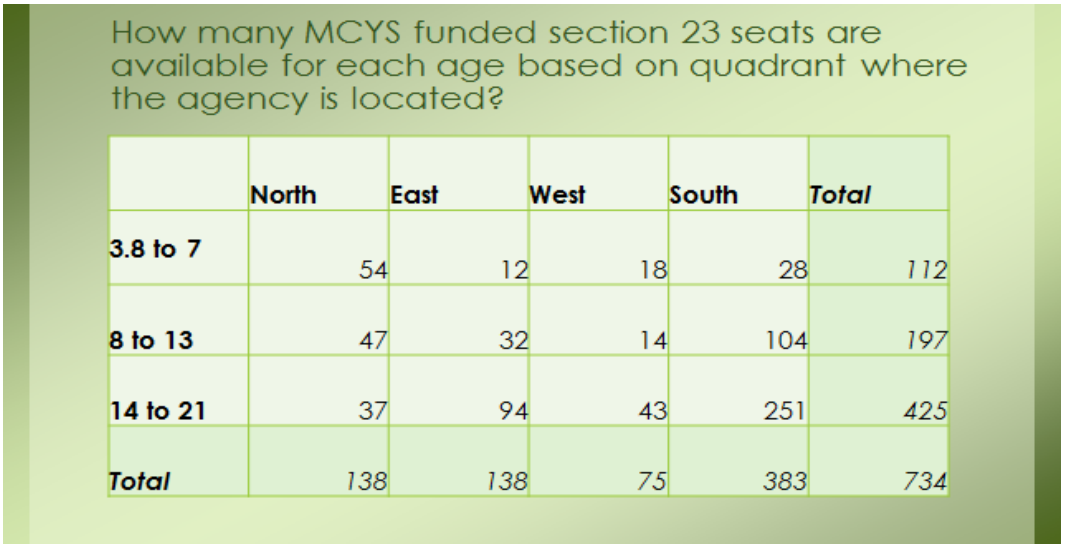
- **What is the city-wide capacity for Section 23 programs?**
  There are 734 Section 23 seats across the city of which approximately 80% were occupied during the 2016-2017 fiscal year

- **Are Section 23 seats distributed well by age and geographically?**
  The majority of seats available across the city are for the 14+ age range (58%), and the lowest proportion of seats are for those 3.8 to 7 years of age (15%)

  19% of total seats are in the North quadrant; 19% in the East quadrant; 10% in the West quadrant; and, 52% are located in the south quadrant.

  *Further information is needed to assess needs in each area to determine whether the distribution ratios are correct.

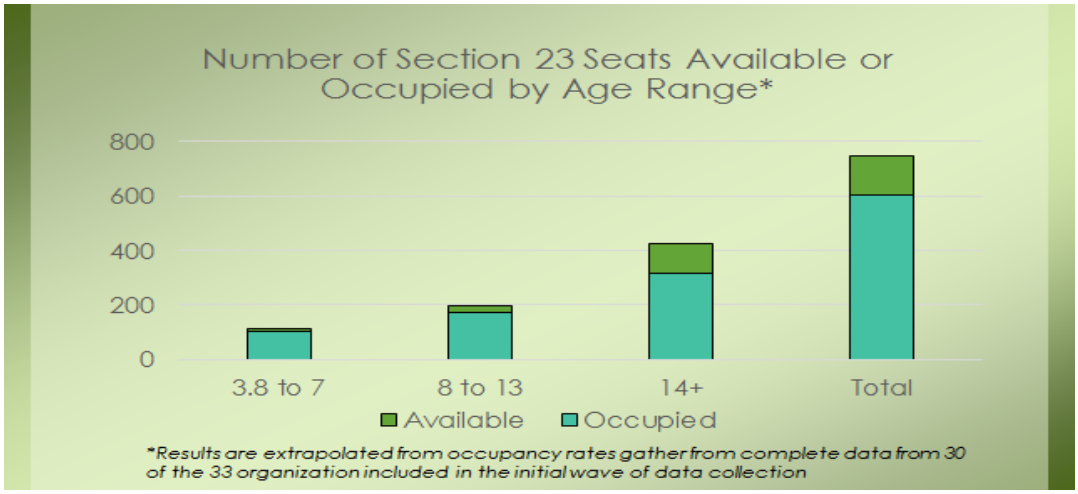




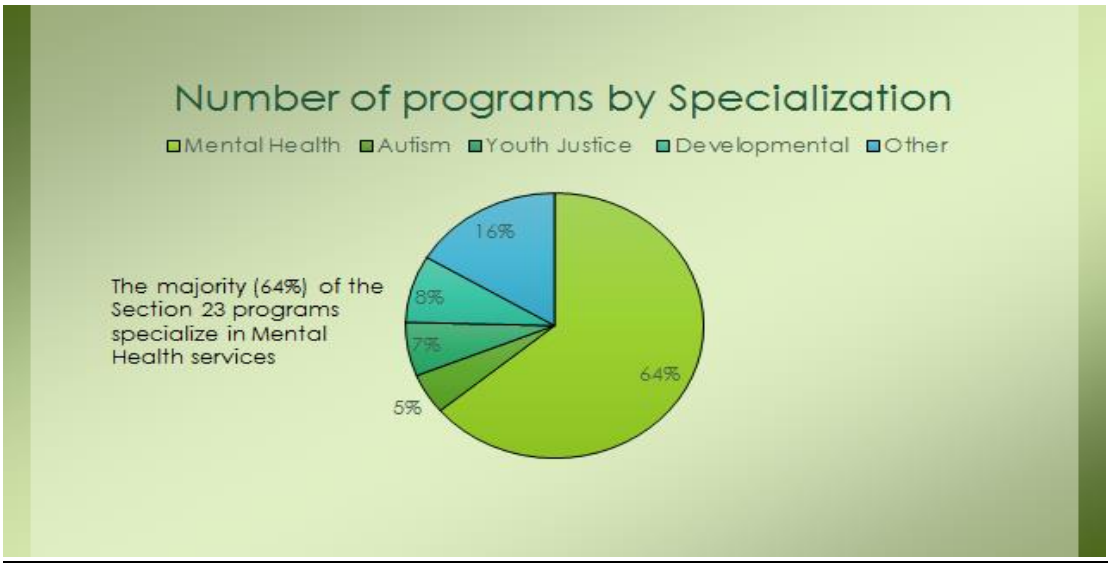
	North	East	West	South	*Total*
3.8 to 7	54	12	18	28	*112*
8 to 13	47	32	14	104	*197*
14 to 21	37	94	43	251	*425*
Total	*138*	*138*	*75*	*383*	*734*

- **Are Section 23 programs operating at capacity?**
  Programs which serve younger ages are more likely to be operating at full capacity than those who serve the 14+ age group

  Unexpected withdrawals and high client needs were the most commonly reported reasons why programs were not at full capacity; However, 6 sites serving the 14+ population reported a lack of referrals as the primary reason they were not at capacity.



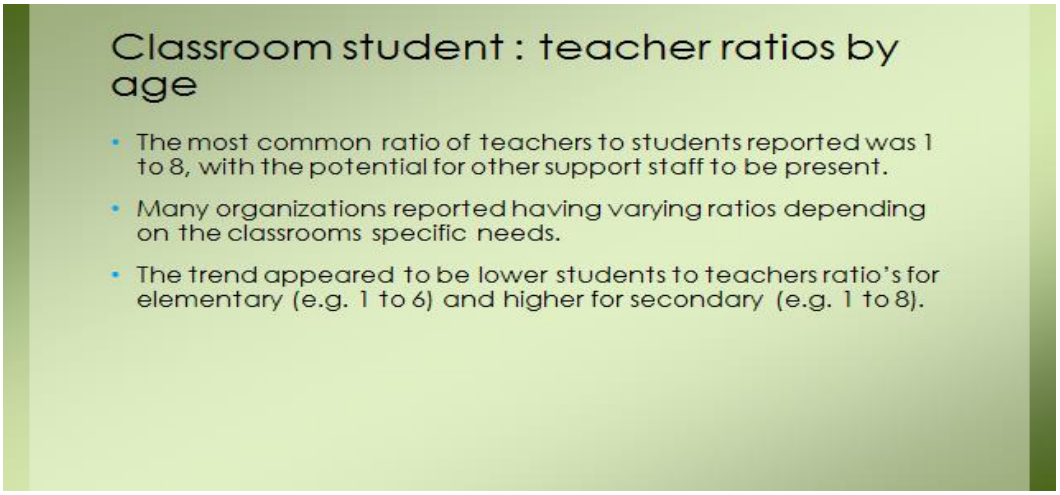
- **How are Section 23 programs divided by specialization?**
  The majority of Section 23 programs (64%) focus on the mental health population



- **Section 23 components of treatment services**
  The most commonly reported support components of the Section 23 programs were Social work/ Counselling and Treatment Groups (82%). Both Psychological assessment and consultation services (46%) and Psychiatry (43%) were utilized in almost half of Section 23 classrooms.

  *Further information should be gathered to determine total capacity within each treatment component.

- **What are Section 23 classroom student:teacher ratios?**



STRENGTHS AND NEEDS – GAP ANALYSIS

The work group completed a detailed SWOT analysis to explore key pillars of the Section 23 model. Specifically, access and intake, transitions in and out of the program, and general program structure and components of service issues were explored.

Many **strengths** were identified through SWOT discussions and it is perceived that the Section 23 partnerships are successful due to strong and meaningful relationships. The blended teaching model is recognized as a powerful approach when it works and when relationships are established and sound.

Other strengths noted included: partnership, integration of education and treatment plans, access to space, creative approaches and opportunities for students to integrate within schools, joint intake meetings, and the significant funding allocation for Section 23 programs across the City.

It is believed that the capacity of service in Toronto for Section 23 programs is high – representing 734 spaces across the city which is understood to be one of the program's strengths. Access points to service are relatively clear to stakeholders though expectations regarding criteria and processes are not. A centralized intake system that was established by the TDSB has helped to improve clarity for principals and school personnel regarding access and it is believed to be a good model to further develop together with other school boards. It is also believed that the CARS model is worth exploring to improve access and to build on existing capacity.

The depth of service that clients receive in Section 23 programs and the individualized nature of this support were also identified as fundamental strengths of this model, as is the broad multi-disciplinary expertise available to clients. Another fundamental strength of this model is that it promotes an enhanced overall understanding of the child/youth/family in a holistic manner. Assessments, treatment and individualized supports assist in matching appropriate placements with a client's needs as he/she transitions into (or back into) the school system. For a more detailed list of strengths see Appendix 2.

The work group members also identified several areas that are in **need of improvement**. These areas are recognized as 5 key priorities for the purposes of this report, but more details can be found in the Appendix 2.

1. Lack of Consistency in the Delivery of Services and in a System's Approach to Program Development and Oversight:

Key Issues:

- 33 MCYS funded agencies currently deliver Section 23 programs in Toronto with great variation in understanding of goals, philosophy, program components or expectations, multi-disciplinary team expertise, family engagement expectations, criteria, exclusionary criteria, evaluation, treatment models etc. (treatment model driven by agency not based on system needs – creating inequities across the city with no system's vision)
- Inability to identify system support needs and to distinguish these needs from agency support needs (for example: no current capacity to identify which supports could be decentralized and which supports should be centralized)
- Decentralized waitlists and admission processes – not currently an integrated approach to care; inequities in wait times and different screening processes and expectations of clients at admission
- Difficult to build capacity and share resources
- Individualized approaches to evidence-based components and investments.
- No guidelines regarding the location needs and requirements (should they be delivered in open schools; different space ratios with variability in space to address therapy and treatment needs located in open schools)
- Lack of clarity regarding the distinctions between special education programs and Section 23 programs

Recommendations:

Develop a System Approach to Program Development and Oversight

1. Identify a preferred vision for section programs that fosters a flexible model of care that is shaped around the needs of children, youth and families – facilitate a visioning exercise to include all intensive services, including:

- common service philosophy
- common vision
- common program goals
- clear allocation and understanding of roles and responsibilities – be clear about how we understand each other's work
- program access criteria and exclusionary criteria
- evaluation process – identify system level measurement to define success
- look at how to best use our resources from a system's perspective – thinking outside of the box to adopt a flexible system of care that supports clients according to their needs so they can come and go as needed.
- explore a tiered model of intensive care that starts with the least intensive option first
- ensure that counseling and service coordination services are included within the intensive model or ensure that other MH core services are funded in tandem with intensive services so that proper supports can be provided

2. Create one clear partnership agreement between agencies and school boards that fosters a common language
3. Explore opportunities to develop new protocol agreements with Hospitals offering Section 23 programs (design new system that fosters linkages and improves pathways)
4. Explore Humber's continuum model of service – variability of needs are recognized
5. Identify and fund a "system lead" for intensive services to assist in coordinating the system
    - this lead should co-chair the intake and access meetings with the school board
6. Create a single point of access system (explore viability of building upon CARS model)
    - create a centralized collaborative approach that building on extra supports where purposeful
7. Create and standardize service flow and expectations (i.e. intake, assessment, transition etc. – including pathway within schools prior to referring to Section 23)
8. Develop a community of practice model to promote the standardization of care (promoting/strengthening skills, knowledge and partnerships)
9. Focus on joint planning (Ministry of Children and Youth Services and Ministry of Education) not on bringing two separate plans together. Identify two ministerial leads to participate in the process of program development and implementation – one from each ministry
10. Utilization of common language between Ministry of Children and Youth Services and Ministry of Education
11. Clearly differentiate eligibility criteria for special education programs from Section 23 programs with school boards
12. Identify core components of services and multi-disciplinary supports that should be available at every agency
13. Identify a core basket of specialized services that should be available within the partnership but not assigned to specific agencies
14. Identify basket of treatment models and rationale for when each is used

2. Lack of Accountability

Key Issues:

- No systemic evaluation framework; outcomes not known at a systems level
- No system benchmarks and best practice guidelines
- Limited ability to influence change: union needs
- Lack of clarity regarding accountability and shared responsibility
- Perceived disconnect between Ministry of Children and Youth Services and Ministry of Education - program goals do not seem aligned
- Highly ambiguous authority/accountability and responsibility for program combined with the fact that processes and practices are often at odds with lines of authority. Uncertainty about who is in charge of program oversight.

Recommendations:

Develop Mechanisms/Process for Accountability & Measure Impact (Outcomes)

1. Heightened engagement with Ministry of Children and Youth Services and Ministry of Education
    - systems planning required to develop formal accountability "systems" agreement between the two ministries
    - determine who is the lead in this partnership - who is accountable for the program and clients; ensure that processes reflect this position
2. Accountability agreements – clarification on who is responsible for what
3. MCYS to work closely with education sector including the identification of lead contacts at both ministries for Section 23 or "Intensive Services"
4. Assess outcomes at a systems level
    - develop a common program logic model
    - develop a common program evaluation framework and balance scorecard including expectations regarding client outcomes
5. Identify service pathway: the process by which children/youth return to mainstream classrooms following Section 23 participation

3. Sustainability and Cost

Key Issues:

- Lack of a cohesive common vision and understanding of this service.
- No system understanding of costs per client – standard benchmark (variability across the system re: what a Section program costs)
- HR challenges and dual model of Supervision and Management: the model requires strong relationships but does not allow for flexible staffing and resource allocation to promote successful outcomes
- Expectations often do not match capacity tied to HR limitations; staffing inequalities

between agency and school boards

- Inequity in employment contracts, staffing expectations, union limitations, contracts etc. –management of these indirectly impacts team relationships
- Broad variation on quality of service
- Current staffing model does not address needs– lack of resources is influencing criteria and ability to provide service children/youth with challenging needs
- Current model is rigid and some children are kept too long in the program (entry end discharge at prescribed time instead of based on client needs) – this is less of an issue for youth who are obtaining credits
- Duality of supervision model has impact on successful outcomes: philosophy, conflict management, communication, authority, safety, accountability
- Gap in funding model (MCYS and Ministry of Ed) for psychological assessments. Establish protocols of how to best prioritize children/youth; when to complete assessments and for what purpose/s
- Leave children/youth on specialize service waitlists (currently taken off lists once they get into Section 23) so that specialize services can be utilized upon re-entry to school.
- Bussing – expensive and children/youth are unsupervised for extended periods of time (many incident reports and serious occurrences on bus). Many ride-alones due to behaviour. Bussing scheduling has to be set early and if programs are not full until September it is very challenging to get children into program full-time and to secure bussing route.

Recommendations:

Improve Sustainability

1. Examine alternative models of oversight: Ministry of Education currently has Enhanced Education Treatment programs – where they fund all elements of the program.
    - MCYS consider funding a similar program as a pilot
    - both programs should have a common evaluation process to assess outcomes
    - explore secondment options so that one partner is responsible for program and staff
    - explore a re-visioning of best practice and model redevelopment
    - explore other integrated models for intensive support to schools (hybrid models – Section for some; different types of supports for others)
    - identify the key elements of what an effective system of service would include
    - develop an evaluation model for outcomes
2. Leverage existing programs that can add to the flexibility of the Section model and flexible funds (i.e. WIT and/or STEPPS to assist children with transitions and/or placements)
3. Identify target cost per client; cost/benefit analysis based on the identification of a

vision

4. Capitalize on Mental Health leads in hospitals to formulate linkages and stabilization functions (ensure that hospital Section 23 functions are coordinated with MH sections programs – creating one system of care)
5. Examine options to re-allocate resources at a system level and examine models of oversight to determine what would look best for children and youth
6. Examine options for transportation including training for drivers

4. Access Challenges:

Key Issues:

- Limited capacity to accommodate children/youth with complex high needs – especially those with externalized behaviours
- Program "access and discharge" structure limits capacity to adapt to changing needs of families/clients
- Timing of admissions is too restrictive and is not currently tied to the needs of students
- Intake assessments vary (expectations, eligibility criteria, exclusionary criteria etc).adequate assessment at intake
- Duration of time to determine eligibility can be lengthy
- Rigidity of program structures - program is delivered based on a school year calendar not based on client needs; focus on targets and filling "seats" with no guidelines for funding or target modifications to accommodate children/youth with high needs; restrictive busing schedules; timing expectations; capacity to adapt to changing needs of families/client
- Process is driven by IPRC

Recommendations:

Improve Access Mechanisms

1. Create a single point of access system (explore viability of building upon CARS)
2. Determine who should refer to a centralized system for intensive (service provider and/or parent)
3. Develop an access service flow that clearly identify the process that schools follow within their own system when making referrals to Section 23 programs

5. Re-integration Challenges

Key Issues:

- Stigma; when child/youth has met goals during the year – often keep child/youth in program regardless of needs because of systems issues and re-integration barriers
- Process is driven by the IPRC process
- Transition process back into schools is not effective – no resources to do what is

needed. There is a need to shift our approach to improve the depth and breadth of transition supports (may need to do less but do it better or start children differently in a phased manner in the September).

Recommendations:

Improve Transition and re-integration Process

1. Transitions are recognized as a challenging time for these students. Students with complex needs (e.g., MH, ASD, other) have been reported to have significant challenges with such. To support the student to be successful with transitions, frequent and careful planning needs to occur that includes the critical staff involved.
    - transitions into Section 23 programs and transitions from Section 23 back to a community school require planning to support the student to succeed.
    - explore and draw upon the experience of the MCYS initiative Connections for Students, a successful model for supporting children and youth with ASD transitioning from day treatment to full time school has been demonstrated.

      Key elements of this initiative include the formulation of a transition specific team for each child that includes: receiving school administrator, teacher, board support with specific transitions staff (1 from board and one from treatment agency), and the parent is essential.

      Transition functions should be clearly assumed within job descriptions (explore youth justice transition worker positions for details)
3. Regular meetings need to be held to determine transition needs and actions identified to address those needs in terms of consultation, training or resource development to support the child's transition
4. Time needs to be allocated prior to school entry (up to 6 months) and following school entry to ensure the transition was successful (up to 6 months post). Such a successful model should be considered for other students with complex needs to ensure their successful transition
5. Explore options of keeping children/youth registered or engaged at their school by involving school staff in service planning
6. Formalize expectations with schools re: integrating children in Section 23 into school setting throughout the year
7. Transition students back into school system based on student needs (could be partial enrollment; joint enrollment; transition mid-year) – similar models exist in Alberta and Kitchener Waterloo
8. Agency should provide wrap around supports to schools during transition period and for up to 3 months post Section23 (client not to be discharged from agency until transition is rooted)
9. Improve ability to access CCAC support services while in Section 23 programs
10. Create and formalized common transition plans and expectations and

universal understanding of “warm handoffs”

11. Re-think transition process: maintain regular contact with home schools throughout time in Section 23 program; involve social work and receiving school teams in transition process early in the year; phase children into Section 23 in September to allow for time needed to provide hands-on transition supports in schools; possibly consider never removing child/youth from school board oversight
12. Seek further clarification on “best practices”
13. Promote more coaching directly in community placements prior to admitting students into Section 23 programs
14. Pilot transition approaches to assess what works best
15. Establish data tracking mechanisms to assess how well children do in their placements
16. Develop and implement transition plans that support a continuity of care – setting students up for success to promote and measure sustainability of placements

WORKING GROUP MEMBERS

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

- Donald Reid, TCDSB (Co-chair)
- Joy Reiter, TDSB (Co-chair)
- Cheryl Webb, Adventure Place (Co-chair)
- Tom Adams, Ontario Ministry of Education
- Gerald Bernicky, Surrey Place
- Deanna Dannell, Griffin Centre
- Ewa Deszynski, Etobicoke Children's Centre
- Zel Fellegi, Aisling Discoveries
- Ali Lineaux, Centre francophone
- Dawna Raposo, TDSB
- Janice Wiggins, EMYS Lead Agency

APPENDICES

Appendix 1	Section 23 Map
Appendix 2	SWOT Themes
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Appendix 5	Treatment Milieu Treatment Literature Review
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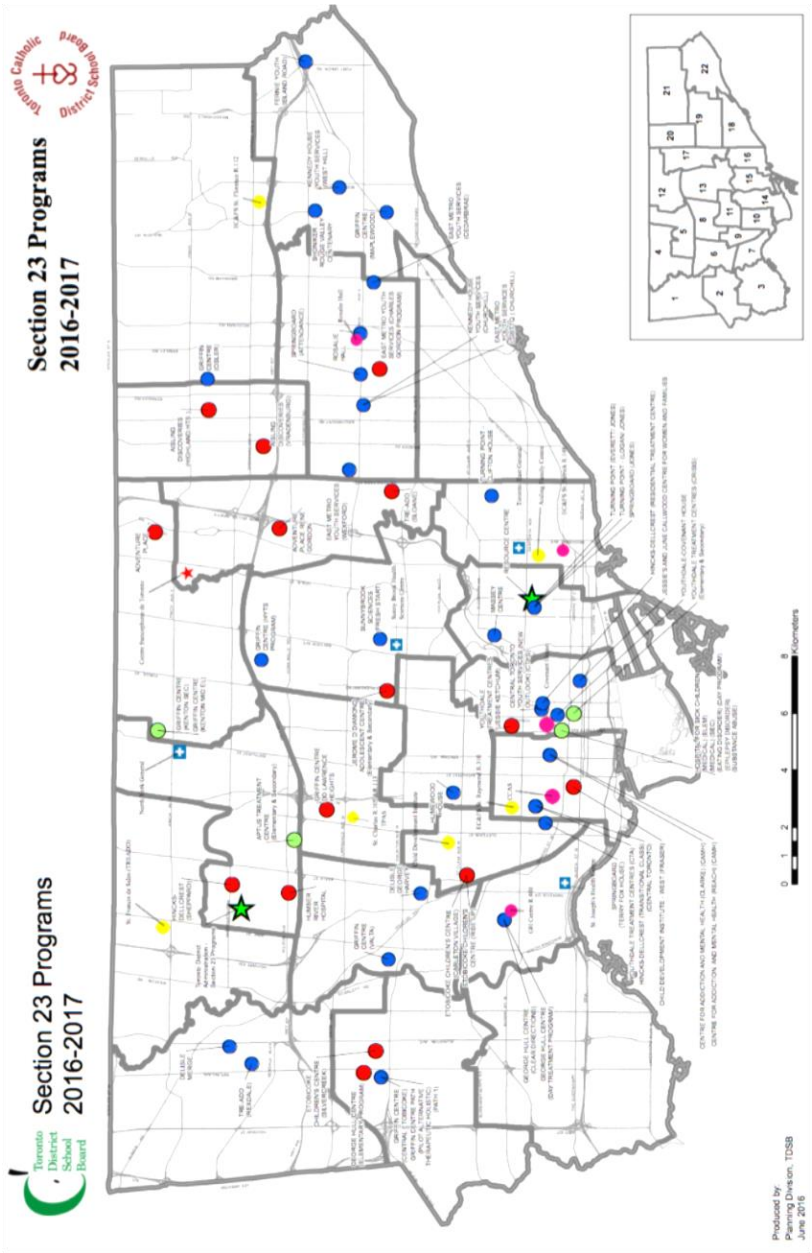
Appendix 1: Section 23 Map



Appendix 2: Section Themes and Groupings

SWOT THEMES

Key Strengths

1. Depth and Breadth of expertise

- The depth of service that clients receive in section 23 programs and the individualized nature of this support
- Broad multi-disciplinary expertise – wrap around services; development of a systematic coordinated plan
- Assessments, treatment and individualized supports really help in matching appropriate placements with a client's needs as he/she transitions into (or back into) the school system.

2.Individualized Supports

- Academic and treatment goals are tailored to each individual child/ youth and family to maximize success
- Service enhances the overall understanding of the child/youth/family in a holistic manner

3.Family Engagement

- Families are involved at the front-end of service and they remain involved throughout service
- Family counselling assists families in understanding their child's/youth's needs
- Positive relationships with teachers and therapists can assist in bridging families back into the school system

4.Capacity

- The capacity of service in Toronto for Section Programs is high – representing over 700 spaces across the City. A significant resource for the city
- Transportation

5.Access

- Access points to service are relatively clear to stakeholders and a centralized intake system that was established by the TDSB has helped to improve clarity for principals and school personnel regarding access

Key Needs:

1. Lack of Consistency and System's Approach

Key Issues:

- 40+ agencies currently deliver section 23 programs in Toronto with great variation in understanding of goals, philosophy, program components or expectations, multi-disciplinary team expertise, family engagement expectations, criteria, exclusionary criteria, evaluation, treatment models etc. (treatment model driven by agency not based on system needs)
- no identification of system support needs vs. agency support needs (could some supports be centralized?)
- decentralized waitlists and admission processes
- difficult to build capacity and share resources
- individualized approach to evidence-based components and investments;
- no guidelines regarding location of programs within open schools

2. Lack of Accountability & Collective Impact (Outcomes)

Key Issues:

- no systemic evaluation framework; outcomes not known at a systems level; no benchmarks and best practice guidelines
- lack of clarity regarding accountability
- perceived disconnect between mcys and mED - program goals do not seem aligned
- ambiguous authority/accountability and responsibility for program combined with the fact that processes and practices are often at odds with lines of authority and contradictory (i.e agency cannot cancel program when buses are cancelled – only the school boards have the authority to cancel the program; agencies register students with school boards; TDSB expects that the program will be cancelled when teachers are on strike even in non-unionized settings; agency staff arrange for busing and have to stay back in case of busing issues etc.)

3. Sustainability and Cost

Key Issues:

- expensive program; HR challenges and Dual model of Supervision and Management: the model requires strong relationships but does not allow for flexible staffing and resource allocation to promote successful outcomes
- expectations often do not match capacity tied to HR limitations; staffing inequalities between agency and school boards
- Inequity in employment contracts, staffing expectations, union limitations, contracts etc. –indirectly impacts team relationships
- broad variation on quality of service
- one staff member is out of classrooms 50% of the time – lack of resources is influencing criteria and ability to provide service children/youth with challenging needs

- duality of supervision can impede upon successful outcomes: philosophy, conflict management, communication, authority, safety, accountability

4. Access Challenges:

Key Issues:

- limited capacity to accommodate children/youth with high needs – especially those with externalized behaviours
- program structure limits capacity to adapt to changing needs of families/clients; Timing of admissions is too restrictive and is not currently tied to the needs of students
- Inadequate assessment at intake
- duration of intake is long
- rigidity of program structures -program is delivered based on a school year calendar not based on client needs; ; focus on targets and filling "seats" with no guidelines for funding or target modifications to accommodate children/youth with high needs; restrictive busing – schedules , timing expectations, capacity to adapt to changing needs of families/client
- process is driven by IPRC

5. Re-integration Challenges

Key Issues:

- stigma; when child/youth has met goals during the year – often keep child/youth in program regardless of needs because of systems issues and re-integration barriers.
- Process is driven by the IPRC process

Appendix 3: SWOT Analysis

SWOT Analysis

Section 23 Working Group

Access/Intake:

Strengths	Needs/Weaknesses
• Centralized Intake – clear process; reduced frustration; informs us of needs within system; builds common language • Relatively clear point of entry • Broad expertise – "multi-disciplinary" • Number of programs; size of total resources allocated to section • Access to wrap around services within agencies/entities • Strong rapport between boards of education and between boards of education and agencies/entities (sharing resources, decision making, expertise) • Access to placements and services for children with "internalized" needs • Fluidity of access to information from schools when making referrals (i.e. assessments) • Schools are receptive to classroom visits by agency/entity team (pre-entry) • Level of involvement of families when making referrals; bringing families into the process earlier (parent engagement at every level) • Flexibility of section partners to adapt to the needs of individual children, families and classrooms (I.e. groupings, space, composition – to accommodate and/or modify admissions) • Staged transitions into section – modified day etc. • Shared/Collaborative decisions about access and info sharing; resource sharing; needs assessments and planning	• Fit between "needs" and number of available placements • Criteria diversity • Changing criteria • Triage process not defined by a rigorous evaluation of a program's capacity to specifically address the clinical and educational needs of the child/adolescent • Very time consuming monthly central intake process • Consent and capacity – roles and responsibilities can impact therapeutic relationships • Capacity to address behavioural needs is often the reason for referral to section – focus should be on mental health • Access inequity for families within Toronto– program expectations for families should not be universal. Cultural norms, SES, etc. should be considered • Regional inequity • We need a better understanding of family needs and demands. Intake staff need to be experienced and the relationship with family's needs to be nurtured and fostered at intake • Timing of admissions is too restrictive and is not currently tied to the needs of students • Inadequate assessment at intake • Duration of intake is too long • Documentation should be shared between programs • Need to capitalize and build on school support services • Move away from education goals and treatment goals to a shared plan of care

• Education: heightened understanding and ability to support families • Transportation • Inclusion of Evidence-based practice • Blended teaching/therapeutic model • Offers the ability to assess children's needs and presenting mental health problems in order to assist them develop skills and strategies; • Helps identify the right placement (e.g. LD, MID, or ASD classrooms) after they leave section • Allows clients to receive highly individualized support in a safe environment – children begin to understand and accept their mental health challenges and also recognize their skills; • Multidisciplinary team with access to Psychological/Psychiatric assessments, individual approaches/modalities; • Development of a systemic coordinated plan; • Access to coordinators who help families look for additional services that we may not offer; • Opportunity for family therapy and increased engagement; • Teachers can take the time to assess child's true abilities and provide more individualized academic programs; • Children experience healthy, supportive relationships with adults (both agency and teachers) which enhances their feelings about school and the people who work in schools • Helps parents to learn parenting skills • Helps parents learn how to more effectively advocate for their needs; • Section can help bridge and repair the relationship between school boards and families when experiences in school have been negative (e.g. why clients have struggled in the mainstream is identified	• Lack of flexibility in transportation to accommodate changes and family needs • Inconsistencies in a teacher's understanding of what he/she can and can't do during the pre-admission stage (i.e. observations) • Lack of intake planning and transfer process: Need for formal case conference to be included in the process; trust information gathered and don't start from scratch • Lack of warm hand offs especially for more complex clients/students • Roles and responsibilities • Order of required steps for admission can slow down the process and restrict timely access (I.e. psychological assessments – current assessments and profiles are not adequate and delay entry • Need a formal process for the transfer of recommendations and treatment plans so that teachers are prepared for students prior to entry • Intake process is too lengthy • Need to share intake information rather than starting from scratch; Trust intake information • Parent engagement • Clear consistent criteria – including admissions • System cannot respond to children with severe externalized behavioural issues • Special Ed/ Section 23 differentiation • Lack of systems approach • Location of programs • Disconnect between MEDU and MCYS • No mcys member at the table • Agreements are not in place at the beginning of treatment regarding a child's future placement upon discharge (transitions are only in June -sometimes January) • There is insufficient availability of 1:1 funding when clients are in crisis or at risk to self or others; takes a long time to acquire; • Section 23 is most successful when families are involved/engaged; many families are very reluctant to engage for a variety o0f reasons ·

and a plan put into place to help address the issues • Some teaching teams find the right balance between treatment and teaching and are very supporting to each other. This provides excellent role modelling for the children.	• referred children/adolescents may not have existing assessment or they are sparse/incomplete. • Kids being referred to day treatment before other options have been explored within school setting; • System is not consistent in terms of how children are referred, what the expectations are of children, parents; what the expectations are of the agency and the board staff;
<u>Transition in and out of Section 23</u>	
<u>Strengths</u> --space for more of a 'transitional' program—yes—boards do provide before going back to regular class; fluidity within the board system targeting greatest area --transitioning/integrating into some programs—fluid conversations about the student between Section 23 staff and the Boards/host schools --transition into the "new", and in start of September, agency(s) the actual program has the staff on-site for a week because they are in a delayed start for more enhanced training; In March an example--receiving schools & IPRCs, parents familiar—important to be seen as passing the baton --some possibility of doing assessments over the summer (eg. For kids in care)—although this is not always possible or common	<u>Needs</u> Dependency on which boards kids are coming from (OUT)—tied to placements --resources attached to kids coming in & out eg. SIP worker, --no resources to support kids going out of Section program (because the ones entering are the ones using the resources) --targetted toward hospital programs, ie. Boards that have specifics --external resources might be avail—but you do not have the people who really does know that student Eg. WIT—for those very high complex --around transitioning is the language around ie community provide and Boards have very different languages --transitions are often a week after the student is back in the school ie. There are existing personnel to work toward --Issue of 'who owns the kid'—no clarity from the Educ side for the Host schools—who counts who where in the numbers (part privacy issue) --Unions in certain workers/schools are a concern vis a vis contractual issues; also issue in hospital programs—liaison with host school, or not connected with the teacher

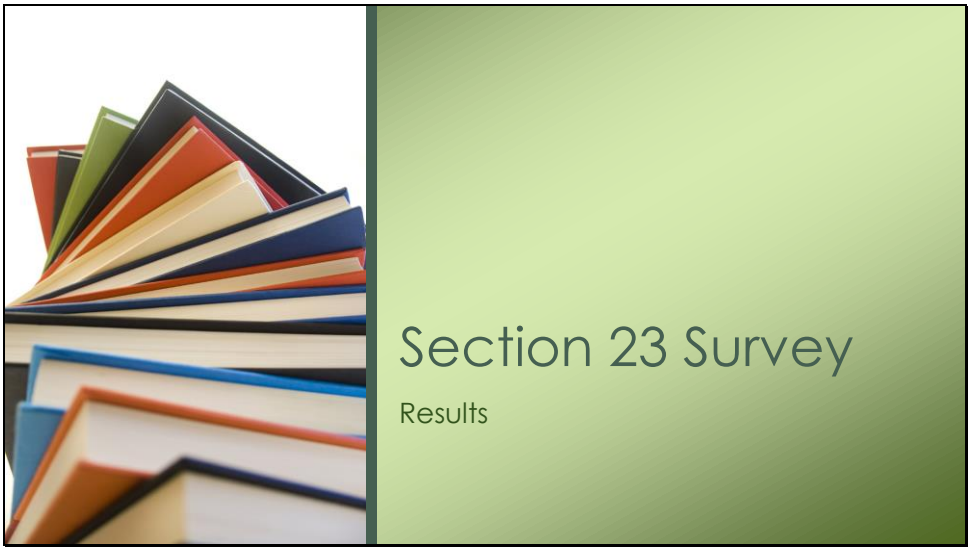
	--Section programs are almost seen as 'special needs" & prep time comparably, so there appear to be no supports in the Section --issue concerning the "who" is in the classroom at given times ie. Teachers, agency staff (CYWs) and who is compelled to do what—if client needs restraint, toileting, etc. Question of the cost of splitting between MCYS & Education --EA, Teacher & 2 CYWs for example in adolescent ASD class are a question of who is doing what/supportive team (mental health staff on the ground have not been getting breaks; ESA compliance etc.) --when transition if family has withdrawn child from Section; tougher to find school to host—tougher to find the kid too (in respect especially not meeting treatment goals) {keep in mind this is more in secondary level) --timing of transitions—what if student meets treatment goals before the given timeline? --Needs of children & families are outweighed by the structure and formality of the formal education system --especially for kids who come in with several matters—the perception of how they are viewed is an issue --HR issues and depth (possible solution to have secondment resolve under the 'care of the agency' where the HR responsibility is held) --challenges in relationships with personnel and how the student needs to be supported; accommodation --transition out, and in start of September, agency(s) the actual program may not be having the staff on-site for a week because they are in a delayed start for regular Section --continuity of treatment—once the student is already "in", there should be no waitlist --could an issue be there is not an up to date assessment??? Do psych assessments interfere? Is it a barrier? Yes (has to be 2 yr or less assessment to be accepted—but then kid waiting is caught

	with the same wait as the internal client in agency which holds an overall waitlist
General Program (i.e. HR, team planning and collaboration, accountability, utilization; location - age capacity and resource allocation; accountability; staffing model; City-wide common components of service and evaluation; centralized vs. decentralized supports; evidence-based service.	
<u>Strengths</u>	• <u>Internalizing/externalizing</u>: dilemma of hard to serve student, and where do they go—capacity issue of the agencies too <u>Not many short term programs serve</u>; thus hard to stabilize student Make sure the program mgr focus is on mh piece not just the behavioural • Resource gap ie. The worn out resources of board—so you are now transitioning—now need the treatment component (but support is gone past) --needs to see a wider change as slowly program is evolving into how agencies are able to stabilize student • gap is the destination (impt. EA really means the academic support in lexicon; not the therapeutic model) {together create a collaborative environment to build on expression of need) ● huge barrier to above point on the ground is TIME {how to create time for all working together—it's a province wide issue) ● limitation in the practicality of time and resources in given Boards

	● Step up and Step down—next is the Step out—some students have chronic mh—so when they are back to school—there are very few resources to support so everything done can be undone ("fractures our kids") ● careful balance of academics and treatments—must continually nurture (eg. WIT cited as a model that has been able to transition kids in/out) ●AGE criteria for programs—does not match with the agency's mandate and the world of the school(s); how to allocate programs and ages of going back into schools (double transition example) & training implications for the needs of the kids ● different approaches to behaviour management—need for a look see on the various modalities; SAFETY Plans are in differences to be be program & system addressed ● HR systemically—ie. Accountability vis-à-vis who ultimately has responsibility for the program—need clarity—trickles down on the day to day ● HR system inequities ● lack of consistency in goals and evaluations; impact; how are the investments faring—decide as a group for coherence ● barriers ie. You are either IN or OUT—system has challenge shaping for needs of kids & parents (it's now around the needs of the system players) ● MOUs are driven from educational component so concern is the legal and relational piece that child treatment centres are faced with accountability that has not been synthesized • MOU creates a very different relationship between agency & the Board—but regional program mgr at MCYS does not have involvement— *Note: Boards have put forward to*

	change and do a different method {Risk Mgmt & Liability} Could partner agency and Board bi-annually sit down and identify/negotiate if there is anything that is unique to add/amend Note—contradiction between the large segment in intensive services dedicated in agency envelopes vis a vis the level of actual attention given to it by MCYS & their corporate culture ● include MOUs—insufficent clarity—it has been a genesis of what many of the confounding challenges are in the sector— Could Min of Educ work with agencies on a hybrid model based on EET example

Appendix 4: Section 23 Survey



Data Collection Methodology

- On February 7, 2017 an online survey was distributed to 30 MCYS funded Section 23 providers identified by the Toronto Section 23 Working Group, of which of 30 responded(100% response rate).
- Follow-up was conducted with a few organizations to clarify data that was provided or gather missing data.
- Seat availability data was also gathered from 3 additional organizations providing MCYS Funded Section 23, bringing the total number of participating organizations to 33.

List of 33 MCYS funded organizations* who provided data for the project

- Adventure Place
- Aisling Discoveries Child and Family Centre
- Aptus Treatment Centre
- CAMH - College Street Site
- CAMH - Queen Street Site
- Central Toronto Academy
- Centre Francophone de Toronto
- Child Development Institute
- Conseil Scolaire Viamonde
- Covenant House
- Crisis Centre
- East Metro Youth Services
- Epilepsy Classroom Sick Kids
- Fernie Youth Services
- George Hull Centre for Children and Families
- Gifford homes
- Griffin Centre
- Humber River Hospital
- Humewood House Association
- Jessie's - The June Callwood Centre for Young Women
- Jessie Ketchum
- JFCS
- Kennedy House Youth Services Inc.
- Massey Centre
- Operation Springboard
- Rosalie Hall
- Scarborough and Rouge Hospital
- Skylark Children, Youth and Families
- Springboard - Attendance Program
- Surrey Place Centre
- The Etobicoke Children's Centre
- The Hincks-Dellcrest Centre
- Turning Point Youth Services

** 8 additional health funded Section 23 sites were located in the region, but their data was not included*

Key Findings

- During the 2016-2017 fiscal year there were a total of 56 MCYS Section 23 sites distributed across the Toronto, plus 8 additional health funded sites (64 total sites)*
- A total of 734 MCYS funded Section 23 Seats are available in Toronto, of which approximately 80% were occupied during the 2016-2017 fiscal year.
- The majority of seats available across the city are for the 14+ age range (58%), and the lowest proportion of seats are for those 3.8 to 7 years of age (15%)
- The majority of Section 23 programs (64%) focus on the mental health population

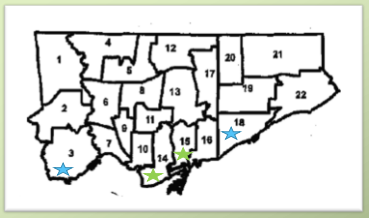
* According to *Section 23 Programs 2016-2017 Map* produced by the planning division of TDSB June 2016

Key Findings (Cont.)

- Programs which serve younger ages are more likely to be operating at full capacity than those who serve the 14+ age group
- Unexpected withdrawals and high client needs were the most commonly reported reasons why programs were not at full capacity; However, 6 sites serving the 14+ population reported a lack of referrals as the primary reason they were not at capacity

Key Findings (Cont.)

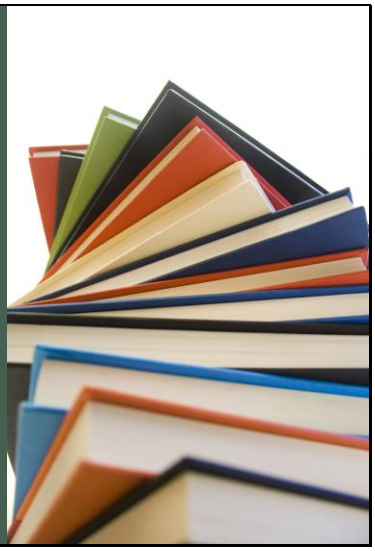
- There is a dense concentration of Section 23 sites in the south quadrant of the GTA (28) and a lack of sites in the West (5)
- The densest geographic region is wards 14 and 15 located in downtown Toronto which contains 13 sites combined ★
- There are two wards which do not contain a single Section 23 site(wards 3 and 18). ★



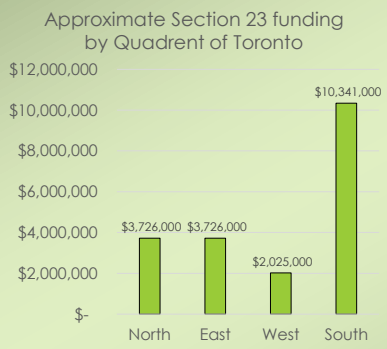
Key Findings (Cont.)

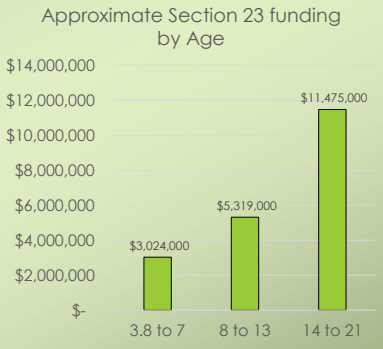
- The most commonly reported support components of the Section 23 programs were Social work/ Counselling and Treatment Groups (82%). Both Psychological assessment and consultation services (46%) and Psychiatry (43%) were utilized in almost half of Section 23 classrooms.

Results



Funding: How much is currently being invested in section 23 by MCYS?





How many Section 23 sites exist across the city? And how are they distributed[1]?

- There are a total of 64[2] Section 23 locations distributed across the city (21 elementary, 34 secondary, 4 mixed, 4 hospital, and 1 French)
  - In the North there are 7 elementary, 2 secondary, 2 mixed, 1 hospital and 1 French (13)
  - In the East there are 4 elementary and 11 secondary (15)
  - In the South there are 8 elementary, 18 secondary, 2 mixed, and 3 hospitals (31)
  - In the West there are 2 elementary and 3 secondary (5)

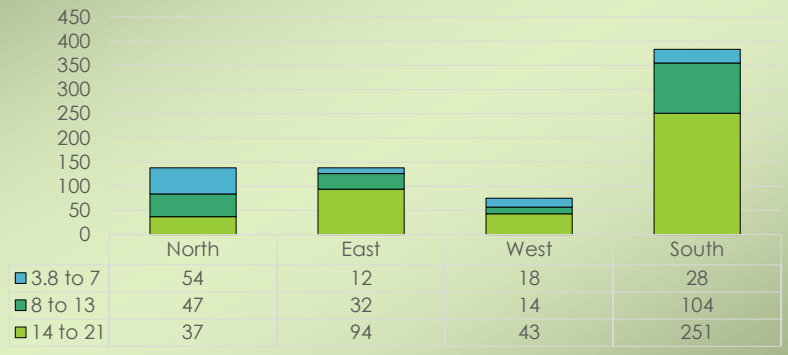
[1]Data taken from *Section 23 Programs 2016-2017 Map* produced by the planning division of TDSB June 2016

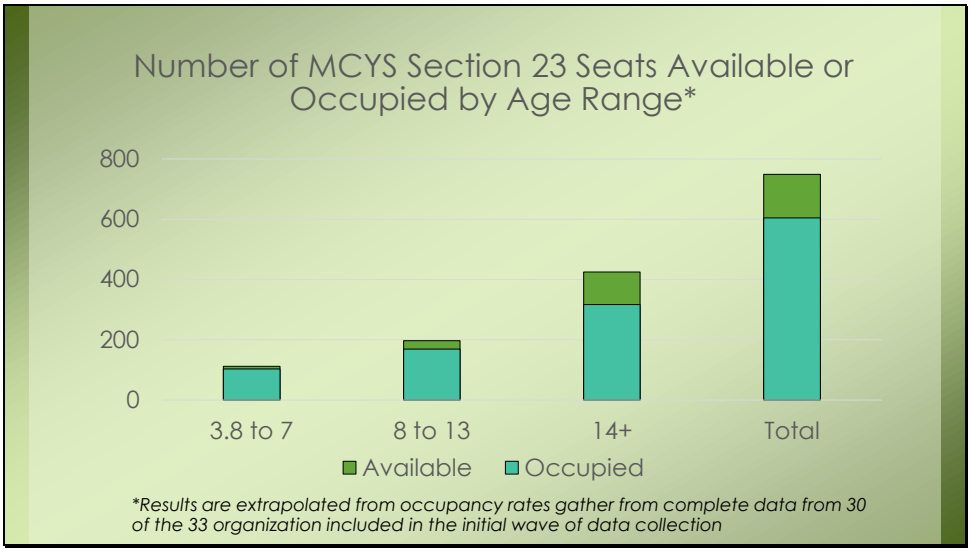
[2]The total count of 64 includes both MCYS funded and health funded sites

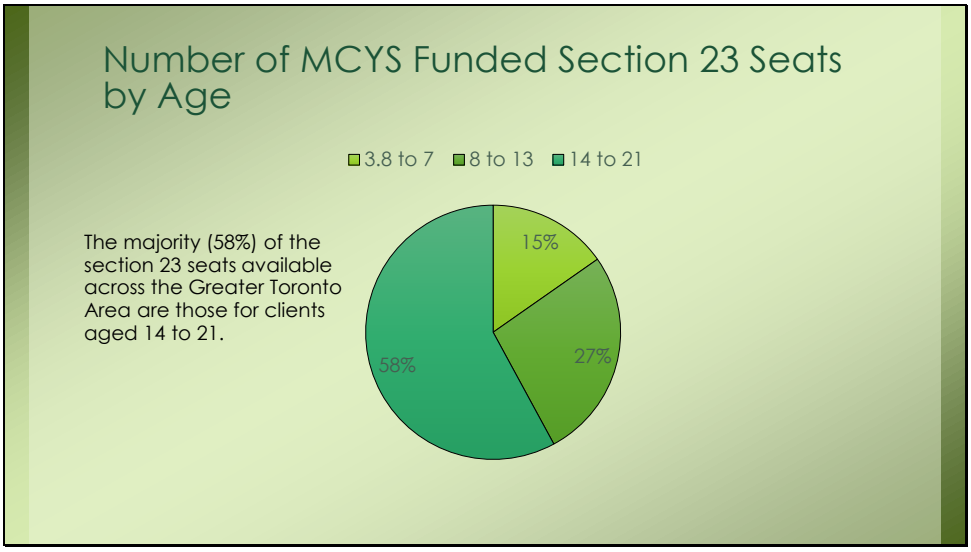
How many MCYS funded section 23 seats are available for each age based on quadrant where the agency is located?

	North	East	West	South	*Total*
3.8 to 7	54	12	18	28	*112*
8 to 13	47	32	14	104	*197*
14 to 21	37	94	43	251	*425*
Total	*138*	*138*	*75*	*383*	*734*

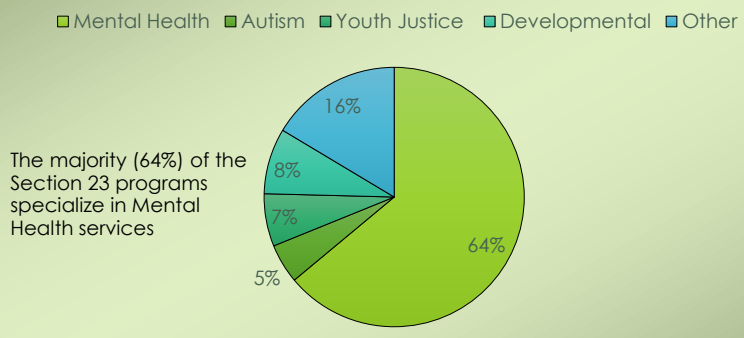
Number of MCYS Funded Section 23 Seats by Quadrant by Age




Number of MCYS Section 23 Seats Available or Occupied by Age Range*
800
600
400
200
0
3.8 to 7
8 to 13
14+
Total
Available
Occupied
*Results are extrapolated from occupancy rates gather from complete data from 30 of the 33 organization included in the initial wave of data collection


Number of MCYS Funded Section 23 Seats by Age
3.8 to 7
8 to 13
14 to 21
The majority (58%) of the section 23 seats available across the Greater Toronto Area are those for clients aged 14 to 21.
15%
27%
58%

Number of programs by Specialization



The majority (64%) of the Section 23 programs specialize in Mental Health services

Classroom student : teacher ratios by age

- The most common ratio of teachers to students reported was 1 to 8, with the potential for other support staff to be present.
- Many organizations reported having varying ratios depending on the classrooms specific needs.
- The trend appeared to be lower students to teachers ratio's for elementary (e.g. 1 to 6) and higher for secondary (e.g. 1 to 8).

What are the commonly utilized components of Section 23 programs?

Component	% who use
Social Work/Counselling	82%
Treatment Groups	79%
Psychological Assessments and Consultation	46%
Psychiatry	43%
Care Provider Education and Training	29%
Speech and Language	14%
Occupational Therapy	14%
Play Therapy	14%
Behavioural Consultations and Therapy (ABA)	4%

Appendix 5: Literature Review

DAY TREATMENT MILIEU TREATMENT
LITERATURE REVIEW
June 2017

Sarah Holden, The Etobicoke Children's Centre
Christopher King, The Etobicoke Children's Centre/Adventure Place
Ewa Deszynski, The Etobicoke Children's Centre

Executive Summary

There are approximately 56 Day School Milieu treatment programs (Section 23 of the Education Act) in Toronto Region that provide mental health treatment in partnership with English and French language school boards. These children or youth present with behaviours or symptoms (e.g., affect regulation, aggression, anxiety, significant diminished executive functioning, oppositionality, poor relationships skills, etc.) that make it difficult to sustain the child/youth in a community school setting. A number of children/youth referred to Day School Milieu Treatment have also had experiences in utero, early infancy or childhood, which may have had negative effects on the structure and activity of their brain. These experiences have impacted on the child's emotional, social, and behavioural functioning, including, persistent fear response, hyper-arousal, increased internalizing symptoms, diminished executive functioning, delayed developmental milestones, weakened response to positive feedback and complicated social interactions (Child Welfare Information Gateway, 2015).

The Day School Milieu Treatment work group, co-chaired by Cheryl Webb (E.D. of Adventure Place), Joy Reiter (TDSB Section 23 Principal) and Don Reid (TCDSB Section 23 Principal) was established by the Education Partnership Table - an advisory body to the Lead Agency to provide recommendations on how to improve mental health supports within the education sector. The work group included representatives from Child and Youth Mental Health, Autism, Boards of Education and Ministry of Education.

This literature review undertook to seek scholarly articles that addressed effective components of day school milieu treatment programs for pre-schoolers, children and youth with mental health issues. A high level, first analysis literature review was conducted on best practices, structures and components of effective treatment programs for children/youth who are not able to be sustained in their community schools due to their mental health needs.

Key Findings: There was a paucity of scholarly literature that focussed specifically on day school milieu treatment settings where there is joint academic and mental health programming. Within the scope of this analysis, the literature indicates that day school milieu treatment is effective for students with behavioural and emotional difficulties (Ontario Centre of Excellence, 2013; Milin, Coupland, Walker, & Fisher-Bloom, 2000 and in improving social skills, behaviour, and family functioning (Clark & Jerrott, 2012). Parents reported significant improvements related to the behavioural and emotional regulation of their children (McCarthy et al., 2006). Additionally, when compared to residential type programs, day

school milieu settings were identified as potentially being more cost-effective and resulting in fewer disruptions to the child and family (Ontario Centre of Excellence, 2013; Milin, Coupland, Walker, & Fisher-Bloom, 2000). The key components of effective day school milieu treatment programs include:

a. Specialized Assessments
b. Focussed Child/Youth Treatment approaches
c. Parent/Family Skills Building, Treatment and Engagement
d. Relationship and Empathy Skills
e. Teacher Attributes, Training and Skills
f. Structure, Size and Style of Classroom
g. Service Planning and Coordination
h. Cross Sectoral Participation and Planning
i. Re- Integration Planning and Transition Practises

Methodology

The following findings were located from a literature search completed through Journal Storage (JSTOR) and Scholars Portal databases, as well as Google Scholar. Some of the search terms included a combination of the following terms: “adolescent mental health”, “children’s mental health”, “pre-school mental health”, “day treatment”, “day treatment program”, “milieu”, “effective, “evidence-based”, “emotion”, “behaviour”, “structures” and “components”. Scholarly articles from Google was also used to search for information on childhood trauma and brain development. Citations in relevant articles were also reviewed to access sources that included applicable and relevant information. It is important to note that very little literature was found that focussed specifically on the three subgroups of children by age or development (i.e. pre-school, children, or adolescent) in relation to DSMTP settings. As such, unless specifically noted, the findings below were attributed to “children” in the broad sense.

Key Components of Effective Day School Treatment Programs

A review of the literature indicates that there are key components of Day School Milieu Treatment (DSMT) programs that contribute to effective outcomes. These include:

a. Specialized Assessments: Specialized assessments are an important component of DSMT settings to ensure students are appropriately placed and to monitor progress. (Flower, McDaniel, and Jolivette, 2011). Assessment and diagnosis should be viewed as an ongoing process and which require ongoing review.

Literature indicates that assessments that test for the following areas are relevant in developing an in-depth understanding of children/youth referred to day school milieu treatment programs:

- **Psychiatry/Psychology Involvement** assist in establishing a greater understanding of students' presenting needs (Centre of Excellence, 2013; Clark & Jerrott, 2012). **Strengths, and learning style** (Pazaratz, 2011)
- **Functional assessments** that identify the causes of challenging behaviours (Flower, McDaniel, and Jolivette, 2011) and that make recommendations that are effective and practical (Evans et al., 2006)
- **Intelligence testing**: (Ontario Centre of Excellence, 2013) provides relevant information that informs academic and treatment approach.
- **Psychoeducational testing** which identifies areas of need, strength, and where academic supports are needed (Pazaratz, 2001)
- **Monitoring subtypes of Aggression – proactive (unprovoked) vs. reactive (frustration-based).** The type of aggression demonstrated by children and the mix of children is relevant to the success of the program. Less improvement in DSMT settings was seen with children who are high on proactive aggression, when compared to children presenting with reactive aggression (Bennett, Macri, Creed, & Isom, 2001). Children with high levels of proactive aggression tend to have more friends exhibiting the same behaviours and are skilled at engaging other children to initiate deviant behaviours (Bennett, Macri, Creed, & Isom, 2001). As a result, introducing children with high levels of proactive aggression to other children exhibiting the same behaviours can mean a lack of progress with externalizing behaviours (Bennett, Macri, Creed, & Isom, 2001).

b. Focussed Child/Youth Treatment Approaches

The following are some treatment approaches reflected in the literature that contribute to positive outcomes and success in day school milieu treatment type settings:

- ***Social Skills Building and Behavior Management Approaches***

Mental health interventions within the classroom are essential to outcomes for children/youth. The development of social skills is important as it helps students work on problem behaviours and their communication skills (Flower, McDaniel, & Jolivette, 2011; Grizenko, Papineau, & Sayegh, 1993; Kanine, Tunno, Jackson, & O'Connor, 2015). Teaching social skills has been shown to be effective using positive reinforcement, including reinforcement of acceptable behaviour and correcting unacceptable behaviours (Hicks & Munger, 1990). Contingency management approaches within a classroom type setting are identified as being effective in reducing aggression for children with conduct problems and ADHD (Hoagwood et al., 2001). **The Incredible Years program (e.g. Dina Dinosaur for pre-school children)** (Webster- Stratton, Carolyn, 2004) has extensive research as an effective model for students under 12 in classroom settings.

- ***Cognitive Behavioral Approaches***

A cognitive behavioural approach that incorporate a token economy, as well as a focus on anger management, social skills, and processing school difficulties, through the use of skill building groups (Clark & Jerrott, 2012; Ontario Centre of Excellence, 2013; Kanine, Tunno, Jackson, &

O'Connor, 2015; Pollastri, Lieberman, Boldt, & Ablon, 2016) have been shown to be effective in DSMT settings. Where an intensive intervention strategy was used within a community school classroom setting, a cognitive-behavioural approach was shown to be effective in the long-term for children with disruptive behaviours, as well as in their school functioning (Clark & Jerrott, 2012).

Cognitive behavioural approaches have also been shown to reduce symptoms of depression, anxiety, conduct problems, and ADHD (Hoagwood, Burns, Kiser, Ringeisen, & Schoenwald, 2001). Specifically, cognitive group-based interventions have demonstrated positive improvements in adolescents' depression and styles of thinking (Hoagwood et al., 2001). Another study using a school-based program that included cognitive behavioural treatment for adolescents with depression reported positive improvements and reductions in depression symptoms (Crisp, Gudmundsen, & Shirk, 2006).

Approaches such as **Collaborative Problem Solving** (Ross Green) and **thinkkids** (Stuart Ablon) focus on building helping relationships and building alternative skills where there are lagging skills (e.g. executive functioning). Adopting CPS in DSMT settings has been shown to reduce restraints and seclusions (Ontario Centre of Excellence, 2013; Pollastri et al., 2016).

Rational Emotive Behaviour Therapy (REBT) (Banks, 2012**)** seeks to address behaviours and feelings to address problems such as depression, anxiety, frustration, self-esteem, emotional regulation, and obsessive-compulsive disorders (Banks, 2012). REBT has shown to be effective with students and can be used as a therapeutic classroom intervention to help students with emotional and behavioural difficulties (Banks, 2012).

- ***Trauma and Attachment Focussed Approaches***

Children/youth in DSMT settings may need to be assessed for trauma and attachment issues. Trauma and poor attachment are known to be contributing factors to child/youth mental health issues. (Child Welfare Gateway, 2015). The mix of children/youth and program components in a DSMT setting can be triggering and result in heightened behavioral and emotional responses. Trauma informed and attachment focussed approaches are relevant to assisting children/ youth in day treatment milieu settings.

- Attachment Focused Approaches for children 0-6 years old:
  - Watch, Wait and Wonder (Centre of Excellence, 2016)
  - Circle of Security (Centre of Excellence, 2016)
- Trauma-Based Approaches:
  - Cognitive Behavioural Intervention for Trauma (de Arellano, Danielson, & Sprague, 2008)
  - Multimodal Trauma Treatment (Trauma-Focused Coping in Schools) (de Arellano, Danielson, & Sprague, 2008)

- ***ADHD Approaches*** (Centre of Excellence, 2013)

A diagnosis of ADHD is not uncommon in children/youth in DSMT settings. A combination of pharmacological and psychosocial interventions are shown to be effective working with children who have a diagnosis of ADHD including:

- Pharmacological treatment
- Cognitive and behavioural-based treatment approaches
- Behaviourally focussed parent training
- Behaviourally focussed classroom interventions
- Behavioural focussed peer interventions
- Neuro-feedback training

➢ ***FAS-D Approaches*** (Paley, & O'Connor, 2011)

Some children/youth who present with emotional, psychosocial, behavioral challenges may also be children/youth whose challenges are related to fetal alcohol syndrome. These children may not have a fetal alcohol diagnosis due to a lack of knowledge regarding maternal ingestion of alcohol prenatally. The following are some approaches:

- Parent-Focused Interventions, including Behavioural Consultation
- Cognitive Control Approaches
- Educational Interventions (i.e. Language, Literacy and Mathematics Training, Working-Memory Strategies)
- Self-Regulation Intervention and Adaptive Skills Training
- Social Skills Interventions
- Safety Skills

c. Parent/Family Skills Building, Treatment and Engagement

There are a number of evidence informed/based parent skill building and treatment approaches. Furthermore, parent and family engagement is an integral part of children/youth in day treatment settings. Involvement in their child's treatment and/or parenting training/groups is an indicator of a positive treatment outcome (Centre of Excellence, 2013).

➢ **Parent and Family Based Approaches**

Parent and family based treatment approaches have shown to be effective for children with experiences of abuse or neglect, conduct problems, ADHD, depression, anxiety, and grief. Parent and Family-based treatments are often offered on a short-term, outpatient basis, using cognitive-behavioural, strategic or structural foundations (Hoagwood et al., 2001). Some examples of family-based interventions include parent training in behaviour management, behavioural-family systems treatment, and structural family therapy (Evans et al., 2006). Examples include:

- **Skills building, Teaching Family Models** are based on the theory that behavioural challenges can be prevented through the development of relationships with adults with reinforcement value, who provide

consequences for positive and negative actions/behaviours, and who teach self-care, social skills, and academics. Components of these models include a family-style token economy, self-government, peer leadership, and teaching of social and academic skills using positive reinforcement. (Hicks & Munger, 1990)

- **Family therapy models** such as Structural Family Therapy (addresses family structures, boundaries and communication), Functional Family Therapy (focuses on children/youth over the age of 12 who are at risk of delinquency, incarceration and/or delinquency (Sexton & Alexander, 2000) and Multi-systemic Family Therapy (MST) (for adolescents who present with high risk behaviors including offending, suicidality, and violence) (Swenson & Duncan, n.d.; Society of Clinical Child & Adolescent Psychology, 2012) are established models of family therapy that are effective in improving child and family interactions.

- **Parent/Family Engagement** is stated in several studies as being an important and integral aspect of DSMT, and often associated with positive outcomes (Flower, McDaniel, & Jolivette, 2011; Vernberg et al., 2006; Centre of Excellence, 2013). In one intensive mental health program, parental involvement is cited as integral to the treatment model and contact with parents is established daily through (communication) sheets students bring home, as well as biweekly home visits where therapists provide psychoeducational parent training, specifically around behavioural management (Vernberg et al., 2006). During parent/family group sessions, the following areas are important: creating an identity, providing for physical needs, setting boundaries, and regulating the emotional climate of the family (Pazaratz, 2001).

d. Relationship and Empathy Skills: Developing a positive relationship with and empathy towards children/youth/families by teaching, and treatment professionals can help to prevent and address challenging behaviours. The relationship between teaching and treatment professionals and students helps them to learn to be responsive socially, emotionally, and cognitively (Pazaratz, 2001). These qualities provide a context and environment for the use of positive reinforcement, rewards and consequences for child/youth behaviours. These attributes also offer opportunity to teach social, academic and self-care skills (Hick & Munger, 1990).

e. Teacher Approaches, Training and Skills

Teachers who teach in a setting with students who have emotional/behavioural disabilities are reported as those teachers who have the highest levels of stress and the lowest levels of satisfaction (Kindzierski, O'Dell, & Marable, 2013). One study analyzed the perspectives of teachers regarding skills required by teachers involved in residential and DSMT settings (Kindzierski, O'Dell, & Marable, 2013). The findings cited the following as missing and needed requisites for teaching students in DSMT programs.

- **Teacher disposition**: Teachers believed this was important and often missing, citing that empathy and patience are areas that are both difficult to teach and need further development in residential and DSMT settings. (Kindzierski, O'Dell, & Marable, 2013)
- **Training on best practices**: Teachers felt it is important to receive more in-depth training on teaching methods, developing lesson plans, and motivating students in these settings. (Kindzierski, O'Dell, & Marable, 2013)
- **Training in special education**: This was cited as an important requisite needed for teachers working with students in residential or DT settings. It was believed that teachers should receive more than one course in techniques for teaching in special education type settings. (Kindzierski, O'Dell, & Marable, 2013)
- **Classroom management skills**: Teachers believed that consistency in classroom management approaches would be beneficial for students with difficulties regulating emotions. (Kindzierski, O'Dell, & Marable, 2013). Behavioural consultations to assist teachers in accommodating difficult children have been shown to reduce the number of referrals and placements to special education settings (Hoagwood et al., 2001).
- **Collaboration skills**: Teachers cited collaboration skills with other service providers and family members as important areas for skill development. (Kindzierski, O'Dell, & Marable, 2013)
- **Experience**: As both an important and missing component, teachers felt that experience should be a prerequisite before entering a residential or DT educational setting. (Kindzierski, O'Dell, & Marable, 2013)

f. <u>Structure, Size and Style of the Classroom</u>

In one study, students currently enrolled in an alternative education setting were asked about their perceptions and experiences in attending an alternative education classroom (De La Ossa, 2005). Many of the students who participated identified school size, classroom size, and personal attention/relationships as having influence over their experience of their alternative education settings.

These experiences reported by students in an alternative education setting also align with other research stating best practices for the structure and style of DT classrooms. Studies seeking to identify effective structures and styles of a DT classroom have found that the following aspects have value in a DT setting:

- **Small Class Size/Low Student to Teacher Ratio:** Small class sizes enables students to remain focused, develop cooperation with peers, and provide more time with teachers and youth workers (Pazaratz, 2001; Flower, McDaniel, & Jolivette, 2011). A suggested teacher to student ratio is 1:2.5 (Centre of Excellence, 2013), or one teacher and one child and youth worker, to every 6 to 8 students (Grizenko, Papineau, & Sayegh, 1993).
- **Structured Classroom:** Highly structured classrooms has been shown to be help students to self-manage their behaviours, as it allows opportunity for prompting as well as corrective feedback (Flower, McDaniel, & Jolivette, 2011).

- **Use of Positive Methods and High Reinforcement Value:** Examples of positive methods include praise for specific behaviour and positive behavioural three-tiered interventions (Flower, McDaniel, & Jolivette, 2011) including
  - ***Universal approaches*** that support appropriate behaviours including a positive strength based approach, effective academic instruction, low student to teacher ratios, and parental involvement;
  - ***Secondary approaches*** that offer a highly structured approach, a higher level of support including social skills teaching and adult mentoring;
  - **Tertiary approaches** that provide more individualized support.

g. Service Planning and Coordination

Service planning and coordination are identified as critical components of DSMT programs (Centre of Excellence, 2013). Vernberg et al., (2006) indicates that attending cross-setting/sectoral meetings and events is crucial. It is important to have agreement, consistency, expectations, and strategies related to the child's goals from all service providers involved. It is also important that school staff collaborate with psychiatrists and psychologists and share important information, particularly as it relates to recommendation and use of medication (Vernberg et al., 2006).

h. Cross-Sectional Collaboration

Working in a collaborative and multimodal team, is also an important component of DSMT as it decreases fragmentation and division between services and service providers, while facilitating am effective case management model (Vernberg et al., 2006). Integration of the education and community mental health systems is necessary in order to implement evidence-based interventions successfully into school and classroom settings (Crips, Gudmundsen, & Shirk, 2006). Collaboration between school systems, researchers, policy makers, and mental health service providers is necessary to support the delivery and coordination of effective interventions (Crisp, Gudmundsen, & Shirk, 2006).

i. Re- Integration Planning and Transition Practises

Research demonstrates that children participating in a therapeutic day treatment setting can successfully reintegrate and function in a regular classroom (Kanine, Tunno, Jackson, & O'Connor, 2015). Best practice in DSMT programs includes a focus on re-integration practises that help students transition back into their community school (Centre of Excellence, 2013; Vernberg et al., 2006).

<u>Additional Strategies</u>

The following have also been identified as components that are enabling practises in supporting children with mental health challenges:

- **Academic Skills Training:** to teach study, organizational, and note-taking skills for adolescents with ADHD (Evans et al., 2006).
- **After School Programs** (Evans et al., 2006).

- **Inclusive Education**: Students with special education needs generally do the same or better in inclusive education settings, with no negative impacts on students without special education needs (Parekh, 2009). Some of the evidence-based strategies for inclusion in the classroom include:
    - **Elementary Classrooms:**
        - Special education teachers work with general education teachers to provide instruction in the classroom
        - Peer tutoring and team problem-solving: teachers guide students through problem-solving processes
        - Promoting shared responsibility and co-operation by involving parents, peer-tutoring, shared teaching, collaborative planning by teachers
    - **Secondary Classrooms:**
        - Peer tutoring, and working with the same curriculum with accommodations as necessary. Accommodations are developed collaboratively by special and general education teachers
        - Co-teaching between special and general education teachers. The planning and teaching is done collaboratively in a shared spaces, with classrooms of heterogeneous student populations
        - Shifting the structural elements of classrooms to be supportive of inclusive environments, such as longer class periods to allow for accommodations of learning differences and to allow for collaborative planning time for teachers (Parekh, 2009)
- **Offering Mental Health Services in Schools:** includes many benefits for students, their families, and school districts including:
    - Reducing transportation barriers
    - Trust, care, and rapport is already established of the school-based service provider, which has shown to be increase effectiveness of service
    - Mental health stigma may be reduced by allowing students to seek help on their own terms and in a space, with which they are already familiar (Repie, 2005)
    - Providing mental health services in schools allow for students to have better access to services that otherwise may not have been as readily available (Richardson & Morrissette, 2012).
    - Schools will also benefit from this partnership by having access to community mental health support during times of crises when quick mobilization is necessary (Richardson & Morrissette, 2012).
- **Psychopharmacology:** Some students may benefit from psychopharmacology and may not require more intensive/intrusive interventions. Although medication can be effective, it should be noted that proper medication is only one aspect of successful treatment (Hoagwood et al., 2001).

SUMMARY:

A high-level examination of literature in relation to the efficacy of day treatment milieu programs was conducted. Literature indicates that day treatment milieu programs have shown to be effective in significantly improving areas such as social skills, behaviour, and family functioning (Clark & Jerrott, 2012). Studies indicate that as a result of day school milieu treatment, parents reported significant improvements related to the behavioural and emotional regulation of their children (McCarthy et al., 2006) Improvements related to family functioning, (Clark & Jerrott, 2012) and decreases in parent stress (Clark & Jerrott, 2012).

This literature review indicated that:

- Mental health and educational performance have an interconnected relationship, and therefore it is important to understand how to measure outcomes specific to education, as well as the impact of the behavioural/psychosocial interventions on educational outcomes (Becker et al., 2014).
- Effectiveness measurement is based on improvements from admission to discharge, and maintaining gains at follow-up (Milin et al., 2000)
- Follow-up after discharge: Follow-up is reported as an ethical responsibility after treatment in order to help the child/youth and their family maintain their gains (Clark & Jerrott, 2012).
- There are a number of components that contribute to effective day treatment services. These include comprehensive assessments, specific treatment and academic approaches that consider the child in context of his difficulties, teacher training, personal style, parental involvement, effective cross collaboration, and follow up to reinforce strategy.

Further examination is required to understand better those approaches that are likely to succeed with children/youth who are not able to succeed academically due to their mental health difficulties. Not considered in this literature review were contributing factors such as the age of the child/youth, type of mental health issue, child development/delays, I.Q., other diagnoses, level of family functioning, and social determinants of health and effectiveness of this approach for marginalized populations. Additionally, alternative models of treatment (milieu type programs) for children with mental health needs that would also support academic success were not explored. Given the challenge in finding literature in this area, additional resources and methodologies may be required to gain deeper understanding of how to assist these children/youth.

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Appendix 6: Questions for External Stakeholders' Consultation

Questions for External Stakeholders' Consultation

Preamble:

History: **The Education Partnership Table** is an advisory body to East Metro Youth Services (EMYS), the Lead agency responsible for the transformation of the community-based mental health system in Toronto. The committee's primary function is to examine how to effectively partner with Boards of Education to ensure the best delivery of mental health services for children and youth in the following four priority areas. Today, we are collecting information pertaining to just one of these priority areas – Section 23 Programs. Section 23 programs fall within the "intensive Services" basket of core services – which also include intensive home support and residential services.

The ***mandate*** of the Section 23 work group includes the following key areas:

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

Purpose of Focus Group Session June 26:

- The purpose of the focus group today is:
  - to broaden and deepen our understanding of Section 23 programs
  - to learn from your experiences and opinions
  - to ensure that the final report reflects the voices of a broad spectrum of stakeholders

Process:

- Your feedback will be collated and included in the Section 23 final report and recommendations that will be submitted to the lead agency in early July 2017. We will send all focus group participants a summary report of the feedback collected.

Section 23 Focus Group Questions for June 26, 2017:

1. What is working well in the Section 23 system? (Top 3) (Poke for information related to themes)

2. What are ways we could influence or design specific parts of the Section 23 programs to work better? *(ie. What is not working well in the Section 23 system?)* (Poke for information related to themes).

3. What is your best advice for the Toronto Lead Agency as it seeks to develop an improved system of care for children/youth (in relation to the school day, or supports beyond, in an innovative, effective way?

   3.1 If you could wave a wand and create the world's best system, what would the future state look like?

4. Overall, here are the general themes of recommendations the Section 23 Working Group developed over the last several months (highlight/probe which ones have not yet surfaced during the focus group—*did the Working Group get it right?*)

5. Are you aware of any innovative day treatment programs/services or innovative approaches to supporting children/youth who face mental health challenges?

Education Table: Section 23 Working Group

Date of meeting: June 26, 2017 9:30 to 11:30 AM
Held at 365 Bloor Street East Suite 1010

Education Table- 4 Primary Subgroups

- Looking at all aspects of section 23 to see what is working well, the challenges, what can be recommended to lead agency to encourage the section 23 program.

Section 23 Focus Group Meeting

1. **What is working well in the Section 23 system?**
   - Partnership with TDSB/TCDSB
   - Ensuring that parents and students are involved
   - Transitions of going back to TDSB and TCDSB
   - Education plans align with treatment plans
   - Better integrations of sections into mainstream (its better now *sometimes*)
     - With youth involved with justice, it's difficult and transitions are not always smooth
   - Access to space
   - Helpful teachers, staff, and teams
   - Creative approaches
   - People who return to their home school are not always better efficient and when kids transition back into the school system, there are not enough bodies.
   - Kids go to a very protective program (Section 23) – it's a big change. They need a lot of support to be successful and they don't have enough resources for that.

Success and Challenges:

There are challenges trying to transition students to less intensive section 23 programs.

- Great challenges in transitioning students back to OTHER school regions
- There are lots of road blocks because of the history of the student
- Agencies and the school board release them from the Fall until the end of June and when they arrive in their new schools, they can use more resources. Some agencies have more resources allocated to transition, others only have someone from the current team
- There are stories of successful students but for the vast majority, there are issues around it
- There have been some very successful transitions with students who graduated and moved onto college/university

- The opportunities for kids to do integration within the school builds the capacity and self-esteem.
    - In 2 cases: everyone was very welcoming, kids attended their integration classes and participated in trips. There was a very open and inviting quality with partnership.
    - As we continue to work together, that is where we go and that is the ideal scenario
    - ➢ For kids starting a new school in September, the transition occurs in June and it's easier for them since they have already seen the school and teachers. It releases anxiety and helps the kids become more successful.
- Best practices should be consistent among agencies
- Question: Do section 23 staff have meetings among themselves to talk about best practices and what's going well in their programs to better understand other programs?
    - Through TDSB, they created partnership meeting that takes place every few months. It took the lead to set up and capitalize on what is working well and people exchange information there. It creates a common service flow that lead agency can think about
    - Not reimbursed for the service
    - Expenses should be looked at and factored into funding
    - The school boards need to be honored towards supporting bussing and Section 23. Both boards build around the routes. They ask for bus transportation around May, and so they will be on the bus for least amount of time
    - There are barriers in supporting students
    - Giving bus drivers education on dealing with students, since they don't always make the best choices.
    - There is a need to try to work in collaboration with bus drivers, but sometimes there is no response from them.
    - Some transportation groups react immediately when there are issues, or students to harness, and this is a good topic that can be addressed and would require hard work to solve it.
    - Bus drivers make little money and it is not a desirable position. Students often don't cooperate with bus drivers.
    - No one comes forward as an agency and offers to volunteer for the extra time to ensure bus drivers do a better job. A question that was raised from this comment was: *Will lead agency take initiative in terms of training/ongoing training?*
    - They put together a training at the last partnership meeting, and they need to address what would be the best way to talk to bus drivers.
    - Transportation has been really great, but the challenge lies in between their program when they are on the bus and uncontrolled factors such as the absence of staff on the bus
    - Often all students from different day treatment/behavioral classes
        - A lot of reports came from bussing issues.
        - There has been a lot of parent worries and drivers would feel challenged because of the mixture of students from different treatments and programs
    - For students in programs beyond Toronto, transportation costs inhibit students from being referred to the program.

2. **What are ways we could influence or design specific parts of the Section 23 programs to work better? What is not working well in the Section 23 system?**
    - Improved support, holistic approach to supports
    - There may be a need for psychological assessments to return to the board
        - Social working sites should be provided with psychological assessments by the agencies while they are in there. The funding agencies need to ensure the partners have the capacity to do that
    - Many agencies don't have staff psychological support and can slow down transitions. Many haven't had a psychological assessment since Grade 1. Therefore, you will need a special funding request
    - We must also be mindful of protocols to do psychological assessments. If the standard length of time is 2 years, you can't overlap assessments.
    - Look at how to prioritize resources across agencies
    - Assessments should be able to support treatment. Reassessing helps you know there are incredible improvements, so it's just about going back to the school board but it's useful to uncover
    - In some programs, there is a gap in the funding model in MCYS – these are children grown up in the school board and if they are the neediest children and require treatment, nothing begins without assessment.
        - If you don't know their needs, you can't have a treatment plan or education plan. It should be to set a goal for the programming on the education side and the treatment side. There is a GAP in NADU funding and MSYC funding.
            - Agreed upon. This would be beneficial.
            - Agencies are doing them several months into the program. Sometimes they get reports back in March and that information would have been more useful in the beginning prior to them entering the program
    - If a student goes from TCDSB program to TDSB, the wait list/wait time is big to be tested for a psychological assessment.
    - A question that was raised: *Would the system be flexible to prioritize (those who are on wait-list, if they can be seen sooner) rather than being taken off the system?*
    - Assessments should occur but it is a barrier when parents are referring kids to stakeholders, and they say they take kids without the assessment, which then becomes a barrier for kids getting back because the system doesn't have the time to assess kids. They are only ensuring kids get the right placement as they come in.
    - The school board has a huge waiting list for psychological assessments. The TDSB is lessening the number of intensive support programs. Going mainstream, they won't have a psychological assessment. Intensive programs are becoming less.
    - They provide them at CDI but they are not funded, so it puts pressure on the agency to provide the service that's not funded
    - Need more support services
    - There are much more options for children with mental health issues as opposed to behavioral issues
    - There are not enough spaces

  - *Who is less served than should be*? People have been turned away from the waitlist because there is sometimes no chance to get a spot
  - If there was a capacity to duplicate the CARS system for day treatment (enough funding)
  - The central intake table tried to coordinate it within the system. They have tried to take action for this because there is not enough funding for the CARS system
  - The CARS is funded for separate positions.
  - There is a gap in the east for latency-aged student. The only agency able to serve is AISLING for that age group in the east and that's a severe gap.
- Section 23 workgroup talked about the gap there and recognize it
- A CARS-like model would be ideal
- Managing wait lists because there are not enough spots
- Kids have to travel too far just to address their issues. They have to look at it in terms of what is available where, for whom as well as in the greater Toronto. As a system, we need to look at how to respond. Each organization has their own practices, and it's on us in terms of mental health power, what we need from schools, and also allow parents to make a decision by looking at our system
- It's about taking a step further. Some organizations have always asked children, youth and families to fit into their model as opposed to working around them, so a big difference can be how to serve children and youth in a non-traditional way by addressing their needs and how the organization can help them, as opposed to how they can fit into their model.
- The traditional way is also referred to as the classroom environment.
- *How do we get more satellites across the city to take care of these if a family is in the West end, so that they are not having to travel to the East to get service?*
  - This is an issue that prevents people from accessing the services.
  - The treatment is not giving its full scope
  - How do we get opportunities to families outside of the office/outside their area for more access?
- This has to do with both treatment but also academics. In the STEPS program (York region), a youth worker or social worker goes out to the families/youth because its challenging for them to access the service, so it's about reaching out to discover where and how you can work with youth
- Parent engagement can improve
  - Partnership with Aisling does very well with parent engagement. It's part of the process so parents can support the student in the program
  - We may need to caution ourselves and make sure we don't zero in on the ½ off situations such as when a parent, for their own mental health reasons, are unable to deal with any expectations – a system may not be 100% full proof.
  - There may be an integration of two difference service streams to have access to.
- A more flexible system when people come in and out when we need it.
- How can we wrap the service around youth and families?? How do we accommodate and build a system that's flexible enough? High/less intensive agencies?
- We need to be mindful not to jam up the system and need a different model and re-visioning, such as giving kids what they need in the best timing

- There is youth entering the residential system (intensive service) without considering what would day treatment offer and keep the family intact.
- SIMCO (new path) dismantled their section programs completely, focusing on working with youth at home, in the community, working with the home school and getting them back to their home school
- Kindergarten is funded for over 6. They talked about transitions working well because the intensive in-home workers work over the summer with the families and getting ready for school. This is why their transitions are working.
- York region model (STEPS) and this year, Skylark had a pilot program working with youth who had a history with schools such as having difficulty in getting to school, and worked to allow flexibility in the classroom with the teacher to do different things. The different methods they used involved working through Skype with the student. They not only focused on attendance, but more on engagement and participation.
    - A youth worker, social worker, and teacher were always working with the student. The addition of more outreach and resources works well.
    - Difficulty: limitation of teachers to leave the school environment
    - They had to get creative of working with technology, but still a gap in working face to face
        - TDSB did not approve for teachers to go to students home
- Not a smooth transition of students going back to school
    - Everyone works to do the best they can. The challenge lies within the complication between what the schools can offer versus what the child needs. *How do we apply solutions to enable kids with complex needs to provide the best transition?*
    - Since programs in Toronto are different, transitions are important for kids' success when they return to their school.

3. What is your best advice for the Toronto Lead Agency as it seeks to develop an improved system of care for children/youth (related to the school day, or supports beyond) in an effective way?

3.1 If you could wave a wand and create the world's best system, what would the future state look like?

- Extended day programs 9am-9pm
- After-care
- A continuum for intensive to less intensive.

Extended day programs

Feedback:

- Starting at 11:00 am rather than 9:00 am. Attendance can be an issue for teens, sleep issues, etc.
- Not all kids who need it in a traditional way, looking at ways to provide treatment in less/more intensive ways.
- Looking at after-care is an important element

- The conceptual vision is helpful. Some pieces allow for more flexibility, using resources both for education and child mental health, including start times, etc. When you try to ensure that these kids are ready for those times when they're entering school again, and the flexibility can get built in.
- Right now, we seem to only focus on the placement (convincing them that the child has some improvement) but there is not any early enough social workers in schools being part of the receiving team, therefore we should be looking at how the intensity cascades into admission and discharge.

A continuum for intensive to less intensive.

What are the barriers for the kids?

- For secondary schools, its completely different therefore we need to differentiate between secondary and elementary. Most schools integrate students even though by willingly they are not their schools
- Referring youth 16-17 to day treatment
- A large part of education with mental health: issues like anxiety and how its identified by different teachers may vary, so there may be a significant difference in the 15-30 days they experience in Grade 8 as opposed to Grade 9
    - This will need to be fixed through education on mental health directed towards the teachers.

How do you pull in social workers earlier within a system, since the social worker makes sure that the student continues on their treatment?

- Flexibility/accessibility – there is a stigma attached to Section 23
    - We have a constant challenge of shifting our theory into practice.
    - The best way to do that within the environment are the skills that are needed, not only to children but also staff by bringing the expertise in the classroom where you really want the child to be. It's the most efficient way to deliver service.
- Third party service providers are often prohibited from working with the child due to teacher-collective agreements. Some schools really want to help, and other times there are barriers.
- The idea that if they can go out and deliver – how many groups can approve of social workers to be provided to a community school? How many kids are not being reached without having them travel by bus to get to the service?
- There are mental health and education needs.

Increased access to TDSB/TCDSB services

- Some programs are within the schools only, therefore expelled students can't access the treatment program within the school until the expulsion is lifted.
- There is a need to add in the therapeutic component to these students
- Need increased flexibility (remembering to step up and step down as needed)
- Need the treatment agency to provide service for the child in the library or community, and keeping in mind that these kids are the marginalized kids who really need the treatment.

Partnerships with other systems

- Different funding models among MCYS, Education, etc.
- More funding for school system

4. **General themes of recommendations Section 23 developed over the last several months. Which did not get surfaced?**
   - **Funding came up as an issue several times**
     - There can be some flexibility of how MCYS funds the intensive services
     - For organizations, if you move resources from one area to another, there needs to be understanding of the community that there will be less counseling being done in other areas, and this may lead to a reduction of counseling services
     - We would need to discuss this with the ministry to see if there is a need for shifting resources to other places, and it will have to come from somewhere else
     - Asking for more funding can lead to the source saying it can't be provided. Some kids may need more counseling which is a different funding stream
     - Need to look at what we have, and the needs of the child and family.

   - **Matching up academic world and treatment world**

5. **Are you aware of any innovative day treatment programs/services or innovative approaches to supporting children youth who face mental health challenges?**

Side Notes:

- Something that did not come up except in one sticky note: "Making sure parents have the language of the first choice"
- Section 23 creates opportunities in care and treatment programs – available on the ministry website
  - shows the guidelines
  - talk about transitions, effectiveness of care and treatment program
  - provide a framework for the administrators responsible for care and treatment program
- The funding model has an additional gap, in which there is a need for a certain number of teachers, including full time teachers and programs before they fund.
- Care and treatment programs don't have the same funding model – if you have 6-7 children, their funding is exactly the same from the Ministry of Education
- We need to look at spending money in different ways, because it is highly unlikely that there will be any more funding, therefore we need to see how much is dedicated to intensive support, and how much is dedicated to other pieces.
- Need pilot programs which operate differently for September 2018
  - There is a mandate to come up with some models and designs
  - Looking at which children are targeted, etc.
  - Timeline: there are about 6 months to figure it out.

Themes

- Lack of consistency in delivery of services; using a systems approach
- Agencies are doing their own thing and there are different eligibility requirements.
- Decentralized wait lists
- Using a CARS model
- Individualized approaches
- Lack of accountability/collective impact outcomes
- Accountability- some practices are different than the students', doesn't take away from partnership component
- Sustainability and cost
- Access challenges
- Complex needs – system does not have a lot of spaces for youth with specific eligibility criteria
- Integration challenges and stigma - getting kids back into home schools is a challenge
- Lack of resources
- Heightened engagement with MCYS and Ministry of Education
- Systems planning to develop formal accountability
- Keep schools engaged so that the kids come back and it keeps them as part of a discussion and potential collaboration
- A reduction in referrals around 4-5-year olds. Early starters are attended to for childcare and kindergarten placement.
- Raising awareness about the difference between Section 23 and Special Education.

Appendix 8 – Working Group Members

- Donald Reid, TCDSB (Co-chair)
- Joy Reiter, TDSB (Co-chair)
- Cheryl Webb, Adventure Place (Co-chair)
- Tom Adams, Ontario Ministry of Education
- Gerald Bernicky, Surrey Place
- Deanna Dannell, Griffin Centre
- Ewa Deszynski, Etobicoke Children's Centre
- Zel Fellegi, Aisling Discoveries
- Ali Lineaux, Centre francophone
- Dawna Raposo, TDSB
- Janice Wiggins, EMYS Lead Agency

East Metro Youth Services | Lead Agency for Moving on Mental Health – Toronto
Head Office: 1200 Markham Road, Suite 200, Scarborough, Ontario M1H 3C3
Lead Agency Downtown Office: 365 Bloor Street East, Suite 1010, Toronto, Ontario M4W 3L4
Tel: 416-438-3697 | Fax: 416-438-7424 | Email: Leadagency_Toronto@emys.on.ca
www.emys.on.ca

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